The Experience of Obesity Among Adolescent Girls: A phenomenological study

by

Marcia S. Wertz

DISSERTATION

Submitted in partial satisfaction of the requirements for the degree of

DOCTOR OF PHILOSOPHY

in

Nursing

in the
Acknowledgements

In writing this dissertation I have been reminded daily of my good fortune in having been thrown into the time, place and family that I was 50 years ago, though my humble beginnings might not be considered privileged by others. Under the influence of my very wise grandmother, I grew up believing that I could do anything if I was willing to work hard. I have indeed worked hard toward this end, my doctoral dissertation. I have spent countless hours pouring through the literature, conducting this research, interpreting and analyzing the data, and writing and revising. But, I could not have done, and did not do, this alone.

I wish to acknowledge the sources of funding for my doctoral studies and research: the University of California Office of the President Dissertation-Year Fellowship, UCSF Graduate Dean’s Health Sciences Fellowship, UCSF employee education program, Nurses’ Educational Funds, Inc.- Miriam M. Powell Fund, and Sigma Theta Tau International Patricia Smith Christensen Scholarship. Their financial support made it possible for me to complete this program of study over the past five years.

My work has also been made possible through the encouragement and support of my families. In my family of origin I commemorate Antonietta Santarini, my immigrant grandmother, who had very little formal education but who passed on to me a sense of wonder and a love for learning. My mother, Virginia Stanley, put aside small amounts in savings bonds over the years, always reminding me that it was for my college education. They expected me to achieve great things and made me believe I could.

In high school and in college I had instructors that shaped my perceptions and supported my dreams. Standing out in my memory of them are Judith Remy and Keith
Parkhurst at St. Bernard High School, and Joseph Fessio at University of San Francisco (USF). I also had friends who helped me understand what it is to be a nurse: Terri Thomassen, Melba Palafox, Patricia Muldown and Robin Williams.

While my grandmother passed away during my fourth year of college and therefore could not witness her dream come to fruition, my mother was proud to attend my graduation from the nursing school at USF. I was the first college graduate in the family.

In meeting William (Bill) Wertz I encountered a helpmate who shares my values, and with him created a new family. Bill supported my decision to return to school for a masters degree in clinical research management at a time when we had three active school-age children at home. As I started the two-year program at the University of California San Francisco (UCSF) everyone pitched in to help mom. At that time 8 year-old Victoria, 10 year-old Jacob, 13 year-old Louis, and their father Bill learned to cook and do laundry. Bill also read and edited many of my papers and provided uninterrupted time for me to study.

In addition to help at home, I had the support and encouragement of my work colleagues at UCSF: Nancy Newton, Suzanne Golden, Jean Millar, and Roderick Phibbs. I had wonderful classmates whose assistance meant a great deal to me: Judy Kirby, Susan Peterson and Roxanne O’Brien. I am very much indebted to my graduate advisor, Catherine Waters, who planted the seed in my brain that I could continue on for a doctorate.

When I did return five years later to UCSF to pursue doctoral study, I had the pleasure of meeting Dr. Ruth Malone. Ruth is a mentor to me in every sense of the word:
she provides advice and support, she watches over and fosters my progress, she is genuinely concerned about my development as a scholar, and she cares about my welfare. When I suffered a major medical event (a brain injury) mid-way into my third year, Ruth made me believe I could still complete this degree. In this way she helped with my recovery.

Ruth has also been a source of inspiration to me. As she studies tobacco control policy and successfully confronts a society-induced health problem, I see the possibilities for addressing the problem of obesity.

During my five years in the UCSF doctoral program in health policy it has been my privilege to be taught by a fabulous faculty. I am especially indebted to Charlene Harrington, Howard Pinderhughes, Susan Kools and Janet Shim. I also learned a great deal from Dr. Leah Fernald at UC Berkeley and appreciate her on-going support.

Extra instruction in phenomenology was made possible by professors Patricia Benner, Hubert Dreyfus, Garrett Chan, Maria Gudmundsdottir, and Ruth Malone. Phenomenology was further discussed in small group seminars with fellow students: Lori Rodriguez, Susan McNiesh, Mats Christiansen, Mary Nottingham, Elizabeth Marlow, and Meera Nosek.

For help in interpreting the experience of the adolescents in this study I am indebted to my advisor, Ruth Malone, and to my colleagues, Gina Intinerelli, and Juliet Chandler. The summer meetings at Ruth’s home in the Oakland hills provided a space for us to share a meal and discuss the meanings present in the data.

I appreciate the thoughtful editing of my writing by my colleague Liz Halifax, my husband Bill Wertz, my advisor Ruth Malone, and my son Louis Wertz. I am grateful for
the nourishment and nurturing I received from Liz Halifax, Liana Hain, and Mary Kay 
(MK) McKown. Over the past year we four have met monthly for lunch to eat good food, 
to discuss themes in the data of our projects, and to support each other. The preciousness 
of the gift of this time was brought home to me in the wake of MK’s recent untimely 
death to cancer. MK’s grace and candor helped shape this manuscript.

Lastly, I acknowledge my gratitude for the terrific mentors that, along with Ruth 
Malone, constitute my dissertation committee. I am grateful to Roberta Rehm, the chair 
of my Qualifying Examination Committee, for her thoughtful comments and edits on the 
drafts of early chapters, and for her support in this process. I am thankful to Claire 
Brindis, a champion for women of all ages, who advised me to name my star and follow 
it. I appreciate Andrea Garber’s insight and her hands-on approach; she inspires me 
through the clinical care she provides to overweight children.

In making the journey that creating this dissertation has been, I know that I could 
not have succeeded without the physical and emotional support, the everyday warmth, 
un-ending love, and complete understanding of my family: Bill, Louis, Jacob and 
Victoria Wertz. It is to them that I dedicate this work.
THE EXPERIENCE OF OBESITY AMONG ADOLESCENT GIRLS: A PHENOMENOLOGICAL STUDY
Marcia S. Wertz

ABSTRACT
The increased prevalence of childhood obesity in the U.S. has been recognized as a complex and multi-factorial issue that requires a comprehensive and multi-pronged approach to deal with it. Obesity is generally considered a problem of errant lifestyle behaviors around eating and exercise. Current approaches address adolescent obesity by aiming to change lifestyle behaviors at the individual level, in the school, and in the larger community. The objective of this study was to understand the experience of overweight adolescent girls who are at the center of these changes.

This interpretive phenomenological study was conducted over a 2-year period. It included participant observation in a San Francisco pediatric obesity clinic, in-depth interviews with 15 obese adolescent girls, home visits and in-depth interviews with 3 mothers of girls in the study, a review of adolescent participants’ medical records, a review of San Francisco Unified School District’s (SFUSD) board meeting and committee meeting minutes since 2001, and participant observation in the SFUSD student nutrition and physical activity committee.

The findings have been grouped under three main themes that were present in the data: the adolescent world, how food is understood, and uncovering “the Look.” Within each theme the girl’s own closest domestic environment and the public we-world intersect in the experience of the adolescent who is faced with changing her eating behaviors.
In being identified as the nexus of the problem of obesity, teenage girls adopt different stances, appropriate to their way of being, to respond to those who want to help them control their weight. “Stance” is the stand a person takes on herself. It is not a conscious, mental or emotional stance, rather it is a non-deliberate, non-contemplated effortless way of being. Stance influences every interaction a person has, including those with the clinic, with school, with peers, and with family. Four prominent stances emerged from the data, and are highlighted for comparison and contrast: oppositional, resistant/bargaining, resigned or accepting, and engaged.

Understanding the stance a girl takes may play an important role in the ability to modify her lifestyle behaviors. This is significant for clinicians, who may need to tailor their practice to the stance of their obese patient in order to be effective. This is relevant for policy-makers, as the implication is that social messages, and legislating toward change, must appeal to every stance if they are to be successful in stemming the epidemic of childhood obesity.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledgments</td>
<td>iii</td>
</tr>
<tr>
<td>Abstract</td>
<td>vii</td>
</tr>
<tr>
<td>Table of Contents</td>
<td>ix</td>
</tr>
</tbody>
</table>

**CHAPTER ONE: Adolescent Obesity: Background**

- Introduction                                                          1
  - Defining the Problem of Adolescent Obesity                          3
  - Policies’ Influence on Pediatric Obesity                           4
  - Philosophical Underpinnings                                        11

**CHAPTER TWO: Review of the Literature: Introduction**

- Health Implications of Adolescent Obesity                            13
- Effect of Obesity on Heart Health                                    13
- Obesity Factors in Diabetes                                          13
- Early Maturation and Stigmatization                                  17
- Impact of Obesity on Overall Well-being                              20
  - The Social Context of Pediatric Obesity                            23
    - Effect of Race                                                  23
    - Effect of Socio-economic Status                                 24
    - The Impact of Place                                              27
- Home and Family                                                       29
- Schools                                                              30
- Clinical Interventions                                               34
  - Empirically Tested                                                34
  - Social Cognitive Theory / The Behaviorist Approach                38

**CHAPTER THREE: Policies Target School Nutrition**

- Public Policy: School Nutrition Program                              42
- Wellness Policy: A Healthy Food and Physical Activity Policy         43

**CHAPTER FOUR: Methodology: Toward a New Way of Thinking**

- Usual Way of Thinking: Mind-Body Dualism                             49
- Alternative Way of Thinking: Transcendentalism                       51
- Reconceiving Reality: Phenomenology                                  55
- Assuming the Phenomenologist’s Stance                               56
  - Researcher Reflexivity                                            57

**CHAPTER FIVE: Methods**

- Design                                                               62
- Methods: Specific Aim #1                                            63
  - Sample Selection                                                   63
  - Data Sources and Data Gathering Activities                         64
  - Data Management                                                    65
<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chapter Six: Introducing the Girls</td>
<td>Ali</td>
<td>79</td>
</tr>
<tr>
<td></td>
<td>Jenny</td>
<td>81</td>
</tr>
<tr>
<td></td>
<td>Annie</td>
<td>82</td>
</tr>
<tr>
<td></td>
<td>Billie</td>
<td>82</td>
</tr>
<tr>
<td></td>
<td>Emma</td>
<td>84</td>
</tr>
<tr>
<td></td>
<td>Kelly</td>
<td>85</td>
</tr>
<tr>
<td></td>
<td>Becca</td>
<td>87</td>
</tr>
<tr>
<td></td>
<td>Flora</td>
<td>89</td>
</tr>
<tr>
<td></td>
<td>Viola</td>
<td>90</td>
</tr>
<tr>
<td></td>
<td>Nora</td>
<td>92</td>
</tr>
<tr>
<td></td>
<td>Hallie</td>
<td>92</td>
</tr>
<tr>
<td></td>
<td>Dina</td>
<td>94</td>
</tr>
<tr>
<td></td>
<td>Jamie</td>
<td>95</td>
</tr>
<tr>
<td></td>
<td>Marla</td>
<td>96</td>
</tr>
<tr>
<td></td>
<td>Maya</td>
<td>98</td>
</tr>
<tr>
<td>Chapter Seven: The Adolescent World</td>
<td>Introduction</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>Part I: The Obesity Clinic</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>An Overview</td>
<td>101</td>
</tr>
<tr>
<td></td>
<td>The Pediatric Obesity Intake Clinic</td>
<td>103</td>
</tr>
<tr>
<td></td>
<td>The Teaching Breakfast</td>
<td>106</td>
</tr>
<tr>
<td></td>
<td>The Adolescent’s Clinic Experience</td>
<td>109</td>
</tr>
<tr>
<td></td>
<td>Part II: The Family</td>
<td>117</td>
</tr>
<tr>
<td></td>
<td>Part III: High School</td>
<td>123</td>
</tr>
<tr>
<td></td>
<td>Part IV: Peers</td>
<td>127</td>
</tr>
<tr>
<td></td>
<td>Part V: Shopping</td>
<td>131</td>
</tr>
<tr>
<td>Chapter Eight: Food</td>
<td>Part I: Food as Product</td>
<td>135</td>
</tr>
<tr>
<td></td>
<td>Part II: Food as Medicine</td>
<td>146</td>
</tr>
</tbody>
</table>
Chapter One

Adolescent Obesity: Background

“The basic principles of good diets are so simple that I can summarize them in just ten words: eat less, move more, eat lots of fruits and vegetables....”

Marion Nestle, in What to Eat

“Move more. Eat less. Burn more calories than you take in. Gee, thanks. That’s so helpful. I already knew…it’s never about knowing the answers. It’s about living them.”

Stephanie Klein, in Moose: a memoir of fat camp

Introduction

The past few years have shown an explosion in literature on the topic of obesity, in both the popular press and in scientific circles. The growing enormity of the problem has been unfurled before us as a crisis, an epidemic, whose effects are only just beginning to be felt in the United States. The obesity problem has been cast onto the public agenda as a health issue that requires a multi-pronged approach to solve it. It makes sense to situate the problem of obesity within the world of health. Obesity contributes to disease in many Americans. It is an awful individual burden that also drains society’s human and material resources. Affecting people of every age, race, gender, education level or income bracket, obesity is an issue so pervasive that virtually every scientific discipline is studying it, its causes, and its sequelae.

This being a wide spread and multi-factorial issue, it also makes sense to situate the examination of the problem of obesity within the context of society. American patterns of diet and exercise change over time as a result of changing economic, political, and cultural forces. Indeed obesity is a socially iatrogenic phenomenon as Ilich defined it (1976), i.e. an impairment to health that is due precisely to socio-economic changes. The primary determinant of the state of general health of any population is the environment
(Ilich). The environment is shaped by institutions (including medicine) and government bureaucracy, which have made conditions possible or necessary for obesity, among other modern epidemics, to happen.

This project is focused on obesity in adolescence, i.e. those years from age 13 through 18. In all of the published discourse regarding this issue, the voice of actual adolescents has been missing. In this project I have met with overweight girls and their mothers and visited their worlds. This effort brings us to a better understanding of what being obese means to the teenage girls who embody it. It describes the health-related constructs that define the problem. It highlights the social constructs that lay the bed in which the seeds of obesity were planted and nourished, and in which it flourishes today. I argue that obesity, when shaped and defined by the medical establishment as a disease, cannot and will not be curtailed. In order to reduce obesity, it must be re-defined as a social problem. Too much is at stake to continue solely on the course prescribed by medicine. If the social and public policy issues are not addressed, the obesity problem is likely to persist and grow.

It is important to clarify that the medical model for dealing with illness is not under attack here. The work by members of the health care field is necessary to provide care and treatment of the afflicted individuals, and for informing the populace of the health effects of obesity. But medicine’s institutions cannot shoulder the responsibility, and should not accept as their charge, to prevent all ills. To do so would exempt the larger society, which is responsible for the political actions that create the circumstances that favor health or illness.
Defining the Problem of Adolescent Obesity

The number of overweight adolescents, and the degree to which they are overweight, rose dramatically in the United States of America over the past 30 years (Hedley et al., 2004; Mokdad et al., 1999; Wang & Zhang, 2006). The problem of pediatric obesity has increased to the point that it was labeled an epidemic by representatives of the National Academy of Sciences, Institute of Medicine (Koplan, Liverman, & Kraak, 2004), and it was a featured section of the current U.S. Department of Public Health’s ten-year plan Healthy People 2010 (DHHS, 2000).

Whether an individual is underweight, normal weight, overweight or obese is determined by calculating the body mass index, a ratio of the individual’s height and weight. Body mass index (BMI) is calculated using a standard formula \([\text{weight (kg)} / \text{height (m}^2\)]\). In children (birth to 19 years of age) it is customary to factor in the child’s sex and age, and compare an individual child’s BMI to other children of the same sex and age, arriving at a percentile value. For purposes of making this comparison, the Center for Disease Control (CDC) in the United States aggregates data from national surveys, most recently completed in 2000, from which they create Growth Charts (CDC, 2007). Growth Charts are used by clinicians to assess the growth pattern of an individual child for signs of underlying nutrition or endocrine problems.

Growth Charts provide ranges for sub-normal, normal and super-normal growth, divided into percentiles. For example, a child who is 5 feet tall and weighs 110 pounds has a BMI of 21.5 kg/m\(^2\): if the child is a 13 year old girl she is in the 78\(^{th}\) percentile and considered normal weight, but if she is 10 years old she is in the 91\(^{st}\) percentile and is overweight. Children, 2-18 years of age, with a body mass index (BMI) greater than the
85th percentile for age and sex are considered overweight, while children whose BMI is at or above the 95th percentile are considered obese (CDC, MCHB, & NAHIC, 2004).

According to the CDC, more than 9 million American children (approximately 16% of those aged 6-19 years) currently are classified as obese (Hedley, et al., 2004). Obese children are at increased risk for becoming even more overweight as adults, for developing diabetes, cardiovascular disease, liver disease, depression, and other life-shortening disorders (Mossberg, 1989; Pinhas-Hamiel et al., 1996). The prevalence of overweight in adolescents has nearly tripled in the past 20 years (Hedley). For those in the adolescent group, 12-19 years of age, approximately 31% had a BMI ≥ 85th percentile for age and sex. When compared to reports in previous years there is no indication that the prevalence for overweight is decreasing (Hedley; Ogden, Carroll, & Flegal, 2008). This increased prevalence of overweight and obesity correlates with increases in hospitalization of youths for diabetes, sleep apnea, and gall bladder disease (Diabetes in Children Adolescents Workgroup of the National Diabetes Education Program, 2004).

Policies’ Influence on Pediatric Obesity

In the U. S., minority populations, except for Asian Americans, have higher rates of obesity than do whites (Drewnowski & Specter, 2004; Hedley et al., 2004). Prevalence data on obesity in America indicates a disproportionate rise in the rate across different ethnic groups, and different socio-economic groups (CDC, 2004), i.e. the rate of rise of obesity over time is not the same for all groups. But, in all ethnic groups, obesity tends to be associated with low income and low education levels (Drewnowski & Specter, 2004). Historically, there are social policies and food policies in America that have led to this situation (Nestle, 2002; Schlosser, 2002).
Prior to discussing specific policies, it is important to clarify that any discussion of food policy must consider both issues of hunger, or food insecurity, and obesity, an excess of calories. It may initially seem counter-intuitive to consider that food-insecurity and obesity may be related. Studies have shown a strong association between food insecurity and obesity, particularly in low-income women (Drewnowski, 2004; Townsend, Peerson, Love, Achterberg, & Murphy, 2001). This may be a reflection of when food-deprived people eat – such as, forgoing meals when food is in short supply and consuming it excessively when it is available. Or it may reflect what they eat – choosing high calorie foods to overcome the periods of deprivation. Or it may be both (Townsend et al., 2001). Food insecurity or hunger can and does exist in the same individuals that are obese (Dietz, 1995). The relationship between hunger and obesity may be found in one condition that is manifest in both, i.e. malnutrition. They are two sides of the same coin.

Thus, children’s nutrition is an issue that may be viewed in a couple of ways: as one of hunger and one of obesity. This line of thinking may help explain the increased rates of obesity among the poor in the United States. Consider one example of a social policy that influences children’s nutrition: the public assistance program called Temporary Assistance to Needy Families [TANF] (Poppendieck, 1998). TANF was created by welfare reform legislation in 1996, under the Personal Responsibility and Work Opportunity Reconciliation Act ("P.R.W.O.R.A." 1996). It replaced welfare programs that had been in effect for some time, such as Aid to Families with Dependent Children [AFDC] (1935 to 1997), the Job Opportunities and Basic Skills Training [JOBS] (1988-1997) program, and the Emergency Assistance [EA] program. The mission
of TANF is to help needy families achieve self-sufficiency. The scope of this legislation was far reaching, and had significant effects on childhood nutrition.

The P.R.W.O.R.A. created a big hole in the food stamp program, a safety net for many families (Poppendieck, 1998). The food stamp program was previously the major program for the poor based only on need, without reference to family status or age. Philosophically, it was an unconditional right to food, i.e. to not starving in America. Under TANF things changed, and three of these changes actually may have increased food insecurity. First, food stamps were made available for only three months every three years for adults over 50 years of age who were not raising children. Secondly, TANF eroded the value of food stamps for every recipient as it froze the standard deduction and lowered the Thrifty Food Plan (the basis for food stamp allotments). Thirdly, it deprived non-citizen immigrants of food stamps, along with a host of other federal benefits, unless they qualified for an individual exemption. In decreasing the ability of the Food Stamp Program to bring all households to a level of food security, TANF contributed to food insecurity in American households.

An association between household food insecurity and risk for being overweight or obese has been demonstrated in children (strongest in Caucasian adolescent girls) (Casey et al., 2006), and in women (Townsend, Peerson, Love, Achterberg, & Murphy, 2001). National experts define household food insecurity as the limited or uncertain availability of or access to nutritionally adequate and safe foods, in contrast to food security which is defined as: “Access by all people at all times to enough food for an active, healthy life. Food security includes at a minimum: (1) the ready availability of nutritionally adequate and safe foods, and (2) an assured ability to acquire acceptable
foods in socially acceptable ways (e.g., without resorting to emergency food supplies, scavenging, stealing, or other coping strategies)” (Bickel, Nord, Price, Hamilton, & Cook, 2000). It was suggested that the Food Stamp program is linked to the food insecurity – obesity relationship. This may be due to the role food stamps play in the condition of food security or insecurity for America’s poor, through a cycle of feast and famine: feasting when food stamps are available, and hunger when the money runs out (Dinour, Bergen, & Yeh, 2007). This is offered as an example of the complex connection between social policy and obesity. There are other governmental policies that also influence the two-sided “coin” of malnutrition in America.

Federal agricultural policy has contributed to the rise in malnutrition on the obesity side of the coin. During the Great Depression of the 1930s the U. S. Department of Agriculture (USDA) established the Commodity Credit Corporation to stabilize and protect farm income and prices, to assist in the maintenance of balanced and sufficient supply of useful or serviceable agricultural goods, and to promote the orderly distribution of agricultural products (USDA, 2009). Farm loans and price support began in 1933 for these specific crops: wheat, corn, cotton, peanuts, rice, tobacco, milk, wool, mohair, honey, barley, oats, grain sorghums, rye, soybeans, sugarcane, and crude pine gum.

Circa the Great Depression the federal government found constructive outlets for surplus commodities in the growing numbers of needy families and hungry children. In 1935 the government distributed food through their Federal Surplus Commodities Corporation. In that way, needy schoolchildren were fed foods at school that could not be sold at market, and farmers had an outlet for their food at a reasonable price (Gunderson, 1971). By 1937 there were 3,839 schools that received commodities for their lunch
programs. Two years later the number had grown to 14,075 schools. In 1946 the 79th Congress enacted the National School Lunch Act, based on the House Committee on Agriculture Report that stated, in part: “The need for a permanent legislative basis for a school lunch program, rather than operating it on a year-to-year basis, or one dependent solely on agricultural surpluses that for a child may be nutritionally unbalanced or nutritionally unattractive, has now become apparent” (Gunderson, 1971).

Schools that participated in the National School Lunch program entered into a contract with the state and federal governments. Schools received matching state and federal funds and food, and in return they promised to serve lunches that met the minimum nutritional requirements prescribed by the Secretary (of the USDA), and to utilize the commodities declared by the Secretary to be in abundance, among other agreements. In order to make commodities more conveniently available to schools, they are processed into finished products by commercial processors. In this way bulk cheese and wheat flour become frozen pizza (New Jersey Dept. of Agriculture, 2006).

In the 1960s and 70s in the U.S. there was an expansion of food programs for the needy: the Food Stamp program became permanent; the Commodity Supplemental Food Program began to target at-risk women, infants and children (this was a predecessor to current-day WIC [Women, Infants and Children] program); the School Breakfast Program, Summer Food Services Program and Child Care Food Program were launched; and a Nutrition Program for the Elderly started (Fernald, 2007). More meals were provided to poor children. This was fortuitous for addressing the hunger side of the coin. Ironically, more meals made from surplus wheat, corn and milk products constituted a
gain also on the obesity side due to the increased caloric density of these products (e.g. frozen pizza).

Another result of having a Commodity Credit Corporation is the abundant supply of relatively cheap food available in America. This has likely contributed the most to over-consumption. The low cost of calorie-dense food is the result of policies that favor, through government subsidy, some crops over others, and that allow certain agricultural and livestock practices to prosper. That millions of acres of American farmland are mono-cultural and planted with corn is no coincidence, it is the natural result of policies set in motion in the 1970s by USDA chief Earl Butz (Critser, 2003; Nestle, 2002; Pollan, 2006). Corn surpluses soon became a boon to the food industry. Less expensive than sugar, high-fructose corn syrup led to the development of new food products and increased corporate profits. Excess (i.e. cheap) corn, subsidized by the government, has found its way into most foods that Americans eat daily. It is found in its obvious grain form in breakfast cereals. It is present, covertly, in its sweetener form in baked goods and beverages. The most indirect way corn shows up in the American diet is through its use as feed for beef, pork, poultry, and farm-raised fish.

There is a paradox inherent to my argument thus far - on one side of the coin we had a food stamp program that increased food insecurity and hunger, while on the other side we had an increase in programs to provide commodity-rich meals to children and provide calorie dense food products (like frozen pizza) – and both contribute to obesity. This is illustrative of the complexity of the issue of malnutrition. The poor in U.S. society are caught in situations pursuant to these policies. The evidence is clear and strong that poor Americans have the highest rates of obesity (Drewnowski, 2004; Townsend,
Economic policy is also a major factor in the rising rates of obesity. The availability, accessibility and affordability of food for people are directly tied to economics. Tax laws favoring corporations and the very wealthy, as well as stagnant wages among the low-income earners, and cuts to their benefits, have increased the gap between low-income and high-income families in America over the past few decades. Data reported by the *New York Times* (Mar. 29, 2007) indicated the top 300,000 Americans collectively received almost as much income as the bottom 150 million Americans. Per person, the top group received 440 times as much as the average person in the bottom half earned. This is almost double the gap from 1980. Unequal income distribution is a factor in obesity. The mechanism for this relationship may have to do with the fact that the greater the concentration of income in the hands of the wealthy, the greater is their tendency to consume livestock products (Leathers & Foster, 2004).

The American population consumes a great deal of livestock products (Koons, 2004), regardless of which side of the income gap one is on. A quintessential American food is the hamburger. While the rich may pay any price for it, the not-so-rich also have access to the prototypical American meal. With just one dollar a person can buy a McDouble®, two all-beef patties on a bun, at any one of the nearly 14,000 McDonald’s restaurants in the United States (McDonald's, 2009). The low cost of meat is also related to USDA policy and a vociferous beef lobby (Nestle, 2002). Low prices encourage consumption. Simultaneously, a diet high in meat consumption is positively associated with obesity in American adults (Wang & Beydoun, 2009). Ironically, raising more
livestock products so that more Americans can eat meat requires more feed grain to be grown. Growing grain for animal feed crowds out subsistence farming and increases the price of grain. This in turn makes it more challenging to feed the poorer humans on this planet, and ultimately contributes to malnutrition both in the form of hunger and of obesity (Koons, 2004; Leathers & Foster, 2004).

It probably was not the intended consequence of the U.S. government’s agricultural policy to create an epidemic of obesity by adding 500 extra calories per day to every American’s diet (Nestle, 2002). The explicit intent of the policies and programs was laudable, i.e. to stem the rising cost of food in the U.S., and to end starvation around the globe. It is true that keeping the cost of food down is important for preventing under-nutrition and hunger. It cannot be overlooked that U.S. agricultural policy helped make it possible to feed the exponential growth in population of the planet in the past 40 years. But, it is time now to consider the negative impacts of these policies and make some needed changes to improve the food environment for everyone.

Philosophical Underpinnings

This project has been undertaken in part to understand how policies that are made at a level far removed from America’s dining tables are experienced at those tables. This study draws on Elmore’s classic theory of policy implementation, “backward mapping” (Elmore, 1979-80). This theory stresses distributing control over the implementation of a policy to the field level, i.e. to the abilities of the local administrators and the incentives and bargains they negotiate in the process. This differs from a top-down perspective, or the “forward mapping” approach, where the focus is on the control exerted by the policy maker, by authority and through budget controls.
Backward mapping, according to Elmore, begins “with a statement of a specific behavior at the lowest level of the implementation process that generates the need for a policy:” such as, children putting potato chips and cookies on their lunch trays, instead of carrot sticks and strawberries. Having established a relatively precise target at the lowest level of the system, the analysis backs up through the structure of implementing agencies and asks, at each level, these two questions: What is the ability of this unit to affect the behavior targeted by the policy? And, what resources does this unit need to have that effect? (Elmore, 1979-80). Backward mapping never assumes that policy is the only, or even the major, influence on the behavior being targeted. The standard of success in this analysis is conditional, i.e. it is predicated on the limited ability of actors at one level to influence the behavior of actors on another level, and it accepts that public organizations, as a whole, have a limited ability to influence private behavior. Using this approach to frame this study enhances the opportunity for understanding the ways in which the nutrition interventions are or are not implemented by their targets.
Chapter Two

Review of the Literature: Introduction

The large body of literature on the topic of childhood obesity has been whittled down to focus on five areas most relevant to the research project at hand. First I deal with some of the health implications associated with being obese in adolescence. Next I review the evidence that social context (i.e. race, socio-economic status, and place) plays a large role in this issue. I examine research that looks at the contributions of home and family, and also of the school, to both the problem and its potential solutions. Lastly, I explore some of the interventions that have been tried to ameliorate the problem.

Health Implications of Adolescent Obesity

“‘Health,’ after all, is simply an everyday word that is used to designate the intensity with which individuals cope with their internal states and their environmental conditions.”

Ivan Illich in Medical Nemesis, p7.

Effect of Obesity on Heart Health

Due to its strong correlation to vascular disease, specifically coronary heart disease, dyslipidemia is described as a serious consequence of being overweight. Dyslipidemia is defined as an elevation of the plasma triglycerides, cholesterol, or both, or a lowering of the high-density lipoproteins. Studies in adolescent girls showed a relationship between fat distribution and plasma lipid levels (Cali & Caprio, 2009; Caprio et al., 1996). Caprio et al. used magnetic resonance imaging (MRI) to assess abdominal fat content and demonstrated a positive correlation between the amount of sub-cutaneous and intra-abdominal fat and triglyceride and low density lipoprotein (LDL) levels, and an inverse relationship between intra-abdominal adiposity and high density lipoprotein
(HDL) levels in 14 obese and 10 non-obese female adolescents, a majority of which were Caucasian. Cali and Caprio (2009) studied the fat distribution of 118 obese adolescents using MRI and found that those with more visceral fat than abdominal subcutaneous fat had a phenotype similar to partial lipodystrophy. These studies confirmed the findings of larger, more diverse studies performed in adults such as the Bogalusa Heart Study (Patel, Srinivasan, Xu, Chen, & Berenson, 2006) and the Framingham Study (Castelli et al., 1986).

The Bogalusa Heart Study, begun in 1973, is a long-running study of the natural history of heart disease sponsored by the National Heart Lung and Blood Institute. Participants were 0-38 years old at the time of entry to this large biracial cohort, i.e. black and white Americans, and lived in Bogalusa parish, a semi-rural area of Louisiana (n > 16,000). Analysis of a subset of data from the study (n=783) in 1996 demonstrated that early dyslipidemia associated with adolescent obesity (at age 13-17 years) was a strong predictor of adult overweight and multiple cardiovascular risk factors (at age 27-31 years), and required early intervention in young adults to prevent cardiac disease (Srinivasan, Bao, Wattigney, & Berenson, 1996).

The Framingham Study, also sponsored by the National Heart Lung and Blood Institute, represents 50 years of research into heart disease and its risk factors, and continues to study two generations of Americans in the town of Framingham, Massachusetts today. From this study of a large Caucasian cohort, including both men and women, has come most of the medical community’s knowledge about the development of cardiovascular disease over time, and its findings have led to the knowledge of risk factors for heart disease. This study dispelled the widely held belief
that heart disease was an inevitable consequence of aging, and proved instead that it is a preventable condition (Levy & Brink, 2005).

A study in 1980 of young adults (n=4260), second generation participants in the Framingham study aged 20 to 49 years, indicated a strong positive association between obesity and serum LDL levels, and a strong inverse relationship between obesity and HDL levels. A serum cholesterol profile with high levels of LDL and low levels of HDL is considered to be the single best indicator of coronary heart disease risk (Garrison et al., 1980).

Thus, overweight children and adolescents have been shown to demonstrate the HDL/LDL ratio associated with high risk of cardiovascular disease. It has also been shown that they have the greatest risk of becoming even more overweight as adults. In spite of what we have learned from the Framingham and Bogalusa heart studies, heart disease remains the number one cause of death among American adults. This suggests that perhaps intervening to reverse dyslipidemia associated with obesity, thereby decreasing risk for heart disease, should begin in childhood.

**Obesity Factors in Diabetes**

A pattern of insulin resistance and an increase in Type 2 Diabetes Mellitus (T2DM) among children and adolescents is also associated with pediatric obesity. Children as young as eight years old are being diagnosed with T2DM, a disease once known as “adult onset” diabetes (Brosnan, Upchurch, & Schreiner, 2001). Diabetes is a chronic complex disease that, if not well controlled, results in serious complications that have a significant negative impact on quality of life and cause premature death. Among
these complications are blindness, kidney failure, neuropathy, and cardiovascular disease associated with micro- and macro-vascular conditions caused by poor glycemic control.

According to a study of children and adolescents in Cincinnati, Ohio, the rate of T2DM increased ten-fold between 1982 and 1994, accompanying the rate of increase in adolescent obesity (Pinhas-Hamiel et al., 1996). In the study, a review of the medical records of 1027 children and adolescents seen in a regional pediatric diabetes referral center from 1982 to 1995 (ages birth to 19 years), the average age of diagnosis of T2DM was 13 years. They found that, prior to 1992, T2DM represented 2% to 4% of new cases of diabetes seen at the center, and in 1994 this had risen to 16% of all cases. A majority of the study sample was obese (only 8% had a BMI in the normal range), and 38% of them were morbidly obese (BMI ≥ 40, i.e. in the 99th percentile). Two-thirds of the sample had a family history of T2DM. Among the children diagnosed with T2DM there were other findings associated with obesity: cardiovascular risk (17% had hypertension and 4% had elevated serum triglyceride levels), sleep apnea (6%) and depression (8%).

Similar findings in studies of adolescents in San Diego, California (Glaser & Jones, 1998), which included Mexican-American youth, and in Japan (Owada, Hanaoka, Tanimoto, & Kitagawa, 1990) indicate that the increased prevalence of obesity in childhood leads to an increased prevalence, and the earlier onset, of diabetes. Prevention of diabetes, a major cause of disability and premature death with long-term public health consequences, may start by preventing obesity in childhood. Early evaluation and intervention to maintain healthy weight in children and adolescents is the key.
Early Maturation and Stigmatization

Another serious consequence associated with being overweight in childhood is early maturation (Dietz, 1998). Children that are obese tend to be taller and have increased bone age (on skeletal x-ray) relative to their normal weight peers. Early puberty, especially early menarche associated with overweight in girls, and early termination of peak bone mass acquisition in both boys and girls, can have serious psychosocial ramifications for these young people that are significant and long lasting (Dietz, 1998).

Early physical maturation is the most prevalent morbidity associated with obesity in adolescents. Early maturers have been shown to have increased school disciplinary problems and higher school drop-out rates (Lynne, Graber, Nichols, Brooks-Gunn, & Botvin, 2007). Being the object of mockery and contempt may place teenagers at high risk of social isolation and depression, and may disadvantage them in future education, employment and health care opportunities (Puhl & Brownell, 2001). Stigmatization associated with overweight in childhood and adolescence has lasting effects.

Stigma is defined as something that detracts from the character or reputation of a person or group, something considered disgraceful (Neufeldt & Guralnik, 1996). Stigma is commonly thought to be a reflection of the norms and values of a society; those who live outside the norm experience being treated differently, that is, being stigmatized (Becker & Arnold, 1986; Goffman, 1963). With so many overweight people in the population today one might speculate that the stigmatization previously reported to be associated with obesity in children (Richardson, Goodman, Hastorf, & Dornbusch, 1961) would be much less. Recent research has reconfirmed that the bias against overweight
children persists (Latner & Stunkard, 2003; Zametkin, Zoon, Klein, & Munson, 2004). Negative attitudes toward overweight continue into adolescence (DeJong, 1980; Sobal, 1984). Overweight people are thought to cause their own condition. The condition is often ascribed to a lack of willpower, poor lifestyle choices, general laziness and gluttony (Puhl & Brownell, 2003). If the person can be blamed for the condition then it does not inspire sympathy, but rather elicits derision and derogation. These negative attitudes translate into discrimination and prejudice against the overweight individual (Crandall, 1994; Puhl & Brownell, 2003).

Obesity in youth is linked to poor social outcomes in adulthood. From a cohort of adolescents and young adults enrolled in the National Longitudinal Survey of Labor Market Experience, Youth Cohort (NLSY), a random sample (n=10,039) was chosen for comparison of annual interview data for the years 1981 and 1988. Follow-up data, for 1988, was available on 65-79% of the original sample, depending on the variable (Gortmaker, Must, Perrin, Sobol, & Dietz, 1993). In analyzing the relationship of being overweight to outcomes such as score on the Rosenberg self-esteem scale, marital status, education completed, employment status and income, and controlling for factors such as health status (co-morbid conditions), parents’ education and level of income, the researchers found that overweight adolescents and young adults married less often and had lower household incomes in their early adult life, independent of their socioeconomic origins and aptitude-test scores.

Seven years later, women who had been overweight had completed fewer years of school (0.3 year less; 95% CI, 0.1 to 0.6; p = 0.009), were less likely to have married (20% less likely; 95% CI, 13 to 27%; p<0.001), had lower household incomes ($6,710
less per year; 95% CI, $3,942 to $9,478; p<0.001), and had higher rates of household poverty (10% higher; 95% CI, 4 to 16%; p<0.001) than other women, independent of base-line characteristics. Overweight men were less likely to have married (11% less likely; 95% CI, 3 to 18%; p = 0.005) (Gortmaker, et al., 1993). This study, and others like it (DeJong, 1980; Maddox, Back, & Liederman, 1968), provide evidence that being overweight as an adolescent interferes with life chances and opportunities for success, and suggests that this is due to discrimination and stigmatization associated with being fat in America.

Overweight stigma persists in spite of the increased numbers of overweight people living in this country. It is difficult to counter anti-fat attitudes when society and medicine are strongly urging Americans to lose weight, when the visual media of magazines, film and television continues to portray only thin women as beautiful and lean men as handsome, and when the very person who is being stigmatized believes they are the cause of their own problem. Some people can and do successfully lose weight and keep it off through diet and exercise, though this is notoriously difficult to do with long term success for reasons that are still unclear (Wilfley et al., 2007; Wiltink et al., 2007). America is traditionally a land where hard work is the key to success. In such a setting a person who is overweight and cannot lose weight may be viewed as having a character flaw or a moral failing of some kind. The overweight teenager in this land may be less likely to feel she can succeed in the future, and this puts her at risk for having decreased goals and expectations, lower educational achievement, higher unemployment, and poorer health throughout her life (Gortmaker, et al., 1993).
Impact of Obesity on Overall Well-Being

In the discussion of the problem of childhood obesity there has also been a small amount of research in the area of the psychological and social problems associated with the condition of obesity. A child's perception of his ability to function in life, physically, socially, emotionally, and in his role as a student, is a factor in his overall well-being, his future livelihood and longevity, just as are the physiological components. Previous studies of children and adolescents indicate that obesity is one of the most stigmatizing and least socially acceptable conditions (Zametkin, Zoon, Klein, & Munson, 2004). In their review article, Zametkin and colleagues summarize ten years of obesity literature, examining it especially for psychiatric implications. They conclude that pediatricians and psychiatrists must work with the obese child and adolescent to build self-esteem, so that the individual can lead a full life at any weight.

The World Health Organization (WHO, 1948) defines good health as not merely the absence of disease, but also the ability to function fully in the activities of daily life. Health related quality of life (HRQL) has been defined as an individual’s subjective perception of health, representing the concept of well-being as well as functioning (Bullinger, Schmidt, & Petersen, 2002). Examining the quality of life reported by obese adolescents, investigators report finding low HRQL scores, similar to the HRQL reported by children with cancer (Schwimmer, Burwinkle, & Varni, 2003).

Health-related quality of life is a multi-dimensional construct, including several domains of functioning: physical, emotional, social, and school/work. Schwimmer et al. (2003) found that obese children and adolescents were four times more likely than healthy children and adolescents to report school-impaired function. Most surprising was
that the obese youth were 5.5 times more likely to report a quality of life score >1 standard deviation lower than non-obese healthy children.

Using a cross-sectional research design, Schwimmer and colleagues (2003) administered a validated tool for measuring HRQL, the PedsQL4.0® (Varni, Seid, & Kurtin, 2001), to a sample of 106 obese children (BMI ≥ 95th percentile for age and sex), ages 5-18 years, and 105 parents over a six-month period at the Children’s Hospital and Health Center in San Diego, California with the approval of the local institutional review board. The child-parent dyads were recruited from new referrals for evaluation of obesity to the pediatric gastroenterology and nutrition clinics in that setting.

The self-reported HRQL of these obese children was compared, using independent sample t tests, to published quality of life reference data of healthy children recruited from private practice pediatric offices and community health clinics at the time of their well-child visits (n=401) (Varni, Seid, & Kurtin, 2001). The obese children’s HRQL data was also compared to published data of children with cancer and receiving chemotherapy recruited for a study of HRQL at two large children’s hospitals (n=106) (Varni, Burwinkle, Katz, Meeske, & Dickinson, 2002). The researchers established a clinical context for the HRQL of obese children and adolescents by choosing another group with chronic illness. The cancer patients were chosen for this comparison because they reported the lowest HRQL scores of any chronic illness that had been assessed with a pediatric quality-of-life inventory (Varni, Burwinkle, Katz, Meeske, & Dickinson, 2002; Varni et al., 2002; Varni, Seid, Knight, Uzark, & Szer, 2002; Varni, Seid, & Kurtin, 2001). The investigators’ hypothesis, that obese children and adolescents would
have worse HRQL findings than healthy children, as seen in other pediatric chronic health conditions, was confirmed.

They also tested a second hypothesis: that greater BMI values would correlate with lower overall HRQL (Varni, Seid, & Kurtin, 2001). For this analysis the BMI values were converted to $z$-scores to compare subjects across age and sex. Pearson correlations between BMI $z$-scores and Peds QL scores showed a statistically significant inverse correlation with child self-report for physical ($p=.02$) and social ($p=.02$) functioning. The sample demographics were explored as either independent or group contributors to the HRQL scores. A stepwise regression indicated no significant contribution of age, sex, socioeconomic status or ethnicity to the HRQL scores in the obese group. Seven co-morbid conditions were also assessed for their contribution to the HRQL scores: obstructive sleep apnea, tibia vara, polycystic ovary syndrome, non-alcoholic fatty liver disease, hyperinsulinemia, dyslipidemia, and depression. Of these, only children with obstructive sleep apnea (OSA) reported significantly lower HRQL scores when compared to obese children without OSA. Overall, there was not a significant difference in the mean total score for obese participants with and without an obesity-related co-morbid condition, both were equally low (> 1 standard deviation below the mean HRQL score reported by healthy non-obese children).

The sample for this study was notably 63% Hispanic, and 54% male. This has particular relevance since epidemiologic studies report a higher prevalence of obesity for Hispanic boys that other youth in the United States (CDC, 2004; Ogden, Flegal, Carroll, & Johnson, 2002). One limitation of this study is that the cohort studied was markedly obese (with a mean BMI of 34.7 kg/m$^2$) and was referred to the clinic on the basis of their
obesity. Seeking treatment for their condition may reflect that obesity has had an impact on their life. In spite of this, Schwimmer, et al.’s study (2003) is significant because it draws attention to the effects that being overweight has on the physical and psychosocial functioning of obese children and adolescents, and it highlights the impact of co-morbidities on their lives.

The Social Context of Pediatric Obesity

Effect of Race

While the prevalence data indicate that obesity in general is increasing across all groups in the United States, no matter how the groups are defined: by age, sex, race, ethnicity, annual income, or geographic region, research also shows that obesity, while on the rise for every group of Americans, is disproportionately affecting people who are poor and/or racial/ethnic minorities. Epidemiologists and researchers use various terms for racial and ethnic populations. The terms used here are those reported by authors.

As reported in Health, United States, 2004 (CDC, 2004), in 1999-2002, 22.8% of Black or African American girls, ages 6-11, met the criteria for obesity (i.e BMI >95th percentile for age and gender), as did 17.1% of Mexican girls in that age group. Compare these rates to that of white girls the same age, which is 14%, and the disparity is apparent. Boys in the 6-11 years age group do not fare any better: 17% of Black or African American boys, 26.5% of Mexican boys, and 14% of white boys meet the criteria of obese. Similar rates are found in the 12-19 year old age group.

Obesity rates in the minority groups have increased by 7-9 percentage points in the five years since the data from the National Health and Nutrition Examination Survey
(NHANES) conducted in 1988-1994 were reported, while the rates in whites increased by only 4 percentage points (NHANES, 2002). Conclusions drawn from looking at the NHANES data for 1999-2000 are that non-Hispanic black and Mexican-American adolescents ages 12-19 were more likely to be obese than non-Hispanic white adolescents; Mexican-American children ages 6-11 were more likely to be obese than non-Hispanic black children and non-Hispanic white children; and, for preschool-aged children, Mexican-American and non-Hispanic white children were more likely than non-Hispanic black children to be obese. In addition, the data show that another 15% of children and teens, ages 6 to 19 years, are considered overweight. In the United States, Black and Hispanic youths are not just at greater risk for being overweight than their white counterparts, but the increased prevalence of type 2 diabetes and cardiovascular disease among these groups is also disproportionate to their white peers (NHANES, 2002).

Effect of Socio-economic Status

In all ethnic groups obesity tends to be associated with low income and low education levels (Drewnowski & Specter, 2004). Additional analyses of the National Health Interview Survey (NHIS) data collected in 1997-1998 showed that the highest obesity rates in adults (those aged \( \geq 18 \) years) were associated with the lowest incomes and low education levels (Schoenborn, Adams, & Barnes, 2002).

Family income has been shown to be associated with obesity in adolescents 12-17 years old (CDC, 2004). In the CDC study, family income was defined as poor (below the Federal poverty level in 1995, i.e. less than $15,569 for a family of four); near-poor (between 100 and 199% of the Federal poverty level); and, middle or high income (at or
White and black non-Hispanic poor and near-poor adolescents were more likely to be overweight than Mexican-Americans at the same level of family income. Mexican-American teens at middle- to high-income levels, however, were more likely to be overweight than either white or black teens at any family income level.

Increased prevalence of overweight in the more affluent Mexican-Americans seems paradoxical, given that as socioeconomic status improves in other racial/ethnic groups the obesity rate falls. This may be partially explained by nutrition transition, a phenomenon that is receiving global attention (Craven & Hawks, 2006; Kruger, Kruger, & Macintyre, 2006; Lukito & Wahlqvist, 2006). Transition is the situation that many immigrant Mexican-American families, and other newer immigrants, are in. These people have moved rapidly from being impoverished in their homeland, and therefore undernourished, to being more well off, and better able to afford things (including food products) in the presence of excess and accessibility in American society.

Additional evidence in support of this theory comes from a study reported in 2003, in which the investigators examined whether the degree of acculturation of Hispanic immigrants (including those from Mexico, Puerto Rico and Cuba) affected differences in degree of overweight and its proximal causes (diet and activity pattern) (Gordon-Larsen, Harris, Ward, & Popkin, 2003). Acculturation was defined as acquisition of dominant cultural norms, and was measured by place of birth, language spoken at home, and proportion of foreign-born neighbors. Using data from the National Longitudinal Study of Adolescent Health (Add Health) (NICHD, 1997) their analysis indicated acculturation differences between foreign- and U.S.- born immigrants, with
foreign-born adolescents being more likely to have lower family income and maternal education, and to live in areas with higher immigrant density. U.S.-born immigrants had more rapid acculturation of the overweight-related behaviors (diet and activity pattern), and longer U.S. residence was associated with higher overweight.

Drewnowski and Specter (2004) studied the relationship between obesity and diet quality, dietary energy density, and energy costs. Their analysis provides evidence that there is an inverse relation between energy density and energy cost, i.e. food that is higher in calories per pound has less cost per calorie, so that energy-dense foods composed of refined grains, added sugars, or fats may be the lowest cost option for the consumer. As shown in animal studies, foods with high energy density and palatability, such as sweets and fat, are associated with higher energy intakes.

Furthermore, Drewnowski and Specter report that poverty and food insecurity are associated with lower food expenditure, low fruit and vegetable consumption, and lower-quality diets. Citing the linear programming models used by French researchers, having less money to spend on food means that the food purchased will be high-fat and energy dense. Such food choices are more affordable than a prudent diet of lean meats, fish, fresh fruit and vegetables. This is further illustrated, the authors report, by a study of low income women enrolled in the U.S food-assistance nutrition education program, the Expanded Food and Nutrition Education Program.

The purpose of the program is to aid in nutritional welfare of low-income families. A savings of $10 to $20 per month in family food expenditures was associated with a net increase of 300 calories per day in daily energy intakes, and a significantly higher consumption of carbohydrates. This is evidence in support of an economic
hypothesis for the cause of obesity in the U.S. and around the world: high energy intakes are driven by a very low cost and are reinforced by the taste and pleasure associated with eating energy-dense foods (Drewnowski & Specter, 2004). Taking an economic approach may be a successful step in addressing this public health problem.

The Impact of Place

Poor families often live in neighborhoods where there are no grocery stores, or stores that sell only processed foods with long shelf life (Powell, Slater, Mirtcheva, Bao, & Chaloupka, 2007). Such foods are both high in carbohydrates (rice, noodles/pasta, canned fruits) and high in sodium (canned vegetables, processed meats, packaged bakery and snack items). Poor children often live in urban neighborhoods where fast food restaurants, and super-sized meals, are plentiful and cheap (Nestle, 2006; Schlosser, 2002). They frequently live in communities where it is unsafe to walk to the corner store, to walk or ride a bike to school, or to play outside (Lumeng, Appugliese, Cabral, Bradley, & Zuckerman, 2006). It may be that those with more resources are more able to avoid becoming overweight, and more able to lose weight as needed. A lack of these resources may be a fundamental cause of the higher rates of obesity in the socially disadvantaged.

Children of color are especially vulnerable to the effects of poverty: poor diet quality, and residing in poor areas. Data show that poor areas are three times more likely than non-poor areas to have obesity rates that exceed 25% (Boardman, St. Onge, Rogers, & Denney, 2005). The purpose of the cross-sectional research conducted by Boardman, et al. was to examine aspects of individuals’ residential areas (neighborhoods) as possible determinants of their physical size (BMI). The investigators hypothesized that residential racial concentration leads to the elevated rates of obesity in blacks compared to whites.
Among the results reported, it is striking that only 9.8% of non-black areas had obesity rates that exceeded 25%, but 37.6% of black neighborhoods had high obesity rates. Also, more than 50% of poor black communities had high obesity rates, compared to only 22% of poor non-black communities. The prevalence of high obesity among black communities was the lowest in non-poor areas, but the rates of obesity in these non-poor black communities were still higher than obesity rates in non-black communities (Boardman, et al., 2005).

Neighborhood socioeconomic status is not fully explained by the designation as poor or non-poor, gleaned from income data in the survey, and the study is somewhat limited by this. For example, high poverty areas are less likely to provide structural resources essential to healthy living, such as health care facilities and recreational facilities.

Spreading to accommodate the growing American population in recent decades, communities have sprung up tracts of homes designed with neighborhoods without sidewalks or bike lanes, and without local services such as a grocer, a bank or a post-office, thereby increasing reliance on the automobile and decreasing walk-ability (Frank, Andresen, & Schmid, 2004). It has been demonstrated that individuals who live in the most “walkable” neighborhoods are more than twice as likely as those living in the least walkable neighborhoods to engage in 30 minutes or more of moderate physical activity per day (Frank, Schmid, Sallis, Chapman, & Saelens, 2005).

The built environment in cities and neighborhoods as they are now, especially in low income areas, offers a lack of access to exercise facilities, having a deficiency in both number and type of public recreation facilities, parks, YMCAs, as well as dance studios.
and private gyms available to the community members (Gordon-Larsen, Adair, & Popkin, 2003). If instead neighborhoods were built to encourage walking and other physical activity, the public health benefit could be significant.

The place where a child lives is a product of its family’s economic resources, and may be determined by the racism of political and legal structures that create and sanction segregated communities in the U.S.A. The environment into which a child is born and is reared, be it resource-rich or resource-poor, may determine the child’s likelihood of becoming overweight.

Home and Family

The family is a crucial contributor to the health and welfare of the growing child, in both the ontogenetic sense and in the sociological sense (White & Klein, 2008). It provides the genetic material for the offspring, except in the case of adoption, and, in all cases, situates the child socially. Family income (which is just one aspect of family) determines where a child is raised, what foods are available to him or her, and what activity is acceptable for the family. The home world is an obvious influence on the diet and activity of the developing child.

Nutrition, exercise, and behavioral interventions are the mainstay of treatment for overweight children and their overweight parents (August et al., 2008; Wadden & Stunkard, 2002). The aim of such treatments is to improve nutritional choices and increase physical activity. Some childhood obesity interventions target parents and children together (Epstein, 1996), others target children alone (Dietz & Schoeller, 1982; Hoerr, Nelson, & Essex-Sorlie, 1988). Still others target parents primarily, as parents are often viewed as agents of change in the child’s immediate environment (Golan, 2006). A
study by Berry and colleagues is illustrative of these efforts (2007). Adding parental coping skills training to nutrition education, exercise, and behavioral interventions was found to decrease BMI (p=.003), decrease % body fat (p=.02), and increase pedometer use (p=.03) in the overweight parents of overweight children ages 7 to 17 (Berry, Savoye, Melkus, & Grey, 2007).

Given the increased prevalence of obesity in Hispanic and Black Americans (CDC, 2004), the study by Berry and colleagues (2007) is notable for including a diverse population: 35% African-American, 28.8% Hispanic, and 36.2% Non-Hispanic White. Prior to this, most family intervention studies have been conducted with white groups. The study confirms that involving parents in weight loss interventions for overweight children is important to successful implementation of diet and activity practices taught to children, and suggests that coping skills training for multi-ethnic parents improves health of the family, though the effect on the children is weak. A major limitation of this study, much like other intervention studies in obesity, is that it does not provide evidence that either the control intervention, or the addition of coping skills training, has any long-lasting effect on the health of family members.

Schools

In 2001, the U.S. Surgeon General called for action to address obesity (DHHS, 2001). This call, extended to multiple stakeholders, identified five key settings on which to center actions and interventions. Among these, schools were identified as a key setting for public health strategies to prevent and decrease overweight in children. Many states have responded to the call with policies to improve nutrition in their schools. For example, in 2004 the Texas Commissioner of Agriculture created a state-wide
comprehensive policy, restricting the type of food and beverages that could be sold in schools, from the maximum sugar content to the serving size, and the hours of operation and location of vending machines on school campuses (Goldberg & Hogan, 2004). The effects of statewide policies such as this, also on the books in Alabama, California, Colorado, Florida, Georgia, Hawaii, Illinois, Louisiana, Maine, Mississippi, New Jersey, New York, North Carolina, Virginia, and West Virginia, have not yet been determined.

Besides restricting the availability of foods of minimal nutritional value, also called junk foods, in schools, some school districts have re-vamped their school meal programs to improve nutritional content, notably in communities such as Berkeley, California (Ness, 2006) and New York, New York (Spake, 2005). A progressive nutrition policy, similar to the ones begun in Berkeley and New York, was implemented in the San Francisco Unified School District, beginning in August 2003, and has been evaluated at the middle school level (Wojcicki & Heyman, 2006).

From their case study of one middle school in the district, Wojcicki and Heyman (2006) concluded that provision of healthy menu options led to increased student participation in the school lunch program. The investigators retrospectively compared school revenue and lunch participation from the 2002-2003 school year (before implementation of the nutritional changes) with data from the 2003-2004 school year (after implementation of the changes), for both their case (Aptos Middle School) and the school district as a whole. The revenue data are routinely collected monthly by the School Nutrition Service and were made available to the researchers. They also accessed information on student enrollment and on eligibility for free and reduced-price lunch for
the two years to compare revenue and participation changes with demographic changes in
the student body.

Changes that were implemented at Aptos were the removal of sodas, Twinkies, Slim Jims and giant pizzas from the snack bar. These were replaced with sushi, fresh soup, deli sandwiches, 100% fruit juice and baked chicken with rice. Giant pizzas were replaced by individual slices served with a side salad. The results show that Aptos’ food service, which had lost nearly $1000 during the final full month before the changes occurred, had generated instead nearly $2000 two months after the changes. The increase in revenue is explained by the increase in participation. Forty-six percent of the 1500 students who regularly ate in the cafeteria (at least 3 times per week) at Aptos in 2003-2004 reported that they thought the food offered tasted better than in the previous year. Half of the students said they thought the cafeteria was serving more fresh fruits and vegetables than before.

The authors of the study point to the success of the program in decreasing consumption during the school day of high fat, high calorie items and increasing the consumption of fresh fruits and vegetables. One strength of their report on the successful change to healthy foods at Aptos Middle School is acknowledging that students play a role in the success of the program: student input was requested regarding menu items before the change. The study is limited, however, by its focus being predominantly on whether the policy could be implemented and whether it was cost effective; it did not explore the experience of students, parents and school personnel in the process of change as the policy was implemented. Nor did it evaluate whether the policy had any affect on the rate of overweight in students at the school.
Assuming that good nutrition and diet practices can be taught and should be modeled for youngsters, making changes to improve school menus and other food in the school environment is a logical step. Moving in this direction, however, has met with some resistance. In recent years, schools have developed a reliance on food and beverage vendors to fund their programs. Soft-drink pouring rights contracts, for example, are so lucrative that school administrators resist acknowledging the health consequences to students (Opalinski, 2006). A few high school students in a northern California community protested the impending ban of soda pop in their school, and proposed a legislative initiative to allow for a variety of beverages to be sold on campus in vending machines, but with nutrition information posted on the machines (Lucas, 2006). In spite of resistance by some, schools may be an important arena for addressing the problem of adolescent obesity.

As children spend a great deal of time at school, it stands to reason that the school environment would have a great deal of influence on the child’s development. The U.S. Surgeon General considers the school environment one of the main venues for addressing the problem of pediatric obesity (DHHS, 2001). The vast majority of children (about 53 million ages 6 to 18 years) is in school every day (CDC, MCHB, & NAHIC, 2004). Given the sheer presence of what might be considered a captive audience, it is no wonder that schools are the setting for many health improvement and disease prevention programs. Besides teaching children the academic knowledge and skills they need, schools are also responsible for feeding and sheltering children, and helping them develop the social values and skills they will need to be productive, contributing members of society (CDC, MCHB, & NAHIC, 2004).
A great many students are fed through the federal school breakfast and lunch programs every day. Approximately 29.6 million children participated in the national school lunch program in 2005 (USDA, 2006). Participation in the national school breakfast and after-school snack programs is also very high. In California alone 6 million children are fed 2 meals a day, 180 days a year, for 13 years (Hecht, 2007). The school meal programs offer the opportunity to provide good nutrition to those who might otherwise go hungry. They also have the opportunity, or rather, the responsibility to model for everyone in the school just what constitutes healthy eating.

It is not my intention to ignore the importance of physical activity to addressing the issue of obesity. It is known that schools offer physical education classes and recreational time during the school day to varying degrees. Because of this, they also have the responsibility for developing fitness in the nation’s youth. A close look at the changes in student fitness, if any, brought about in schools through the implementation of the wellness policy is warranted. However, the focus of this project is on nutrition.

Schools are also important as a social setting for children and youth, and as such play a role in the child’s psychosocial development. Children develop peer relationships and expectations about interpersonal relationships at school that they take home to their families. School is also the place where they create the social expectations of each other that result in peer pressure (Ingersoll, 1992).

Clinical Interventions

**Empirically Tested**

There is no doubt that a better understanding of the biological and chemical factors and effects of increased adiposity in an individual will help clinical researchers
design interventions to better control weight gain and treat early effects, in order to prevent hypertension, heart disease, stroke and diabetes in at-risk patients. With millions of patients who may potentially benefit, these interventions cannot come too soon. Research regarding clinical trials of pharmaceutical agents, devices and surgical procedures remain important for understanding potential treatment options. Yet, that sort of intervention is not likely to be effective in prevention, nor applicable to the majority of the population of overweight and obese Americans. However, there have been studies of interventions that have greater potential for widespread use that have encouraging results. There is evidence that making even modest modifications to dietary intake and energy expenditure, known as lifestyle changes, has a positive effect on weight and weight-related disease in individuals (Epstein, Myers, Raynor, & Saelens, 1998; Wilfley et al., 2007).

Studies of overweight children and adolescents, and interventions aimed at reducing BMI by reducing weight or stopping weight gain in a growing child using behavior modification techniques show some efficacy (Boon & Clydesdale, 2005; Jelalian & Saelens, 1999). Studies conducted of reducing caloric intake (diet) alone, of increasing energy expenditure (exercise) alone, and of the two in combination with each other have had positive results, as was summarized in Jelalian and Saelens’ review article. Forty-two randomized clinical trials were assessed using Chambless criteria for determining treatment efficacy (Chambless & Hollon, 1998). The criteria are defined as: 1) a minimum of 2 well-designed between-group studies demonstrate the efficacy of a particular treatment, when compared to a control; 2) equivalent to an already established
treatment; 3) includes treatment manual; 4) clearly defined sample characteristics; and 5) treatment effects must be demonstrated by at least 2 different investigators.

The studies included in the review met these inclusion criteria: studies with children or adolescents that targeted weight loss as a primary objective, and were conducted in outpatient clinics or inpatient settings. Excluded were studies conducted primarily in the school setting, those conducted with special populations (i.e. chronic illness), those that used medication for weight loss, or those that included subjects older than 18 years.

The authors conclude that the trials have shown that behavioral treatment is effective for modifying either diet or exercise (or both) to control weight gain, and that behavioral treatment is superior to wait-list control or nutrition education alone. They determined that there are promising interventions among those studied. One strength of this review article is the appendix, which includes not only a summary of the 42 randomized studies in their sample, but also 19 non-randomized studies that met the other criteria. Jelalian and Saelens’ article reinforces the knowledge that lifestyle modification can be effective, and calls researchers to identify the factors that promote the maintenance of weight loss. A limitation of this review, which is actually a limitation of the body of work it reviews, is that there are few studies that targeted weight loss in adolescents; most target children aged 8-12 years.

Boon and Clydesdale (2005) also examined published studies of popular intervention strategies targeting childhood obesity: school-based interventions, afterschool and summer camp interventions, and medical community interventions. The focus of their review was to assess the potential of these strategies for meaningful public health
impact. Their work confirms that the current intervention data does not provide one solution to the problem of obesity (many varied interventions showed some success), and concludes that major lifestyle changes are key in addressing the problem.

As much as it is known that modifying diet and exercise behaviors can result in lowering one’s BMI, it is also known that the new behaviors, and therefore the BMI changes, are difficult to maintain (Vogels & Westerterp-Plantenga, 2007; Wiltink et al., 2007). There is a dearth of long-term, randomized trials in this field, and therefore the full benefits of behavioral modification weight loss strategies are not known.

A shortcoming of the interventions for obesity that aim to alter lifestyle as the means to decrease BMI is that they all have a common assumption: that changing lifestyle is something a person can and will do. There is the belief that if a person is given the correct information and taught basic skills, he or she will do what it takes to improve, i.e. will change his or her lifestyle. The fault in this is that it fails to acknowledge the social impediments to making such a change.

This assumption is consistent with the behaviorist approach based on Bandura’s social cognitive theory (2004). An array of intervention studies designed to prevent and treat overweight in children, by decreasing calorie consumption and increasing activity, have used social cognitive theory as their explicit framework (Brownell & Kaye, 1982; Figueroa-Colon, Franklin, Lee, von Almen, & Suskind, 1996; Foster, Wadden, & Brownell, 1985; Manios, Moschandreas, Hatzis, & Kafatos, 1999; Muller, Asbeck, Mast, Langnase, & Grund, 2001; Robinson, 1999).

Each of these trials aimed to change dietary intake and/or physical activity behaviors in children and measured success by a decrease in body mass index. Targeting
the health behaviors of school-aged children, these studies were all carried out in schools, from pre-school to high school. The emphasis in each was on changing the behavior of individuals using techniques to motivate and educate children – techniques linked to social cognitive theory. Short-term success was claimed in each of these studies, but the long-term effects were not measured and remain unknown.

Social Cognitive Theory / The Behaviorist Approach

At the core of social cognitive theory, when it is focused on health promotion and disease prevention, are these concepts: knowledge of health risks, perceived self-efficacy, outcome expectations, health goals, and perceived facilitators and impediments (Bandura, 2004). Knowledge of health risks and benefits is essential to the motivation for change. If the individual has no knowledge of how his lifestyle habits affect his health, he has little reason to change these habits. Self-efficacy is the idea that one is capable of organizing and carrying out an action to produce a certain goal. If a person does not believe they can get the desired effect by changing their habits they will have little reason to change.

Having a desired effect, or the health outcomes that a person expects their actions to produce, is also required to motivate change in health behaviors. These outcome expectations may be physical, social, or self-interested. Physical expectations may be the pleasures or adverse effects, as well as the material losses or benefits, derived from the habit. Social expectations may be approval or disapproval of others regarding the behavior. Expectations for self-interest, or self-satisfaction and sense of self worth may also be derived from the health behavior.

Having personal goals that are rooted in a value system provides further incentives for change. Long-term goals can set the course for personal change, but it is
short-term, attainable, goals that keep a person motivated. A person’s perception of having facilitators, i.e. physical or social assistance, will improve the chance for change; whereas the perception of impediments or obstacles will make change less successful. 

*Facilitators and impediments* are a part of the self-efficacy assessment, in the person’s determining whether they believe they can adopt a new health behavior and maintain it (Bandura, 2004). To illustrate Bandura’s theory in action, we return to the issue of adolescent overweight.

Consider that 21 ounces of carbonated soft drink was the average amount consumed daily by adolescents in the years 1999 to 2002. This is approximately 250 calories, or about 11% of the total daily calories recommended for youth (Jacobsen, 2005). Most American adolescents have a working knowledge of what food calories are. The concept of food as fuel is taught in many homes, and health education in schools includes information about calories. Much nutrition information is also relayed to the public though the media. For example, the revised food pyramid (USDA, 2005), and the “5-a-Day” campaign (Produce for Better Health Foundation, 2007) includes public service announcements, posters and billboards to encourage consumption of nutritious foods. Therefore, one could assume that achieving the goal of decreasing an adolescent’s sugar-beverage consumption begins with increasing his or her knowledge about the detriments of drinking so many empty calories, one of which is excess body weight.

Explaining the importance of maintaining a healthy weight to the adolescent may influence him to care about gaining weight, and provide a reason for him to drink less or no sodas each day. The knowledge may motivate the adolescent but, in order to be
successful in changing his beverage consumption behavior, the adolescent also needs the perception that he has it in himself to reach this goal. This is the self-efficacy concept.

The adolescent may have physical expectations about what will happen if he drinks less soda. For example, he is likely to lose weight and will save money by drinking water. He is also likely to miss the sweetness and satisfaction derived from drinking a sugar-laden beverage. He may also have social expectations around drinking soda. For instance, his friends may drink their “Big Gulps®” (32 oz. sodas) in front of him, and may tease or mock him for not joining them. His friends may be just as likely, though, to admire him for making the change and may decide to join him.

The teenager also has expectations of his own values and self-worth, a sense of what will help him achieve his goal to drink less soda, and what things might get in the way. Ultimately the adolescent’s success at eliminating sugar-sweetened beverages from his life will depend on how easy it is for him to make the change.

Bandura’s theory is clear, it is concise, and has been demonstrated to be useful in designing and evaluating interventions aimed at changing the eating and exercise behaviors of children (Brownell & Kaye, 1982; Figueroa-Colon, Franklin, Lee, von Almen, & Suskind, 1996; Foster, Wadden, & Brownell, 1985; Manios, Moschandreas, Hatzis, & Kafatos, 1999; Muller, Asbeck, Mast, Langnase, & Grund, 2001; Robinson, 1999). One limitation of the theory is that it does not readily extend to encompass changing behaviors of groups. In response to this criticism, Bandura acknowledges the role of others in health behavior when he states “the regulation of behavior is not solely a personal matter. Some of the impediments to healthful living reside in health systems rather than in personal or situational impediments.” p.3 (Bandura, 2004).
A major concern about the use of Bandura’s theoretical framework in the research on adolescent obesity is that it reinforces the idea that this problem, dealt with by modifying behavior, is solely the result of the individual’s behavior. This contributes to a blame-the-victim kind of thinking, when clearly it is not only the victim who is to blame. Another shortcoming is that it assumes a cognitivist stance with regard to the problem of pediatric obesity. This assumption includes the idea that human beings are solely rational decision-makers about their actions, rather than engaged, situated participants in a world for whom things show up and whose actions are fluid. Influencing change in the world and the food experience of adolescents is also an important way to address this issue.

Another problem with using a social-cognitive theory approach to address this issue is that, while individual responsibility has a role to play in the phenomenon of obesity, social issues that support the growing epidemic are overlooked. These must be examined, too. For example, pouring-rights-contracts, between soft drink vendors and schools, contribute to the pervasive availability of sweetened beverages on school campuses and are linked to increased beverage consumption (Opalinski, 2006). Providing social support, through improved nutrition and school wellness policies, is an important way to stem the rise in adolescent obesity.
Chapter Three
Policies Target School Nutrition

Our mission is to address the issues of childhood obesity and physical fitness, remove junk food from the schools, increase participation in the National School Lunch Program, reduce the dependence of schools and school-related organizations on food-based fundraising, expand and improve opportunities for physical activities for students, and increase the amount of nutrition education offered to students and families.
San Francisco Unified School District (SFUSD) Student Nutrition and Physical Activity Committee

Implicit in the mission of the SFUSD Student Nutrition and Physical Activity Committee is the concept that the wellbeing of children is paramount to their success in school, and ultimately their success in life. Public school policy is one area that is seen as a way to intervene in the problem of malnutrition that has been identified in American youth. Historically this was borne out through the enactment of the National School Lunch Program, and locally this is carried out through adoption of a Wellness Policy.

Public Policy: School Nutrition Program

School nutrition programs evolved from temporary domestic food aid programs created in the 1930s and 1940s as a response to a growing problem of hunger in America, during the time of the Great Depression and World War II (Gunderson, 1971). In 1946 the need for a permanent school food program was agreed to by the 79th Congress, and signed into law by President Truman:

It is hereby declared to be the policy of Congress, as a measure of national security, to safeguard the health and well-being of the Nation's children and to encourage the domestic consumption of nutritious agricultural commodities and other food, by assisting the States, through grants-in aid and other means, in providing an adequate supply of food and other facilities for the establishment, maintenance, operation and expansion of nonprofit school lunch programs. ("National school lunch act", 1946)

Over the ensuing years the Act would be expanded to include a School Breakfast Program, After-School Snacks, a Special Milk Program, and Summer Food Service to
ensure that needy students do not go hungry when school is not in session. These programs are administered through the U.S. Department of Agriculture (USDA), Food and Nutrition Services (FNS) Division. Through FNS, the USDA is charged with providing children and needy families better access to food and a more healthful diet, through its food assistance programs and through comprehensive nutrition education efforts (USDA, 2007).

However, the USDA has a competing responsibility to maintain U.S. agribusiness that may interfere with meeting this goal (Nestle, 2002). The mission of the USDA also includes expanding and developing markets for agricultural products (USDA, 2004). School meal programs are designed in accordance with the Dietary Guidelines finalized by the USDA (USDA and DHHS, 2005). These guidelines may be based more on commercial interests and politics than on nutrition science (Nestle). Due to this, the macro- and micro- nutrient quality of meals provided through the federal program has been a source of debate.

What is not debated is that school meals are an area in which a great impact may be made in decreasing the risk for overweight in youth (DHHS, 2001; Lytle et al., 2004). The school meal programs currently meet 35-55% of the daily caloric needs for 17.5 million children in America (USDA, 2006). The creation of school wellness policies is one method to assure that the daily nutrients needed by children are delivered through the school nutrition programs.

**Wellness Policy: A Healthy Food and Physical Activity Policy**

Federal food assistance programs and their budgets are reviewed annually. In June 2004 the 108th Congress passed the Child Nutrition and WIC Reauthorization Act. This
public law, signed by President G.W. Bush, includes a provision requiring all public school districts participating in any federally funded child nutrition program to establish a locally developed school wellness policy by the beginning of the 2006-07 school year (California Healthy Kids Resource Center, 2005, "P.L. 265 - 108th congress. June 30, 2004", 2004). Implementation of this legislation is left to state level departments of education.

In California, support for this initiative is evident in the California Department of Education instruction letter to county and district superintendents in which wellness policy guidance is offered:

…one of Superintendent O’Connell’s top priorities for kindergarten through twelfth grade education is improving student health and the school nutrition environment. Locally developed school policies will promote student health by providing nutrition education and physical education to foster lifelong habits of healthy eating and physical activity and establishing linkages between health education, school meal programs, and related community services. (Cover letter, p.1) (California Healthy Kids Resource Center, 2005)

At a minimum the federal law requires: a) involvement of parents, students, representatives of school food service, the school board, school administrators, and the community in the development of the school wellness policy; b) goals for nutrition, physical activity, and other school-based activities designed to promote student wellness; c) nutrition guidelines for all food available on each school campus during the school day; d) assurance that guidelines for reimbursable meals will not be less restrictive than federal regulations and guidance issued by the USDA, and e) a plan for measuring the implementation of the local wellness policy and designation of one or more persons in the district or at each school to oversee the implementation of the adopted wellness policy
Consistent with these requirements, the California Department of Education (CDE) plans to utilize a comprehensive approach to ensure students in the state are healthy, and has developed these four specific goals to accomplish it: 1) support high-quality instructional programs in health education and physical education that provide students with the skills, knowledge, and confidence to develop and maintain active, healthy lifestyles; 2) implement nutrition standards for all food and beverages sold on campus; 3) increase participation in school meal programs so that no child goes hungry; and 4) create a school environment that supports the health of students (California Department of Education, 2005).

The local school board in San Francisco, California (the city in which this study was conducted) adopted a Wellness Policy in 2007. The nutrition guidelines that were adopted exceeded the recommendations of the federal law. They were written and implemented as follows:

a) The Food Minimal Nutrition Value (FMNV) is the Federal Nutrition Standard. SFUSD is recommending a more rigid standard to be phased in for school year 2003-2004.

The FMNV: Elimination of foods at or below Food Minimal Nutritional Value (FMNV) as defined by the USDA. “Foods of minimal nutritional value” means (i) in the case of artificially sweetened foods, a food which provides less than five percent of the Reference Daily Intakes (RDI) for each of eight specified nutrients per serving; and (ii) in case of all other foods, a food which provides less than five percent of the RDI for each of eight specified nutrients per 100 calories and less than five percent of the RDI for each of eight specified nutrients per serving. The eight nutrients to be assessed for this purpose are protein, vitamins A, C, niacin, riboflavin, thiamin, calcium and iron.

b) SFUSD Nutrition Standards - BEVERAGES:
Water - Plain or carbonated; no added sweeteners (natural or artificial, including sucralose and aspartame); no added vitamins, caffeine, or herbal supplements; may be any size.
Juice - 100% fruit juice, plain or carbonated; no added sweeteners (natural or artificial); no caffeine or herbal supplements; maximum size 12 oz.

Juice/Water blends - No added sweeteners (natural or artificial); no caffeine or herbal supplements; maximum size 12 oz.

Milk - 1% or fat free (skim) milk; enriched rice, nut or soy milk (may be “lowfat”); flavored milk may contain no more than 40 grams of sugar total per 12 oz. (27 grams of sugar total per 8 oz.), including both naturally-occurring and added sweetener; no Bovine Growth Hormone; maximum size 12 oz. Rice, soy or nut milks must be enriched with calcium to at least 30% of the RDA per 8 oz. serving, or 40% of the RDA per 11 oz. serving; maximum size 12 oz.

THE FOLLOWING IS THE NUTRITION STANDARD FOR ALL FOOD SERVED IN K-12 SCHOOLS AND CHILD DEVELOPMENT PROGRAMS INCLUDING CAFETERIA SALES, A LA CARTE, CELEBRATIONS, FUNDRAISING, CLASSROOMS AND VENDING MACHINES:

1. Have 30 percent or less of its total calories from fat (excluding seeds, nuts, and eggs).
2. Have 10 percent or less of its total calories from saturated plus trans fat (excluding eggs).
3. Have no more than 35% total sugar by weight.
4. Snack foods and side dishes must meet United States Department of Agriculture (USDA) standard for minimal nutritional value; specifically, must contain no less than 5% of all of the following 8 nutrients: protein, calcium, vitamin A, vitamin C, riboflavin, niacin, thiamin and iron (excluding fruits, vegetables, seeds, and nuts).
5. Be limited to the following maximum portion sizes:
   a. One and one-quarter ounces for chips, crackers, popcorn, cereal, or jerky;
   b. Two and one-half ounces for trail mix, nuts, seeds, or dried fruits;
   c. Two ounces for cookies or cereal bars;
   d. Three ounces for bakery items;
   e. Three fluid ounces for frozen desserts, including, but not limited to, ice cream;
   f. Eight ounces for non-frozen yogurt;
   g. Twelve ounces for beverages, excluding water.
6. Fruits and vegetables shall be offered for sale at the school site where foods are sold. Non-dairy vegetarian meals shall be included in the weekly vegetarian menu.
7. Food shall be minimally processed, using whole meat whenever possible, whole grains or converted grains that retain most of their whole grain nutrients, minimal dyes, sodium and added sweeteners. No artificial sweeteners (includes aspartame and sucralose) may be used. Cooking methods shall retain the maximum nutrients possible.
8. Preference will be given to products that contain no trans fat. In school year 2004-2005, to the maximum extent practicable, there should be no added trans fatty acids/partially hydrogenated oils in any meal component. As of school year 2005-2006, there shall be no added trans fatty acids/partially hydrogenated oils in any
meal component. Processed vegetable oils with high omega-6 fats should be used as minimally as possible.

9. Preference will be given to products grown, processed, and/or packaged in California and to products which are certified organic.

10. No products containing peanuts or peanut residue may be sold or offered in the school meal program. Vending machines stocked with peanut products will carry a warning label on the machine or on the wall immediately adjacent to the machine.

11. Exceptions to these guidelines may be made for individual products, which have sufficient nutritional value to offset sugar or fat content, or other requirements, or to prohibit the sale of individual products which are deemed inappropriate for sale to students despite meeting these guidelines. Nutritional information, along with actual samples of the product in question (when possible) shall be provided to Student Nutrition Services for approval before products are placed in schools. (SFUSD, 2007)

There has as yet been no evaluation of the effects on student wellness from this relatively new local school nutrition program. However, the program does undergo regular internal review for budgetary reasons. Providing healthier food was expected to cost the school district more than was previously spent. They had hoped to recoup the additional cost through increasing the amount of federal dollars received as reimbursement for the free and reduced-price meals by enrolling more eligible students. However, for a variety of reasons they fell short of their goal, for it has not been possible to register as many qualifying families as are actually eligible. Another problem is that the federal rate of reimbursement at $2.61 per lunch does not cover the rising cost of the meal, calculated to be $3.30 in November 2008\(^1\). Additionally, many meals are given to students without any reimbursement due to an unwritten policy in the school district that no child goes hungry. In the current school year, 2008-2009, the projected loss for the

\(^1\) The current federal reimbursement rate for school meals is available on line at www.fns.usda.gov/CND/. At the time of this project, in meal-equivalents the per-meal revenue was estimated by the local school district to be $2.87, while the per-meal cost was $3.30, a gap of 44 cents. Figures were reported at the Feb. 18, 2009 School Nutrition and Physical Activity sub-committee meeting and recorded by the author in her field notes.
department of student nutrition is anticipated to be $4 million. These funds will come from the overall education budget, which is already under-funded during these difficult economic times in the state and the nation.²

² The state of California had a serious budget crisis in 2008 causing a loss of funding to the Department of Education budget. Additionally, federal funding for the National School Lunch program was under review for reauthorization with the Child Nutrition and WIC Programs. Any legislation to change the program was tabled while the nation’s leaders dealt with stock market collapse and bank failure. A serious economic depression in 2008-2009 created a greater need for meal assistance services, but did not provide resources for it.
Chapter 4

Methodology: Toward a New Way of Thinking

What would happen if we started to think about food as less of a thing and more a relationship? Michael Pollan, p.102 In Defense of Food

Usual Way of Thinking: Mind-Body Dualism

The prevailing idea regarding what we know, i.e. ontology, and how we know it, i.e. epistemology, comes to us through a long tradition traced back to ancient Greece and Plato’s theory of Forms, in which the world is separated into dual realities of particulars and universals. Plato described particulars as sensible objects, or entities that can be detected by the senses, the imperfect copies of the universals. Universals are the abstractions that exist apart from the particulars. Plato argued that true knowledge could not be gathered through senses, which are changing and imperfect and therefore only present opinions. The way to knowledge, suggested by Plato, is through the power of the mind, i.e. reason (Watt, 1997).

In the 17th century the idea of abstracts and particulars was taken up by Rene Descartes as part of his attempt to provide the method for obtaining knowledge. Knowledge, in this method, existed when there are clear and distinct ideas (Descartes, 1999). These clear and distinct ideas are gained through his method of doubt, which is to suppose that ideas are false until it is no longer possible for the idea to be false. This persists in Western science in the form of the null hypothesis. In this case, Descartes argued, all knowledge stems from one proposition that cannot be doubted: Ego sum, ego existo (I am, I exist). Descartes knew himself to exist through his thought processes, and
it was his thought processes that made him distinct from the physical body he had if he had one.

Descartes noted that there are two essential attributes to the world: the characteristics of thought (the mind) and the physical things that exist or occupy space (the body). The mind cannot be certain that the body exists, as people often do make mistakes about what they see, hear, smell, etc. The mind can only be certain that it exists (Descartes, 1999). Descartes’ emphasis on thought is the basis for Rationalism. To this day Plato and Descartes have a great deal of influence on philosophy and science, on how we think about and understand our world (Wilson, 1969).

There have been other influences in this tradition. In the 16th and 17th centuries, Sir Francis Bacon developed the scientific method of experimentation that is still in use today. Bacon emphasized that experiments be done to produce knowledge that would be useful to service of the public good, not just to produce knowledge for its own sake (Bacon, 1995). Empiricists that followed Bacon, such as John Locke and David Hume, placed the emphasis in knowledge development on the relationship between experience and knowledge. Locke argued that humans begin as a blank slate with a capacity to receive ideas. Ideas come from sensations and reflections, i.e. the examination of the operations of the person’s own mind. The mind forms complex ideas from simples ones. These complex ideas have an objective reality and, having an underlying physical realism, are not purely rational (Locke, 1975).

David Hume argued that the connection of these ideas was not left to chance, but that there are mental processes involved, ruled by custom and instinct. According to Hume, knowledge is based on a comparison of ideas. Truth, or real knowledge, is derived
from experience of the objects of the world, and the mind is responsible for sorting and organizing the ideas and impressions (Hume, 1975). The traditional Western view of science is derived from the empiricists. Templates of truth and knowledge are defined as the end product of rational processes, as a result of experiential sensing, i.e. as the result of empirical observations (Lincoln & Guba, 2000).

Alternative Way of Thinking: Transcendentalism

A different way of thinking to that of the traditional Western, i.e. Cartesian, method used by many scientists, also has roots in ancient Greece and was further developed in the 18th century (Losee, 2001; Rodgers, 2005). In ancient times, Aristotle argued that the two worlds described by Plato should be united, the everyday particulars with the knowable forms in things. In this union, knowledge could be obtained through contact with the objects of everyday experience. It was possible to know of beauty and justice, for example, as they exist in objects. For him knowledge was of the universal, not of the changing discrete objects of the world and was acquired by the soul’s recognition of the forms of these things. Matter and form were not separated from each other. Aristotle showed, though his use of logic and syllogism, that sensory data contribute to knowledge, but could not be relied upon for knowledge nor are they the source of knowledge (Aristotle, 1947).

This philosophy was further developed in more modern times by Immanuel Kant in his attempts to clarify that knowledge is a unity of particulars and abstracts. In response to the empiricism of Locke and Hume, Kant wrote *Critique of Pure Reason*. Published in 1781, it has had a powerful and lasting effect on philosophy (Kant, 1965):

“…though we cannot know these objects as things in themselves, we must
yet be in position at least to think them as things in them-selves; otherwise we should be landed in the absurd conclusion that there can be appearance without anything that appears. “ (p 27.)

In the *Critique of Pure Reason* Kant argued that reason is necessary in making connections about causality, and that reason is universal in understanding those things that we cannot experience through our senses. Kant confirms that an external reality exists, but in the way humans view it, as it appears in space and time, it is phenomenal, rather than concrete. It follows that sensory experience is an important component of knowledge, but there is a possibility for knowledge that does not originate in experience. According to Kant, “Knowledge is transcendental if it is occupied not with objects, but with the way we can possibly know objects even before we experience them” (p.12), i.e. an *a priori* knowing.

Kant distinguishes between things as they appear to our senses, which he termed *phenomena*, and things that are purely objects of thought independent of sense perception, which he termed *noumena*. These ideas, that the mind makes experience possible and that knowledge is possible without relying on the senses, open up a new realm of possibilities for methods of obtaining knowledge, and give us language for talking about it. Implied by this kind of inquiry, dualism persists in the idea that both senses and intellect are involved in understanding. A problem with this philosophy is that it still comes from the basic viewpoint of objectivism. It pre-supposes a world of material bodies that exist in linear space and time.

This philosophical stance was formally criticized by Edmund Husserl (1936), the founder of phenomenology, in his work *The Crisis of European Sciences and Transcendental Phenomenology*. He made the point that the study of the material world,
the natural sciences, is founded on practical activities. The natural world, described mathematically, presupposes the life world, and because we always take our life world for granted, it is easy to forget that it is a fundamental pre-supposition (Fjelland & Gjengedal, 1994; Husserl, 1970). Kant and Husserl had in common that they sought to transcend the material world in considering reality, providing a foundation for a post-positivist or humanistic way of thinking.

The post-positivist thinker assumes a subjective reality - ontologically, what we know is shaped by our world-view, i.e. reality is relative. It assumes the epistemological stance that research findings are value-mediated, i.e. subjective to both the researcher and to the subject of inquiry, and that the research method is dialogic and interpretive (Lincoln & Guba, 2000). This is generally known as the qualitative research paradigm. Qualitative research methods make it possible to make sense of human action and the social world, and to understand the human experience of the world. It allows for context, space and time, to be taken into account, and considers the situation of the subject and the researcher in its method. According to Denzin and Lincoln (1994):

Qualitative researchers stress the socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints that shape inquiry. Such researchers emphasize the value-laden nature of inquiry. They seek answers to questions that stress how social experience is created and given meaning. (p.12)

Several categories of qualitative methods are employed in nursing research: phenomenology, grounded theory, ethnography, historical, and participatory action research. Briefly defined, phenomenology is used to explore the lived experience of individuals, grounded theory is used for understanding processes, ethnography’s purpose is to fully understand a particular culture or social situation, historical inquiry delves into
the past, and participatory action research is used when an outcome of social change is sought (Creswell, 1998). The choice of which qualitative method to employ depends on the question being asked. In being classified as qualitative research methods, these categories share the assumption that the role of the researcher is as an instrument in the inquiry. In this way the investigator acknowledges that in doing the research (collecting the data) he is affecting the data as it is being collected (Denzin & Lincoln, 1994).

Investigations using methods in these categories have other similarities, e.g. small sample sizes that are often purposefully selected (Sandelowski, 1995), and the use of interviews and observation for data collection (Kvale, 1996). Analysis of qualitative data employs sifting and sorting through dialogue and narratives. It is iterative, has an interpretive style and requires careful attention to linguistics. The researcher in qualitative research takes an active role in both collecting and analyzing the data. The qualitative researcher in all categories is reflexive, i.e. aware of balancing the role of researcher and being a member of the shared world of the study subjects (Clarke, 2005).

In the shared world of the researcher and what is studied, there is the potential for problems that do not arise when using the distant-observer mode of the quantitative paradigm. There is concern that the intimate relationship between the researcher and the phenomenon being studied may introduce a bias to the research that is undesired. Qualitative research acknowledges the intimacy, and rather than rejecting it by assuming a detached posture, researchers in this tradition embrace it and deal with their involvement by taking a reflexive pose. The qualitative researcher knows that their self is fundamental to their work, and if they are to be successful, they must be aware of the contributions of hidden or unrecognized elements in their own background to their
interpretation, i.e. they must be reflexive (Olesen, 2005). The qualitative researcher assigns importance to communication with informants and determines relevancy, during the interpretive interview process and iterative analysis. This does not happen in a vacuum, it happens within the shared world that is being brought to the foreground through the research process (Bourdieu, 1977).

There is an idea of a subjective reality inherent in most, but not all, categories of qualitative research. The concept that reality is relative arises in qualitative research from its acknowledgement that people experience entities and phenomena each from their own perspective – in a subjective way that may or may not be objectively noted by external observers. Many who undertake qualitative research using grounded theory, ethnography, or historical methods assume research examines all parts of reality, subjective reality as well as its objective counterpart.

**Reconceiving Reality: Phenomenology**

Heideggerian phenomenology takes exception to this way of thinking about reality. In the phenomenological view of Being, there is no subject-object split. The idea of subject and object are reconceived (van Manen, 1997), and what is experienced is the whole. There is no “out there” to be apprehended, what we have is our experience as beings for whom things have significance (Leonard, 1994; Taylor, 1985). Both objectivity and subjectivity find their meaning and significance in the relationship that the researcher establishes with the phenomenon under study. “Thus”, according to van Manen, “objectivity means that the researcher is oriented to the object, that which stands in front of him or her. Objectivity means that the researcher remains true to the object.” (p. 20). Subjectivity in this sense means that the researcher needs to be reflexive. The
phenomenological researcher avoids being distracted by his or her own unreflected preconceptions, and strives to be perceptive and discerning in order to disclose the object “in its full richness and in its greatest depth.” (van Manen, p.20).

Human health, and health promotion are embedded in human traditions, practices and actions, and the use of qualitative research methods to examine human health has increased in recent years (Hill Bailey, 1997; Rodgers, 2005). In spite of this, just a few published qualitative studies exist on the phenomenon of obesity. A database search of all literature in Cinahl and Pub-Med using the terms “obesity, qualitative method” yields just 63 distinct studies, five of which focus on children or families. When looking specifically for published research on the topic of the lived experience of overweight teenagers, none was found. Questions raised in this realm remained unanswered in the literature. How do teens experience being overweight? What do teens perceive as contributing to their being overweight? What barriers do they face when attempting to lose weight or control their weight gain? What role does their home/family play? What about their peers/school? What roles do media attention to obesity and changes in food policies play in this?

Assuming the Phenomenologist’s Stance

Building on the concepts of transcendentalism introduced by Husserl, Martin Heidegger expanded phenomenology as a philosophical methodology to uncover the meaning of being human beings (Dreyfus, 1999). Past philosophical approaches, according to Heidegger, covered over the significance of ontology and played down the familiarity and the every-day-ness of what it means to be. In his major work, *Being and Time*, Heidegger deals directly with the human condition and gives an account of the nature and limitations of philosophical and scientific theory (Heidegger, 1962).
In laying out his philosophy Heidegger discusses what it means to be human, which necessarily encompasses a concept of world and what it is to be in-the-world. In the phenomenological sense, world is more than the totality of entities which are present to us in the world.

To understand what is meant by ‘world’ in this paper it is important to acquaint oneself with a Heideggerian perspective on the several ways in which the word is used. Heidegger (1962) asserts that by unraveling the different ways ‘world’ is used we can come to see the different kinds of phenomena each is, and the ways they are interconnected. He provides us with four distinctions, i.e. different ways the word ‘world’ has meaning. The first of these is the concept of world as an object, as a totality of all things, such as the universe and planets. Secondly, world may convey a realm, or a multiplicity of entities, like the world of sports or the world of medicine. The third sense of the term ‘world’ is that wherein a human lives. This can be the public we-world, or one’s own closest domestic environment. This is the space where human agency is. And, fourthly, there is a larger a priori concept of worldhood that makes these other meanings possible (Heidegger, 1962). It is the third form of the word that is relevant to this study of the experience of being overweight in adolescence. It is the inhabited world that will be described in this work.

Researcher Reflexivity

Phenomenology involves a hermeneutic circle, in which interpreting a text requires one to move back and forth between the overall interpretation and the details, to let what is significant stand out (Dreyfus, 1999). Therefore, I must acknowledge that the analysis begins from within the practices I seek to interpret. In order to understand the
phenomenon of obesity as it is experienced by teenage girls in 21st century America, I am obligated to consider the practices, the lived way of being, that is already always there.

As a phenomenologist I acknowledge that my choice of phenomena is already guided by my understanding of being-in-the-world. I understand this kind of being comes from having been thrown, as I was, into a mid-20th century single-parent household in rural northern California. Being born at a specific time, into a particular family, in a specific place, growing and aging over time, receiving traditional accounts of objects, subjects, language, and truth, affords me some possibilities and disallows me others.

In reflecting on how I have come to this area to study, among all of the fascinating areas for human health research, I have asked myself repeatedly why has the problem of obesity pronounced itself to be paramount for my investigation - why is it significant to me? I have not yet (in my 50 years on this planet) been what could be termed obese. However, I have yo-yoed back and forth between normal- and over-weight throughout my adult life, and have teetered near the brink of obesity. It is perhaps because of this that I can relate to the teens in the clinic. I have shared the experience of learning nutrition information, watching what I eat, and incorporating exercise into my lifestyle – all core values taught in the clinic – and I have experienced the feelings of success and failure accompanying these attempts.

My concern about weight gain did not start in adulthood, as I was trained early in the ways of dieting and weight loss by my mother. Her battle with obesity was ever-present in our household – from the boxes of chocolate appetite-suppressant candies on her nightstand and on the kitchen table, to her weekly meetings with the Take Off Pounds Sensibly group, to her foray into diet pills – it was my world. I watched my mother go
from 150 pounds to 300 and back again, over and over again, as she measured her
happiness and her worth by her dress size. As a school-aged child I was embarrassed by
the looks that we got when my mother’s weight was up. I was frustrated that she never
seemed to have the energy to go for a walk with me, much less play with me. I vowed
that I would not be a fat mother when I grew up.

In retrospect I see my mother’s obesity as related to her psychiatric illness – life
with a manic-depressive adult is confusing, full of ups and downs, prosperity and
deprivation. My older sister and her husband became my guardians in my teen years in an
effort to stabilize my environment. This is my skinny older sister, who trained me in the
ways of binge eating and excessive exercise. A Saturday night spent eating Nacho Cheese
Doritos and drinking Coke floats could be worked off by running, doing housework and
gardening every other moment between work/school and sleep. My sister was a link to
the mother and father I never knew. Born 14 years before me, her world included our
father who was known as “Skinny” (due to his thin frame) to his family and friends, and
included his food preferences and eating habits. His death when I was only 18 days old
had tremendous impact on my world, not the least of which was a childhood full of being
told how much I looked like him, and how he had wanted a son. Looking like him
brought me love and attention. Looking like him meant that I was “Skinny” too.

Even though I was not an obese child, my size was an issue for me because I was
taller than most of my classmates from kindergarten through high school. My height drew
unwelcome looks and remarks from strangers, peers, and from family members. My
grandmother ironically took to calling me “Shorty” when I was 11, as I had passed her
height by 6 inches. As a pre-teen and a teenager, I experienced what it is like to be
different from the others, to dread the attention it brings, and to not be able to find clothes that fit off-the-rack.

My battle against my own weight gain began in earnest about 6 years after my third child was born, when I joined Weight Watchers and successfully lost the excess 30 pounds added to my frame. This was only the beginning of my own yo-yo experience with weight gain and loss, a secession of time spent being thin and feeling energized alternated by times of being large and feeling slothful, but mostly being somewhere in between. I kept my childhood vow, and introduced my own children to hiking, biking, skiing, skating and many other fun physical activities by teaching them how and then playing with them.

As a mother I nurtured my children in many ways; important among these was safeguarding their nutrition. Starting with their fetal life and through years of breast-feeding I did my best to eat wholesome, natural, and nutritious foods. Whenever possible, I turned homegrown, garden-fresh fruits and vegetables into the food they ate as infants and toddlers. As they grew into active school-aged children I packed their lunches and snacks to ensure a balanced diet through the day. I understood my role as their mother to nourish their bodies, souls, and minds. As they blossomed into adolescents each learned how to prepare and cook real food, not just assemble pre-made and or re-heat packaged food products. As a mechanism for my survival, living in a busy household with three teens and a husband, the chore of planning and preparing the evening meal was shared, and alternated nightly by each of us. Everyone gathered together in the evening to eat, and to share the news of our days. The concept that good food is necessary for a good life was one I embraced as a young woman, and one I shared with my family.
My world is also colored by my education and training as a pediatric nurse. In 2002 I became the coordinator of a pharmaceutical trial of a drug to treat obesity in adolescents. This was my initiation into the area of childhood obesity. As I read more on the topic, and spent more time with the adolescents I enrolled into the two-year trial, I came to believe that the issue of their weight gain was not just the result of their individual eating and exercise practices. I also saw that many teens and their parents were looking for a “magic bullet” to take away the excess weight, while few were able to make the lifestyle changes that were recommended. In getting to know the young men and women in that study, I heard about the struggles, the embarrassment, and the pain associated with being a fat kid. I remember thinking that we, the clinicians, are not doing all we can to help. Medication use and medical advice did not seem to be making a dent in the pediatric obesity epidemic. It seemed to me that the interventions, in order to be effective, had to have a broader scope than the individual child and family. In order to find a way to reverse the trends of the past few decades and the toll it takes on our nation’s health now and in the future we must intervene with preventive public policies.

In being reflexive on this topic, I make myself the subject. This is the general way of the self-interpreting being, which human beings are. In conducting this investigation, it was necessary for me to understand that what I observed and interpreted in the work shows up as significant for me because I have a relationship with the phenomenon of obesity. I have done this study because it was possible for me to do it.
Chapter 5

Methods

Design

The philosophy of interpretive phenomenology guides the approach to this study. There are several basic assumptions of this philosophy: 1) humans are social, dialogical beings; 2) humans are self-interpreting, i.e. hermeneutic activity is always already underway; 3) interpretation presupposes some shared understandings; and, 4) interpretation requires involvement in a dialogical relationship of the interpreter and the interpreted (Dreyfus, 1999; Heidegger, 1962; Plager, 1994; Taylor, 1985). Phenomenology as a research method is especially well suited to study of persons, events and practices on their own terms (Benner, 1994b). It is characterized by interpretation of text leading to an understanding of world, self, and other. Text is defined as a hermeneutic term, and extends beyond what is written to other aspects of a phenomenon that are open to interpretation, such as observed practices, habits, and experiences.

It is at the core of this method to cultivate the ability to understand things from someone else’s point of view and to appreciate the cultural and social forces that may have influenced their outlook (Merleau-Ponty, 1962). As a research method, it is a dialogical process of learning that involves creating, understanding and interpreting texts, for which one has the preexisting ability to understand world and read texts for meaning (Benner, 1994). The goal of interpretive phenomenology is understanding the everydayness or taken-for-granted assumptions individuals make about living in the world. It was employed here in interpretation of the life world of the overweight adolescent.
Data collection included a review of archived documents such as school board meeting minutes, field observations, and interviews with overweight adolescents and their parents. Interviews were audio-recorded and transcribed verbatim into electronic word-processing files. The archived documents, transcripts and field notes, are the data to be analyzed.

The primary focus of this investigation is on the experience of the overweight adolescent. Study of home and school are added to provide situation and context, and for triangulating the themes uncovered during interpretation.

Methods: Specific Aim #1

Specific Aim #1: Describe how overweight adolescents experience and articulate the meaning of being overweight through open-ended interviews.

Sample selection

Twenty-two girls who met the entry criteria were referred by the pediatric obesity clinic for potential participation in this study. Seven teens declined to participate. Individual interviews with 15 overweight adolescent girls were conducted. I limited the focus of this study to the experiences of young women, i.e. I deliberately did not include boys. This was done to decrease the potential “noise” in the data related to gender differences. In support of this idea, there exists a body of work in the area of body image and self-esteem, and disordered eating (e.g. binge eating), that has been conducted primarily in females (Biro, Stiegel-Moore, Franko, Padgett, & Bean, 2006; Striegel-Moore & Bulik, 2007; Kirsh, McVey, Tweed, & Katzman, 2007; Striegel-Moore et al., 2007; Thompson et al., 2007).
**Inclusion criteria:** Ages 13 to 17.99; female; obese, as defined by BMI ≥ 95th percentile for age and sex, or > 30 (whichever is smaller) (American Medical Association, 2007).

**Exclusion criteria:** Unwilling or unavailable for participation in an interview; non-English speaking.

**Recruitment:** Potential participants were referred to me by the staff of the pediatric obesity clinic at the urban academic medical center, where I had already established entrée through my pilot research and employment. I approached the teens referred to me in order to determine the youth’s interest in participating in the study. If interested, the informed consent process ensued. I explained the study purpose and procedures to the youth and their parent or guardian, and an Assent for Minors/Parental Consent form was used to aid in the research recruitment process (See Appendix 1). I explained that the interviews would be audio-recorded, and that the text of the discussion would be used for research. Signatures on the assent/consent constituted enrollment.

**Incentives:** Each participant received a $10 gift card for use at a local store (e.g. Target, Borders, Trader Joe’s) to thank them for their time and effort for each interview they had.

**Data Sources and Data Gathering Activities**

Demographic information about the participants was obtained using a non-standard questionnaire (see Appendix 2). The medical chart was accessed, per HIPAA policy, to glean the calculated BMI in kg/m² nearest to the time of the interview, as well as any diagnoses of comorbidities.
Teen interview protocol (see Teen Participant Interview Guide in Appendix 3): I used open ended questions designed to elicit details, through narratives or stories, of the interviewee’s experience of being overweight. The stories were interpreted to gain understanding about how teenagers create meanings from the events in their lives. The guide for this interview included questions such as: What is the hardest thing about being overweight? What is the best thing about it? Tell me a story about when your weight has been an issue for you. Tell me what eating is, or what mealtimes are, like for you.

Interview procedures: A private, quiet space located either at the medical center or in the teen’s home, depending on preference and availability, was the setting for the interviews. The time and date for the interviews were pre-arranged, and mutually agreed upon. The interviewee was asked to sign a consent form allowing audio-taping of the interview, and granting permission to use of the text for research purposes. Initial interviews took between 30 and 60 minutes. Second interviews were conducted with 2 participants and followed the same protocol.

Data Management

Audio-recordings of the interviews and focus group discussions were transcribed verbatim. The text of these transcriptions was added to the data set in a qualitative data management software program, Atlas.ti.

Atlas.ti was used to organize the data for this project and to attach codes to text passages. In addition to many other functions, the software allows searching documents by codes and organizing coded passages into families or themes. In this way the software is an aid in analysis, but does not do any actual analysis.
Data analysis:

Demographics

Fifteen female adolescents were interviewed for this project. Mean age was 15.8 years (range 14 to 17 years), and mean BMI was 40.13 kg/m² (99th percentile) (range 31.8 to 50.1). All were obese, i.e. BMI > 95th percentile for age and sex. Race was self-reported by the girls: 33% were African-American and 60% were Caucasian, one Latina did not select a racial category. Sixty percent reported their ethnicity as Hispanic or Latina. Co-morbid conditions had been diagnosed in 14 of the participants (93%). Significant among them were: 1 case of type 2 diabetes mellitus, 2 cases of poly-cystic ovarian syndrome (PCOS), 1 obstructive sleep apnea, and 1 pseudotumor cerebri. Other co-morbid conditions frequently (i.e. >50%) listed in the medical records for the participants were: impaired glucose tolerance (“pre-diabetes”), hyperinsulinemia, hypertension, and dyslipidemia. All but one girl in the study had acanthosis nigricans (a darkening and thickening of the skin fold areas, e.g. neck, underarms), and one-third had hirsutism (increased facial and body hair). (See Table 1)

Interpretation of the Data

Interpretive phenomenology was employed to examine the interview data, with regard to the adolescents’ lived experiences of being obese. Interpretive phenomenology has been used by other researchers to explain particular patterns of meaning and action in the lives of the informants, and takes into account the context in which they live, their history, and their concerns (Chesla, 1995). This method is explicit in its attempt to articulate, through careful interpretation of a text, the meanings embedded in human experience.
Data analysis for this study began with my outlining this line of inquiry for my doctoral thesis. From my initial foray into the literature on this topic I had already entered into interpretation of what it may mean to be an overweight adolescent girl. In performing an interpretive ethnographic study such as this, I acknowledge that I have been influenced by the data, and that I have influenced the data. An example of this is when I modified some interview questions based on themes that emerged from interviews with earlier participants.

The digital-audio interviews were transcribed in turn, as each was finished, rather than waiting to have them all done at the same time. This allowed for data collection and data analysis to be underway simultaneously. The interview transcripts were read and re-read, initially to assess the overall tone and general themes.

While I was responsible for data analysis, my work was enhanced by collaboration with the small research group comprised of other doctoral students and my advisor who had trained in interpretive phenomenology. They co-analyzed portions of data and critiqued my emerging analyses. This was done in order to arrive at a shared interpretation, one that was agreed upon by multiple readers and informants (van Manen, 1997). By its nature, this kind of research employs an iterative process; one that is self-critical and self-corrective in its iterative-ness.

With the help of my colleagues, important or repeating-themes were identified. The text was further explored and labels, or codes, were applied to the thematic passages in the text. Some of the labels or code names, such as “the Look”, were in vivo, i.e. they are a word or words used by the participant, and they presented themselves to the readers as important and truly representing a concept. Codes were formally defined in order to
assist with my, and the group’s, re-call of the nuance and meaning held in a particular code when reviewing new text.

Written memos were also kept to help prod my memory of events or lines of thinking that may have had analytical importance later, as data collection and analysis went on at the same time. Having other members of the interpretive group read text and code it helped confirm the use and goodness of fit of the interpretive codes I had chosen.

During analysis some stories were written up as paradigm cases. Paradigm cases are “strong instances of concerns or ways of being in the world, doing a practice, or taking up a project” (Benner, 1994, p. 113). They are illustrative of an important theme or themes and are indicative of the findings of this sort of research.

The issue of rigor in qualitative research is complicated, often by continuing confusion with quantitative assumptions (Sandelowski, 1995). Several strategies were used to enhance interpretive validity: use of multiple data sources, collaboration with other skilled doctoral students and my advisor, and careful documentation of how the study was conducted.

I used the overall strategy described by Denzin (1989) as “data triangulation,” to flesh out the dimensions of the phenomenon of adolescent obesity by considering it from several perspectives. Data for this study came from multiple sources, which helped widen the view of the phenomenon. I engaged colleagues to read the raw data and paradigm cases, and found that they perceived similar meanings, thus adding dependability to the findings. The findings and their implications are presented in the chapters ahead.
Methods: Specific Aim #2

Specific Aim #2: Describe the ways in which the family environment influences adolescent overweight through interviews with mothers of participants, and through observations in the home.

Sample selection

On the demographic questionnaire completed by each teen participant in the study they provided a Yes or No response to the question “May I contact your parent/guardian for an interview and home visit?” Only parents of teens who responded Yes were contacted for an interview. Of four parents contacted, three agreed to participate. Individual interviews were conducted with the mothers in their homes.

Inclusion criteria: Parent (or guardian) of obese teen participant enrolled in this study; English speaking. Teen participant gave affirmative response to question about parental participation.

Exclusion criteria: Parent unwilling to allow home visit by investigator.

Recruitment: The project had initially been explained to a parent (or guardian) of each of the teen participants in the study, during the teen assent/parental consent phase. I further explained the study purpose and procedures to the parent, and explained that the interview would be recorded and that the text of the discussion would be used for research. A separate Parent Participant Consent form was provided to aid in this process (See Appendix 4).

Incentives: Each parent participant also received a $10 gift card to thank them for their time and effort.
Data Sources and Data Gathering Activities

Parent interview protocol (see Parent Participant Interview Guide in Appendix 5): I used open ended questions designed to elicit details, through narratives or stories, of the mother’s experience of being the parent of an overweight teenager. The stories they told were interpreted to gain understanding regarding the influence of the home environment on teen eating practices. The guide for this interview included questions such as: How did you come to recognize that your son/daughter’s weight was an issue? What are some ways you deal with it? Tell me a story about some time when your child’s weight or size was an issue for your family…Tell me what a normal breakfast routine is like in your family. How about dinner? Do you have a family routine around dinner? Does your family all eat together? (Which meal? How often?)

Interview procedures: A private, quiet space located in the home was the setting for the interview. In all cases, this was the kitchen at a time when no one else was home. The interview was in each case pre-arranged, and mutually agreed upon. The mother was asked to sign a consent form to allow recording of the interview, granting permission to use of the text for research purposes. Initial interviews took 30 to 60 minutes.

Observations: I took detailed notes at the conclusion of each visit, in which I described the general physical appearance of the home and neighborhood, and the presence of any foodstuffs visible on my tour of the home, noting particularly those open for consumption (e.g. bowl of fruit, bag of chips, pot of soup, etc.). These observations were recorded and transcribed verbatim as Field Notes.
Data Management

Audio-recordings of the interviews were transcribed verbatim. The text of these transcripts were added to the data set in the qualitative data management software program. Field notes, as text, were also entered into the data set.

Data analysis: Use of interpretive phenomenology was employed as a method to examine the interview data, similar to what was described above under Specific Aim #1. Attention was focused on confirming themes found in the adolescents’ interviews and not on developing new themes. Field notes were examined for trends and provided a method for triangulating the data with what the teen and parent said in their interviews. For example, a teen mentioned a family practice around food that she felt affected her overweight status, i.e. rushed household activity in the morning interfered with eating breakfast. This practice was also described by the mother during the home visit/interview, and was further explored during the parent interview in order to better understand the phenomenon. A review of field notes indicated I observed breakfast pastries in the home, one of the grab-and-go breakfast items described as being consumed by the members of the busy household, including the obese teenager.

Methods: Specific Aim #3

Specific Aim #3: To enhance understanding of the ways in which the school environment influences adolescent overweight through a case study based on review of archival school and media documents, and observations at a high school attended by one or more of the teens interviewed in Specific Aim #1.
Sample selection

I visited one public high school in the San Francisco Unified School District. I met informally with a health teacher and the principal to discuss the phenomenon of adolescent obesity and how it is being addressed at the school.

Inclusion criteria: A high school, attended by at least one adolescent participant in the study; operating a full food service with at least 50% of students eligible for and participating in the free or reduced-fee lunch program.

Exclusion criteria: Unwillingness of school administration to allow observations on-site.

Recruitment: In order to meet this aim I originally proposed to conduct formal, recorded interviews with school personnel. My request for approval to do that was declined by the school district’s research and evaluation committee, as it was “not consistent with their goals.” While awaiting their decision on my proposal I began attending the school nutrition and physical activity (SNPA) committee meetings as a public citizen. The SNPA is an advisory committee to the school board and is composed of representatives of parents, students, the public health department, the student nutrition services, the school administration, and the school board. The quarterly meetings are open to the public, as are the minutes of all the past meetings. I was invited by the committee chairperson to attend the interim sub-committee meetings in an ex-officio capacity. My notes from these meetings are data that contribute to my understanding of the school food milieu.
Data Sources and Data Gathering Activities

Data collection also included a review of archived documents such as school board meeting minutes, field observation notes recorded during and after my visits to the high school.

School Personnel: I engaged in two telephone conversations with the high school’s principal, and had one in-person meeting with her, during which we discussed the phenomenon of adolescent obesity and what was being done at her school to address it. I participated in a health fair on the school grounds during the lunch period, the focus of which was on nutrition. In setting up for the event I spoke with a health instructor regarding the issues of the day. These informal conversations add color and depth to my interpretations, but are not considered data per se.

Observations: I described in my field notes after my visits to the school the general physical appearance of the school and neighborhood, with particular attention to 1) areas where food is sold and consumed and its proximity and availability to students, and 2) areas where physical activity are designated or found to occur.

Data Management

Field notes, as text, were entered into the data set using Atlas.ti software. Historical documents that were available electronically were also entered into the data set. Notes were made regarding documents that could not be scanned, and the transcribed notes were entered as text into the data set.

Data analysis: Historical documents and field notes were examined to understand the background regarding changes in student nutrition in the school district. They were explored for trends, and provided a triangulation point for examining what the teens and
parents said in their interviews. For example, a teen and their parent independently referred to school policies that they felt affected the teens eating practices, i.e. receiving the free school meal. I have a thorough understanding about the application process for the free or reduced-price school lunch through my review of school board advisory committees meeting minutes and my participation in the SNPA subcommittee. This affords me a better understanding of the phenomenon.

Human Subjects

Permission to conduct this study was granted by the local institutional review board.

Participant Time Commitment

All enrolled adolescent participants were interviewed initially for 30-60 minutes. Two key adolescent participants were re-interviewed once more, for 30-60 minutes each. Adult participants (parents) were interviewed once for 30-60 minutes.

Confidentiality and Privacy

Potential participants were referred to the investigator by the staff of the pediatric obesity clinic. I approached individual teens privately to ascertain their interest in participating in the study.

Confidentiality of research participants is carefully guarded. Data for this study, including all recordings, transcription, field notes, and copies of archived documents, are kept secure in a locked cabinet in a locked office. I acknowledge that a loss of privacy could result in embarrassment for the study participant.
The recorded interviews were available to me, and to the qualified individual hired to transcribe them. Once I had compared the recorded medium and transcript for accuracy, the recorded medium was erased. A participant ID code is used on study records in place of the name, and the ID code key is kept separately from the records.

Informed Consent

Prior to any data collection activity, I discussed the project fully with the potential participant. The potential participant had the opportunity to have her questions answered, either in person or on the telephone, and was allowed to take as much time as needed to decide whether or not to participate. An IRB-approved, written informed consent document detailing the study purpose, procedures, voluntariness of participation, the potential risks and benefits, and providing the investigator’s contact information was reviewed with all parties. Individual interviewees were asked to sign a form giving permission for the interview to be recorded and used for research. Parental permission was requested for adolescent participants under the age of 18 years old. The minors were asked for their assent.

Subject Compensation

Every participant (interviewee) received a $10 gift card for use at a local store (e.g. Borders, Target, Trader Joe’s) to thank them for their time and effort.

Potential Risks

Potential risks of individuals participating in this study include: loss of privacy, inconvenience, embarrassment and boredom.

There is also a potential risk of embarrassment for the clinic or the school should
their identity be revealed.

**Minimizing Risk**

The individual interviews were conducted in private. All interviews were kept within a one-hour time limit. Participants were reminded that they do not have to answer any question they do not want to, and that they may withdraw at any time.

**Discussion**

This project increases understanding of the experience of the overweight teenager, told through their stories and through glimpses of the home and school environments. Asking adolescents how being overweight affects their lives is key to helping them in the situation. Having a deeper understanding of the youth’s perception of being overweight may help fuel efforts to re-shape the way food is experienced in American culture, transitioning conceptualization from coveted brands to essential nutrients (Nestle, 2006; Pollan, 2006; Willett, 2001). Asking adolescents what would help them manage their weight, and how the environments in which they live, study and socialize shape their diet and activity practices offers exciting new insights into areas on which to focus prevention and intervention efforts. In putting together the pieces expressed by teens and their parents we have an opportunity to be re-oriented to the phenomenon of adolescent obesity, and to understand this phenomenon in a way it previously was not.

The teens in this study offered their stories so that we might better understand their experience. The interpretations of the text, i.e. the findings of this research study are reported in the section that follows. The chapters are prefaced by a series of brief vignettes that acquaint the reader with the participants. The findings have been grouped
under three main themes that were present in the data: the adolescent world, how food is understood, and uncovering “the Look.”
Chapter 6

Introducing the Girls

The participants in this study had many things in common. They were all teen-aged girls who lived in northern California, they all went to high school, they were all obese, and they all came to the same clinic because of their obesity. They were, however, fifteen very different individuals. They varied in race, ethnicity, and socio-economic status. Some took advanced placement courses while others struggled just to stay enrolled in high school. They lived in a variety of neighborhoods. Their families were differently composed: one parent, two parents, no parents – one, two, three or no siblings – large extended families or small nuclear families.

In interpreting the data for this project, I acknowledge the similarities found in the girls and their stories, but I also discern the contrasts and contradictions that exist. The reader will recognize that these are real people with real lives; just their names have been changed in order to preserve their confidence. In the chapters ahead the reader will encounter the girls in the stories they told. Here is provided a brief description of each girl so that you might become better acquainted.

Ali

Ali was fifteen years old and a sophomore in a public high school when we met at her first obesity clinic appointment. She had been a life-long patient of the medical center, and was referred by a doctor in the Teen Clinic. Ali lived with her maternal grandmother, mother, and step-father. Often her aunts, uncles, or cousins also stayed in the grandmother’s home, located in a working class neighborhood in San Francisco.
was an African-American teenager with smooth skin and sparkling eyes. Her curly black hair was done up in twin plaits with colorful hair-ties on the tips. She was cheerful, energetic in demeanor, and quite dramatic, repeatedly touching her bandage from the blood draw at the lab right before the interview began. She complained about having to fast, and that things took too long at the appointment.

Ali spoke wistfully of her extended family living in New Orleans in the aftermath of Hurricane Katrina, and how she had visited there once with her grandmother, whom she called “Mama” – the family matriarch – when times were good. Ali relied on her grandmother, who was the supporting character of the narrative of her life story. For example, when asked to describe a good day, Ali replied, “I know a good day would be not having to deal with people always talking about you. Like, it don’t have to be just about what you do, I don’t like people talking about me. My grandma says “I don’t care.” She don’t care if nobody talking about her, but I do. I don’t like people... I hear my auntie mumbling under her breath, talking about me behind my back. I walk up in the room and people talking about me and - they really gets annoying. Always some criticism about everything you do. That would be a good day, if I didn’t have to deal with none of that.” (Line 483)

Ali was friendly and engaging, yet she said she had no close friends. She had recently stopped spending time with the only friend she had at school because the girl threatened to beat her up. Ali could not figure out any reason for her friend’s change of heart. Ali wrote poetry, and she said she enjoyed being at the beach. She never went into the water, though. She was afraid of it because she had not learned to swim.
Jenny

Jenny appeared shy and somewhat reluctant when I approached her to be in the study. She surprised me by talking a lot during the interview. A fair-skinned Latina with dark brown hair, Jenny was 15, a sophomore who attended a religious-sponsored school on a scholarship. She was an only child who had no close friends. Her idea of playing was to go to Coyote Point (a park 16 miles south of San Francisco) where her parents watched her ride her bicycle back and forth on a path. Her mother sat in the car, while her father yelled at her to “turn around now” and “take another lap.” Jenny said her parents worked hard nearly every day, and they were tired. The weekend outings were rare.

Jenny described not having had friends at school since she was six or seven. She did not play ball, jump rope, or run with the others, instead at recess she sat on the bench with a book to read. In middle school, Jenny had been on the baseball team. Through that she became friends with the only other girl on the team. The girl moved away to a suburb before starting high school, and they kept in touch by telephone. Jenny had not made any friends in her first year of high school, but she planned to try out for the softball team as a sophomore and she hoped that would bring fun and recreation into her life. She had not joined any clubs or sports teams her first year, she told me, because she was afraid her grades would suffer and she would lose her scholarship. Jenny was used to being alone.

When she wasn’t studying Jenny loved to draw. She considered her best work so far to be a sketch of a scene from *The Lion King* animated movie. She had a thing for lions, she said, probably because she was a Leo.
Annie

I went to Annie’s group home to conduct her interview. It was on a quiet tree-lined street near the university medical center. Annie had lived in the house for 13 months, with four other teens. Two staff members were on duty at all times, and did the cooking for the “family.” She and I sat comfortably in the private front parlor of the Victorian-style home for our conversation while the afternoon sun lit the room.

The 17-year old African-American girl was a public high school senior who liked to participate in her PE class, but otherwise did not care much for sports. Her favorite after school activity was hanging out and shopping with her friends on nearby Haight Street. Annie described herself as “nice, smart and intelligent,” and she aspired to operate her own daycare center after finishing the early childhood education program at the local community college.

Annie’s biological family members lived across town. Their lives were chaotic and “crazy.” She saw some of them occasionally, but they had “some serious issues” that led to Annie’s becoming a ward of the state. She described other family members as “big and beautiful, too”- just like her. Annie had style and confidence, yet when I asked her to tell me about a good day she’d had, she said, “I don’t have good days.”

Billie

I knew Billie for about a year before I asked her if she would participate in this project. She had ended her participation in another study done at the medical center, and was being seen in the obesity clinic. She was 17 years old and a public high school senior nearing graduation when we did the interview. She was excitedly waiting for college
admission reply letters to arrive, and her hopes were on a university in Alabama. Her family was originally from the south, and she still had “people” there.

Billie had an imposing presence. She was an African-American girl, nearly six feet tall, and quite rotund. She had a husky voice and an all-business attitude. She had been in the Junior Reserve Officer Training Corps (JROTC) at her high school, but had to give it up when she could not keep up with the exercise and running. She regretted that she did not have the energy for capoiera either; she had loved taking classes in the Afro-Brazilian martial art. Billie suffered from sleep apnea and joint problems because of her excess weight. She wanted so much to reduce her size.

Billie was being raised by her aunt, her mother’s sister, in a low-income neighborhood in San Francisco. Her aunt adopted her as an infant because Billie’s mother was a drug addict. (She adopted her sister’s other three children, too; two older boys, and a girl younger than Billie.) Billie had started life as an underweight premature infant, had been thin as a young child, but started to put on weight when she began puberty. It became excessive when she was in high school, coincidental to when her birth mother, who had kicked her drug habit, moved in with the family. Billie’s mother, who was waif-like in appearance, did all of the cooking – a lot of southern style dishes that were mostly fried.

Billie was bright, fun loving and adventurous. She enjoyed the challenge of a high-ropes course and the thrill of roller coasters. She was also quiet, thoughtful, and studious, with reading and internet-surfing among her favorite pastimes. She had an after school job at a foundation that gave grants to community youth activities, and she was a
self-proclaimed “shop-aholic” in search of a perfect prom dress. For Billie, “Every day is a good day!”

**Emma**

Emma had a comfortable upbringing in her Marin County home. She was fair-skinned, a pale blonde with blue-eyes who appeared self-assured. I interviewed Emma just after her first visit to the obesity clinic. At 16, Emma described her life as “average…except for the fact that I am overweight.” Her weight began to increase when she was nine, and she first realized that she was “fat” at the age of 10 when a family member told her so.

Emma lived with her nuclear family - mother, father, and one older sister, who was “hardly ever home.” Her mother was also overweight, and had lost more than 80 pounds in the past, which she had regained. Emma went with her mother to Weight Watchers when she was 12, but Emma did not take it seriously: “I really didn’t care what I did. So, I basically just BS-ed my way through.”

Emma had a “passion” for singing and once attended a school where she received vocal training in opera, until she was “kicked out” for poor grades, which she attributed to ADHD. She had been diagnosed with attention deficit hyperactivity disorder in middle school and was treated with medication.

At her new high school Emma’s grades were still poor. She said she was spending more time “focusing on the social aspect” in the first semester, and had let her studies slide. Emma was chatty and sociable. She spoke of many different friends, and of an older boy she dated. She liked to have fun. She described a good day as one spent in the
Haight Street area in San Francisco – shopping and hanging out with friends – 27 miles away from home.

Emma believed she could get her grades up and be a candidate for college. She aspired to study psychology and train to be a therapist. Emma had a lot of experience with therapists, she had seen one regularly since the age of 9. She said it was “awesome” to confide in someone.

Emma confided to me that the hardest thing for her about being overweight was that people judged others based on what was on the outside. Emma had created a hard shell on the outside. She used her size to intimidate, her glaring looks to hold back mean comments or glances, and her angry outbursts to distance others. This shell protected what she considered her true self, the “skinny girl personality” on the inside. She told me that if people looked close they would see she was a “big teddy bear.”

Kelly

Kelly was 16 years old, a junior at a religious-sponsored all-girl high school in San Francisco, at the time of our interview. I had known Kelly through the obesity clinic for several months, and was invited to her house in a nearby suburb to do the interview. Kelly lived with her mother, father, younger sister and a black Labrador retriever in a modest, middle-income neighborhood. The house was cluttered and noisy with everyone home on that Saturday, so Kelly and I went into her bedroom to conduct the interview in peace and privacy.

Kelly was a tall, fair-skinned, Caucasian girl with long shiny ash blonde hair. She had been an athlete throughout elementary school, excelling at basketball. And she had been a dancer. Her weight gain made it hard for her to do those things; she complained
about back strain, as well as knee and hip pains. Yet, she missed the activity. She had been out for a run with the dog earlier in the day of our interview, and said her legs hurt “in a good way.” Kelly described a good day for her as one spent “shooting hoops” with her friends, or hanging out at the mall. She was a very good student who planned to study medicine in the future.

Kelly shared many wonderful stories with me that day. There was one I believe exemplified her sensitivity, discernment, and courage. I include it here, in her words.

_Actually in the last year we took an Ethics class, and we had to do these papers on gay rights, or something, something that was controversial. And, I brought up the thing of obesity in teenagers. And my teacher’s like, “That’s a great idea.” But some of the class didn’t think that was a controversial issue. It’s not really a controversial issue that’s in the news, but it’s a controversial issue with yourself, and with other teens that are bigger, and like how...when I read some of the stuff that’s on-line. Some of it’s really blunt, and curt. If someone really sensitive read it, they would...I mean, it was mean. I mean they just laid out the facts. I mean, if I were, when I wrote something... I mean it’s not like I avoided the subject by making it all sweet, but I didn’t flat out say like, “Fat kids don’t have skinny friends.” That’s like a study that was done, I guess. One really said that, it even said “Fat” it didn’t say like bigger, obese. You know, obese is like a scientific term. It’s, you can’t get around that term. But I mean, ‘Fat’? Who uses that? Well, people use it. I mean this guy was a reporter. I mean you shouldn’t use that word. It’s just like, it’s really bad.

I just remember presenting it to the class and people were like, well you know, ‘how is that controversial, how does that compare to gay rights or gay discrimination?’ And I was like, ‘Actually it really compares to gay discrimination because we’re being discriminated against. People don’t hang out with us because they think we are weird in some way or it’s like it’s a disease or something. Like you’re going to catch it if you stand next to somebody.’ It’s just weird. Some people will be like totally your friend, and some people will be just like, ‘Hi,’ and then not talk to you the rest of the time. They just didn’t get it. I tried to explain it. And, when I couldn’t explain it anymore, because it was getting too personal, I was just like, ‘Whatever - I’m not going to explain it anymore. Just let me get on with my presentation.’ Because, I mean, no one wants to stand up there and cry during their presentation. So, I was like, ‘No. I’m not going to talk to you about it anymore!’ I was like, ‘Do your own research, because this is my presentation,’ and just went on. And, um, I’ve never really...well, that was the first time I ever really addressed a group of people about it. (Line271)

Kelly confided that she has considered addressing the whole student body at her high school regarding the issue of discrimination against obese people sometime during
her senior year. Her teacher and her parents were supportive of the idea. She hoped it would help others.

Becca

I interviewed Becca twice, a couple of months apart. Our first meeting was after her first follow-up appointment at the obesity clinic. She was fifteen and in the 10th grade, a Latina with smooth tan skin and long dark wavy hair that she wore fastened back, out of her face. She looked sullen, but agreed to talk with me while her mother waited. Becca seemed more interested in the $10 gift card than in participating in research.

Becca flunked out of her first year of high school and was in an alternative program for teens that had gotten off-track. She said the new school was not an academic school. Becca told me there were about 20 other students and the focus was on helping the community. They were regularly assigned to an elementary school to tutor second and third graders, plan field trips, set up ropes courses, and they also went hiking, backpacking and camping. She said she planned to go back to a ‘regular’ high school after making up some academic courses in summer school, for her junior year. But, at that time she enjoyed the activities of her new school and described a sense of accomplishment after completing a 10-day backpacking trip in the Sierras. Becca lived with her father, mother and two brothers. Her father played in a garage band and Becca liked to sing with them. She aspired to produce music videos in the future.

In Becca’s narratives she often reported feeling irritated or angry. She had been teased at school for being “fat” starting in 7th grade. When she was at a family party in 9th grade her relative’s friend mistook Becca’s girth for a pregnancy and asked when the baby was due – that really made her angry. She was irritated by the doctor at the obesity
clinic whom she heard tell her she had diabetes and may not ever have children, or live beyond the age of 50. She was annoyed that her father broke promises to play tennis with her, and that her on-line boyfriend broke up with her when he saw her in person. She said, “I feel like I'm a skinny girl trapped in a big girl’s body.”

The second time we met for an interview was two months after Becca was discharged from the hospital for a very rare and serious illness related to being obese. She had the symptoms of a brain injury: severe headaches and loss of sight. In the week before her hospitalization there had been two trips to two different emergency rooms just days apart. Each time a lumbar puncture was done to obtain spinal fluid to check for an infection. The draining of the spinal fluid improved the headaches, and there was no sign of infection. Other diagnostic tests were done. She had an accumulation of fluid in her brain and her eyesight dimmed, but no actual mass was found. She underwent surgery to shunt the fluid to her abdomen and relieve the pressure on her brain. The headaches subsided and her vision returned. These events were terrifying for Becca and her family, who were tearful at her bedside throughout her hospitalization.

The mysterious disease is called pseudotumor cerebri or benign cerebral hypertension. It is not well understood, but is known to affect young overweight women (NINDS, 2008). Since her discharge from the hospital Becca said every person in her family “nagged” her about what she ate. She said that having the brain surgery made her realize how serious being obese was and that she ate less than before. She wanted people to stop nagging her about it.

Becca was about to start 11th grade at a “regular” high school the time of our second interview. She had not passed the math competency test, and had dropped out of
summer school because she was bored sitting in a classroom for three hours each day. This did not deter her dream to attend the state university and study music. She still loved to sing.

Flora

Flora had been a patient of the obesity clinic for about a year when we met. She was a 15-year old Latina with short, curly medium-brown hair and lively green eyes. Her aunt, her mother’s sister, was her legal guardian. She, her aunt and her older brother came to the city on that day via the MediVan shuttle from Modesto (approximately 90 miles east of San Francisco) as they had done on other occasions. The trip had a dual purpose, as her brother had an appointment with another pediatric specialty clinic the same day. Flora was initially reluctant to make a decision about participating in the study. She appeared bored as I explained the purpose and procedures to her and her aunt. Her aunt strongly encouraged her to talk with me, but ultimately, Flora told me, it was her brother that convinced her to do it.

As we walked from the clinic to the interview space, Flora and I chatted easily. She was more talkative that I had expected. She was a freshman in high school and had two siblings who attended the same school - the older brother whom I met was in 11th grade, and their sister was a senior. Flora and her sister lived with their aunt, while her brother lived with his father. Their mother had a drug problem and was not involved in their lives.

Flora was less talkative during the recorded interview. She wanted to give the correct answers to my questions, even though I told her there were no right or wrong answers. She talked about food she ate - recited from the list she was taught were
“healthy” from the clinic, e.g. chicken for dinner, apple with peanut butter for snack. She denied that being overweight was an issue for her, but she was concerned about getting diabetes. “At school they don’t really tease me. It’s not a problem. It’s just for my health.” She fidgeted with her sweatshirt sleeves and picked at her dark red nail polish, she shrugged and spoke in short sentences.

Afterward, the talkative Flora re-emerged. As we walked back to meet her aunt, she told me of her plan to go to college, and be a high school teacher in the future. She told me she liked the warm weather (in Modesto), because there were more opportunities for swimming. She loved to swim. She also liked having a bus pass so she could go all over Modesto by herself or with her sister. When reunited with her aunt and brother, Flora resumed her bored expression and our conversation was over.

Viola

Viola was a congenial Latina teen with light tan skin and dark brown eyes and hair. She lived in the “projects” with her single mother, who had been born in Puerto Rico. They had moved to the subsidized urban housing center from a single-family home with a yard in nearby Daly City when Viola was 8 years old and her parents separated. At the time of our interview she was almost 17 years old and a high school junior.

Viola described her current neighborhood as one so dangerous that she was not ever allowed out the door to play. There was a play structure outside and “even bad things happen there” – so she could not climb on the bars nor use the swing. She was not allowed outside to jump rope or to ride a bike. She had to stay inside where the only activity was to go up and down the stairs – she had tried this and found it boring. She pleaded with her mother to be able to go outside, but the answer was always no. She was
happy to have recently found a program on television along with which she could dance and exercise.

Viola visited her father on weekends. He lived about 15 miles away, in an East Bay community. Viola had an older sister and two older brothers who were married with children. Each lived in different San Francisco Bay Area cities. She described being closest to her sister, whom she spoke with every day by telephone. She enjoyed spending time with her nieces and nephews, whom she said were like younger siblings to her.

Viola attended one of the public charter schools in San Francisco where she got good grades. In her freshman year she volunteered at the Wellness Center at her school and was a peer advisor. In her sophomore year she earned a paid position in the Center. She liked that people asked her for information. She had considered herself shy, but said she found confidence to talk to groups. She “gave classroom presentations about alcohol, smoking, safer sex, gang violence, all these different things.” She was direct and articulate in her interview with me, which occurred after one of her follow-up visits at the clinic.

Viola was happy the day of the interview, she told me, because she was 14 pounds lighter than at her previous clinic visit. She said was very motivated to eat healthier and exercise because she wanted to look good – there was a boy she liked. She said she knew it was “stupid” to lose weight for a boy and that she needed to do it for herself, but still she considered it strong motivation. She also desired to shop and to “fit clothes that [she] actually wants”. The main reason Viola was making the effort, she said, was “so [she’ll] be just like everybody else.”
Nora

Nora was a fast-talker. She was a lively, brown-skinned Latina who needed no coaxing to tell her story. She was a 17 year-old high school sophomore at one of the city’s public charter schools. She lived with her adopted mother and her birth mother in the same house. Her birth mother was a recovering drug addict whose two daughters were adopted by the same woman. Nora’s 13 year-old half-sister was half-black. Nora’s father was Nicaraguan. She explained that she looked more like the Nicaraguans she knew than like the Caucasian women she lived with.

Nora was a fast-mover. She was independent and driven. She told me she had been getting up early and taking responsibility for herself for years. At the age of 12 she took the train and a bus to attend a private school 20 miles away, in the suburbs, for special needs students to “work on [her] dyslexia.” She had a job at a spa after school and on weekends, and she studied hard to earn good grades. She spent time every day at the gym, and referred to “working out” frequently during the interview.

Nora was frustrated that she had been coming to the clinic for three years and had stayed the same weight. She was tired of the clinicians saying that she should be glad she was not getting bigger. “Get over it,” she said, “I want to get smaller.” She claimed to eat the right foods and get plenty of exercise, and was certain her Nicaraguan genes had condemned her to obesity.

Hallie

Hallie had moved with her mother from New York City to California about a year and a half before we met in the clinic. She had been born in South America and adopted in infancy by her Caucasian North American mother. She described herself as a Hispanic
American Native. Home for Hallie was with her mother and her mother’s partner in Virginia until she was five years old. Then the family moved to Manhattan. She had been in the “talented and gifted” classes in her elementary and middle schools. Hallie was an accomplished musician. She began with piano lessons at age 3, but also studied choral and other instrumental music. At the time of the interview Hallie played violin with a youth orchestra, and attended a public art school where she was a sophomore. She had lived in San Francisco for about a year and a half.

Hallie was less than five feet tall and appeared to be younger than the 15 years of age she was when we met. Yet, she was poised and spoke maturely during the interview. She had light-tan complexion and wore her medium brown hair divided into two braids. Hallie had experienced a life of privilege prior to the move to California. She had traveled widely and attended a private school. Their move to the west was precipitated by a change in the family’s finances when her mother became a single parent. This coincided with the onset of puberty for Hallie, who described her body’s changes and increased weight gain to me. Hallie’s San Francisco home was in a modest neighborhood. It was there that she learned from her mother to ride a bicycle and skate outdoors.

Hallie was an active, popular girl. She swam regularly at the local YMCA. She spoke genuinely about having many friends, old and new. Fun for her was described as “window shopping” at the local mall. She said she did not have an issue with her weight per se. Her reason for being in clinic, she told me, was solely a health issue. She had been diagnosed with “insulin resistance.” Although she did not know what that meant, she understood it to be serious because the doctor gave her medicine for it, and her mother
Dina cleared out the kitchen cabinets and bought all new foods after their first visit to the clinic.

Dina smiled and giggled through most of the interview. The 16 year-old dark-skinned raven-haired Latina described herself as someone who “loves to laugh a lot, and loves to hang out with friends.” A good day for Dina was one like the birthday she had just celebrated. On that day she slept in, ate breakfast with her mother, went to a movie with some friends, and then shopped on Haight Street. They ended the day with karaoke at Dina’s house – it was a day full of laughter.

Dina lived with her adopted mother and younger brother in a rented flat on an eastside hill in San Francisco. Dina’s biological mother was a drug addict who gave up care of her children to her sister when they were very young; they saw her infrequently. Dina’s father was unknown to the family. Dina had several older siblings who lived in their own homes in other California communities. At the time of the interview Dina’s 16 year-old male cousin was also living in the home, but it was planned that he would return to his family in southern California, as he had proven too difficult for Dina’s mother to handle.

Dina, a junior in high school, animatedly described her school to me. It was a small public charter school of which she was very proud to be a part. She had recently finished a short course in which she learned to ride a bicycle. By the end of three weeks she had ridden on several trips that exceeded 5 miles, over the hills in San Francisco, across the Golden Gate Bridge, onto the Marin Headlands, and back home again. Her description of avoiding calamity on the rides was hilarious. Her enthusiasm for the
bicycle trips was evinced as she talked about the breathtaking views she had never seen before. She wanted to own a bicycle and was saving money from her after-school job to purchase one. The extra exercise had paid big dividends when she weighed in at the clinic on the day of our interview and found she had lost 12 pounds.

Dina was most proud that she was on track to attend college. She told me that her high school focused on making attainment of dreams possible for the students. In the curriculum they discussed the concept of dream deferment, which Dina described like this: “Like when you’re young you have dreams of becoming a doctor or something but maybe your parents don’t have money for college so you get into gangs or you decide to do drugs and that just puts you out there for failure. So that’s what our school tries to help you with, so like, no matter what – even if your family doesn’t have money or you don’t have all the things you need, you can achieve your dream. So it’s pretty cool. Then we watched the movie *Raisin in the Sun*. We read the play and talked about deferred dreams.” Dina’s dream was to be a medical examiner, or maybe a therapist.

Jamie

Jamie’s family – she and her mother, father and two brothers – had to move in with her paternal grandmother, an older, active retired Mexican woman, when the mortgage on their home in the suburbs became too expensive for them. Her family was caught in the wave of poor lending practices, declining home values, and bank closures that affected millions of Americans in 2008 and 2009. Rather than lose their home to foreclosure, the family rented it to make the payments, and moved into two bedrooms in the grandmother’s home. Jamie had her own bedroom while her parents and two little brothers shared one.
The tall Latina high school junior had a medium-tan complexion and hair that was “highlighted” to a medium brown. She had a no-nonsense attitude and stated plainly that she liked the way she looked. She said she had no problem with being overweight – it was her mother’s problem. She argued with her mother about nearly everything, including her diet and activity. Jamie’s mother had successfully lost 50 pounds using the Weight Watchers plan in the year before, and she tried to get Jamie onto that program.

Jamie and her brothers continued to attend public schools near their house in the suburb. The commuting added hours and stress to everyone’s day, but her parents believed the schools were better in that city than in San Francisco.

Jamie’s mother worked in a pediatrician’s office and her father worked for the municipal transit system. They had always staggered their work shifts so that they would not need day care for the children. Because of this, however, the family was rarely all together at once. Jamie’s grandmother was fastidious about her home and the added noise and mess associated with a family of five created strain in the household. Jamie was looking forward to her 18th birthday, when she planned to move out. While she admitted to being a poor student who purposely failed courses so she could take them in summer school when they were “easier”, Jamie had a dream of attending the local community college’s culinary school so she could one day be a chef.

**Marla**

Immediately after concluding my interview with Marla I wrote in my field notes “What an impressive young woman!” Fourteen-year old Marla was the youngest participant in my study, and she was very poised and well spoken. Her intelligence was
evident in the vocabulary she used, but sometimes I felt that she was role-playing or acting the part of an older person, by her choice of words and by her mannerisms. The “goofy” child side of Marla did show up briefly during the interview, but mostly she was quite serious.

Marla was African-American. She was dressed for summer in a paisley green and white cotton skirt, no stockings, flats, and white tank top with beige short-sleeved lacey cardigan sweater – even though the day was gray, windy and cold. She said she was not cold, and was used to San Francisco weather. Style was important to her. She quipped, “Fashion is a right, not a privilege.”

Marla was the eldest child in her family “on both sides.” Her parents separated when she was young, and her father remarried and had three children. Marla saw him and his family often. Her 7 year-old half-sister sometimes stayed at Marla’s house. Marla’s mother had also remarried, but the man had brought a lot of “grief” to the family. He was a drug addict and he stole from them and others to support his habit. He had spent time incarcerated and in rehab centers, and was in jail at the time of our interview. He was the father of Marla’s 9 year-old brother, and an infant brother who had recently died.

The young girl shouldered much responsibility in the family. As the eldest, she told me, she had to set a good example for the younger children. She cooked the family’s dinner each day, and did the washing up. Marla’s mother worked daily at a group home for disabled men, and sometimes Marla helped out there, too. She studied hard and did well in school.

Marla said she felt as though her youngest brother was her own child. She was with her mother he was born, and she cared for the infant throughout his short life. The
infant succumbed to sudden infant death during the night in Marla’s bed when he was six months old. She did not cry when she told the story, she said she was used to tragedy – people she loved had been dying around her for years - her grandparents, her uncles and cousins, some from natural causes and others from violence.

Our first interview took place a few days before Marla started her freshman year of high school. She was eager to begin, and anxious about the new surroundings. The new-to-her school, an alternative public school, was across town from her home. She would have to take two buses to get there. This was no problem for the independent Marla. In a follow up interview Marla said she liked the new school very much.

Marla was also friendly and outgoing. She described a good day as one spent with friends shopping for clothes. She described her style as “weird” and said she liked to set trends, not copy them. Her dream was to be a fashion designer.

Maya

Maya was a sixteen-year old junior at a large public high school. She was medium height and had shoulder length brown hair. Her skin, exposed by the tank top she wore, was dry and blotchy on her arms and neck. Her hands were dry and her fingers were cracked at the joints. Her fingernails were rough, with dried blood at the cuticles. She scratched her arms and picked at her fingers throughout the interview. She appeared both physically uncomfortable and socially awkward.

Maya lived alone with her parents. Her older brother had moved away. Maya’s parents had emigrated from Panama to the U.S. before their children were born, and Maya had always lived in California. Maya’s parents were concerned that their daughter
had gotten “fat” – she, on the other hand, said she liked how she looked. They were worried about her “pre-diabetes,” yet she did not believe it was an issue.

Maya told me that she had tried to hint to her parents, and to the clinic staff, that she really did not want to lose weight. She had not been able to tell them outright, but was working up to it. She decided to tell me, she said, to put it into words and see my reaction. Maya confessed that she, her boyfriend and several of their friends, had a “fat fetish.” They “got off” on the feel of each other’s fat. She thought she would never want to be skinny. She had a social group that was founded on fatness. She had no incentive to lose weight.
Chapter 7

The Adolescent World

The adolescent world may seem to be too broad a topic to undertake in one chapter. Surely, if I purported to describe everything that an adolescent encounters it would fill more than even one book. That is not the purpose of this discussion about ‘world’ – rather, I aim to share an understanding of the close-in world in which the participants in this study live, and how it shapes their practices with regard to dealing with being overweight.

The adolescent world has many components. Family, school and peers are just a few of the prominent ones. These themes come up most often in the narratives of the study participants. Through interpretation of their narratives, the world of each teen is revealed, i.e. the world in which it makes sense to be who they are and do as they do. In the pages ahead we will move into the worlds of these young women, to discuss family, high school, hanging out with friends and shopping. We begin, however, with a description of the world that these young women share, and in which I first encountered each of them: the pediatric obesity clinic.

I. The Obesity Clinic

The intervention employed by the major metropolitan university medical center’s pediatric obesity clinic follows the behaviorist approach and is aligned with social cognitive theory. This particular clinic was the location chosen for convenience in recruitment and enrollment of the adolescent participants for this project. It will be
referred to herein as ‘the clinic.’ This following short description of the clinic’s goals was found on its webpage (accessed 3/16/09):

The clinic brings together doctors, nutritionists, exercise physiologists and psychologists with expertise diagnosing and treating childhood obesity. The team of experts evaluates patients and their families both behaviorally and biochemically, paying close attention to the links between biochemistry and behavior, especially as they apply to energy balance.

The clinic assists with weight management while also treating other diseases the child may have associated to weight, such as asthma, high blood pressure, high cholesterol and diabetes. Weight management is achieved through nutrition education and behavior modification. Drug and surgical therapy is considered when appropriate. The clinic’s research efforts examine the causes and treatments of obesity.

I am a pediatric nurse employed at the academic medical center where the clinic exists. I became involved with the clinic initially through my role as a study coordinator for a staff physician’s pharmaceutical research project, into which obese adolescents were enrolled and followed for two years. It was while conducting that study that I began to consider the bigger picture regarding the problem of pediatric obesity. Over the years spent conducting that study (as a staff member) I became a part of the clinic. Overlapping with that time, I began my doctoral studies to better understand the phenomenon of pediatric obesity. During the past few years, while gathering data for this project (as a student), I continued to be invited to attend the clinic’s staff meetings, and to meet and observe my study participants in the setting of the clinic. This vantage point has allowed me a unique perspective, as I have been the only nurse associated with the clinic.

An Overview

The university medical center sits atop one of San Francisco’s many hills. The place is like an anthill as it bustles with activity. People move into and out of the
buildings at all hours of the day and night, but the greatest multitude is on the hill on those days when the clinics are open. The clinics draw people to this place. People are everywhere and always on the move, whether on the street, on the sidewalks, or in the hallways. They arrive in this place on foot, on bicycle, by automobile, via city bus or train, and by university shuttle.

It is like a village on market day on this street. Food, drink, clothing, newspapers, flowers and books are sold to folks who wait in lines to purchase the items. Close your eyes to the scene and the noise and the smells confirm its frenzy. The whoosh of vehicle movement is constant, indicating the traffic lights are green in one direction or another. Other sounds of motor vehicles include the repetitive beeping of trucks in reverse, the squeal and huff of air breaks of buses, and the alarming sirens of ambulances and fire-trucks. In front of the tall clinic building the aroma of brewed coffee and warm pastries wafts from the coffee cart, interrupted occasionally by the tobacco burning scent of someone who has stepped outside for a cigarette. The valet parking personnel call to each other and to their clients, people converse and ask for directions. There are people from every walk of life in this scene in addition to these regulars: police officers, postal delivery persons, doctors, nurses, other medical center employees, construction workers, and those unfortunates who appear to be homeless. Some of these people are ill, and some are well. Persons of every age and race come to this place for healing, some who are neighbors to the facility and others who travel a great distance to consult with the medical experts in this place.

The frenzy is only slightly calmer inside the lobby of the clinic building, as people rush to keep on schedule. There is an expansive waiting room at the entrance with
an information desk under a large clock. The bank of five elevators take people up and
down from here, as the building has eight floors serving patients above ground and three
below.

In exiting the elevator onto the pediatric floor of the clinic building it is noticeable
that care has been taken to make this a child-friendly place. The décor includes murals of
scenes from the animal kingdom: tropical fish adorn one wall, tropical birds and jungle
cats another. The waiting room for the specialty clinics includes a round dark room in the
center. This is a womb-like place where a screen near the ceiling plays an animated film.
It has entries on two sides and a low bench lining each of the two curved walls. The
larger space outside this is very bright, with the north-facing floor-to-ceiling windows
letting in the sunlight. This main waiting room is where patients check in, make co-
payments if they have any, make their follow-up appointments, and, of course, wait to see
the doctor.

The Pediatric Obesity Intake Clinic

In order to be seen as a new patient in the pediatric obesity clinic at this university
medical center one must wait for an appointment at the Intake Clinic. At the time this
project was underway, this wait took, on average, 6 months. Authorization from
insurance for payment was sought during that time, and families had time to arrange to be
off work or have other children cared for so they could attend the clinic with the child
who was the patient, i.e. the one that had been diagnosed as obese. In the early days of
the clinic’s establishment (2003 and 2004), few health insurance carriers covered obesity
services, and patients were told that the cost of attending the Intake Clinic would be
approximately $1000.
The Intake Clinic was held only once a month, usually on the first Friday. The appointment began at 8:00 AM and ended at noon. The families were sent information by mail in advance, so they could prepare for the visit. The letter explained that the child had to fast the night before the visit, i.e. no food or drinks except water after 10:00 PM the night before the clinic appointment. This was so that the laboratory tests to assess for risk of diabetes, other metabolic diseases, and heart disease (e.g. glucose, insulin, cholesterol) could be drawn and the results compared to the accepted normal ranges. It was expected that one parent or guardian accompanied each patient. Rarely, in the case of adolescents accustomed to going to the doctor on their own, or when a parent could not take off from work, the patient was there alone.

In the case of the teens in this study, each had been weighed and measured in their pediatrician’s office – often in a place they had been going most of their lives, by people they knew – and told that they needed to see a specialist. A few of the participants had their primary care needs met at this medical center before, and for them the environs of the obesity clinic were familiar. This was because the location of the obesity clinic functioned on different days of the week as space for other pediatric specialty practices, e.g. adolescent health, endocrinology, rheumatology, and nephrology, among others. It was also located on the same floor as the general pediatric practice and pediatric urgent care clinics. In this bustling place, patients ranging in age from a few days or weeks old to 23 years old, and their assorted family members (siblings, parents, grandparents, guardians), milled about.

On the mornings of the intake clinic the check in line was long, as everyone arrived at about the same time. After check in at the counter, each child in turn was
brought into the nurse’s room to be measured: temperature, heart rate, respiratory rate, blood pressure, height and weight. These values were written into the patient’s medical record. After this, the first 4 to 6 patients to arrive were shown into separate exam rooms, where they would each see one of the physicians. This was called Group A. The next group, Group B, was directed, after their visit with the nurse, to go to the lab located on the same floor, to have their blood drawn before they saw the doctor. When Group B was done in the lab they were escorted to a small conference room where they received information about nutrition as a group during the teaching breakfast.

The patients who saw the doctors first (Group A) then went to the laboratory to have their blood drawn, and those that had their blood drawn first and attended the breakfast (Group B) moved into the exam rooms to meet with the doctors. While Group B met with the doctors, the second Teaching Breakfast was underway with Group A. Careful coordination was required to make things run smoothly, so that all of the patients were seen in all four stations, i.e. nurse, lab, doctor, breakfast, and never breakfast before lab. Since people were involved, there was an element of unpredictability that sometimes threw off the choreography. Patients or physicians were late, staff members were absent, or the lab had a longer wait than usual due to concurrent clinics being conducted on Friday mornings. Or perhaps a patient needed special counseling by a psychologist, or the family needed to consult with the social worker. Any of these things, and more, could lead to an interruption in the smooth flow of the intake clinic.

The pediatric obesity clinic was by design a multi-disciplinary unit, and therefore had a lot of different individuals who staffed it. The medical doctors in attendance were all pediatricians by training, but some were also specialists in endocrinology, cardiology,
and gastroenterology. They were often shadowed by visiting physicians and post-docs with an interest in pediatric obesity, for education and training.

**The Teaching Breakfast**

The teaching breakfast was developed by a nutritionist and was taught either by her or a registered dietitian. The teaching breakfast was the standardized nutrition education intervention given to all clinic participants at their first encounter with the clinic. The group included patients (ages 2-20 years) and their parents or guardians of diverse race, ethnicity, education and socio-economic status. A translator may have been present to assist patients who were not fluent in English. A psychologist and a social worker were also available for consultation if needed. One notable omission from the design of this clinic was that of an advanced practice nurse. There was no nurse case manager, nurse practitioner, or clinical nurse specialist associated with this clinic, as there were with the other specialty clinics. This was an issue of funding, and is best left for discussion in a different forum.

The purpose of the teaching breakfast was to engage the overweight child and his or her parents in learning to eat in a different way. Dietary recommendations followed the scheme of the Traffic Light Diet (Epstein, Valoski, Wing, & McCurley, 1994). In this diet foods are divided into three categories: red (high calorie/low nutrient foods to avoid), yellow (high calorie foods that are part of balanced diet but should be consumed in moderation), and green (low calorie foods that should make up the majority of foods consumed). The concepts of meal planning and portion size were illustrated by the Plate Model (Camelon, 1998), in which a divided dinner plate was used. Handouts of the diet,
a sample shopping list, the plate model, and a sample food label were provided to the attendees at the start of the session.

Actual food was available on the table around which the children sat during the group session, with their parents seated on the periphery. The food was grouped into proteins, fruits and vegetables, and starches. The basic lesson, modeled by the plate schema, was that the protein should always be the first item chosen and should fill only ¼ of the plate. The second item in the meal was chosen from the fruit and vegetable group, to fill up ½ of the plate. The last ¼ could be filled by a choice from the starch group. If a starch was chosen, it was to be a whole grain (described as a “brown crunchy”) and not a refined grain or potato (called a “white fluffy”). Additional lessons included 1) how to read a food label, with emphasis on identifying the fiber content on the cereal and bread labels, and 2) decreasing sugar intake through eliminating sweetened beverages and fruit juice from the diet.

Food was provided in order for the participants to practice making a nutritious meal in compliance with the diet, in order to reinforce the lessons they learned, and to feed the fasting children. Each person was invited to make a “plate” and eat breakfast, following the example of the nutritionist who led the session. The food was arranged pleasantly on the table, along with the divided plates, bowls and utensils. The items in the protein group, from which to choose, included low fat soymilk, low fat and fat free milk, low fat cottage cheese and yogurt, nuts and peanut butter. Items in the fruit and vegetable group depended on availability, but included at least one spread-able fruit (to flavor yogurt or eat on bread), and a variety of fresh-cut fruits, frequently banana, orange, and apple. The starch group included offerings of sliced whole grain bread, bran and fruit
muffins, and granola-style cereal. A toaster was available, and a butter-substitute was introduced in a brief discussion of fats. Appropriate serving sizes for the items were discussed and demonstrated by the instructor.

This description of the intervention is provided as background for the reader to understand the clinic environment where I first met and observed the teenage participants for this project. A full study of the effect of the intervention is currently underway by other researchers.

After a patient was enrolled into the clinic through the intake clinic appointment, they made regular visits to the clinic, which was more like a traditional medical clinic. After seeing the nurse to have vital signs (body temperature, heart rate, blood pressure, and respiratory rate) and height and weight measured, the current BMI was calculated. Once an exam room became available, the patient and parent were brought to the back and invited to wait for the physician in the exam room.

When the patient was seated in the exam room, the clinic staff are informed of the location, i.e. room number, and provided with the latest measurement information, which is added to the patient’s chart by the clinic coordinator. It is then determined which health care professionals (physician, nutritionist, psychologist, social worker) will see the patient and in what order. These private appointments are tailored specifically to the individual’s needs.

There were numerous other folks who were on hand at the clinic - to learn, and to help with the research that was underway. At the university medical center there was always research being done, and the clients of the pediatric obesity clinic were all participants in a study. The ethics board approved the clinic directors’ research to assess
the health of the obese patients’ and test the effectiveness of the intervention (i.e. attending the clinic). Pre-professional students in medicine, nursing, nutrition, physical therapy, and other health fields were enlisted or hired to conduct additional research (also with ethics-board approval) with the patients and their families. These were surveys, pharmaceutical trials, device trials, or interviews. The patient and family come to this clinic to be evaluated and treated individually, but they were also subject to investigation in the aggregate.

As a nurse employed by the university medical center I spent quite a few hours in the pediatric specialty clinic space. I knew the staff and they recognized me. I moved about freely and was confident in my dealings with patients and professionals alike. In my role as a novice researcher, which I inhabited when doing this project, I experienced the place differently. As an observer I attuned to the sights and sounds that were otherwise background and would usually be taken-for-granted by me. In the present-at-hand mode, I looked for nuances and paid attention to how everyone moved throughout the space of the clinic.

The Adolescent’s Clinic Experience

In coming to the university medical center for their first obesity clinic appointment some found the experience to be different from what they expected. For some it was a pleasant encounter. Each girl came to the obesity clinic with individual fore-knowledge, perceptions and expectations. As an example, recall 16 year-old Viola. She was encouraged to come to the medical center for her routine health care by a trusted family member.

*My godmom introduced me to here because her kids go here and*
she said this was a really good hospital to go to, especially for me because it has a teen clinic. Because I was previously going to [the county] Hospital and that wasn’t really like helping me a lot so she took me here and I now I go here. (line 21)

After several visits to Teen Clinic, a staff member suggested to Viola that she might find an appointment with the nutritionist beneficial. Viola was not aware this transaction meant that she was being referred to the obesity clinic.

Well, um - they - they asked me if I wanted to go see a nutritionist and they made an appointment and that’s the first time I ever been to it and that’s when I - that’s when I went. I thought it was just going to be like one person talk to me directly but then it was like a whole breakfast thing with like a lot of other kids and it was surprising because I just thought they were just going to talk to me and tell me what kind of food that I need. They actually showed me by the food and showed me diagrams and all these things. It was like I didn't know it was going to be exactly like that. I was surprised in a way but I didn’t really think it would be all that stuff, that long and like blood tests and everything. (Line 25)

When it is possible, many teenagers want to know in advance what will happen, so they can prepare themselves physically and mentally for the tasks ahead. It is widely accepted as developmentally appropriate for adolescents to be partners in decision-making regarding their own health care (Dickey & Deatrick, 2000). For example, an adolescent’s assent is required for participating in clinical research even while their parent or guardian takes the legal responsibility to sign a consent form. This is not always fully explained to the teens, and as minors, they are vulnerable in this regard. They may feel compelled to obey or comply with the demands of their parents and other authority figures in their lives, such as doctors. In Viola’s case, she had not been informed beforehand of the length and complexity of the visit.

We understand foreknowing to be important to Viola’s way of being in the world. This is made clear to us in her narrative, in which she used forms of the word surprise
twice. While being caught off-guard may have been disarming, Viola was able to adapt quickly, and was able to absorb some of the information provided to her on that first day.

*Well, since they taught me important things like low sugar, and how to keep portions and stuff and what things are bad and what things are healthy for you, I've been learning how to control my portions and I don't drink soda anymore, I just drink water because I've learned soda has a lot of sugar and juice, even though it says juice is healthy but it's really not. And, um - I don't eat after a certain time and I exercise at least 30 minutes or more a day or I at least have to get like some kind of physical activity in daily to help me. And, um - my mom also learned stuff too because she didn't really know a lot from the pamphlets they make us - like a survey pamphlet that they give us to do. And she learned a lot about things. Like she thought some things were healthy but actually they're not like bread and potatoes and stuff like that. And that’s about it… (Line 33)*

Viola’s adaptation to the surprises thrown at her by the Intake Clinic makes sense for someone who operates within a world where things are often explained and participation is encouraged, a world where unexpected things do happen and can sometimes yield favorable results. Viola’s world is one that is open to change. Viola is pleased to show us that she learned the lessons taught to her at that first visit, and that her mother did, too.

In contrast, it is possible to imagine teens living within a world where things are not explained, and collaboration of the teenager is not sought. An adolescent in such a world might feel powerless, and express this as hostility. Open hostility toward the medical setting and its staff can block any intervention intended to be therapeutic, and in the Intake Clinic setting it interferes with learning and establishing a willingness to change. Sixteen year-old Maya’s story exemplifies this.

*All I know is that my doctor just pretty much sent me here. With bunches of papers. That’s all I know... Pretty much it was like - they were talking to me and then all of a sudden it was like free breakfast and that’s it. (Line 51)*
The referral and the appointment were made without Maya’s knowledge. She admitted during the interview that her primary physician had advised her in the past to watch her weight, but she did not agree with him. She said her mother had made comments about what she ate and told her to try to slim down. No one, however, explained to Maya that they considered this a serious problem, nor that she was being taken to a specialty clinic to treat her condition. It only became clear to her when she got there. In Maya’s world the adults have all the power and make all the decisions. Being brought to the intake clinic by her parents felt like being ambushed to Maya. She recalled being confused by what she heard that day, as the lessons conflicted with the nutrition information she had already been taught by other authorities whom she trusted.

Pretty much they [the clinic staff] were talking to us about how to eat healthier... They just told us to ignore the pyramid, the food pyramid. That’s kind of awkward 'cause I remembered I'm supposed to follow all of that during my times in like school. So, yeah... They said if like - just change around what you eat. So that was kind of confusing... (Line 89)

The clinic shook Maya’s world in asking her to throw out her previously received knowledge and to modify her diet. It was conveyed in a way that trivialized the request. It was dissonant from the major impact that actually doing it involved for Maya. This was experienced as rejection by Maya. She felt as though her way of being in the world was under attack.

And all of a sudden they just want me to change things around. It kind of made me angry 'cause they're asking to change my lifestyle. (Line 90)

She responded to the clinicians with resistance and opposition. It colored her subsequent encounters. She was suspicious of them, and disbelieved them when they counseled her about her risk of disease. She reasoned that they had mixed her lab results
up with someone else’s when they discussed her “pre-diabetes.” Maya’s world did not include diabetes as they told her it did. Since, in her experience, they were not truthful with her, she would not be truthful with them. In her meetings with the dietitian she lied about what she ate, and in dealing with the doctor, she ignored him.

I kind of wanted to avoid the truth about being at risk and all that...They're like just mentioning the risk of diabetes and all that on - and pretty much I just didn’t want to tell the truth knowing that that’s not going to happen to me. (Line 133)

Maya experienced awkwardness, confusion, uncertainty, and anger in her intake clinic visit. Her initial understanding of the specialty clinic, that it is a place she is forced to go in which people give her conflicting information and tell her things she does not want to hear, colors her subsequent encounters with the clinic. When I asked the clinic’s medical director if I could approach Maya to participate in this project he warned that I would not get anything out of interviewing her as “she only replies in single words and grunts.” The clinic staff experienced Maya as difficult and resistant. She was not taking on the role of patient in the way that was expected. Frustrated and annoyed by their interactions, both Maya and the physician assumed that their visits in clinic would not be fruitful, and they were not.

Others experience hope when they are referred to the clinic. Hopeful for the opportunity to be skinny, for an obesity cure, they are grateful that such a place exists and that they have access to it. The blame has shifted off of them by the medicalization of obesity. In the clinic, obesity is not seen as the individuals’ sins of gluttony and sloth that need contrition, but rather as the diseased body that needs treatment. In making a medical diagnosis of the condition of obesity, what was once seen as a personal failing can be
viewed instead as an illness that befell a person. On the one hand, this lessens the stigma of obesity, but on the other hand it victimizes the obese.

In her fourteen years Marla had been so overweight that she was teased and scorned by her classmates. She sought help from the trusted adults in her life, and she expressed that, for her, coming to the clinic was a gift.

It was like I was feeling bad about myself. I didn't like how my weight was and I didn't like how I looked. And I was very - - self-conscious -that’s the word. And we went to see this therapist lady and I remember her name was Regina. It was about probably three years ago. And well, we was about to go to the clinic and we found out it was like - it was so expensive, like my mom said it was around like a thou - around a thousand dollars. So we told my doctor and he was like “Okay.” He’s like “That’s a really good clinic.” And so around another year we got a call that I got accepted in because my doctor, he made some way...But he was the way to make me able to get in and it was like “You can miss no appointments or you're out,” because there’s like - there’s a long waiting list for it. And ever since then - that was about - that was 2006 in January and I started from there...Because it was also watching my weight so I could be healthier. And I'm glad I was coming because I found - like the first day I came here I found out I had a high risk of diabetes. I had a high risk of diabetes, it was probably diabetes 2, I think. And they came and they told me that I really have to have like no sugar at all because this is like really - if I had - like my insulin probably got just a little bit higher I could have had diabetes. (Line 53)

Marla was a black teen who lived with her mother and younger siblings in a tidy home in one of the city’s low-income neighborhoods. She described to me that she had survived many tragedies in her fourteen years. Her story was a chronicle of grieving the loss of significant people in her life: grandmothers died of disease, cousins and family friends had been murdered, and her infant brother recently died of SIDS. She said she realized that she ate to feed her depression. She said she was trying to fill a hole that could not be filled – she traced it back to starting with the death of her “Nana” when she was 9 years old. Yet, she was hopeful. Marla had faith in God, and bore witness to the
power of prayer in her life. For example, she shared that when she asked God to show her
she was beautiful that people came up to her and said, “Oh, my goodness, you are so pretty” just “right out of nowhere.” When she prayed for a best friend at her new school
she found someone on her second day. It was from this perspective of hope that Marla
approached the clinic. She was thankful for having a doctor who was able to get her into
the exclusive clinic, she was grateful for the tests and the information she got from the
clinicians. Marla was engaged in her recovery from obesity. She followed the program,
took her medicine, and went to all of her appointments to avoid having the opportunity
taken from her.

Jenny’s voice croaked when she told me how she came to be a patient in the
clinic. In her fifteen years, Jenny was told that she was too fat by many people, but none
had offered to help her before. Retelling the experience choked her up. In her world,
being referred to a specialist because she was overweight was appropriate, i.e. it made
sense because her parents, her classmates and even her doctors, had been telling her she
was too fat for a while. But it was the difference in being told that someone would help
her with this problem that struck a chord with Jenny. She lived in a world in which being
obese was bad, and since she was obese it followed that she must be bad, too. That is how
she interpreted what her parents, doctor and classmates had been telling her. Being in the
clinic made it evident that others thought she was worthy of being helped, when she had
come to believe she was not.

*Jenny:* Oh, it’s okay...I mean, I’ve been told by my doctors that I must lose
weight. And so, coming here was another thing telling me I must lose
weight. So being informed about it was okay. I’ve never been told, you
know, come here and we’ll help you - so, that was interesting.
Interviewer: So, do you feel like this time you were told that somebody will help you?

Jenny: No, I’m saying that...well, how do I explain this?...it’s a lot for me for someone to say we’ll help you with your problem. So, I...(voice choked up - unintelligible) ...silence

Interviewer: I’m trying to understand what you are saying. So, when your doctor suggested that you come here, did you think that it was a good thing - that someone was trying to help you? Or, did you think that somebody was trying to just tell you again that you need to lose weight?

Jenny: No, it was a good thing. Because when I came here they showed me that there are programs, that I wasn’t the only one that was overweight. And I thought that was a good thing, that I’m not the only one. I don’t have to keep worrying that it is just me. (Line 49)

In Jenny’s world she had been subject to “othering” by her classmates, doctors, and parents. This isolated Jenny, and caused her to be alone. The conversion Jenny experienced, to learn that she was not alone with this problem, is evident in the strong emotional impact coming to the clinic had on Jenny. She has gained, in a sense, validation. She now knows that she is okay – in the way she is and who she is - for she is not “the only one” with this problem. She was overcome to feel supported in this way.

Even though the common ‘world’ of clinic was inhabited by all of the girls, the experience of it varied among them. Some found it strange and scary, and others felt it to be supportive and helpful, and for some it was a little of both.

In the next section I explore the ways in which the meaning of obesity takes shape in the family of the adolescent study participants.
II. The Family

In being born each of us arrives into a world that is already underway. Our mothers and fathers, and our extended family members, have experiences and understandings that they bring to bear on what constitutes that world. One’s world is shaped through being situated in a specific community and country, receiving language in traditional or newly acquired tongues, and dwelling with people. The teenaged participants in this study grew up in different families. Therefore, they have different experiences and understandings of the world, which provides them with different possibilities. There is also much that is similar, and there are shared understandings of the larger world of community. They have all been thrown into the 21st century, in the western region of the United States of America, where English is predominately spoken. They have all made their way to the pediatric obesity clinic. The ways in which the girls experience the clinic reflects their formation within a unique family.

Family is those closest other humans with which we dwell. Adults can choose partners and mates and create family groups. In the case of children and parents, they do not choose each other. As children grow into adolescents they often initiate a process of distinguishing themselves from their family of origin in some way, in which they are learning their own identity (Grolnick, Deci, & Ryan, 1997). This part of the journey to adulthood is accomplished by experimenting with alternative behaviors and, in some cases, through rebellion. This can be extreme, as in participating in risky activities with illicit drugs, or mild, such as choosing a vegetarian diet. The adolescents in this study are learning to take a stand on who they are. They endeavor to ask and answer for themselves the existential question “Who am I?”
Um, I’m 16 years old, I’m very outgoing, very talkative. Umm, I have a reasonably good life, a family that supports me, puts a roof over my head. I have an older sister. Um, I’m German and Italian. My family is very close, you know, for the most part. Um, I don’t know...like I have, pretty much, like the average life, I guess you could say, except for the fact that I am overweight and that food plays a big role in my family. It’s usually there for comfort and it’s usually there for, you know, for the good times and for the bad times, but other than that, it’s pretty much like the normal life, I guess you could say. And, I love sports. I love...like TV. I like talking on the phone. I like meeting new people. I like everything. I guess you could say that’s basically me in a nutshell. (Emma, Line 7)

Emma’s family was Caucasian and lived in a middle-class neighborhood. Her parents were married. Her father was the provider, employed outside the home, and her mother was a full time homemaker. Emma’s family did fun things together when she was young - they went on hikes, they went to the county fair. It was after a family hike that Emma’s uncle had first pointed out that she was overweight. He compared her weight, at the age of 10, to his adult fiancée. Her aunt mocked her when she was fifteen and told her she needed to go to “Jenny Craig.”

Emma remembered a close-knit family, but her narrative disclosed this had become less so as she got older. The members argued more frequently and were openly hostile to each other. There was often silence between them so that they rarely ate meals together. Instead, each took a plate of food prepared in the evening by her mother to separate locations in the house to eat alone. The increased tension in the family was experienced as a reason to eat for Emma.

And my mom started yelling at me, and I was like begging her to just let me go out. And she wouldn’t let me go, and we got into an argument so she started like saying stuff. And my dad was all, “I’m never gonna let you go to my funeral. I hate you.” And he said, “You’re never going to my funeral,” ‘cause my dad has like anger problems. And, I got

---

3 Jenny Craig® Personal Weight Management program.
really upset. So, I went and made myself like 5 sandwiches and sat in my room and ate sandwiches all night. (Emma, Line 550)

It was unclear what Emma’s father may have meant by his excluding her from his funeral at some time in the future, but the vituperative quality of his remarks to his daughter was not unique to this one evening. In Emma’s world verbal abuse was regularly dished out, and Emma found that eating eased the pain of it, at least for a little while. Emma told me she frequently used this behavior as a way to comfort herself. She admitted it always initially made her feel better, but that later she would feel awful again. It was a vicious cycle and she was caught in it, and she tried to nourish her emotions with food.

In the life of an overweight teenager who is trying to control her weight gain, and for those who want to lose excess weight, it is fortuitous to have a supportive family. Seventeen year-old Nora was growing up in a less traditional household. Hers was a multi-racial family with two mothers, living in subsidized housing.

I'm lucky that my parents support me like that because I know there’s people who don't. So there’s always stuff I can eat in the house, like I like - I'm getting older. Like when we first started there really wasn't much that I couldn't have, like there was not the bad food. But now I'm getting older and I'm not there as much so like they're incorporating some stuff that I wouldn't - I can't eat but they can eat but it's like I know I can't eat it so I'll either eat it or I don't. (Line 26)

Having appropriate food available for Nora to eat meant to her that her family was supportive, that she mattered to them. She attributed their slip into old, “bad food,” habits to the reality that she was older and away from home more often. This teen had an after-school job, and also went frequently to the gym after school or work. Her home was a long public transit ride from her high school. In one breath she stressed to me how she
avoided “bad food” and in the next she told me she left the house without breakfast on many days and would “grab a bagel and cream cheese at Noah’s” near the transit station on her way to school. Avoiding “bad food” was more difficult than she admitted.

Nora was frustrated that she was not losing any weight. She chalked it up to having inherited a certain body type from her paternal lineage. In Nora’s fast-paced world it seemed to her she was doing what was needed to lose weight, so there had to be another reason her BMI did not change. She traced it to the genetic antecedents that she did not know - her absent father and his family.

Like I know I'm curvy, like [my friend] J. Because - it’s really my dad’s side of the family. Like my mom’s frickin’ - she’s not a stick but she’s not overweight either. I got my hair - which half the time I hate but half the time I love, I got his body type. I got his hair, his body type, and something else, I can't remember. So it’s like I’m getting all his features. I don't even know the man and he gave me all this crap that I don't like half the time. Like it’s never been like - like I'm overweight but I honestly don't look what I weigh at all, I really don't. (Nora, Line 287)

I know I'm bigger like because I'm built this way and like all my family - all my dad’s side of the family, like all my aunts and my cousins, like they're all - none of them all like - like - Because you have people from Nicaragua and Latinas and whatever, some of them are really skinny, some of them aren't. Like I'm not one of those skinny ones and like, yes, I would love to get where they want me and that’s what I want but it’s not working so - (Line 443)

In discovering who she is Nora found she was like her father in appearance, and other Latinas she had seen or met. She closely identified with her paternal aunts and cousins, rather than with her two thin white mothers or her half-white/half-black half-sister. In birth families people look similar, but not so in adopted families. In figuring out how she fit into the family she lived with, Nora was very conflicted – she concurrently described herself as overweight and denied that she saw herself as overweight. Nora had a burden in the body she had been dealt – half the time she loved it and half the time she
hated it. In the hope of reconciling this she accepted her body, but desired to change it at the same time. This dilemma can be paralyzing - it was the regular state of affairs in Nora’s world. She inhabited the world in these two ways simultaneously. She was indeed “stuck.”

Family can also actively sabotage the adolescents’ attempts to control their weight. At sixteen years old, Kelly, who lived with both of her biological parents and one sister, was caught in a power struggle with her father at mealtime. She asked him to limit her meal portions and he would not honor her request, and then appeared hurt if she did not eat all the food he prepared and placed on her plate.

*Dad [does the cooking]. And dad just, I mean, he’s not blind to the fact that I’m bigger but I’m like, “Dad, cut down my portions in half.” I don’t know... he doesn’t get it. I tell him, “Dad, half the rice.” He’ll put everything, and then when I don’t eat it it’s like, “Oh, did you not like it?” “No, Dad, I’m trying to cut down on my portions.” And then I’m like, “Dad, that’s enough.” “No it’s not, blah.” I mean he just doesn’t... because he doesn’t have to worry about it, he doesn’t get it. And like you know, one scoop of rice is fine “Dad, that’s enough.” “No, it’s not, uhh.” You know, or like, “Dad, a little piece of chicken’s fine.” “No, Kelly, you need to eat.” It’s like... it’s just weird. (Line 201)*

I mean, it’s weird because my dad makes sure my mom and I have enough food and then if there’s less food for him he doesn’t say anything. It’s like he’ll do this - when we have Shake-n-Bake chicken or something - I’ll only eat one piece because it has the skin on it. You know, if I’m going to eat the skin then I’ll only eat one piece, instead of two without the skin. If I say, “Daddy, I only want one piece.” And then he’s like, “Are you worried that there’s not going to be enough? ‘Cause there’s going to be enough.” I was like, “No, Dad, just one.” And then he gives me, “Okay, if you don’t eat it fine,” and just puts it on my plate and then when it’s on your plate then it’s really hard. I mean it is really hard for me, if something is put on my plate, like I don’t want to be - it’s not like I don’t want to be rude, ‘cause it’s my dad, but it’s just there. (Line 218)

I’m trying to get it through, I’m like, “Dad!” He’ll do the portion thing for about a week and then be back to giving me two pieces of chicken. Dad is like, “Well, you need to eat.” And its like, “Dad, I’m fine.” I don’t know, I guess he’s like paranoid that I’m gonna go all anorexic or something because I’m not eating two pieces of chicken. It’s
so weird. I don’t know...and then, I don’t know... that’s the only reason that I can give, because he’s, “You need to eat.” I mean I eat, it’s not like I don’t eat all day... So, it’s just like, “Dad, just one.” “No, you need to eat.” “Okay, fine.” And then I’ll usually eat one and a half. Some nights I’m just like, no, and then I’ll eat just one. And then, he’s not like mad at me, but he just doesn’t get it, ’cause he doesn’t have to worry about it. It’s just weird. (Line 239)

Kelly was trying to puzzle this out, to understand the “weird” behavior of her father that seemed so incomprehensible. Kelly was a tall, pretty, high school junior. She had lived in the same house in the suburban neighborhood her whole life. Both of her parents worked full-time, her father was a fire fighter and her mother an office manager. She had one younger sister and a pet dog. She had suffered throughout elementary school from the brunt of bullying and teasing by her classmates because of her obesity. Her weight problem was not a new one to this family when they brought her to the clinic for help. Kelly struggled to make sense of her father’s behavior. Was he forcing food on her as a way to show his love? Was he genuinely worried she might starve or become anorexic? Was he trying to keep her (and her mother) fat for some reason? Or, was there some other motivation? Whatever it was, Kelly found it troubling because she had known her father to be supportive in all other areas of her life, and here he was not only not being supportive, he was actually hindering her progress.

Home and family are the close-in world of the adolescent. It is the space in which dietary preferences and eating habits are established. This is the arena in which the first lessons about nutrition are expressed by what is available on the dining table. It is the place that establishes whether changing eating and activity practices, and therefore controlling weight, is a possibility or not.

The influence of the home and family play out in the actions of children at school.
Likewise, the lessons learned at school - on the playground as well as in the classroom and lunchroom - are brought back to the home. In this way school is an extension of the close-in world of the adolescent student. In the next section I uncover the ways that the school environment contributes to the meaning of obesity for adolescent girls.

III. High School

A good portion of the adolescent’s waking hours are spent in school, ranging from 4 to 8 hours a day depending on a school’s standards, on the grade level and the academic interests of the students. There are many, varied, high schools in the metropolitan area where the participants lived. The schools are different in many ways that could be easily observed. For example, they differ in the size and condition of the buildings and grounds, and the size and diversity of their student bodies. They also vary in countless ways by those things that cannot be seen by the casual observer. A few of these covert differences are the involvement of faculty, the engagement of the students, and the mutual respect people have for one another.

Within the high schools the food service environments also vary in physical ways, and in less obvious ways. Many high schools do not have full kitchens and serve pre-made meals delivered by truck and heated at the school, while others have on-site cooks. Some campuses are ‘open’ for the students to leave to get meals, while others are closed and students either bring their lunches or eat the school lunch. Vending machines have been removed from some campuses completely, while others have replaced the items previously sold in the machines, such as soda/pop and candy, with water and protein bars. Several high schools attended by study participants had recently installed salad bars for
lunchtime service. These latter changes have been brought about by implementation of the school district's Wellness Policy.

In talking about the lunches provided by the Student Nutrition Services, participants’ stories were mostly negative. When asked if she ate the school lunch, Nora replied:

*Oh, hell, no. I will not put that stuff in my body. It makes me sick...Whatever. I don't know. I won't even touch it, it's gross. I don't even think I get free lunch because I don't apply for it but that stuff’s gross, it’s like nasty.* (Line 319)

They do [have a salad bar], it's gross. [chuckle] And they just got it, it's nasty. I don't –The lettuce isn't good and then I heard they don't have dressing. Actually, I've never been, my friend's been. I've heard lots of other stuff and me and [my friend] I like to eat the same stuff. (Line 351)

Nora was convinced, without trying the food from the salad bar, that she would not like it. This was reinforced for her by the comment made by her friend, and by a similar one made by one of her teachers. This influenced Nora’s decision not to eat lunch at school from the salad bar. Nora’s negative attitude toward school meals was a factor in her failure to apply for the school lunch program. Not returning the school meal application was not an uncommon choice, which was unfortunate for the school district. In order for the student nutrition program to receive adequate funding, applications are needed from all students - whether they think they will eat at school or not, and whether they think they are eligible for a free or reduced-price meal or not. An under-funded nutrition program is less able to provide a variety of healthy food choices to students. In the latter half of the 2008-2009 school year the higher-price items such as jicama and mushrooms were eliminated from the salad bars in the SFUSD schools. Additionally, in an effort to decrease food and labor costs, a pilot program was instituted at one high
school in the district to provide only “mainline” or whole meals, thus eliminating ala
carte sales. 4

Participants in the study had another reason for not eating the school meals. They
were concerned that the food provided at school conflicted with the recommendations of
the clinic. Fifteen year-old Ali found it easier to stay on track with the dietary changes
prescribed for her if she brought food from home.

*Yeah. I don’t eat school lunch anymore, ‘cause that’s worse. You
don’t even know what’s in it, or anything. At home, I could possibly count
some of the calories that be in that stuff. ‘Cause I know I had some
sausages, and they was good, and there was only 100 calories in them
sausages.* (Ali, Line 228)

It was Dina’s experience that school food was of questionable value – it lacked
freshness, flavor, and did not meet the clinic’s recommendation to decrease starches.

*I don't like school lunch... I don't want to eat it and I don't want to
buy what they have there. Well, I don't know what they have for school
lunch anymore but it’s like frozen stuff they just like defrost. I guess they
defrost it and then like put it into a warmer or something, I don't know.
But they do have like a little salad bar but the salad doesn't look very good
so I just like looked at it and I was like (wrinkled nose). And then I think
they sell like - they just sell a lot of the bread stuff, like things that are --
They're like easy to like just give out.* (Dina, Line 294)

Disdaining the school lunch was also something Jamie did since she started
coming to the obesity clinic. She had more control of her food intake if she brought a
lunch from home.

*Jamie: Like I’ll have turkey sandwich with mustard only, I hate
mayonnaise. I bring my lunch. I never buy lunch anymore. So like -I used
to buy lunch in middle school and -- when I just started coming here,
coming to the clinic and like I cut off all like buying foods because it was
greasy and like fat. Like you could take a napkin, like put it on there and
it'd go [imitating sound of sucking up] --

4 SFUSD Student Nutrition sub-committee meeting notes, February 18, 2009.
Interviewer:  It soaked up all the grease?

Jamie: Yeah. And at the school it would be so much more and so I stopped eating all like bought lunch food and I started bringing my lunch and that worked out better because I know what I liked anyway and if they don’t have something I like I'd be like “Okay, well, I guess I'm not eating today.”(Jamie, Line 283)

For others bringing lunch from home was not an option. Families with less economic means rely on the federally subsidized school meal program to feed their children each school day. Marla, a 14-year-old study participant, had always depended on her schools to feed her, but this meant that her choices were limited to what was provided by Student Nutrition Services.

I mostly eat a free school lunch but - yeah. I really wanted my own lunch. I don't really like the school lunch at all. I don't think it's really healthy at all. I only ate the healthy stuff. Like they have salad every day so I’ll get a salad and I’ll eat that with some milk. They have white milk - on some days they didn't have white milk so I just drink water, like outside on the thing. But this year I'm focused to bring my own lunch because I really - depends on how the lunches are at this school. (Line 313)

At the time of Marla’s interview she was just about to start high school. The young woman was not happy that she had to eat the school lunch and would have preferred to pack her own. But, this was not possible in her low-income family. When I interviewed her mother a few months later, she related that Marla had been eating the free lunch at the high school during the first weeks of the school year, until one day when the principal denied her access to the lunch line.

The first week when I found out about Marla, she came and told me that she wasn’t eating no lunch. I'm like “What? I sent in the form. Why not?” She said, “Well, it didn't come in, Mommy, and they told me I can’t eat no more.” So I talked to the dean up at the school about it and the next day they called me and said that they gave Marla a card so she got on it. So I was glad about that.”(P014. Line 145)
In order for the school district to be reimbursed for the free and reduced-price meals that it provides to its students the school district has to provide documentation of the need for the resources. The higher proportion of students in a district that demonstrate need, the higher the rate of reimbursement from the government. At the beginning of each new school year every family is asked to complete and return the school meal form for each of their children in the public schools in the district, whether or not they believe their child is eligible for the free or reduced-price meals. In return for submitting the form, a meal card is issued to the child. In the school year in which this study took place there was a tremendous effort on the part of school administrators to have forms returned for each student, so that each student had a meal card and meal expenses could be tracked. At the high school level at least one principal denied students without meal cards access to the meals as a way to induce them to bring back the forms which would ultimately help the district control the cost of student nutrition services.

While the general opinion of school lunch was unfavorable, it was apparent that having lunch at school was a shared experience. Considered by some to be more important than the food was whether she ate her lunch alone, with one friend or with a group. A girl’s peers also convey meaning about what it is to be an obese teenager.

IV. Peers

Peer relationships are very significant to adolescents (DHHS & HRSA [Health Resources and Services Administration], 2003; Spear & Kulbok, 2001). In school, children are expected to interact, cooperate and collaborate with their classmates. Friendships may be born from these relationships, or physical and emotional pain may
result. As children progress into and through adolescence, and begin the process of
separating one’s self from one’s parents, peer relationships may take on new meanings
and have influence on the world of the adolescent.

Kelly, a 16-year old high school junior at the time of this interview, recalled that
she was treated badly by her peers throughout elementary school. She routinely endured
degrading schoolyard confrontations with her classmates.

Just in grammar school it was kind of hard, because, I mean, I was
the only overweight person in my class...so, I would get teased a lot...I
would get teased every week. They would corner me. A whole group of
them and go on and on about it...It was like I didn’t fit in, and they would
always single me out...; It started, I would say, in 4th grade. And then it
went to 8th grade, because I guess you know...little kids, they’re not
really... or you don’t really realize it, like if someone calls you fat in
second grade, you’re like “Whatever.” But in 4th grade you start getting
self-conscious, and you start getting into this like awkward years, like 10,
11, 12, you know. So, yeah, that’s when it really started. That’s when I
really started realizing it, and it really like...umm, yeah it was just hard;
Mom took care of it – well, she didn’t really take care of it, ‘cause it still
happened, but I was in the principal’s office a lot telling what happened,
and then they would have to write letters to me, which really didn’t make a
difference, because they would just turn around and do it next week.
(Lines 18; 46; 89)

This changed when Kelly entered high school. There she found that the bullying
was less overt, and that made it easier to live with.

Yeah, and then you know getting into high school I was really shy
at first because I didn’t want to put myself out there like I did in grammar
school, I was really outgoing, and then have someone cut me down like
that. But now that I have friends and we all hang out together it’s not a
big deal like it was in grammar school. No one’s ever called me fat to my
face. No one’s ever teased me about it to my face. So, it’s better in high
school, I have to say. (Line 64)

In elementary school Kelly could not avoid the peers who teased her, but in high
school she was able to distance herself from those whose disparaging remarks and snide
glances interrupted her smooth way of being in the world and revealed to her that she was
fat. In Kelly’s world she was a victim; she experienced the hurt of public humiliation by her peers.

Fifteen year-old Flora also experienced teasing in elementary school and acknowledged a change since starting high school a year and a half before the interview. Flora did not see herself as a victim. In her world it was appropriate to defend herself against peers who wanted to make an issue out of her obesity. Instead of being bullied, she became a bully.

But now that I’m in high school they don’t really tease me. They’re like - they’re scared of me. [chuckle] They’re scared of me because I play around too much and I sock them and they’re like (makes a surprised facial expression) - that’s why they won’t do nothing to me. (Line 665)

Well, there’s this kid named Ernesto. He’s always teasing me. Like I’m walking down or something, he goes “Earthquake.” [chuckle] Yeah. Or he’ll call me oompa-loompa or something. But I don’t get mad or nothing, I don’t get upset, I just ignore him. Yeah. Because there’s like - they’re not mature enough.

Sometimes I’ll make him look bad. They tell me some more, I hit him or something or - I slap him in the face. [chuckle] and [chuckle] they look stupid. (Line 709)

Emma also did not just take it when students at her high school drew attention to her size. She experienced derisive comments by her peers and dealt with it by confronting them.

To me, I imagine usually that they’re making it [a rude comment], and then sometimes people do, usually at school, ‘cause people in high school are cruel, they’re horrible, but usually though I’ll pass by and they go, ”Ho, oh my god!” and stuff like that. Yeah, that’s basically the bad parts, but I mean like people saying stuff to me. But, really if someone said something about me I’d probably glare them down or something and look all intimidating and like that. So, people usually don’t really say that much. (Emma, Line 182)

Likewise, Jamie developed a technique for dealing with would-be abusers. As a youngster, she figured out that her increased size was intimidating to her peers and could
be used to defend herself. Then she used her girlish charm to fool adults and kept out of
trouble, even as she beat up her peers in schoolyard confrontations over her obesity. As
she grew up, Jamie changed her tactics and developed conflict-resolution skills in
adolescence that kept her out of physical brawls in high school.

Elementary school, I was a bully. I would beat on other kids when
they messed with me. Like they'd try and pick on me, I'd be like “What?”
And, you know, I'd chase after them and I'd beat them down. And teachers
would tell my parents, “She doesn't know her own strength.” Because I
would do it in a way that didn't look like I was beating them, it looked like
I was playing with them. [chuckle] Because I'm very smart. I know what
not to do and what to do and how to make it look. [chuckle]
Once I hit middle school they tried picking on me and I'm like
“You know what, you're not even worth my time anymore, I'm not even
going to bother because it's a waste of energy. I could do stuff so much
better than mess with you.” So, I don't know, throughout middle school,
which was like two years in a different school with other people I learned
so much different stuff to like control my anger because I have horrible
anger issues from my dad. Like when it's hot I cannot stand it. That's the
only reason I cannot control anger is in heat. I love the cold for a reason.
[chuckle] But in middle school I met so many new friends that they were
just so calm and mellow I was like “That's really cool.” And like people
would mess with them and they'd be like “No, dude, don't.” And they'd be
like ‘Oh, you're no fun, go away,’ and so they'd just walk off. I'm like
“how'd you…? What?” [chuckle] They're like “Just don't even bother.”
I'm like “I think I'll try that.” [chuckle] So since then I haven't fist-
fighted at all. (Jamie, Line 199)

But I don't fight, I talk it out instead. Like at school they have peer
mediations because there's a whole bunch of fights that happened. And so
many times I hate those but I'm like “No.” I go down the office, “I need a
peer mediation with such-and-such.” And so they'd be like “Okay, why
do you need it?” I say, “I want to kill them. I seriously don't want them
in my face. I don't want to be around them, I want to hurt them.” They're
like “Okay, perfect, let's talk now.” So they calm me down, we have a
peer mediation, I get everything off my chest and I wouldn't talk to them, I
wouldn't ignore them because I no longer had a problem with them. And
that like calmed me down so much to not bother. (Jamie, Line 203)

Jamie experienced an alternative to violence when she saw her new peers’
approach to conflict. She adopted that as her preferred way of being. It allowed her to
continue to be confrontational and oppositional to those who had something to say about
her being big or fat, but in a more socially acceptable way. In Jamie’s world, which includes a father with “anger issues,” it is expected that she stand her ground. Jamie was powerful, whether she was throwing her fists or using her words.

Transactions with peers play a large part in an adolescent’s life. Many of the girls described their relationships with friends being centered on shopping. Shopping was an activity that significantly contributed to the meaning of being an obese girl.

V. Shopping

Consumerism is an important feature in a capitalist society such as the United States of America, and children are imprinted early with brands of things that they must buy in order to belong to this culture (Quart, 2004). Advertising to children begins with marketing to parents of expected children on the latest and greatest of baby supplies to purchase for the home: layettes, diapers, formula, baby food, car-seats and strollers. Infants, toddlers, pre-school children, school-aged children, and adolescents are targeted by advertisers for toys, games, candy, clothing, food and beverages through television and print in the American world, where everything is for sale all the time (Committee on Communications & Strasburger, 2006). In order to see the merchandise and bring some of it home, shopping is necessary. Shopping has become a national pastime. Shopping malls have even been billed as vacation destinations, including the Mall of America in Minnesota and the Great Mall of the Great Plains in Kansas. The ubiquitous nature of retail marketing in America, and the shopping that it generates, makes them a part of the background in all of the study participants’ worlds (Quart, 2004). Marketing and shopping are part of the shared ‘we-world’ of American society.
Purchasing is power in a capitalist society. The adolescent, who is physically mature enough to get to the mall without a chaperone, may have money of her own to spend on whatever item she desires, i.e., discretionary income. Those whose business is advertising capitalize on this. Adolescents are not strangers to marketers. It was in 1941 when the term “teenager” was coined on Madison Avenue. In the year 2000, U.S. teens spent $155 billion in “discretionary income” (Quart, 2004). They are an important market.

Shopping was an everyday activity for the participants in this study, typical of other girls their age. Going to the mall with family or friends was just part of what they do. For many it was an enjoyable experience. Amy, Marla, Hallie and Dina considered it to be a good way to spend time:

*Usually I have a good day, usually one of my best days, is when I go and get my hair done. I go get my hair done, me and my grandma. And then, we uhm, go out to eat, and then sometimes we go shopping too. So that’s usually a good day.* (Amy, Line 245)

*hmm…* I love shopping. I’m a shopaholic. [chuckle] I love to go shopping. Then me and - and I have this other friend and we are not good together. [chuckle] We would probably shop - we would probably buy the whole store. I probably would have had some money left over from my job but, no, we went shopping. We had to go to Bloomingdales and [chuckle] - We had to out to movies and everything. (Marla, Line 375)

*But I love shopping. I like going to the mall with my friends. It’s fun. Oh, we like to go lots of - we like to shop - well, window shop for different video games that are coming out. And we like to go to look at clothes and see what they have. Because she always has so many gift cards and she just wants to spend so, okay. So - and we like looking at jewelry and talking.* (Hallie, Line 475)

*We like going shopping for shoes and clothes. We went to Macy’s the last time and there was this really cool jacket but, unfortunately, I didn’t have that much money [chuckle] so - it was kind of expensive.* (Dina, Line 572)

The majority of the young women interviewed for this project made similar
comments, but there were a couple for whom shopping was not enjoyable. It was actually aggravating.

*I don’t like shopping. They [my friends] just go in one store and they go around and around. And I don't like that. I just like going in the store and getting out.* (Flora, Line 825)

*I get so irritated. Like I get so frustrated because I remember my dad gave me like, I don't know, $300 to go shopping and like I know most girls like if their dad would give them $300 they'd be like “Oh, my god,” like they'd know exactly what to buy. Like they wouldn't even have to try it on, they'd just grab it from the rack and then go. And then like I get hella frustrated 'cause like all pants hecka different, like some are stretchy and some are just normal and it’s like the length and whatever. I get hecka frustrated keep having to - like keep trying them on and going into the dressing room and stuff. I get hella frustrated. So I just - like when I get frustrated all I do is just buy sweats, you know. Because I get hecka frustrated when I can't find things in my size. Like even - like I have - like I see other girls that are like hecka bigger than me and they can find clothes that fit and they look nice, you know, but then when I go I can't find anything. Like I know my friend, um, she’s like hecka bigger than me but she’s hecka tall, that’s the thing. And like - like when I'm with her it makes me feel hella skinny. Because she’s hecka bigger than me. And like, um - like she’d tell me, she’d be like “Oh, come on, let’s go shopping,” or something like that, I'd be like “Nah.” [chuckle] I didn't want to go.* (Becca, Line 226)

Shopping, for Becca, was an activity that brought to the foreground that she was different from “most girls.” Her extra-large size got in the way of her being able to appreciate a gift from her father – one she said other girls would know exactly what to do with. Instead, Becca grudgingly tried on clothes that were too small and got angry at the situation. Becca was unable to share in the common activity of shopping that she saw as something normal girls do. This may mean to Becca that she is not a normal girl, or not a genuine teenager.

Other girls had a love-hate relationship with shopping as an activity. They felt that
they should enjoy it, yet the activity of doing it revealed to them that they were overweight. This was Billie’s experience. The 17-year old girl was drawn to shop like a moth to a flame; she did it in spite of the discomfort it brought her. Because she was forced to see herself as obese when she tried on clothing, Billie’s joie de vivre (embedded in the practice of shopping) was impeded when she did it.

Sometimes I deal with it, other times I can’t. Like, I have a big issue ’cause I like to shop. I’m a shop-a-holic. But then I can’t even fit into stuff. Stuff I want, I can’t even fit. So sometimes you get mad, right? And if I was skinny I could be able to fit this, but then you’re like, “Dang, you can’t.” So you want to lose weight. But then you can’t, so then you be stuck in that little moment like, “Dang.” (Billie, Line 4)

Billie struggled to find apparel for the important events in her life, like high school proms and her up-coming graduation. She liked pretty clothes, but did not feel she looked pretty in them. She did have, as did all of the study participants, some success finding appropriately styled clothing in large sizes that fit them at plus-size clothing stores found in local malls. These stores fill a niche market created by the increased rate of childhood obesity. Well-fitting apparel allows for clothing to return to the background of life for the large-sized person, and for the uncomfortable experience of being obese to also recede.
Food

“We forget that, historically, people have eaten for a great many reasons other than biological necessity. Food is also about pleasure, about community, about family and spirituality, about our relationship to the natural world, and about expressing our identity.” Michael Pollan, *In Defense of Food*

Food is that which we eat so that we might live, in the fullest sense of the word. In this chapter I will explore how what we eat has evolved into the food products that line the grocer’s shelves today. I will argue that food, as it is experienced by Americans today, represented by the teens and families in this study, is present in the world as 1) an industrial product, 2) an ingredient for health, and 3) a matter of choice.

1. Food as product

The human preference for foods that are sweet has been explored and shown to be an innate response (Reed & McDaniel, 2006; Sanderson, 2001). Calorie dense foods offer the organism the greatest chance for survival and growth. The human preference for foods that are industrially designed and factory made is not innate, however. It has been deliberately cultivated by the climate of capitalism, by corporations who cleverly matched a vast profit-making enterprise with the innate desire for sweets. It is so much a part of what eating means to Americans that most do not even see it.

In visiting the homes of several of the study participants I observed that there were very large boxes of packaged goods present on the tables, floors and countertops. Several families shopped at least monthly at a warehouse store, to stock up on items with long shelf-lives, such as breakfast cereal, noodles, crackers, cookies, chips and beverages.
During their visit to the big-box store they would also pick up perishable items from the meat counter and produce section, and from the fresh-baked goods section. These purchases were intended to last the family several weeks, but the packages once opened were likely to be consumed quickly. Families shop this way to save time and money, and do not appear to recognize that their perception of what foods are satisfying, and what portion-size is appropriate, has been shaped by the market.

Just like any other commodity in American society, food is marketed in order to sell it. I refer to marketing in the broad sense, as defined by the American Marketing Association: “Marketing is the activity, set of institutions, and processes for creating, communicating, delivering, and exchanging offerings that have value for customers, clients, partners, and society at large” (American Marketing Association, 2009). It includes all of the aspects of moving a food product from an idea on a drawing board to the consumer’s lips. Doing this involves both creating a product people think they need, and creating in people a need for that product. In order to do this, market research is conducted, and advertising campaigns follow. Food and beverage manufacturers in the United States spend billions of dollars annually to figure out what people want and then how to sell it to them (Bakan, 2004). In marketing’s most sublime implementation, people purchase the item or items repeatedly without reflecting on the manipulation that steered them to that choice.

Advertising is now inescapable, whether on our television or computer screens, huge outdoor billboards and electrical signs, wrapped around buses…at museums, concerts, galleries and sporting events…Beyond these tangible signs, an even more subtle process is under way: the places where we interact as social beings, our public spaces, are increasingly commercialized. (Bakan, 2004. p129).
The commercialization of public spaces is overt in some U.S. cities. Downtown Minneapolis is an example of this. Sidewalks in the city have been virtually replaced by private tunnels and skywalks (hailed for their use in inclement weather). Those who use them are exposed to acres of advertising in the form of posters and billboards, and audio-visual displays.

The commercialization of our shared world is also covert, such as when “undercover marketing” is used. An example of undercover marketing is this: imagine you are standing on the subway platform after a long day at work. You are tired and hungry. Two other passengers standing near you are talking just loudly enough for you to hear about the tasty food they have eaten at a chain restaurant that opened recently. You decide in that moment to go to the restaurant for dinner that evening. What you do not know is that the conversation was intended for you to hear, and in fact the couple were paid by a marketing firm to have it (Bakan, 2004).

The pervasiveness of food marketing is illustrated by the fact that not one teenager or parent whom I interviewed mentioned either the concept of food marketing or any advertisement for food or food products. It is ever-present, so much a part of the world it is rarely even noticed – like the air we breathe. Yet, the influence of food marketing is very apparent. The results of market research are scrutinized by corporate executives eager to sell more products and increase corporate profits (Simon, 2006). The outcomes of various advertising campaigns are tracked and measured as the profits or losses of food manufacturers and retailers, who spend billions of dollars on marketing every year. Consumers, whose response to the market strategies is obvious to those investing in them, do not acknowledge the marketing is even there.
This subliminal quality is deliberate. The idea is to sell more product by inducing
the public to buy more of it. In the case of food, the product is often designed to be sweet
and plentiful. Society has evolved so that Americans need not give much thought, or
time, to gather and prepare food. No sowing or harvesting, no hunting or husbandry, and
very little bother for the average American. Fruits and vegetables, meats and poultry, are
all cleaned and packaged, canned or frozen for convenience. Food is easily available to
those with access to a store and money to buy it. It comes into our homes in cardboard
boxes and plastic wrappers. Much food sold in the supermarkets of America is either
microwaveable or “instant.” It barely resembles the food items consumed by our parents
or grandparents when they were young. It may be that the seeds of this migration to a
preference for prepared foods took hold during the Industrial Revolution (Thompson,
1966), and began with a replacement for mother’s milk.

The first experience of eating is one that is not recollected by most people. In
being born into the world as human being, the human infant first experiences food as
nourishment while suckling at its mother’s breast. Notably, this is no different from other
species who have been scientifically defined and sorted, with other members of the
animal kingdom, as belonging within the order of Mammalia. Being a mammal means to
have milk-producing organs for feeding the young. The significance of milk-production
for the survival of this group was noted by Swedish naturalist Carl Linnaeus who coined
the term “mammal” and who argued for this nomenclature in the 18th century by saying
that “no man born of a woman would dare deny that he was nourished by mother’s milk”
("Linné on line", 2008).
Human milk provides perfect food for human infants to grow, develop and thrive. It takes no bother to prepare. It is available to the mother and infant at no additional cost. It requires no consideration of its nutrient content. It is a part of the natural mother-infant world, always already there for the acceptance and taking. Breastfeeding is openly endorsed as the best practice for feeding infants by the American Academy of Pediatrics and the Centers for Disease Control, and increasing the rates of exclusive breastfeeding and ever-breastfed infants in America is a part of the Healthy People 2010 project of the U.S. government. Yet, the rates still fall below goals; while approximately 70% of American infants receive some breastfeeding in the post-partum period, only a little more than 30% of infants are still being breastfed at 6 months of age (CDC, 2008). How did people come to believe that human infants should be fed something other than their own mother’s milk?

The debate on this topic goes back to Linnaeus’ time, when large numbers of European women were refusing to breast-feed their babies, and instead hired servants to do it. Considering this a serious social issue Linnaeus addressed this in a treatise he wrote in 1752 titled “Step nurse, or a dissertation on the fatal results of mercenary nursing” (Schiebinger, 2003). At that time in colonial America, wet-nurses were not nearly as common as they were in Europe. The Puritans believed human milk was divine. Cotton Mather preached it was from the pulpit, and the belief was spread through primers of popular catechism of the time. One of these, written by John Cotton, was “Spiritual Milk for Boston Babes. Drawn out of the Breasts of both Testaments” (Cotton, 1735). Colonial Americans nursed their babies, and generations of American women did the same, until the end of the 19th century when things changed.
There was a notable decrease in the number of American women who nursed their infants that began in the mid 1800’s, after the invention of infant formula and rubber nipples. Infant formula, made from cow’s milk initially, was commercially produced as a substitute for breastfeeding. These inventions saved the lives of babies who would otherwise have perished due to absence of a mother, or babies who could not breastfeed due to congenital defect such as a cleft palate. Another significant result of these inventions is the affect they have had on the way Americans view food. Breast milk, once considered the optimal food for human infants, was pushed aside in deference to “modern” manufactured milk. Human milk, the real thing, was replaced by an imitation substitute, in increasing quantity (Schuman, 2003).

The decline in breastfeeding by American women coincided with the evolution of baby bottles, and mass marketing of Nestle’s Milk in the late 1800s (Schuman, 2003). The first food for the majority of infants born in the late 19th and early 20th centuries in America was not human milk, it was a cow’s milk-based formula. Throughout the 20th century, ironic as it seems, the dominant cultural practice was to feed another animal’s milk to American babies. Despite a concentrated effort by the government to convince mothers to feed their milk to their children in the latter part of the 20th and early 21st centuries, the U.S. still falls short of the goal. The government has taken on this challenge in part because evidence shows that breastfeeding may offer protection from obesity in childhood and adolescence (Koletzko et al., 2009; Nelson, Gordon-Larsen, & Adair, 2005).

While acknowledging that there are many reasons why we have come to rely on packaged foodstuff to feed ourselves, one still cannot help but note that this strong
preference for food that is manufactured and commercially available has been cultivated by corporatism, commercialism and marketing – hallmarks of a capitalist society. If we can embrace feeding our infants re-constituted formula, it is not difficult to imagine ourselves consuming other processed and imitation foods. And, having modeled this behavior for several generations now, it is easy to see how this has become the cultural norm in America.

For example, it is difficult today to find a loaf of bread in the supermarket that contains just the four ingredients necessary to make it: whole grain flour, yeast, water and salt. This is now considered unusual artisan-quality, which increases the cost of the simple loaf of bread. Instead, the vast majority of the widely available bread-like items on the grocers’ shelves contain a myriad of other ingredients added to make the item resemble bread, have the flavor and nutrients of bread, and preserve it so it will last longer on the shelf and in the home. One common added preservative is high fructose corn syrup. It also happens to be a potent sweetener, appealing to the human’s innate taste preference. Truly a wonder of industry, the mass produced “bread” is priced at half the cost of the real thing. Economies of scale, and favorable subsidies by the U.S.D.A. afforded to corporations, make it possible for this imitation food to be a much more cost effective alternative for feeding their families to those on a budget. Processed food has become “regular,” while real food has become exotic (Nestle, 2006; Pollan, 2008).

The concept is represented in 16 year-old Viola’s household. She described the ways in which the usual purchases, i.e. the “regular stuff” that her mother bought to feed herself and other family members, was in disagreement with the “healthier” foods recommended by the obesity clinic:
Well, it [staying on the clinic’s diet plan] has been easy and hasn’t because my mom, she doesn’t eat like what I eat, she eats like regular stuff because she doesn’t like a lot of food so like she doesn’t eat Chinese food or any - she only eats like Latin food and American food and she doesn’t really like it [the food on the clinic’s diet plan]. So she has all this food in the cabinet like it’s so like ugh, like it - so I have to say no because I know it’s bad. So I go to the alternative eating like healthier snacks and protein bars or something. I’m like “Mom, why do you have to buy that kind of food? You know I’m on this diet.” She’s like “Don’t eat it, it’s for me. I got you your food.”

She has like regular stuff, like chips and - her candies, her cookies and stuff. And we buy like other kinds of - like other kind of food like chips and stuff because my nephew and nieces come to the house so they eat like the corn dogs and TV dinners and stuff like that so I have to teach myself that’s bad, bad, bad. I have to get like a healthier option and it’s hard sometimes because I so want it badly because it tastes good but I know if I’ll eat that I’ll just like gain more weight and I don’t want to happen.

There is a conflict inherent in Viola’s household, where the mother would provide food that is considered “bad, bad, bad” to the children because it has become customary and expected that children eat chips, corn dogs and frozen dinners. Viola offered an explanation for her mother’s non-compliance with the clinic’s recommendations: in their world this was the “regular stuff” – cookies, candy and chips. In this family there was Viola’s food, i.e. the “healthy” stuff on the clinic’s diet plan, and there was everybody else’s food. Everyone else could eat the things they liked, but not Viola. For the rest of the family it was Latin food, corn dogs and T.V. dinners. This is was what regular people ate. Fresh fruits and vegetables would stand out in their nakedness – without packaging – as a stark contrast to the plastic-wrapped and cardboard-boxed food products that fill the cupboards and freezers here. Fresh, real food would be freakish.

In this world there is healthy food and unhealthy food. Viola has taken up the idea from the clinic that eating the healthy foods, and not eating the unhealthy ones, can cure her obesity. Yet, Viola’s choice of healthy food causes her to be strange within her own
family – family, a word whose very essence is familiarity. She stands out, in contrast to the other members of her family. This strangeness is experienced as a tension by Viola. The feeling associated with being different is discomfiting for it reveals to Viola that there is something wrong with her. It thrusts before her that she is overweight, a fat girl who needs special food to change into the better thin girl who can be like the rest of her family. She fights a constant battle in an effort to control her weight. The world is a minefield for those like Viola who are trying to eat “healthier” and control their weight. They must be vigilant and alert in order to choose health. This takes tremendous effort.

It is difficult enough to navigate the world in a body that is larger than others, one that shows up as different from the norm. The vast majority of teenagers do not want to be different from their peers in any apparent way. So, to draw additional attention to oneself because of unusual or special food choices adds another layer of different-ness that is unconscionable for some. As 15 year-old Ali told it, she would be weird.

*Now, me and my stepdad, we go grocery shopping, and I get the kind of stuff I want. A lot of times [my mom] complains about the stuff I get, she’l say “How you gonna lose weight eating that?” But, I mean, it’s not like I’m over 30. I’m 15, what does she expect me to be eating? 15 year olds eat pizza, they eat hamburgers, they eat all that kind of stuff. I can’t just quit all that, and I’ll be, I’ll be so weird. ’Cause they all eat that, it’s not like I’m alone, by myself.* (Line 224)

In 21st century America, in Ali’s experience, authentic teenagers eat pizza. She would not only be “weird,” she would not be a true teen. No child wants others to think she is weird. Yet, this is precisely what we are asking them to do – go out on a limb, be weird - when we suggest they change their dietary habits.

It is also easier for a parent to take the path of least resistance when it comes to satisfying the food preferences we have established in our children. It has become usual
and customary in America to feed children food that makes them happy; thus one company, McDonald’s, built its business by serving kids “Happy Meals.” Children’s food, in this expression, should be fun and not something about which they may whine. Since we started them as infants on sweet imitation food, why spoil this winning formula? Parents, exhausted from working at their jobs, can purchase instant gratification for their hungry youngsters, and buy themselves some peace – avoiding the “Eat your vegetables” battle for one more evening.

The foodstuffs bought and brought into the homes of the participants in this study are the usual and regular for most Americans (Lang & Heasman, 2004; Simon, 2006). Yet, this is only a fraction of the prepared foods that American teenagers consume, as many meals and snacks are purchased and eaten away from home in burger joints, taquerias and pizza parlors. It is part of the social world of teenagers to meet friends, to eat, and to hang out in fast food restaurants. The American landscape is littered with conveniently located places to get high calorie, delicious food at a low cost: McDonald’s, Burger King, Taco Bell, Jack-in-the-Box and Round Table Pizza are just a few of these places that were specifically mentioned by the study participants.

Fifteen year-old Becca was dismissed from her alternative high school at 1PM each day, at which time she and her friends frequently ate lunch at one of the nearby fast food restaurants. Becca confided that she and one of her classmates had made a pact to eat healthier, so they planned to go to Fresh Choice for salad instead of one of the usual places for burgers or pizza. She admitted, however, they had actually done this only once or twice and had lapsed back into going to the usual places with their friends. However, she was quick to mention that, when she goes to one of the other fast food establishments,
she will just order one thing from the menu, “I just get the sandwich thing, or just the fry.” It was important to Becca to show that she tried to practice the lessons learned in the clinic. However, the difficulty of actually doing it is evidenced by her response, when she was asked what would make it easier for her to eat the right foods. She said “If they didn’t have Jack-in-the-Box, or McDonald’s, or Burger King.” Becca chuckled as she said this, expressing the futility of such an idea – the idea that there would be no fast food restaurants at all.

Fast food restaurants have become a part of the taken-for-granted background in the world of American citizens. It is just “how things are”, and thus it makes the choice of whether to dine in them less a choice about food, and more a choice about identity. Are you weird? Are you likeable? In 17 year-old Viola’s world, it comes down to a choice of whether to be her father’s daughter.

But sometimes it’s hard because my dad lives like in Oakland over there and I sometimes get off track. Like he doesn't cook, he goes out to fast food places and it’s hard. “I can't eat fast food every single day, Dad.” He’s like “Well, you're only spending time with me like for a couple days, like the weekend.” “It’s going to get me off track.” And it’s hard to go like back from the food that I was eating back into healthier style. Oh, “Dad, I can't see you anymore.” [chuckle] So there are those times like when I see family members it’s hard because it’s like what I was doing and stuff. And I forget to exercise because I'm spending time with my father. I'm like ugh. The only fun time now. I'm like “Oh, I just gained a pound that I just lost.” It’s like frustrating. (Line 225)

In the dilemma of whether to stay on track, i.e. to use the skills she has learned in the obesity clinic regarding diet and exercise, or to be a member of her family, Viola really has no choice at all. Caught in the conflict between these two worlds, Viola experiences frustration. The clinic is telling her that there is a problem with who she is, and she must change. How can this compete with the message from her father, that he
wants her to be with him and share familiar foods? Viola wants and needs to maintain the relationship with her father. She expresses love and affection for him, and considers his home to be the only place where she experiences fun. Weight gain is the price she must pay to be a daughter in her world.

II. Food as Medicine

Eating food fulfills a basic need for an animal’s survival. Human beings, like all animals, must eat to live. As already discussed, the food eaten by Americans has undergone changes in the past century. These changes have been helped greatly by the increase in knowledge in the area of food science, i.e. nutrition. There has been a huge shift in what constitutes “food”, and a lot of discussion regarding the roles of the nutrients that are found in food (Nestle, 2006; Pollan, 2008; Taubes, 2007; Willett, 2001). In discovering the causes for vitamin deficiency diseases such as scurvy, beri-beri, pellagra, and rickets to be dietary, providing the cures (vitamin enrichment) were dramatic and lifesaving. The importance of nutrition in human health could be clearly seen in these events as both the cause and the cure for physical illness.

Thus, the way was opened for medicalizing the foods we eat. We all travel on this road, where food takes on this new most important quality: healthy or un-healthy. Consider, however, that this idea of “unhealthy food” is only possible in a world where food is commercialized, wherein it is manufactured and processed for its profitability rather than for its utility as fuel for the human body. Using the medical concepts of health and disease when talking about food roots us to the clinical or therapeutic practice. In clinical practice the solution to the problem of disease is directed toward breaking the
most immediate causal link (Foucault, 1973). This has led us to identify some foods as “healthy” or health-promoting, and others as unhealthy or disease-promoting.

As the teenagers in this study come forward as obese individuals through their visit to a medical clinic for treatment, the story they tell is necessarily one that aligns with the medical model. Yet, these medical concepts may actually isolate the individual from the social context in which the problem is acquired. The medical model pre-supposes that the client is deficient, i.e. the obese adolescent in the clinic has a medical problem, and thus it reconstructs the person’s understanding of the problem for which they are seeking help into one that has a medical solution (Crawford, 1980).

The description of foods as “healthy” coincides with the rise in nutrition science. The medical establishment has embraced the expanded knowledge regarding nutrients, and employed it to treat illness and to preserve health. This knowledge is shared with the public through news items almost daily in America, e.g. *New York Times* on March 21, 2009 – “Eating Food That’s Better for You, Organic or Not” (Bittman, 2009). In considering whether to eat something or not, it has become of prime importance to think whether the item is a “good for you” healthy choice. Less important is how it will taste or how it complements the other items on the plate. Indeed, the item need not be a real food at all.

In my neighborhood there is a store that claims to sell “health food,” yet it has no actual food on its shelves. Instead there are only boxes and bottles containing pills, liquids and powders, whose labels indicate they possess the extracted or laboratory-replicated vitamins, minerals, oils, and proteins that would be found in food. In this way, food has been reduced to its health-affiliated parts, and can be consumed in that reduced
form. This is one extreme indicator of the problem of food reductionism that is inherent in the food system we have today.

Foods that are described as “healthy” are those that contain nutrients that science has determined to play a role in lowering the incidence of a particular disease, or disease-related outcome, among a population of people assumed to be at risk of that disease. For example, studies have indicated a “health” role for dietary fiber: it lowers serum cholesterol (Brown, Rosner, Willett, & Sacks, 1999), and it decreases the incidence of coronary heart disease (Pereira et al., 2004). The connection between diet and health has been under scientific study for many years, yet the evidence is still inconclusive regarding what claims are true. But the ability to make health claims at all is a boon to the food product industry.

As was revealed by Nestle in *Food Politics* (2002), cereal manufacturers in the 1980s (specifically Kellogg) sidestepped the Food and Drug Administration (FDA) policy regarding not making health claims on food packages when they printed their All-Bran cereal package with this statement: “The National Cancer Institute believes that eating the right foods may reduce our risk of cancer. Here are their recommendations: Eat high fiber foods. A growing body of evidence says that high fiber foods are important to good health. That’s why a healthy diet includes high fiber foods like bran cereals.” (Nestle, p240). After a series of discussions among various government agencies, the old FDA policy was overruled, and it became standard to allow food manufacturers to make health claims regarding the benefits of eating a high fiber diet on the labels of their products. As a matter of record, the healthfulness of a diet rich in fiber was written into the United States Food and Drug Administration Code of Federal Regulations in 2001.
Health claims: fruits, vegetables, and grain products that contain fiber, particularly soluble fiber, and risk of coronary heart disease. Making the claim in 1984 increased the market-share of Kellogg’s All-Bran by 47% within the first six months of the campaign. This sent a loud message to the food industry that making health claims sells more products (Nestle, 2002).

The message that certain foods are considered healthy is reinforced by the pediatric obesity clinic as a part of their intervention. Patients and their families are taught to read the food labels and especially directed at the fiber content of two common household items: breakfast cereal and bread. That the message is received is apparent in the narratives about eating practices shared with me by the study participants, such as this one told by 16 year-old Dina.

Well, after seeing the nutritionist – it[breakfast] would always be like some cereal most of the time. And now it’s like fiber cereal and like they’re like these little weird sticks and they look like rabbit food – oh, no, not the rabbit food but like the little things that you put at the bottom of the rabbit cage. And they’re all like “What are you eating?” “It’s full of fiber, okay?” [chuckle](Line 258)

In Dina’s experience food does not have to be tasty or visually pleasing, it can even look like straw, but it has to provide an important nutrient. The point is that the concept of eating for sustenance or pleasure has been overridden by the concept of eating to cure or prevent disease. Fiber, the example from Dina’s story, is one of the current fads in nutrition. Making claims that their food product’s fiber content contributes to good health is a way to sell more food product. This strategy apparently works, because nearly every cereal box and bread wrapper highlights this information.

Breakfast cereal and bread are food items in which one might expect to find fiber, but fiber also shows up on the labels of food items where one might not expect it, such as
yogurt. Yogurt is naturally a dairy product produced by bacterial fermentation of milk. In the 75+ years since its large-scale manufacture in the U.S. began, yogurt has had many things added to it (e.g. sugars, fruits) resulting in an increase of sales and market share (BusinessWire, 2004). Given the current fiber craze, inulin, a soluble fiber, is now commonly added to several leading brands of yogurt, e.g. Yoplait, Stonyfield and Dannon, which are marketed as containing fiber. Inulin is a saccharide, i.e. a compound of chrystalline carbohydrates. It is resistant to digestion and absorption by the small intestine and its fermentation in the colon has a bulking effect, thus allowing it to fit the definition of a dietary fiber (Flamm, Glinsmann, Kritchevsky, Prosky, & Roberfroid, 2001). It also sweetens the naturally tart yogurt. Adding fiber to yogurt allows food manufacturers to make health claims about yogurt that they could not otherwise make, that their product decreases the risk of coronary heart disease and certain forms of cancer.

Interviewer: Do you buy your own food or does your -

Dina: My mom buys it for me and I mean we’ve always eaten like the healthier food but just like we didn't realize that we had to like cut it down. I mean we have two boys in our family so they eat a lot, they're always constantly hungry. And I'm like “I'm not hungry anymore.” They're like “We are, get some more food.” Gee. So, yeah, my mom buys my food actually. Like after seeing the nutritionist – we've always gone to Trader Joe’s but – oh, and there’s this store by my house called the Good Life Grocery and everything’s like organic and stuff so I guess organic’s better in a way, it doesn't have pesticides. So like it’s way more expensive, it’s like double the amount of regular. But my mom, she’s like “Well, if it’s healthier I’ll buy it.” So she bought it, yeah. So we went to Trader Joe’s and we bought like a whole bunch of other healthy stuff. (Dina, Line 258).

It is apparent that food marketers have seized on making health claims in their description of food products. The cereal aisles in the grocery stores are lined with boxes making the claim that the contents are “Made with Whole Grain” and many carry an emblem of their endorsement
by the American Heart Association as being “Heart Healthy”. The general public receives news almost daily on the latest breakthrough in nutrition – fiber from whole grains to fill you up and keep you regular, omega-3 oils in vegetables and fishes to reduce your risk of cancer, and calcium in dairy products to keep your bones from breaking. The message emphasizing increased consumption of “healthy foods” has an equally loud counter-message emphasizing decreased consumption of “unhealthy foods.” Carefully steering away from saying there are any foods that should not be eaten, most nutritionists teach their clients that every food has a place in a healthy diet. This is generally obfuscating. For example, 15 year-old Ali is less than certain about the healthiness of the food she eats.

Ali: I think I eat a lot of bad stuff. Like...pastas...like the doctor was saying “white and fluffy” - that's what I go to, white and fluffy. I always want some bread, some pasta something like tortillas. I don't know if bread is really one of my favorites, or potatoes, but I know the burritos is bad, really bad.

Interviewer: And what do you think is bad about burritos?

Ali: Well, it has two starches – well, probably like...isn't bean starches, too? So it's three, it has beans, rice, tortilla. The only good thing on there I think is the salsa, cause it's got tomatoes – but you never know what they put in that either. And the cheese, I don't know if the cheese is too good. I made me some tacos one time. I tried to get the wheat tortillas, and then get the low fat cheese, low fat sour cream. It's probably still gonna be, you know a lot of fat, but you know, I didn't’ think it would be as much. (Line 208)

Eating has become confusing. The hungry person cannot just pick up the nearest edible food item and eat it without considering whether that item will do her harm. This is not because we cannot identify it as something safe to eat, as our Neolithic ancestors might have done. Rather it is because we have been cautioned by our physicians, the media, and mass advertising to think about the nutritional value. Does it have vitamin x, or omega-x fatty acid, or fiber? These micronutrients, among many others, are only a
small part of what to consider when picking up something to eat. Knowledge about macronutrients, i.e. proteins, carbohydrates and fats, also plays a major role in creating the confusion about what to eat. Ali’s story is typical of the uncertainty people now face when it comes to eating. In assessing the burrito she enjoyed eating Ali determined, with little confidence that she was correct, that it does not comply with the pediatric obesity clinic’s nutritional advice to stay away from “white and fluffy” carbohydrates or starches. In this we can see that eating the right foods, i.e. the healthy ones, requires tremendous effort, and a person still might not get it right. Ali tried to get fiber-filled tortillas and low fat dairy products to make a taco at home that fit into her weight control plan, but she was unable to do it to her own satisfaction.

There really is no way to win in this situation. The teenager who comes to the clinic for help with her obesity has assumed the role of patient with a medical condition. The advice the doctors give her, to change her eating and activity practices, is the “prescription” that will make her well. If she does not follow it, then she is to blame for not getting better, i.e. getting thinner. This creates a paradox.

By medicalizing the problem of obesity we have sanctioned the condition, so that it is no longer deviant or sinful. The person with a disease is pitied rather than scorned (Conrad & Schneider, 1992; Ilich, 1976). In constructing obesity as a medical problem instead of a social one an obese individual is brought to the physician for treatment and cure. In viewing this as a medical problem it is conceivable that there would be a decrease in the stigmatization of obese people. There is no blame cast when someone has a disease as it is something that happens to them, not something for which they are responsible. However, this is not what has happened. Instead medicalizing the problem of
obesity has brought the focus of treatment and cure onto affected individuals. It thrusts the responsibility for getting well, i.e. getting normal sized, onto the obese individuals and the doctors who treat them. When doctors treat the obese individuals with diets, exercise regimens, pharmaceuticals and surgery, it places the onus on the individuals to follow the treatment protocol in order to get well and stay healthy. Society is absolved of dealing with the issue as a social problem (Crawford, 1980; Ilich, 1976; Zola, 1972).

III. The Food Dilemma

The obesity clinic staff deliberately refrains from labeling any specific food as “bad.” This is consistent with the American Dietetics Association’s position that all food can fit within a healthful eating style “if consumed in moderation with appropriate portion size and combined with regular physical activity” (American Dietetic Association, 2007). Yet, food was universally described by the study participants as “bad” or “good.” The overweight adolescents are taught by the clinicians to identify the differences in food “options” and to choose the good one. There is quite a bit of angst involved in choosing, and in living with the choice. The everyday practice of eating is often fraught with trouble, or what a phenomenologist would refer to as breakdown (Dreyfus, 1999). Sixteen year-old Nora described her experience of the difficulty faced in eating a daily breakfast, and the guilt she experienced as a consequence of the choice she made to eat a bagel.

So I get up about 5:30, sometimes 5:40. Like today – I didn't sleep good last night so I woke up late. So I'm not even awake today. So I didn't have a normal breakfast because with intersession I've been to have like eggs, because lots of protein and stuff, but I was running late so I had a bagel and cream cheese at Noah's, which is bad because that's like eight pieces of bread. I was like it's better than not eating because I
would have just not eaten[sic], so it's better than nothing so – And I got a whole wheat so it's not that bad so – but that's a lot of bread.(Line 195)

Given the option of eating or not eating, Nora is comfortable she made the right choice to eat, but then has to characterize her choice of bagel with cream cheese as the poor one she “knows” it to be. Clearly Nora learned that a Noah’s bagel is not good, but it is less bad if some whole grain was thrown into the dough, as this will comply with the obesity clinic’s instruction to choose “brown crunchies” over “white fluffies”. She feels the need to mitigate the potential moral damage of her choice (i.e. choosing a bad food at all) by opting for the higher fiber bagel (which is less bad because it has fiber). What a lot of physical, mental and emotional effort Nora expended just to eat breakfast!

This element of choice regarding which foods to eat implies one has the ability, i.e. the freedom, to choose. Choice about what to eat, however, is limited by two very important modifiers of one’s own food environment: personal financial resources, and the selection locally available. If a person has limited finances, she must choose an option within her budget. If the only vendor in the area that has affordable food is a Noah’s Bagels shop, then Noah’s Bagels is where she stops to buy her breakfast.

There is yet another factor in the concept of choosing, one that exists in our taken-for-granted way of being human. Sometimes we choose items at the grocery store because that is just how we do it, i.e. it is how we have acculturated to shopping for groceries. To do it differently would require effort, would necessitate thoughtful consideration of alternatives, and would interrupt the smooth flow to the natural way of being for the person.

All of the resources available to a family are greatly influenced by social factors of race, education and gender. Each of these contributes to a family’s economic status.
This, the financial means on which a family has to subsist, is perhaps the largest determinant of health outcomes. For many Americans, family budgets are stretched very thin and dangerous decisions are sometimes made in an effort to make ends meet (Cox, 2008). When money is short people have been known to water down milk to feed their infants. This may have catastrophic effects in the short term, causing stunting and death (Leathers & Foster, 2004). When income is low, people may choose from the Dollar Menu at McDonald’s (8 items priced at $1 in a marketing promotion current in April 2009). This may have catastrophic effects in the long term (Spurlock, 2004). It is not logical to think that people want to make themselves obese; surely they would make better choices if they could.

After my visit to Marla’s home, which occurred near the end of a month, I wrote in my field notes that the freezer held only two ice trays and half a package of hamburger buns; the refrigerator held a carton of eggs, a half-gallon of milk and approximately 5 lbs of russet potatoes along with three leftover chicken wings from the previous day’s dinner. The pantry cupboard in this family’s kitchen was also nearly bare, except for a sack of rice, a few canned vegetables, and some cooking oil. The mother commented that it was “almost” time to go grocery shopping again. During our interview she spoke frankly of relying on the school lunch program to feed her children every school day. There is not much choice when it comes to food in the world in which this family lives. Marla’s mother said she “[felt] really bad” that her work schedule and children’s schools’ schedules required them to be up and out of the house very early in the morning, so that they rarely ate breakfast. After going to the pediatric obesity clinic she said she knew it
was important for Marla to have some protein to get started and she described just how hard it was to make that possible.

_So now what I been doing is that we all get up at the same time, so we all get up about 5:45 – between 5:45 and six o'clock in the morning, and them two have to eat breakfast...Yesterday morning it was peanut butter and jelly sandwich. For M, she only eats the peanut butter. She been staying directly with her food guidelines that the pediatric obesity clinic had provided for her so she eats only peanut butter. My son, he picked the peanut butter and jelly off the shelf and I give him that for lunch [sic] for his breakfast. So that's what they would eat with a bottle of water and then we'll go on to school._ (Line 100;113. Marla’s mother)

Fourteen year-old Marla is a typical teen in many ways. Her description of a fun day included shopping, hanging out with friends at a shopping center, and going to movies. She lived in a tidy Victorian-style single-family home with her mother and younger brother on the southeast side of the city. This area is one in which her mother did not want her to walk around unescorted. So, Marla navigated her way to school on public transit, not from a bus stop near her house but from one that her mother drove her to in a safer neighborhood while on her own way to work. Marla’s frequent visits to the obesity clinic were also by bus, sometimes from the direction of her school, but also from her home. In order to interview Marla’s mother, and conduct the home visit for this study, I traveled by bus on the route that connects the obesity clinic to Marla’s house. In the 65 minutes it took me to get from one place to the other (a distance of approximately 3 miles) the experience was mostly uncomfortable and intermittently harrowing.

What started out as a pleasant trip, in my window seat next to a well-dressed middle-aged woman returning home from a visit to a local museum, turned ugly once we left the immediate neighborhood of the clinic and moved on to stops near a public high school and the juvenile justice center. The bus became over-crowded and noisy. There
was an accusation of theft and the police were called. As the driver had to wait for the police to respond, all of the passengers not involved in the incident were invited to disembark and take the next bus. The second bus was already crowded when I boarded it with the other passengers from the first ride. From where I stood in the bus I could not see out any window. I found this completely disorienting. I got off the bus two stops past where I should have and found myself in a part of town that was completely foreign to me. I reached Marla’s home by foot, backtracking the bus route while being given directions over my cell phone by her mother. I was reluctant to hang up the phone until I reached her house, as I felt less vulnerable to attack having that connection.

This is the everyday reality for Marla, her mother, their neighbors, and anyone else who takes that bus line. This world is disordered, dirty, noisy and scary. Experiencing the trip made the nutrition lessons taught in the clean, orderly clinic sound like nonsensical propaganda from an alien planet. Traveling across town by bus that day impressed on me how inconsequential tomorrow’s health consequences seem when a person’s imminent concern is just getting through the day. The girls and their families indicated their attempts to buy and eat “healthy” or “good” foods. We may need to consider that sometimes it is just not possible for folks to make to make the right choice, even though we educate them and encourage them to do so.
Chapter 9

Gaze

Part I: The Look

“Well, sometimes. Sometimes you just get looks, you know. I mean not like every time I walk into a room. Sometimes I’ll walk into a room and like no one, I mean it seems like no one is going to address it. But, sometimes people will look, they’ll be like…they will just give you a look. I can’t even do the look. I mean, it’s just “the look.” And I would get it sometimes, and I’d be like, “Oh, Dad, can we leave? Or, can we just go somewhere else?” It’s something that I just…I walk into a room and I think, “Am I the only big person here?” If there’s other people like me, then I’m okay.” (16 year-old Kelly; Line 178)

Human beings exist in bodies that come in a variety of colors, shapes, and sizes. In different regions of the world there is more or less homogeneity with regard to how people appear. For example, the blue-eyed blond traveler to rural parts of Mexico draws the attention of villagers to the oddity of the light complexion in a land where brown-eyes and raven-colored hair is the norm. The same traveler would blend into a more multi-ethnic region, such as New York City (NYC), where the vast diversity of eye- and hair-color broadens what is accepted as the norm. Context is therefore important to the consideration of norms about human beings.

This concept of norms was taken up by French philosopher and historian, Michel Foucault in *Discipline and Punish*, in which he argued that norms can be extremely powerful (1977). There is a whole range in the degrees of normality that indicate membership into a homogenous social body. This range of normality is involved in classifying, creates hierarchy, and contributes to the distribution of rank. According to Foucault, “In a sense, the power of normalization imposes homogeneity; but it individualizes by making it possible to measure gaps, to determine levels, to fix
specialties and to render differences useful by fitting them one to another” (p.184). Normalization gives an ability to examine and compare, for it is the “normalizing gaze” that makes it possible to qualify and judge. It is the gaze, or “the look” as described by Kelly above, that reveals one’s visibility to oneself and makes evident that one is differentiated and judged.

The fair-skinned visitor to Mexico may be normal with regard to height or language proficiency during travel within a dark-skinned region, but may not be normal with regard to eye- and hair-color. It is the difference that sets our traveler apart, that gives her visibility. The blond moves about virtually unseen in NYC, but cannot help but be seen in rural Mexico. This visibility sets up a power relation as it is manifested in the subjection of the one being perceived as an object, and in the objectification of the one who is subjected to it (Foucault, 1997). In other words, the same person is at once both object and subject. This examination is experienced with unease by the one under the gaze. It is discomfiting to be sized up in this way. This is especially so if previous experiences included being made fun of and ostracized, as was Kelly’s experience.

Throughout her middle school years Kelly was frequently tormented in the school yard by groups of classmates that would corner her and taunt her - calling her “fat” and “going on and on about it” until she would cry. Kelly’s narrative expresses the hurtfulness of this behavior, of being teased because she was overweight. She said she cried a lot and described feeling like she “didn’t fit in, and they would always single [her] out.” Being in the schoolyard was torturous for Kelly. As a consequence for their action her tormentors were punished by the teacher – the penalty was to write letters of apology to Kelly. Yet, this did not deter Kelly’s classmates from inflicting this agony on her
almost weekly. It was Kelly’s experience that just being who she was drew unwanted
attention and mockery. As she entered high school, she had become cautious, she was on
the alert for “the look.”

In Kelly’s experience “the look” was something she sometimes got that made her
feel instantly self-conscious. When she was the object of the look she knew she was
being watched, and her difference in size was being measured against the others present.
She thought to herself “Am I the only big person here?” and, if there were others like her,
the anxiety dissipated. If she found that she was the only big person there, she was
anxious that her deviation from the norm would show up for others. If she showed up as
obese to the others, in Kelly’s experience, she risked being belittled and abused as she
had been in elementary school. This she wanted to avoid.

In part to protect their daughter from the heckling perpetrated by the boys in her
in elementary school, Kelly’s parents sent her to an all-girl high school. (Kelly verified
that it was “always the boys, and never the girls” who had been so mean to her in junior
high.) But even in the single-sex environment Kelly found herself the recipient of the
normalizing gaze.

Kelly, a high school junior at the time of our interview, had a passion for dancing.
She had taken lessons in tap dance and modern dance throughout her elementary school
years. She auditioned for and earned a place in the dance ensemble in her freshman year
of high school, but this prize soon soured. Though they did not overtly tease her, the
other girls in the ensemble made Kelly aware that she was different. Not having dance
costumes that fit her large frame made her difference all the more apparent to everyone,
including Kelly. There was pain in her voice as she recounted this story:
I remembered back to my freshman year how girls would talk behind my back, but I heard it. They were just like, “What’s she doing here? She doesn’t...she’s not in any dances.” ‘Cause I was only in two dances, and I understand that’s like a costume thing, because all of our girls are really tiny, so all of the costumes are tiny except for a couple. And if a choreographer has a costume in mind, they’re not going to change it because - I mean they’re not going to change it because of one dancer. So, I mean I understood that, but it really just brought it to light. (Line 119)

It was two years later, when Kelly planned to try out for the dance team again, that she recalled how she felt, and she “totally broke down.” The strength the old feelings still had surprised her, and to avoid experiencing it all over again she decided not to audition. Instead Kelly worked on the technical crew for the dance productions. Even in that role she fell under the scrutiny and judgment of her peers, as she realized she still did not fit in. The dancers gave her “attitude” with their looks – what Kelly referred to as “mugging” – she knew she was being singled out for being fat like so many times before.

The normalizing gaze is powerful as a method of controlling people (Foucault, 1977). It is used to discipline wrongdoers, such as when a teacher’s cool look brings order to a classroom, or when a father’s scowl stops his children in their tracks when they are caught misbehaving. Fear of reproach keeps many mischief-makers and miscreants in line. In Kelly’s case, however, she had done nothing wrong. There was no conduct that deserved opprobrium. It was in finding herself the object of the gaze repeatedly that Kelly could no longer be comfortable in her body. The taken-for-grantedness was gone, and her body became an obstacle to being at ease in the world.

As well as being an emotional obstacle, a large body can be a physical obstacle for the obese individual. Other participants in this study related stories of their size interfering with their smooth functioning of being a student, and how this revealed for
them the way others saw them. Fifteen year-old Jenny imagined how others might see her as she tried desperately to avoid getting “the look” in her encounter with a desk. Trying to sit revealed to her that she was too big.

*Trying to get into a desk, it was really sad. You know, everybody’s thin. And at my high school, it was the first day, and I was about to take my Algebra test to see which Algebra class I’d be put into. Orientation - it was orientation. And I was trying to fit into my desk, and I’m like “Hmm, this is not gonna work.” So, I kind of like had to inhale and really fast just get into the chair. That’s a little different, how everybody was like thinner than I was. And, I was like “Ooh, I hope nobody saw that.” (Jenny, line 157)*

A desk is everyday equipment for a student. In this case, however, the desk became an obstacle, as her size interfered with her fluid use of it. Effort was required to sit, drawing her attention to the issue of her fatness, and inducing in her anxiety that others might see her predicament. In their experiences, the smooth functioning way of being in the world came to an abrupt stop for Kelly and Jenny in the instant they perceived themselves as visible objects. This led them to a concerned way of being, in which they took note of themselves. This interruption was experienced as a break from a taken-for-granted way of being, and a shift to a mode of conspicuous presence. This is consistent with the philosophy of Martin Heidegger regarding the way in which human beings exist in the world, as he wrote in *Being and Time* (1962).

Heidegger argued that past philosophical approaches covered over the significance of ontology and played down the familiarity and the every-day-ness of what it means to be. In *Being and Time* Heidegger dealt directly with the human condition and gave an account of the nature and limitations of philosophical and scientific theory (Heidegger, 1962). This is especially relevant for trying to understand the meaning in human behavior.
In laying out his philosophy, Heidegger discussed what it means to be human, which necessarily encompasses a concept of world and what it is to be in-the-world. In the phenomenological sense, world is more than the totality of entities which are present to us in the world. According to Heidegger, world is the “wherein” that a human exists – “world may stand for the ‘public’ we-world, or one’s ‘own’ closest domestic world-around” (p.93). It is the relationships, practices and languages that we have by virtue of being born into a culture. World, in this regard, is both formed by and forms the self. The self is constituted by and shaped by the world it is raised up in, but not in the cause and effect way of the world of objects. Instead, the self is formed by the world in a non-reflective taking up of the meanings, linguistics, cultural practices and traditions. The self is always already situated in the world. Being situated in-the-world makes it possible for things to show up for us at all. Heidegger argued that there are different ways in which things, or entities, show up for us; they may be ready-to-hand, unready-to-hand, present-at-hand, and present-at-hand-and-no-more. This is best explained through examples.

Heidegger uses the ‘hammer’ to illustrate the way the world shows up for us, as ready-to-hand or present-at-hand. A hammer that is ready-to-hand is available for use, it is the way it is in itself – i.e. a tool for hammering. It is smoothly picked up and used by the skilled individual. However, if the use is other than smooth (e.g. the hammer is too heavy), then the hammer is un-ready-to-hand, or unavailable for use. In the situation where use of the hammer is obstructed in some way (i.e. there is breakdown in its use), the hammer shows itself differently. In being conspicuous, obtrusive or obstinate, the hammer at once becomes present-at-hand. In the present-at-hand mode, activity stops and the person just looks curiously at the hammer, contemplating what could be the matter
with it, so that the hammer is present-at-hand-and-no-more. There is one more way that a hammer shows up as present-at-hand, and that is when it is considered as an entity in an abstract, theoretical sense. This has less to do with the everyday noticing of the hammer, and more to do with the understanding of hammers. It is akin to my deliberation and contemplation about hammers when writing this discussion of a hammer, as opposed to my use of a hammer to insert nails to hang artwork on a wall in my home.

In their everyday way of being in the world, a person’s concern with and comportment toward a hammer is in the ready-to-hand mode. As such the hammer is inconspicuous to its user. The person has an intelligibility of the use of a hammer, comports the self to swing the hammer because the entity, the hammer, which is present-at-hand is already in the world as ready-to-hand. The intelligibility of the use of the hammer comes from encounters with hammer-like entities. Those skilled in the use of a hammer feel it as an extension of their arm and do not ponder on it, it is already in their world as ready-to-hand.

In Jenny’s story of her first day of high school the experience of the classroom desk exemplifies these concepts. Jenny knows how to sit at a desk. When she comports herself to sit, the desk that had been ready-to-hand (inconspicuous in a classroom as a tool used by students), is now deficient and un-ready-to-hand. In considering how to use the desk it becomes present-at-hand to her, it has called her attention to it, and she devises a way to squeeze herself into it. She copes with this breakdown. Jenny’s large size announces itself to her as her intelligibility of the use of the desk is called into question. Jenny quickly hopes that this break in smooth functioning, that has alerted her, has remained unseen by others. The normalizing gaze is not welcome in the situation, as
Jenny has already assessed that everyone is thinner than she is. She hopes to escape the look, so that the obtrusiveness of her body is not seen by others.

The body of the overweight teenage girl, which is objectified by “the look,” frequently moves from the ready-to-hand mode of being to the present-at-hand mode. Attention directed toward the obese teen in the form of “the look,” drawn because of her deviance from the size norms of society, moves her from being inconspicuous to conspicuous. This causes a breakdown in smooth functioning. Human beings, according to Heidegger, have on-going everyday, non-deliberate ways of coping with breakdown. As Heidegger would have it, in a person’s everyday skillful coping with being-in-the-world, there is awareness but no self-awareness. The self and world belong together in a single entity that is called Dasein (Heidegger, 1975). Dasein is “everyday human existence.” Human beings are beings whose very way of being embodies an understanding of what it is to be. In this way Dasein’s way of being manifests as a stand it takes on itself (Dreyfus, 1999), in how it comports itself.

Our most common way of being in the world is spent in a “concerned absorption in the world” and not in the effortful, subject/object mode (Dreyfus, 1999). But it is the subject/object mode that is noticed and evinced by “the Look.” One’s manner of dealings in the world, and dealing with things closest to one is “not a bare perceptual cognition, but rather that kind of concern which manipulates things and puts them to use” (Heidegger, 1962, p95). Human beings cope or deal in four ways. They 1) switch to some other way of being and keep on going; 2) confront the defect and try to fix or improve it to get going again; 3) decontextualize the object and recontextualize it in formal models and scientific theories; or 4) just stare without recontextualizing (Dreyfus).
The experiences of obese adolescents provide illustration of these concepts. As a human being each girl takes a stand on her way of being in the world and comports herself to that way. In the experience of a break in her effortless way of being, the girl deals with it in a manner consistent with her stance. For example, a teenage girl whose body has become conspicuous can cope with this in the first way, i.e. switch to some other way of being and keep on going, by adapting her comportment as Jenny did – suck in her gut and quickly squeeze into the desk. In this way Jenny was able to keep on going with her purpose to be seated in order to take her Algebra test.

The teenager who comes to the pediatric obesity clinic for help with weight control is coping in the second way, i.e. confronting the defect and trying to fix it. Jenny, along with many of the girls interviewed for this project, worked hard to lose weight in order to resume their on-going everyday activities in a non-deliberate, effortless way, rather than the laborious way they had come to know.

By coming to the clinic, coping with the obese body in the third manner is also underway. The medical clinic decontextualizes the girl’s overweight body from the daughter, friend, and student that she is, and recontextualizes it as a patient. In assuming the role of the patient she necessarily takes on some of the theories, assumptions and explanations of her body offered by the therapeutic setting. This separates her from her experience with family, friends, home and neighborhood, and situates her in the hierarchical structure of the medical setting. These hierarchical relationships between doctor and patient create a context in which the lived (non-medical) experience of the individual is ignored and rendered illegitimate (Crawford, 1980).
The fourth way of dealing or coping with the conspicuous obese body is a sort of disinterested attention, i.e. just staring without recontextualizing. It may be experienced as denial that there is any problem with which to deal. This may happen when a girl’s stance about her way of being does not incorporate obesity. For example, Jamie said she had no problem with how she looked, “I look good, I don't care what you think. I walk around. I put on some like short-shorts, just walk around in a bikini top. I don't care.” (Line 147) Or being labeled overweight may be incomprehensible, as it was for Maya, who said, “I don’t know, they’ve probably got the wrong person. I know, ‘cause I pretty much have like okay eating habits.” (Line 153)

As the object of “the look,” the individual realizes at once that others see her as obese. This simultaneously reveals her fat-ness to others and to her, making her conspicuous and on display to those who would judge her. Being judged by how she looks is a part of the obese teenage girl’s every-day world. In 16 year-old Emma’s experience, being observed by others, and then compared to unrealistic ideal body types was something she dealt with often.

You have to be like the little Cosmo girl or whatever, and I am by far not that. So, I don’t know, it’s just like hard like with guys, and with people just judging you based on what you look like on the outside and really not giving you the time of day pretty much. (Line 47)

That Emma tried to conform to the ideal of the “Cosmo girl” was apparent to me in her make-up, hair style, and choice of fashion. Emma’s appearance was striking for many reasons. She was six feet tall, had sparkling blue eyes, a tremendous mane of wavy light blonde hair, glittering pink fingernails, stylish well-fitting clothes, and a bright white smile. She was closer to the magazine image than she admitted, but she differed
from models in *Cosmopolitan* magazine by weighing close to 300 pounds, i.e. she was obese. In Emma’s experience, this imperfection in her looks made her *persona non grata*.

Being sized-up was something Emma was used to. On the day we met for the interview Emma and I waited together in the medical center hospital building for an elevator to take us to the room reserved for our conversation. Also waiting for the lift were a tall white-haired gentleman and a middle-aged woman who appeared to be his daughter. As the elevator arrived we began to board, first the man’s daughter, then Emma and the gentleman moved forward at the same time. They could not both fit through the door. He stood aside to let her enter, tipped his hat, and commented aloud to her, “Hello there, big girl.” Emma politely greeted him in return, but her face reflected the awkwardness of the situation as she blushed. Afterward I asked her about it. She said that things like that happened to her all the time. She did not like it, but she remarked that there was nothing to be done about it.

Being called “big girl” by an elderly man was strange, but it did not hurt in the same way that it did when boys her age would comment on her size. As a junior in high school, Emma had been called names and told she was stupid. Like many teenaged girls she was interested in romantic relationships (Furman, 2002), yet Emma understood that her weight got in the way. Most “guys” she knew did not want to get to know the girl inside the fat suit.

*So that’s basically the hard part for me. But, umm, then sometimes you do come across those people that do really look close to see what kind of person you are, and that’s always good. But the other majority of the guys really don’t care. So that’s basically like my problem, finding like a guy or whatever. But that’s fine, I’m used to it by now, so it’s really no big deal. Nothing new. (Emma, line 47)*

Emma tried to shrug off the sting these memories brought her during our
She had constructed a way to protect herself from this hurt, by denying that she cared about it, so she could just keep on going. Most often she took this approach to dealing with the situation, she told me “I won’t really show them I care, but then I’ll get myself Ben and Jerry’s…just sit somewhere and just eat. I’ll usually feel a little bit better for the moment and then later feel like crap again” (Line 519). But, Emma had also learned to defend herself in her sixteen years. She described standing up to her tormentors, at times so indignant that they misjudged her or de-valued her that she “cussed them out.” There were times when she just could not take it any more.

Getting “the Look” was anxiety producing for some obese girls, and it was intrusive and sometimes aggravating for others. The fluidity of simply being in the world as oneself is interrupted when one is caught in a normalizing gaze. The ‘gaze’ can be experienced in other ways. Some girls, for example, described the feeling of being monitored.

Part II: Monitoring

An’ the other problem is, every time I go in. I can’t even go in the kitchen with my uncle around, ‘cause it’s every time I go in the kitchen it’s like he’s monitoring me. He walks in and out the room, just looking at every thing I do. Even if I’m doing my work. He always has a comment, ‘bout everything. What I be eatin’. Like his son, it’s ‘cause his son is skinny. He eat up the whole kitchen, he ain’t say nuthin’ to him. But I eat one thing [and he says] “Don’t you eat nuthin’ else tonight.” (Ali, line 96).

Imagine a prison-like setting wherein, under the watchful gaze of the warden and guards, all activities of the inmate are evaluated. Those on the weight control regimen are told to refrain from ingesting sweetened beverages and fast foods, are instructed to eat whole grains and more fruits and vegetables, and are cautioned to view all sweets as treats of which only one is allowed per week. Each morsel or drop of fluid that crosses
the lips and enters the mouth of the inmate is scrutinized. The inmate herself is watched for compliance to this regimen.

While the teenage girl who has joined a program aimed at controlling her weight gain is not a prisoner in her home, and her family members are not correctional officers, it can seem that way at every meal or snack time. The experience of being under watch, i.e. under a constant gaze, by those who would chide her for her missteps and cheer her for following the plan, means that she has always to keep her guard up – alert to the potential for a disapproving glance and possible punishment. She cannot be relaxed in her own home when it becomes a cell in which she can always be seen.

The concept of being constantly visible has been called panopticism by Michel Foucault in *Discipline and Punish* (1977), derived from “panoptic” which literally means all-seeing. Foucault describes the concept by explaining its development in a structural form, that of architect Jeremy Bentham’s *Panopticon*. The Panopticon is designed with an annular building at the periphery and a tower in the center. The outer structure is divided into rooms that extend the width with only two windows, one to the outside world and one toward the tower. The tower is designed with slits so that all cells can be viewed (and, thus, all inmates) at any time, yet the inmates cannot see their guard. The inmates also cannot see or communicate with each other. The cells, described by Foucault, “…are like so many cages, so many small theatres, in which each actor is alone, perfectly individualized and constantly visible” (p.200). This is said to be ideal for use in any population that needs to be kept under constant observation, such as prisoners, madmen, and school children.
The major effect of panopticism is “to induce in the inmate a sense of conscious and permanent visibility” (Foucault, 1977, p.201). This sense of always being under observation is thought to instill order and discipline. Whether or not there is actually anyone watching, the inmates or students behave as though someone is. These subtle and often unseen forces are controlling. Foucault argues that those subjected to this field of visibility, and who know it, are responsible for the constraint of power inherent in the system.

The adolescent girl who has sought help from a clinic to intervene in her unhealthy weight gain is under this type of observation, not in the structural sense of Bentham’s Panopticon, but in the virtual sense of panopticism. She has no privacy regarding her eating behavior. She is weighed and measured on a regular basis at the physician’s office, and every percent change in body mass index is discussed. Nutrition information and diet counseling are key components of the intervention provided by the clinic. She is questioned and quizzed regarding her food choices and compliance with the recommendations. Under the gaze of “the WATCH clinic” (aptly called by its acronym, rather than its long title of Weight Assessment for Teen and Child Health clinic) the client is directly observed. The gaze is perpetuated at home through surveillance and monitoring by the family.

When the lessons learned in clinic were brought into the home, 16 year-old Maya found the monitoring unbearable, so that she no longer ate meals with her parents at home.

“It was kind of annoying...Annoying 'cause my mother would ask – would look at what I eat or something and it kind of annoys me...She’s looking at the nutrition facts...I just felt like I was old enough to eat on my
own, you know, like I didn’t need them to watch me or anything. ” (Line 384)

Sharing a family meal was not the idyllic scene depicted in a Norman Rockwell painting, instead it was experienced as a hostile event where food choices were scrutinized and the diner was subject to reproof.

The monitoring gaze was a negative experience for Maya, but a different study participant, 16 year-old Dina, described the experience as supportive. Her family members are trying to help her by keeping an eye on what she eats.

Like yesterday we had cupcakes and I ate like one cupcake and they're like “Why are you eating a cupcake, you're not supposed to be eating...” “It’s only one.” “Okay fine.” [chuckle] My cousin, he was like “You can’t have a cupcake.” And I was like “Yes I can, I made them.” And he’s like “Okay, fine.” Like they really want to help me out so they're like behind me all the time, especially my mom. But I understand that and it doesn't hurt me. It’s like “Okay, yeah.” It actually makes me like re-think it like “You know what, you're right.” And then I'm just like “I’ll put it back.” So - I mean - it's like it’s good that they're there. Everyone else is going to be like “Okay, yeah, eat whatever.” So, it’s pretty cool...(Line 268)

Dina’s experience of family members actively keeping her on track with the dietary plan/nutrition intervention taught in the obesity clinic demonstrated to her their care and concern for her well-being. She was willing to be monitored, and accepted that all were watching her in order to help her. Dina’s mother commented that her daughter was strongly motivated to lose weight and they wanted to do all they could to help her succeed. Two flyers from the clinic (nutrition guidelines/stop light diet and plate model) were posted above the kitchen table, and everyone was expected to read, understand and follow the guidance.

As demonstrated, monitoring and surveillance can be perceived by the subject as either irritating or supportive. It may be effective in modifying behavior in an adolescent
if it is perceived as supportive. However, the annoyed adolescent may react by attempting to hide from view in order to consume forbidden foods, or large quantities of food, or it may lead to defiance and conflict, as Kelly recalls from her childhood:

Yeah. I was just thinking that when I was little, I would just eat. I mean, my mom, she was always like “K, you have to stop. K don’t eat that. Don’t eat that much.” But, I mean, when I was little I didn’t think about it. If I had known that...and, not that this is bad, but like if I had known that I would look like this, I wouldn’t have done it. Because, I mean, everyone else, just look like what everyone else is, I wouldn’t have done it. Like, I would have been like “Oh, I’ll just take a portion.” But, you know, you don’t know what’s going to happen, so you can’t...you can’t really gauge it. And it’s not like my mom just let me eat, but, I mean she would restrict me and then I would get really mad. I’d be like “Oh, I want that so bad now!” I’d be like defiance, you know. I want that because I can’t have it. (Line 71)

In retrospect, Kelly realized that her mother’s attempt to restrict her food intake when she was younger was an effort to prevent her from becoming obese. At the time, however, the close monitoring angered her and made her want to eat more to assert her independence. Kelly was regretful when she recounted not heeding her mother’s advice. The wistful, helpless plaint – if she had only known then what she knew now – galvanized Kelly to try to protect her younger sister from the same fate. She did not want Kaitlin to repeat her mistakes and suffer as she had from the teasing and the stares of others.
Part III. The Voyeur’s Gaze

‘Just a gaze. An inspecting gaze, a gaze which each individual under its weight will end by interiorizing to the point that he [she] is his own overseer, each individual thus exercising this surveillance over, and against him/her. self.’

Michel Foucault, in Power/Knowledge, p 155

There is something titillating to human beings when they come across scenes in life that are different or unexpected, that deviate from the norm. The eye espies the deviance, the looking extends beyond the moment, and in that moment becomes a voyeur’s gaze. One aspect of this is illustrated by the “Lookie loo” who holds up traffic by slowing down to look at the scene of an accident or fire or some other reality (Peckham, 2007). Another aspect of the voyeur’s gaze is that it is associated with sexual arousal or erotica, such as a Peeping Tom. There is still another aspect – one that takes an investigative turn, the voyeur is obsessed with seeing more as if to know more (Denzin, 1995).

The gaze can be one-sided or interactive. Two people can share a mutual glance. A gaze can be secretive, furtive. It can be overt and leering. It nearly always produces emotions for the person who is under the gaze – for some it could be indifference, for others pride. As described by the obese teenager, the voyeur’s gaze brought up feelings of humility and paranoia.

“On the negative side? ... Um, people looking at you. Like, if you’re sitting in a restaurant and people looking at you like, “Oh my god, look at that fat person sitting there, she’s gonna eat, like. I wonder what she’s ordering off the menu.” And, umm, people just looking at you and people saying, “Oh my god, look at her.” (Emma: Line 73)

Um – when I go out to eat with my friends. Like, um – like they're hella skinny and they order hella food. And like people wouldn't look at them hella weird but I mean if you see like a big person going to like Burger King and McDonald’s or something like that and you see them order hella food, they’d be like “Damn, what a fat ass,” and they'd be like “Damn, oh
Like they talk hecka stuff. And I don't want to say nothing about my friends but I'd be like “What the hell?” (Becca: Line 351)

Becca expressed that her thin friends were not subject to the voyeur’s gaze when they dined out as she experienced herself and other obese people to be. She experienced this as unfair treatment, unwanted attention, and a source of impediment to her every-day activity of going out with friends. Becca, and Emma quoted before her, have interiorized the gaze. In so doing, they see themselves as they perceive they are being seen – as negatively different from others, as an object of disapproval.

The voyeur’s gaze can be inquisitive and investigative (Denzin, 1995). In its act of perception, it renders the invisible world visible (Merleau-Ponty, 1968). Under a gaze, that which is noticed emerges from the background and is seen.

The gaze is embodied, an extension of the corporal self, and likewise it embodies those being looked at. In this way it is defining. If I am looked at as an oddity, then I am an oddity in that moment.

But then when I look at myself like – I don't even like full body mirrors in my room but then at the same time like I don't know. Like if I would just take a picture, like just like from – like my neck up, like people wouldn't think that I was hecka big. I don't think I'm hecka big but like they wouldn't think that I was hecka big and then like if they see me like my full body they'd be like “Damn,” like “I didn't think you were that big.”(Becca, Line 774)

Becca experienced her own self-reflecting gaze, and the gaze of others – when seen only from the “neck up” she was normal, but viewed at full length, she was obese. Becca perceived herself as a “skinny girl” until the voyeur’s gaze (her own and the others) said otherwise. Becca was not a stranger to the gaze. She described humiliation of being defined as a “fat girl” by a couple of voyeurs at a shopping mall:
I remember this one time me and my friend – the one that I told you she’s hecka bigger than me, we went to the mall one day, right? And you know how kids play on the escalators? Like the one that goes down you want to run up it? She was like “I dare you to run up the down escalator.” I was like “What am I going to get for it?” She’s like “I’ll give you five bucks if you make it in like three minutes.” And I look at her and I was like all right. So I ran all the way up the down escalator and these two old ladies were coming down, right, and once I got to the top I was like [panting]. Like “Holy shit.” And I came back down the down escalator and then she [my friend] was like – like she looked at me hecka sad and I was like “What?” I was “Where’s that five bucks?” Like I was hecka happy and she was looking at me hella sad and then she was like “Man, that’s hecka fucked up.” And I was like “What?” Then she was like “Did you see those ladies that were coming down the elevator – the escalator?” And I was like “Yeah, what about them?” And then she was like “They were like ‘Yeah, I bet you that fat girl lost ten pounds.’” And then I was like “Ah.” I was like “No.” I was like “That’s hecka mean.” And then I ran up to the ladies, I was like “Excuse me.” I was like “Do you have something to say to my face?” And they – they just laughed at me and walked away. (Line 794)

Gaze is a powerful concept. We who are sighted are always seeing, always looking. And we live in a world with others that also always look. The gaze is everywhere and is most often everyday and non-reflective. But, as has been explored here, through the description of obese adolescent girls, the gaze may also sometimes be judgmental or normalizing, it may survey or monitor behavior, and it may be voyeuristic. In any of these ways the gaze interrupts the flow of a human being’s everyday way of being in the world, for in apprehending the gaze one is forced to look and see.
Chapter 10

*If we propose to affect behavior, where is the closest point of contact we have with it?*  
Richard Elmore in *Backward Mapping: Implementation Research and Policy Decisions*

Conclusion

This project was an interpretive social inquiry into the phenomenon of adolescent obesity. The fundamental philosophical idea upon which this project was based is that of phenomenology, i.e. the philosophy of Martin Heidegger, wherein the meaning of human being (called Dasein) is explored. This assumes that the self is constituted by and shaped by the world it is raised up in. The self is always already situated in the world. It is this that makes it possible for things to show up for us at all, and for us to act in the ways we do (Heidegger, 1962). Dasein’s way of being is manifest as a stand it takes on itself, on what it means to be Dasein. This is a self-interpreted way of being that always comports itself toward its being.

I take up this philosophy in the way I comport myself as a nurse. I see the nurse’s role as one that deals primarily with the “lived social and skilled body in promoting health, growth, and development and in caring for the sick and dying” p. xviii (Benner, 1994a). What this means, in the context of this project, is that when I encounter real adolescent girls whose obesity impedes their normal growth and development, and affects their overall health, I endeavor to care for them. In this act of caring for others, I understand that they already exist in a lived world and embody a skilled way of being toward promoting their own health. They live within families and communities that shape that world, and have their own ways of promoting health or caring for the sick. I must take this into account if I am to change disease-producing behaviors, such as over-eating and lack of exercise, into the desired health-promoting behaviors.
I also acknowledge that my professional health promoting activities are allowed and limited by policies and politics, at the micro level of the health system in which I work, and at the macro level by professional associations and governmental agencies. It was a concern regarding the rising rates of childhood obesity, both locally and nationally, that led me to inquire how policies might influence the phenomenon. Initial forays into this line of inquiry demonstrated a plethora of policies, yet none that had made progress in reversing the trend.

By my estimation there seemed to be appropriate policies on record, or in planning, to arrest childhood obesity from many different angles (e.g. medical, agricultural, educational, city planning). Authors such as Michael Pollan, Eric Schlosser, and Marion Nestle; celebrities like chef Alice Waters and film producer Morgan Spurlock; and politicians such as California state senator Mark Leno and Congresswoman Lynn Woolsey are some of the more visible stakeholders working to increase public consciousness, start movements, and craft legislation regarding issues around the food environment, in large part because of their concern about the epidemic of obesity. The problem – the reason why the policies have not had the desired effect – may be due to the implementation, or lack of implementation, of the policies. Perhaps, when policies come down from the top, bureaucracy gets in the way. A bottom-up approach may be more successful. It was this line of thinking that led me to consider what those at the bottom, the overweight teenagers themselves, might have to say about the issue. No one else had taken this approach toward the problem of adolescent obesity in a systematic way before. It seemed like it was about time to talk to the people that the policies were intended to effect.
A theoretical framework for taking a bottom-up approach to look at policy implementation was explicated by Professor Richard Elmore in his essay, *Backward Mapping: Implementation Research and Policy Decisions* (1979-80). Elmore wrote “the closer one is to the source of the problem, the greater is one’s ability to influence it; and the problem-solving ability of complex systems depends not on hierarchical control but on maximizing discretion at the point where the problem is most immediate” (p.605). Following Elmore’s framework, I sought to go to the “lowest level of the [policy] implementation process” in this project (Elmore, 1979-80). I examined the level where the need for the policy arose, i.e. the girls who experience the phenomenon of obesity.

The results from this examination help us answer the chief questions presented in Elmore’s framework: what is our ability to affect the behavior change we want to see, and what do we need to do it? This requires us to name the behavior we wish to change. Our overarching goal is to reduce the prevalence of adolescent obesity. Eating less (through eating well) is the desired behavior.

Considerable effort is put into modifying the lifestyle behaviors (diet and exercise) of the youth, in San Francisco and beyond, in an effort to reach the goal. School Wellness Policy has altered the immediate school food environment. The Clinic treats individuals with diet and exercise counseling and with pharmaceuticals. These interventions have been described in the preceding chapters. Using Elmore’s framework as the lens for viewing the data collected and interpreted in this project may be valuable for understanding why we are not closer to achieving our goal.
What is our ability to affect a lifestyle behavior change in obese youth?

Before answering that question it is important to acknowledge the tremendous magnitude of the request to change lifestyle behavior. This is really a request to alter a person’s self. A person’s lifestyle is synonymous with their “world” in the Heideggerian sense. It is not one thing, it is everything, and much of it is pre-conscious. The phenomenological interpretation of the interviews and observational data in this study revealed that a girl’s way of being in the world was exhibited as her stance, and that the stance a girl took toward her obesity was consistent with the stance she took on her way of being in the world.

The word “stance” is used here to mean the stand which Dasein, i.e. a human being, takes on itself. It is the person’s own understanding of her existence, how she is situated in the world, and the way in which she interacts with the world. This is not a conscious, mental or emotional stance, rather it is the non-deliberate, non-contemplated effortless way of being that a human being is. A girl’s stance influences all of her interactions, including her transactions with the clinic, with school, with peers, and with family. Understanding the stance a girl takes may play an important role in the ability to modify her lifestyle behaviors, i.e. her diet and activity.

I have labeled the stances that were observed in the obese girls in this study as oppositional, resistant/ bargaining, resigned, and engaged. These categories are points on a continuum and not discrete groups. It may be that girls with a more engaged stance are more receptive to the current methods aimed at changing their lifestyle behaviors, and therefore more successful. It therefore becomes important to understand girls with an alternate stance and consider how to address them in order to meet our goal.
Oppositional Stance

A young woman that embodies the oppositional stance is generally suspicious of the motives of others and does not take people at their word. She is doubtful and assumes others are not truthful with her, until it is proved otherwise, and she is not truthful with others. She is opposed to having her world view changed at all. She actively denies there is any need to change. She is hiding or holding back her true self until she is certain it is okay to reveal it. She has to be convinced, and it has to be on her terms.

Maya exemplifies this way of being. During the interview Maya held her body in a rigid fashion, with her arms crossed, and a look of defiance on her face. Intermittently she looked away from me, scratched her dry skin, and fidgeted. She gave generally short answers, as though she did not want to reveal too much. She said directly several times that she did not consider obesity to be a problem for her. I wanted to understand why she kept coming back to the clinic if she did not want to lose weight.

*Interviewer:* But you keep coming back to the clinic?

*Maya:* Because they force me to come here. It’s not my decision.

*Interviewer:* Who forces you?

*Maya:* My - pretty much my doctor and my dad.

*Interviewer:* Your dad is concerned about you?

*Maya:* No, he just pretty much listens to what the doctor says. 

*Interviewer:* So you don't think this is a problem?

*Maya:* No.

*Interviewer:* Tell me a little bit more about that.
Maya:  I - I just think it’s not a problem with me.  Uh - [pause]  
Pretty much what they're saying to me, it’s like go on a diet and  
[pause] - um - and just pretty much be thin as a model or  
something like that.  That’s what they feel - it’s what it feels like  
they’re saying to me is just get on a diet and be really thin.  In a  
way it feels like they're saying that but more in technical words.  
(Line 179)

Maya was opposed to changing her view of herself, and she was opposed  
to changing her behaviors regarding diet and exercise. She doubted the need for  
change as she did not trust the doctors, and by extension her father since he was  
just following the doctors. In advising her to change her eating habits to control  
her weight Maya heard them say she should be model-thin. Maya doubted the  
idea that she would ever be “really thin.” Seen from her oppositional stance the  
doctors and her father were lying to her, which meant that she was not really  
obese, did not really have “pre-diabetes,” and did not really need to watch what  
she ate.

The girl with an oppositional stance presents to clinicians as a difficult  
patient. She does not willingly assume the patient role or do what is prescribed.  
Her trust must first be won if she is to be open to the possibility of change, or to  
any interventions that might be tried. Her approach to the world frustrates and  
repels others, creating conflict in her transactions. This stance makes her  
particularly vulnerable to failure in achieving the goal, which is to eat less through  
eating well.

She might, however, respond to messages that acknowledge her  
perspective and give her a more acceptable target for opposition. She might find  
the food industry or the fast food industry as an opponent, instead of the doctors
and her parents. She might be convinced that her eating habits are poor once she is aware of the profit-seeking motives of the industries that are behind the “branding” of American youth, especially the manipulative marketing tactics that are used to hook children and youth on soft drinks and snack foods. The girl with the oppositional stance might understand that food and beverage corporations lie in their marketing campaigns, and would not want to play the fool for them.

*Suffering/Despairing* is a variation of the oppositional stance that was observed. Instead of denying that she is obese, she denies that it is possible to change. She suffers in her longing to be normal weight, she is desperate to lose weight, but is not comported to believe she can do it. In this way of being the girl is doubtful that anything will change. Jenny’s story is an example of this stance.

> My parents are the ones calling me fat. I try not paying attention. But then, it gets into me, and I’ll be like yeah – I should lose weight...well, I’m okay with it. I mean I’m not okay being “fat” but I kind of deal with it and know that I have to lose weight. (Line 81)

> But, I’m still overweight. I have no idea [why this is]. I think is a lot of the exercise I’m not doing. I mean I have not been a big dieter, and I don’t want to go diet crazy. But I think it’s less exercise. I’m not big on exercising. I’m big on walking. But, my exercise is not happening. (Line 409)

Jenny denies that she is able do the dieting or exercise that she knows is essential for her to lose weight. This stance is obstructive to accepting the prescribed clinical interventions. It does not allow for the openness that is required for change to be successful. Similar to those with the more blatantly oppositional stance, the girl operating in a suffering/despairing style needs special handling from clinicians to engender trust in their methods. She may benefit most from group interaction with peers who have the same goal to eat less through
eating well, in order to provide structured support to her as she tries on the new behaviors. The girl with this stance may reach her weight loss goal from the addition of physical activity into her daily life. Adopting a policy, making physical education a required element in school curriculum at all age levels, might offer a better chance for success to the despairing girl.

Resistant /Bargaining Stance

The young woman who states that she does not see herself as obese yet acknowledges that she needs to lose weight embodies the stance I have called resistant/bargaining. She is resistant to being labeled obese and claims she does not see her self that way, yet she diligently throws herself into following the prescribed diet for weight management. She is resistant to being seen as different from everyone else, i.e. those with a normal weight. She bargains with herself: if she eats the “healthy” food and loses weight, she can go back to eating “normal” unhealthy food again. Yet, this will cause her to gain weight, and the cycle continues. This is a veritable Catch 22.

The resistant/bargaining stance was embodied by Becca, the teen who resisted making a real change in her eating practices by continuing to frequently dine at fast food restaurants, and bargained by selecting just one item from the menu.

*Becca: Like I could eat healthy but I just think like that I wouldn't like it. Like - I don't know how to explain it. Like in my head like I could think that I do it but then I don't do it. Like I tell myself I'm going to do something but then I don't do it and I don't know why.*

[pause]

*Interviewer:  So when you go someplace for lunch is it always Round Table?*

*Becca: Nuh-hm. [no]. I don't go every day, just like occasionally when [my friend] asks me like “Oh, you want to go eat?” I'll be like*
“All right, ... whatever.” [chuckle] And like we go to Jack-in-the-Box. (Line 586)

The girl with this stance understands the need to eat well (she has the information and is mentally motivated) yet she cannot actually do it on a regular basis. For someone to approach the goal to eat less (or eat well) without really changing what or where she eats is counter-productive. She bargains that she will do it later, or do it right next time. At best this leads to a cycle of weight loss and weight gain, at worst the weight gain trajectory continues. She will appear interested and motivated to the clinicians, and will verbally affirm she is complying with the program. However, her fluctuations in BMI will disclose that she is not actually able to do it for an extended period or with any regularity. For her the regimen will always be a temporary plan, just until she gets to her normal weight.

A campaign to re-frame what normal food is may be useful for addressing those who have this stance. What would public modeling of the desired behavior to eat less (through eating well) look like? One way to get at this might be to restrict the marketing of junk foods (e.g. soda/pop, candy, chips and cookies) in ways similar to the way alcohol marketing is restricted. This could shift the perception of junk foods as being something everyone eats all the time, to being something that is unnatural and toxic, that should be consumed only rarely if at all.
Resigned or Accepting Stance

The girl who shows up as being ready to change because everyone tells her she must, and who makes an earnest attempt to eat less, will make allies of the clinic staff. This girl embodies a stance that is resigned to her fate and accepting of the situation (i.e. she is a patient of an obesity clinic). She has come to the experts for help and accepted the consequences. If it means she has to take medications, so be it. If it means she has to cut out drinking soda/pop and eating Flamin’ Hot Cheetos, she can deal with that. She accepts that her individual actions have brought her to this point and does not consider that the food environment, in her home, school or community at large, may have something to do with it.

An example of a girl with this stance is Kelly. She was motivated by the humiliating experiences of being a fat child, and felt encouraged by her doctors that weight loss was an attainable goal. She was resigned to eating less, but realized how hard it was to do. From her stance she accepted that healthy eating alone was not enough to shift her BMI down significantly. She was already on medication. The last strategy left was to add in exercise.

Because just dieting doesn’t really work, ‘cause I really do try to eat less. And, in my gym class we are actually counting calories now. So I think that is going to kinda, sorta kick it up again. But I just need to go to a gym, like I try to tell my mom, but it’s expensive. So, it’s like, I can’t...I walk a lot, but it’s like I know that if you run you work more, you do more cardio, and then you lose weight, you know, more weight...(Line 79)

The girl who is resigned or accepting will assume the patient role in a way that makes the clinicians glad to work with her. Her stance may validate in them a sense that their work is appreciated and useful, as this girl assumes many of the medical concepts of health and disease in approaching her obesity. The girl with
this stance may or may not be successful in managing her weight, but she will
always feel responsible for her own success or failure.

The girls with a resigned or accepting stance will benefit by knowing that
the responsibility for her success or failure to control her weight is shared by
society. It may reduce her own level of guilt or anxiety to know, for example, that
the availability and affordability of gyms and exercise classes in her community
play a large role in her ability to access and participate in opportunities for
physical activity, and that these are determined by society.

Increasing the awareness of every patient and family in the clinic
regarding the societal barriers to any one’s success at weight control could be
incorporated into the lessons taught in the clinic. This message could also be
disseminated to the community through participatory action and media
campaigns. Efforts are needed to improve public parks and recreation facilities,
including funding for buildings, grounds and trained staff, to create an
environment that affords fun, safe options for physical activity to all members of
society.

Engaged

The young woman who approaches her obesity with an upbeat, can-do attitude is
likely to have the most benefit from any currently available weight loss program. This
young woman shifts the environment around her to match the “eat less” behavior she
adopts. She engages in eating well and being active for the sake of doing it, not just as a
temporary effort to lose weight. Although she may have started the new behaviors under
the guidance of the clinic’s experts, she has incorporated them into her world. She comports herself to engage in a healthy lifestyle.

The engaged stance is exemplified by Dina. Dina’s openness to change and optimism for a bright future are attributes that help her stay on course even though it is difficult. This is the girl who recently learned to ride a bicycle. She actively sought out friends and activities that helped her attain her goal.

\[\text{We did a lot of walking and then we went to Yosemite for like almost a week and we hiked there and it was really fun, it was really pretty. That was really fun too. It was like heat and exercise so they like worked together.}\]

\[\text{Like we would eat things that were low in fat in order to keep us energized and we could not drink soda at all. So, it was just basically a lot of water - I mean, which I already do. I don't drink soda or juice anymore. It's just water, more water. So, just water. (Line 214)}\]

The engaged adolescent is a joy to be around. She is enthusiastic and takes an active role in changing her lifestyle behaviors. She is a girl who might be enlisted as an agent of change, as an activist for the “healthy lifestyle” cause. She might offer peer support for others whose stance along this continuum interferes with their being able to comport themselves to the goal of eating less. Any public media campaign that sends a message promoting a healthy-lifestyle will be affirming to the engaged girl’s stance, and will be affirmed by it.

The significance of a person’s stance must be kept in mind as we consider the answer to Elmore’s second question.

\textit{What do we need to affect the change in lifestyle behavior?}
I have suggested that we can affect this change in the lifestyle behavior of teens, i.e. get them to eat less while eating well, and we can do so by acknowledging the stance they take on themselves, on their obesity, and their ability to change, and by modifying our approach to them.

While obesity has been medicalized as a problem of individual behavior for teenage girls, it is really a reflection of our larger world in which they find themselves positioned - a world in which “bad” food is “normal” food. Bad food has been elevated to be what there is to eat. If instead, healthy food became normal, then less bad food would be consumed. If bad food had the smaller share of the food market, it might be produced, distributed and marketed in a less aggressive manner. If healthy food became what people want, the production of real food would increase and we would see more of it available to everyone.

What we must do, to make a real change in the eating behaviors of our youth, is join in a concerted, targeted effort to reassert the prime importance of eating real foods, instead of artificial or re-constituted food products. In order for any one human being to change their own lifestyle, their “world,” so that eating less while eating well is possible, there must be a shift in the collective definition of what food is in our common “we-world”, i.e. what constitutes the food choices available to all Americans. This argument has been made by other experts in this area, for example Kelly Brownell in Food Fight (2004), Michele Simon in Appetite for Profit (2006), and Michael Pollan In Defense of Food (2008).

My contribution to this discussion has been to shed light on the issue as the social and individual conundrum that it is. As we endeavor to feed our nation, our society has
created a food system that relies heavily on industry and a market economy to do it. In our efforts to make food abundant and cheap so that no one will starve, we have created a system that is making us sick. The current food system employed in the U.S. is not inescapable. It was designed, and it can be changed. Likewise, the way we perceive of food is contrived and can also be changed.

This project also illuminates how policies made at the national, state and local levels actually play out in the life of the individual young person who is obese. Further, it shows that the implementation of the policies must consider how we can actually make the changes needed at each level. If we want teenagers to eat salad for school lunch, we must make attractive, fresh salad ingredients available to schools. The school lunch program needs adequate funding to provide real, nourishing food to students; contracts with distributors should favor organic and local produce; and schools should be equipped with real kitchens and personnel who can prepare meals from real ingredients on-site instead of distributing pre-heated processed meals delivered by truck early in the day.

It has also been my intention to complicate the idea regarding how to solve the problem of obesity. There is a predominant idea that what it takes to fix this problem is to change individual behavior. This is supported by the medicalization of obesity, and it makes the solution seem simplistic. As has been described in this study, through our visit to the world of obese adolescent girls, changing one’s behavior is not easy. It is akin to learning to ride a bicycle on the steep hills of San Francisco. It may be fraught with peril, yet it is exhilarating, and it will open up new vistas never before seen.

Changing the world is never simple. However, changing the world, both the close-in world and the larger we-world, is exactly what is needed. This will require
shifting the collective social consciousness. It is a large project to be sure, but one has been done before. Consider, for example, the institution of seatbelts in automobiles, or the strides taken to address the issues of smoking and tobacco control. Many strategies that have been used in those instances may transfer to the issue of childhood obesity. Further exploration in this area is warranted.

In being identified as the nexus of the problem of obesity, teenage girls adopt different stances, appropriate to their way of being, to respond to those who want to help them control their weight. What this means for clinicians is that they need to tailor their practice to the stance of their patient in order to be effective. The implication for policy-makers is that social messages are needed to appeal to every stance. The fallacy that we can choose to eat well in a world where unhealthy food is idealized must be exposed. Change is needed at every level, so that it is possible for all to perceive that real food is normal; so that when a child reaches for food there is only health promoting food available.
REFERENCES


Retrieved February 28, 2009, from

http://www.marketingpower.com/AboutAMA/Pages/DefinitionofMarketing.aspx


Cotton, J. (1735). *New-England primer: For the more easy attaining the true reading of English: To which is added, milk for babes*. Boston: S. Kneeland & T. Green, on Queen Street.


NHANES. (2002). *National health and nutrition examination survey.* Washington, DC.


Spurlock, M. (Writer) (2004). *Super size me* [Documentary Film].


USDA. (2004, June 3). Mission statement. Retrieved May 6, 2007, from http://www.usda.gov/wps/portal/!ut/p/_s.7_0_A/7_0_1OB/.cmd/ad/.ar/sa.retrievecontent/.c/6_2_1UH/.ce/7_2_5JN/.p/5_2_4TR/.d/0/_th/J_2_9D/_s.7_0_A/7_0_1OB?PC_7_2_5JN_navid=MISSION_STATEMENT&PC_7_2_5JN_navtype=RT&PC_7_2_5JN_parentnav=ABOUT_USDA#7_2_5JN


TABLE 1 Sample Demographics

<table>
<thead>
<tr>
<th>ID #</th>
<th>Age (years)</th>
<th>Race*</th>
<th>Ethnicity (Yes=Hisp/Latina)</th>
<th>BMI (kg/m²)</th>
<th>Co-morbidity (documented by MD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>15</td>
<td>4</td>
<td></td>
<td>46.0</td>
<td>acanthosis nigricans, high cholesterol</td>
</tr>
<tr>
<td>02</td>
<td>15</td>
<td>5</td>
<td>Yes</td>
<td>33.2</td>
<td>acanthosis, acne, snoring</td>
</tr>
<tr>
<td>03</td>
<td>17</td>
<td>4</td>
<td></td>
<td>45.0</td>
<td>acanthosis, high chol., snoring, hirsutism</td>
</tr>
<tr>
<td>04</td>
<td>17</td>
<td>4</td>
<td></td>
<td>43.9</td>
<td>acanthosis, hirsutism, obstructive sleep apnea</td>
</tr>
<tr>
<td>05</td>
<td>16</td>
<td>5</td>
<td></td>
<td>46.0</td>
<td>acanthosis, acne, ADHD, ovarian cyst</td>
</tr>
<tr>
<td>06</td>
<td>16</td>
<td>5</td>
<td></td>
<td>37.4</td>
<td>acanthosis</td>
</tr>
<tr>
<td>07</td>
<td>15</td>
<td>5</td>
<td>Yes</td>
<td>46.8</td>
<td>acanthosis, T2DM, pseudotumor cerebri</td>
</tr>
<tr>
<td>08</td>
<td>15</td>
<td>5</td>
<td>Yes</td>
<td>46.0</td>
<td>hypertension</td>
</tr>
<tr>
<td>10</td>
<td>17</td>
<td>5</td>
<td>Yes</td>
<td>31.8</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>15</td>
<td>1</td>
<td>Yes</td>
<td>32.0</td>
<td>acanthosis, hyperinsulinemia</td>
</tr>
<tr>
<td>12</td>
<td>16</td>
<td>4</td>
<td>Yes</td>
<td>32.4</td>
<td>acanthosis, hirsutism, insulin resistance, PCOS</td>
</tr>
<tr>
<td>13</td>
<td>17</td>
<td>5</td>
<td>Yes</td>
<td>33.2</td>
<td>acanthosis, hirsutism, hyperinsulinemia</td>
</tr>
<tr>
<td>14</td>
<td>14</td>
<td>4</td>
<td></td>
<td>36.9</td>
<td>acanthosis</td>
</tr>
<tr>
<td>15</td>
<td>16</td>
<td>5</td>
<td>Yes</td>
<td>50.1</td>
<td>acanthosis, acne, enlarged tonsils</td>
</tr>
<tr>
<td>16</td>
<td>16</td>
<td>5</td>
<td>Yes</td>
<td>41.3</td>
<td>acanthosis, hirsutism, depression, PCOS with insulin resistance</td>
</tr>
</tbody>
</table>

*Race categories: 1 = American Indian/Alaskan Native; 2 = Asian; 3 = Pacific Islander; 4 = Black; 5 = White

Summary

<table>
<thead>
<tr>
<th>Mean Age</th>
<th>Mean BMI</th>
<th>% Black</th>
<th>% White</th>
<th>% Hispanic</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.8 years (range 14 to 17 years)</td>
<td>40.13 kg/m² (99th percentile) (range 31.8 to 50.1)</td>
<td>33</td>
<td>60</td>
<td>60</td>
</tr>
</tbody>
</table>

Co-morbid conditions were diagnosed in 14 of the 15 participants (93%).
CONSENT TO BE IN A RESEARCH STUDY

Teen Participant

Study Title: Factors Related to Overweight in Adolescents: A Qualitative Study

What is this study about?
You are being asked to participate in this study because you are a teenager who is overweight and because we, who are doing this study, Marcia Wertz, RN, and Dr. Ruth Malone from the UCSF School of Nursing, are interested in knowing how you feel about being overweight. Your experiences are important to us so we can better understand what being an overweight teenager is like and how to be more helpful. Up to 60 teens will be in this study at UCSF.

What will happen to me if I am in this study?
If you agree to be in this study you will have at least one, and maybe as many as three, visits with Marcia Wertz, RN. During these visits, which will last no more than one hour each, Marcia will ask you some questions related to your experiences of being overweight. The questions and your answers will be recorded on audio-tape. You may be interviewed alone or as part of a focus group discussion with other teens. If you are part of a group, you will meet with other overweight teens the same sex as you to discuss what it is like to be overweight. The group discussion will be recorded. You will fill out a short questionnaire about your age, race/ethnicity, height and weight. Marcia will also review your WATCH clinic medical record to obtain information about your health.

You will be given an ID number for the study, so that your name will not be used in the study records.

Being in this study may take as little as one hour of your time, or as much as 3 hours if you are asked to and you agree to come in for a second or third visit.

Will any parts of the study hurt?
No. It is possible that you may feel uneasy, embarrassed or even bored by the visit. If you are upset by the visit, and you request it, a referral to a counselor will be given to you.

Being in a research study may involve a loss of privacy, but information about you will be handled as confidentially as possible. Your name will not be used in any published reports about this study. The voice recordings will be erased completely after the words have been typed onto paper. The paper copies will be kept in a locked file cabinet.

You may feel that you are losing your privacy. If you are feeling this way, you should let Marcia know. You do not have to answer any question that you do not want to. You should know that the information you give to Marcia will be kept confidential, except for anything you may tell her that she has to report to Child Protective Services.

Will I get better if I am in this study?
No. It may feel good to express how you feel about being overweight, but we don’t know if this will happen.
APPENDIX 1

Do I have to pay to be in this study?
No. Being in this study will not cost you any money. We ask that you give us your time (1 to 3 hours total) at the visits only.

What do I get if I am in this study?
You have the chance to let others know what being overweight is like for you. The information may help doctors and nurses understand better how to treat you and other teenagers like you in the future. You will also receive a $10.00 gift card for each visit you come to.

What if I have questions about the study?
If you have any questions you should ask us. You may ask them now, or anytime. You can call Marcia Wertz, RN at 415-514-3597 if you have questions later.

What are my choices?
You do not have to be in this study. You can still come to the clinic at UCSF and get all of the care you need even if you do not want to be in this study. If you decide to be in the study and then change your mind later that is okay, too. You just have to tell Marcia. No one will be mad at you if you do not want to do this.

This study has been explained to you by Marcia Wertz, RN, or the person who signed below and your questions were answered. If you have any other questions about the study, you may call Marcia Wertz, RN at (415) 514-3597, or Dr. Ruth Malone at (415) 476-3273.
If you have any comments or concerns about participation in this study, you should first talk with the researchers. If for some reason you do not wish to do this, you may contact the Committee on Human Research, which is concerned with the protection of volunteers in research projects. You may reach the committee office between 8:00 and 5:00, Monday through Friday, by calling (415) 476-1814, or by writing: Committee on Human Research, Box 0962, University of California, San Francisco/San Francisco, CA 94143.

If you want to be in this study, please sign below.
You have been given a copy of this consent form and a copy of the Research Subject’s Bill of Rights to keep,

PARTICIPATION IN RESEARCH IS VOLUNTARY. You have the right to decline to participate or to withdraw at any point in this study without penalty or loss of benefits to which you are otherwise entitled.

<table>
<thead>
<tr>
<th>Date</th>
<th>Subject’s Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Person Obtaining Consent</td>
</tr>
</tbody>
</table>

Since you are under 18 years of age, your parent or guardian’s permission is also needed in order for you to participate:

| Date     | Parent/Guardian Signature |
First 3 letters of your first name: □ □ □

Age: _________ years     Grade in School:________________

Sex :    Female      Male  
       (circle one)

Race: (check all that apply)                  Ethnicity:

□ White               □ Hispanic or Latino

□ Black or African-American   □ Not Hispanic or Latino

□ Asian

□ American Indian or Alaskan Native

□ Native Hawaiian or Other Pacific Islander

High School you attend: ____________________________________________

Current Height: _________feet _________inches

Current Weight: _________pounds

May I contact your parent/guardian for an interview and home visit?  
□ Yes        □ No
Thank you for agreeing to talk with me today.

I am interested in learning about what it is like for you to be overweight. I am interested in hearing about your experiences. I am really interested in any examples you can give me about your situation. Remember, if you don’t want to answer a question you don’t have to, and if you want to stop at anytime just let me know.

1. Please begin by telling me a little bit about yourself….

2. How did you come to be a patient in this clinic?
   • Is this your first time here, or…?
   • How did you feel when you came here for the first time?

3. As you know, this clinic is especially for people who have weight concerns. Tell me what it is like for you being a person of your size…
   • What’s the hardest part about being your size?
   • What’s the best part of being your size?

4. In this study I’m really trying to just hear what people have to say about their own experiences with being overweight, because nobody has ever studied that.
   • Tell me a story about some time when your weight or size affected you or was an issue for you…
   Probes: Has anything else like that ever happened?
   o What did you do?
   o Did you share that with anybody?
   o What about at home?…at school?

5. Tell me what eating is like for you, at home…at school…
   • Does your family all eat together? (Which meal? How often?)

6. What do you like to do for fun?
   • Describe a good day that you have had.
   • What made it good?

7. Is there anything else you think I should know, or that you would like to tell me?

8. What advice do you have for me so that I will understand what it is like to be a teen with your experiences, or that might help other teens with weight issues?
Study Title: *Factors Related to Overweight in Adolescents: A Qualitative Study*

**What is this study about?**

You are being asked to participate in this study because you are the parent or guardian of a teenager who is overweight and because we, who are doing this study, Marcia Wertz, RN, and Dr. Ruth Malone from the UCSF School of Nursing, are interested in knowing more about the everyday life of overweight teens. Your teenager has already been interviewed for this study and has agreed that we may also talk with you.

**What will happen to me if I am in this study?**

If you agree to be in this study you will have at least one, and maybe as many as three, visits with Marcia Wertz, RN. During these visits, which will be conducted in your home and will last no more than one hour each, Marcia will ask you some questions related to your family’s experiences around diet and exercise. The questions and your answers will be recorded. You will be given an ID number for the study, so that your family’s name will not be used in the study records.

You will be asked to escort Marcia on a tour of the areas in your home where you prepare, store and eat food. Marcia may take some photographs to assist her later in recalling details of her visit to your home.

Being in this study may take as little as one hour of your time, or as much as 3 hours if you are asked to and you agree to a second or third visit.

**Will any parts of the study hurt?**

No. It is possible that you may feel uneasy, embarrassed or even bored by the visit. If you are upset by the visit, and you request it, the interview will end and Marcia will leave.

Being in a research study may involve a loss of privacy, but information about your family will be handled as confidentially as possible. Your name will not be used in any published reports about this study. The voice recordings will be erased completely after the words have been typed onto paper. The paper copies will be kept in a locked file cabinet. Any photographs taken for the study will be the sole property of Marcia Wertz. They will be stored on a password-protected computer in her locked office. If a photograph contains the image of a person, that person will be asked to sign a release to use the photo in the event that, in the future, the photo might be used in presenting the research findings.

You may feel that you are losing your privacy. If you are feeling this way, you should let Marcia know. You do not have to answer any question that you do not want to. You do not have to sign the photograph release form, and your image will not be used without your permission. You should know that the information you give to Marcia will be kept confidential, except for anything you may tell her that she has to report to Child Protective Services.
APPENDIX 4

Will I get better if I am in this study?
No. It may feel good to express how you feel about your child being overweight, but we don’t know if this will happen.

Do I have to pay to be in this study?
No. Being in this study will not cost you any money. We ask that you give us your time (1 to 3 hours total) at the visits only.

What do I get if I am in this study?
You have the chance to share your concerns about your overweight teenager with others. This information may help doctors and nurses understand better how to treat your child, and other teenagers like him or her in the future. You will also receive a $10.00 gift card for each visit to thank you for allowing us to spend time with you.

What if I have questions about the study?
If you have any questions you should ask us. You may ask them now, or anytime. You can call Marcia Wertz, RN at 415-514-3597 if you have questions later.

What are my choices?
You do not have to be in this study. Your child can still come to the clinic at UCSF and get all of the care that is needed even if you do not want to be in this study. If you decide to be in the study and then change your mind later that is okay, too. You just have to tell Marcia. No one will be mad at you if you do not want to do this.

This study has been explained to you by Marcia Wertz, RN, or the person who signed below and your questions were answered. If you have any other questions about the study, you may call Marcia Wertz, RN at (415) 514-3597, or Dr. Ruth Malone at (415) 476-3273.

If you have any comments or concerns about participation in this study, you should first talk with the researchers. If for some reason you do not wish to do this, you may contact the Committee on Human Research, which is concerned with the protection of volunteers in research projects. You may reach the committee office between 8:00 and 5:00, Monday through Friday, by calling (415) 476-1814, or by writing: Committee on Human Research, Box 0962, University of California, San Francisco/San Francisco, CA 94143.

If you want to be in this study, please sign below.
You have been given a copy of this consent form and a copy of the Research Subject’s Bill of Rights to keep,

PARTICIPATION IN RESEARCH IS VOLUNTARY. You have the right to decline to participate or to withdraw at any point in this study without penalty or loss of benefits to which you are otherwise entitled.

_________________________________________  __________________________________________
Date                                           Subject’s Signature
<table>
<thead>
<tr>
<th>Date</th>
<th>Subject’s Printed Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Person Obtaining Consent</td>
</tr>
</tbody>
</table>
Thank you for agreeing to talk with me today.

I am interested in learning about your family’s routines regarding eating and exercise, and your experiences dealing with weight issues. I am really interested in any examples you can give me about this.

Remember, if you don’t want to answer a question you don’t have to, and if you want to stop at anytime just let me know.

1. Please begin by telling me a little bit about yourself and your family…

2. How did your son/daughter come to be a patient in the WATCH clinic?
   • What was that like for you?

3. How did you come to recognize that your son/daughter’s weight was affecting their health?
   • What are some ways you deal with it?
   • Tell me a story about some time when your child’s weight or size was an issue for your family…

4. Tell me what meals and eating are like for your family…give examples…
   Probes:
   o Who decides what to eat?
   o Who shops? Who cooks?
   o Does your family all eat together? (Which meal? How often?)

5. Tell me what your family likes to do in the “free time” you have?

6. Is there anything else you think I should know, or that you would like to tell me?

7. What advice do you have for me so that I will understand better what it is like for families with your experiences, or that might help other families managing weight issues?
Publishing Agreement
It is the policy of the University to encourage distribution of all theses, dissertations, and manuscripts. Copies of all UCSF theses, dissertations, and manuscripts will be routed to the library via the Graduate Division. The library will make all theses, dissertations, and manuscripts accessible to the public and will preserve these to the best of their abilities, in perpetuity.

Please sign the following statement:
I hereby grant permission to the Graduate Division of the University of California, San Francisco to release copies of my thesis, dissertation, or manuscript to the Campus Library to provide access and preservation, in whole or in part, in perpetuity.

[Signature]
Author Signature

26 - May - 2009
Date