

THE CHILDHOOD OBESITY EPIDEMIC AS A BURGEONING SITE OF SOCIAL STRATIFICATION

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This article deconstructs the childhood obesity epidemic, examining the anthropological, social, and political meanings of the constructs of fatness, obesity, and epidemic. It chronicles the emergence of a speciously objective obesity construct that preserves the underlying moral significance of a fatness construct. The political deployment of the obesity construct marginalizes certain groups, such as low socioeconomic-status (SES), racial-minority, and ethnic-minority families, in ostensibly scientific terms. So too, the political deployment of the epidemic construct secures the ascendancy of childhood obesity on the policy agenda. The article argues that social workers are obligated to deconstruct the constructs of obesity and epidemic.

*F*atness and obesity: the terms are related yet distinct. Crusaders who constitute a group of people that includes researchers, physicians, public health officials, and activists (Basham, Gori, and Luik, 2006) have subsumed the moral aversion to the construct of fatness under the speciously objective construct of obesity. Hereafter, the article eschews the moniker “crusaders,” coined by Paul Campos (2004, p. ix), for the less-emotive moniker “stakeholders.” This article presents the results of analysis of the ways in which the stakeholders have constructed obesity through the use of body mass index (BMI). Although the construct of obesity is ostensibly based in science and statistics, the stakeholders deployed it ahead of, or in spite of, attenuated and ambiguous evidence (Basham et al., 2006). Indeed, the obesity construct is value-infused and culturally produced (Cogan, 1999), in spite of its objective veneer. This article argues that the putative scientific aura of obesity shields the stakeholders from potential allegations of discrimination associated with class- and race-related discourse.

To fatness and obesity, one can add two additional terms: epidemic and childhood. Both of the latter terms heighten the salience of childhood obesity

on the policy agenda. The term “epidemic” functions as a warning that all must be vigilant against childhood obesity, as it is allegedly a highly contagious disease that can strike anyone anywhere (Gard and Wright, 2005). However, stakeholders also assert that obesity does not strike all equally; poverty and cultural values allegedly render some children more vulnerable than others to the epidemic (Okie, 2005). The modifier “childhood” elevates the obesity epidemic in agenda-setting processes. Children occupy a unique position in the realms of policy and politics. They have potential as future citizens and as limitations due to their developmental stage (Basham et al., 2006). Thus, policy makers both privilege and protect children; this raises child-related initiatives to the agenda (Basham et al., 2006).

The deployment of the obesity and epidemic constructs reveals the underlying social anxiety associated with an ostensibly health-related problem. Recommendations for policy interventions focus on low-SES, racial-minority, and ethnic-minority families. Children from these families are susceptible to being classified as obese according to the construct. Thus, the obesity construct ostensibly validates intervention into the lives of such families on the basis of health, yet the article contends that the posited interventions confound morality with health.

The article concludes with an analysis of the commitments social work has to the deconstruction of the childhood obesity epidemic. The profession’s role to examine the largely taken-as-a-given childhood obesity epidemic stems from a commitment to evidence-based practice. Based on this commitment, the article concludes that social workers might question existing policies that purport to eradicate the childhood obesity epidemic.

FATNESS: THE MORAL EPICENTER OF THE CHILDHOOD OBESITY EPIDEMIC

Cultural and social significances imbue the concept of fatness. The symbolic value of fatness differs over time and across cultures (Gard and Wright, 2005). At times, fatness has signified good health; at others, poor health. At times, it has signified high moral standing; at others, low moral standing (Gard and Wright, 2005). Presently, fatness connotes poor health and moral deviance (see National Association for Advancement of Fat Acceptance, n.d., for stereotypes about fat persons). Its current commonly held, though not monolithic, significance initially emerged at the end of the Victorian Era (Gard and Wright, 2005).

An aversion to fatness surfaced in both the medical literature (Gard and Wright, 2005) and the popular press (Stearns, 1999) at the turn of the twentieth century. The *Ladies Home Journal*, for example, noted in 1901 that every pound of unneeded fat should be shed (Stearns, 1999). Peter Stearns (1999) notes that moral stigma quickly attached to fatness during this epoch. Published texts, such as magazines and novels, portrayed fatness as a result of moral indiscretion (Stearns, 1999). The negative moral connotation of fat has persisted from the turn of the century until today (Seid, 1989). Writes Roberta Seid: “We, too, view with horror ... every bit of subcutaneous fat” (p. 22). Seid describes society’s revulsion to fat, which is perceived as “evil” (p. 22). Society perceives fatness as a “crime,” a result of personal deviance (Seid, 1989, p. 22). In the popular imagination, fatness signifies the moral failings of sloth and gluttony (Gard and Wright, 2005).

The moral aversion to child fatness did not rise concurrently with the moral aversion to adult fatness. Rather, the moral aversion to child fatness lagged several decades behind. Stearns (1999) chronicles this imbalance. Until the 1940s, underweightness preoccupied doctors more than overweightness. In the 1940s, medical articles began to indicate that excess fatness in children could cause problems. Popular opinion caught up to published medical texts in the 1960s. According to Stearns (1999), several causal mechanisms, two of which are discussed here, explain the temporal lag that separated moral aversion to fatness among adults from that among children. First, middle-class parents prior to the mid-twentieth century plentifully fed their children in order to distinguish them from undernourished immigrant children. Second, Stearns (1999) delineates a shift in religious culture. There was a softening in the Puritan conception of original sin, a conception that called for strict discipline of children; parents at the turn of the twentieth century began to regard children as innocent. Middle-class parents perceived the moral cleansing that a diet could provide as unnecessary for children. Eventually, however, the anxiety surrounding the fatness construct subjugated the hallowedness of the childhood construct. Both medical and popular opinion shifted to accommodate an emphasis on regulating children’s weight (Stearns, 1999). This article argues that the results of the opinion change persist to present day, albeit not universally.

In spite of the present prevailing consensus that fatness is inherently bad, subpopulations do not universally concur with this view (Gard and Wright, 2005). Among some Latino populations in the United States, for example, fatness is a sign of good health. Examining fatness of Latino children in San Antonio, TX, Lisa Tartamella, Elaine Herscher, and Chris Woolston (2004)

note that some of the mothers of these children perceive food as an expression of love. Thus, the significance of fatness is not immutable but rather is contingent on time and culture. Fatness does not inherently constitute a social problem; it must be shaped in order to construct one.

This article argues that the dominant significance of fatness has played a role in the construction of a social problem. The obesity stakeholders and the media have eschewed the fatness construct, which is infused with an explicit connotation of moral laxity (Seid, 1989), for obesity. The concept of obesity is perceived as a medicalized and, thus, a neutral category. Patrick Basham and colleagues (2006) buttress this assertion:

The focus—perhaps even obsession—with obesity is due to a carefully orchestrated campaign on the part of a group of researchers, physicians, public health officials, activists and, more recently, the plaintiff bar, many with significant financial interests in the obesity issue, who have managed to use Europe's and America's moral aversion to fat as the foundation for a way by the public health establishment and the government on obesity. (pp. 33–34)

This article next turns to the political constructions of obesity and epidemic. The author argues that both are underpinned by the construct of fatness.

CONFLAGRATION OF SCIENCE AND POLITICS

Estimates indicate that nearly half of children are either obese or at risk of becoming obese (Hedley et al., 2004). Some researchers predict that, if left unchecked, the childhood obesity epidemic may negatively affect life expectancy for children born after 2000, contributing to the first decline in life expectancy in the modern era (Olshansky et al., 2005). This article asserts that such statistics and predictions are repeated so frequently and without scrutiny that the childhood obesity epidemic and its high-priority status on the policy agenda are largely unquestioned. This section subjects the constructs of obesity and epidemic to close examination and deconstruction.

Obesity Construction and Deconstruction

The stakeholders have offered obesity as a scientific construct that is contingent on neither time nor culture. Obesity is defined as excess body fat (Cole and Rolland-Cachera, 2002). The obesity construct relies on the BMI to quantify

excess fat; indeed, the BMI has played an intrinsic role to the medicalization of obesity (Basham et al., 2006). In the process of medicalization, obesity came to be classified as a disease with defined symptoms, diagnosis, and treatment plans. The BMI is the ratio of weight in kilograms to the square of height in meters. It does not directly measure the percentage of fat in the body (Cole, 2002), but the Centers for Disease Control and Prevention (CDC) claim that the BMI serves as a reasonable proxy for body fat (Anderson and Butcher, 2006). Because of its universality, accessibility, noninvasiveness, and affordability, BMI maintains status as an acceptable measure of fat, in spite of the fact that it does not measure fat directly (Cole, 2002).

A child's BMI is compared to standardized distributions by age and sex to ascertain whether the child is obese. Children's normal curves are statistically constructed to correspond with the adult definitions of obesity; an adult is considered obese if he or she has a BMI greater than 30 kg/m² at age 18 (Cole, 2006). The distributions were generated from data collected between 1963 and 1980 for children ages 6 to 19 and from data collected between 1971 and 1994 for children ages 2 to 5 (Institute of Medicine, 2005). If a child's BMI is at or above the ninety-fifth percentile, he or she is considered to be overweight. If a child's BMI is between the eighty-fifth and the ninety-fifth percentiles, he or she is considered to be at risk of becoming overweight. Children with BMI's that fall between the fifth and the eighty-fifth percentiles are considered to be of healthy weight. A child whose BMI is less than the fifth percentile is considered to be underweight (CDC [Centers for Disease Control and Prevention], n.d.).

The classification system highlights political dimensions of the obesity construct. First, it does not include obesity as a category. Despite the classification system's exclusion of the term, stakeholders continue to rely on the term obesity in reference to children. For example, U.S. Surgeon General Richard Carmona testified on July 16, 2003, before a congressional subcommittee about a growing epidemic: "childhood obesity" (The Obesity Crisis in America, 2003). The Institute of Medicine, which also plays a prominent role in public health, published an influential 2005 report entitled *Preventing Childhood Obesity: Health in the Balance*. The report justified using the term "obese" in lieu of "overweight," because "'obese' more effectively conveys the seriousness, urgency, and medical nature of this concern than does the term 'overweight,' thereby reinforcing the importance of taking immediate action" (2005, p. 80). Hence, both the surgeon general and the Institute of Medicine are complicit in intentionally propagating the obesity construct in reference to children. Such a designation elevates the political urgency of the problem.

Second, deciding which children's measurements to include in the normalized data set is, at least in part, a political decision (Cole, 2002). Tim Cole (2002) questions whether the sample should be chosen based on its health status or on the extent to which it is representative of the population. Indeed, depending on the chosen sample, the normal curves generated may be applicable only to the children who constitute the sample (Pařízková and Hills, 2005).

The decisions to include or exclude data sets to generate normal curves were political decisions. Data from 1988 to 1994 were not included in the BMI charts for children 6 and older (Institute of Medicine, 2005). Including such data would have shifted the curves upward, decreasing the number of children classified as obese (CDC, 2002). Shifting the curves upward was deemed "biologically and medically undesirable" by unspecified actors (Institute of Medicine, 2005, p. 89). Negatively framing obesity as a widespread condition is in the best interest of the obesity stakeholders, as such framing facilitates research funding (Campos, 2004). Thus, in light of the curves' political foundations, it should not be taken for granted that curves deemed normal are, in fact, normal.

Third, the BMI does not measure what it sets out to measure: fatness. Rather, it is a ratio that indirectly represents fatness (Institute of Medicine, 2005). J. Eric Oliver (2006) traces the BMI's development as the established measure of obesity, finding that its roots lie not in the measurement of fatness but rather in efforts to map a population's normal weight distributions. In the 1800s, Adolphe Quetelet mapped the heights and the weights of army conscripts. In doing so, he realized that the heights and the weights clustered around the mean were similarly proportional to each other. He concluded without any scientific basis that height and weight should be proportional to each other (Oliver, 2006).

The relationship between weight and height resurfaced in the 1940s as a predictive measure of mortality (Oliver, 2006). Louis Dublin, the chief statistician for the Metropolitan Life Insurance Company, found that thinner people tended to live longer (Oliver, 2006). He constructed ideal weight tables according to height. People soon mistook the weight-to-height correlation's predictive capacities for causality (Oliver, 2006). Since the 1950s, the weight-to-height ratio has become lodged in the medical landscape as a measure of obesity and, ostensibly, of fatness (Oliver, 2006). Indeed, BMI has been instrumental in constructing obesity as both a disease and an epidemic (Basham et al., 2006).

Recent evaluation of the BMI suggests that it is not an accurate measure of body fat. The index captures only 60 to 75 percent of body fat variation (Gard and Wright, 2005). This is due in part to the BMI's inability to account for the effect of muscle mass density on the height-to-weight ratio. For example, actors Russell Crowe and George Clooney would both be considered obese according to BMI distributions (Campos, 2004). Applying the BMI to children is especially problematic. Children grow at varying rates, and taller children are more likely to have higher BMIs than shorter children (Cole, 2002). Also, stage of sexual maturation affects a child's BMI (Daniels, Khoury, and Morrison, 1997). Among children with similar BMIs, the more sexually mature children have lower percentages of body fat than the less sexually mature children (Daniels et al., 1997). Additionally, the application of BMI yields results that differ according to a child's race (Daniels et al., 1997). Among children with similar BMIs, White children have higher percentages of body fat than Black children do (Daniels et al., 1997). Interpreting a child's BMI in reference to a standardized distribution can subject the child to stigmatization and ultimately can be more harmful than beneficial. Sharron Dalton (2004) observes, "Labeling a child 'overweight' can risk not only his or her physical development but the child's social and emotional development as well" (p. 13). Thus, children may suffer needlessly because of a fallible, inaccurate measure.

Finally, there is no objective basis to establish BMI cutoffs with respect to the categories overweight, at risk for overweight, healthy weight, and underweight (Cole, 2006). Such cutoffs are arbitrary for at least two reasons. First, a logical cutoff, if one exists, would be based on an outcome for which obesity is a risk factor (Cole and Rolland-Cachera, 2002). Given that children have less obesity-related disease than adults, no such self-evident cutoff exists (Cole and Rolland-Cachera, 2002). Few studies link the BMIs of children and adolescents to comorbidity and mortality (Cole and Rolland-Cachera, 2002). Second, the link between childhood obesity and health conditions experienced as an adult is mediated by adult obesity (Cole and Rolland-Cachera, 2002). Adult obesity is the bridge between childhood obesity and putative adult disease (Cole and Rolland-Cachera, 2002). Thus, childhood obesity is once-removed from many health conditions for which it could be a risk factor. In sum, the cutoffs delineating childhood obesity are inherently political (Cole, 2002).

By deploying BMI as a scientific measure, the obesity stakeholders have been able to supplant the discourse of fatness with that of obesity. Fatness is laden with moral assumptions. It is difficult to bend public will to act on such a construct. The BMI effectively repackaged the concept of fatness into the

purportedly neutral construct of obesity or, to be more precise, into the category of overweight. Although careful not to pursue an antiscience agenda, Michael Gard and Jan Wright (2005) caution that scientists may have constructed obesity in a way that is “unhelpful” and “misleading” (p. 11). Indeed, science is not infallible. Georges Dreyer, for example, posited that doctors could determine one’s physical well-being solely from the relationship between lung capacity and such body measures as weight and sitting height (Smith and Horrocks, 1999). For several years, his construct met no documented opposition. Government institutions and medical establishments employed the construct as if it were valid until a few dissenting statisticians proved it to be erroneous (Smith and Horrocks, 1999) and the construct was abandoned. In sum, the quantitative nature of BMI does not render it self-evident. Rather, this article posits that it is a political construction. Calls to monitor BMI as consistently as vital signs (Dietz, 2006) could be “unhelpful” and “misleading” (Gard and Wright, 2005, p. 11) without explicit acknowledgment of its limitations.

Epidemic Construction and Deconstruction

Epidemic, similar to obesity, is another concept central to the creation of childhood obesity as a problem. In 1998, the World Health Organization officially classified obesity as an epidemic (Mahoney, Lord, and Carryl, 2005). Through its links with AIDS, malaria, and tuberculosis, the epidemic concept has become associated in the popular imagination with infectious diseases. Constructing obesity as an epidemic reinforces the perception that obesity is a distinctly medical problem. It also conveys a sense that obesity is a matter of extreme urgency. Gard and Wright (2005) state: “Using the term ‘epidemic’ in relation to increases in rates of ‘obesity’ thus metaphorically evokes the high levels of emotion associated with infectious disease epidemics and legitimates the same kinds and levels of intervention and public response” (p. 174). Public responses to the language of epidemic may include media attention, financial support for research, and heightened professional prestige for those who address obesity (Oliver, 2006). Furthermore, there is the perception that “it is not just a minority of children who are classified as overweight and obese who are at risk—obesity is now a disease that can strike anywhere, anytime and we must all be vigilant” (Gard and Wright, 2005, p. 25).

To support claims of epidemic status, stakeholders delineate associations with childhood obesity. Childhood obesity is associated with increased blood pressure, increased total cholesterol, insulin resistance, and sleep apnea (Berg, 2004). Socially, obese children are more likely than nonobese peers to be stigmatized, rejected, and victimized; they are less likely to be befriended than

nonobese peers (Mahoney et al., 2005). In addition to physical and social morbidities, obesity has been linked to decreased academic performance (Cline, Spradlin, and Plucker, 2005). In fact, obese children and adolescents are more likely to receive low scores than “healthy” children and adolescents on several measures of development, including those that assess physical, psychosocial, emotional, social, and school functioning (Schwimmer, Burwinkle, and Varni, 2003, p. 1817).

Stakeholders speciously package these assertions such that only an attentive reader can distinguish correlation from causation. For example, Stephen Daniels (2006) titled an article “The Consequences of Childhood Overweight and Obesity.” The term “consequence” implies causality, according to Merriam-Webster’s (n.d.) online dictionary. In the body of the article, however, the author writes about “obesity-related health conditions” (Daniels, 2006, p. 47) and “health problems associated with obesity” (p. 48). The incongruence between the article’s title and its content may lead readers into conflating correlation with causation. In another example, the influential Institute of Medicine report notes that childhood obesity has “ramifications” for children’s health (2005, p. 22). A synonym for the word “ramification” is the word “consequence,” according to Merriam Webster’s (n.d.) dictionary. As previously argued, “consequence” connotes causality. In the paragraph following the use of the word “ramifications,” the report’s authors comment on the startling increase of type-2 diabetes incidence (Institute of Medicine, 2005, 22). The casual reader may infer from the report’s structure that type-2 diabetes is a ramification of childhood obesity rather than associated with it.

According to existing evidence, obesity is the cause of few comorbidities (Oliver, 2006), and interventions may create rather than alleviate comorbidities. Although childhood obesity has been associated with several diseases, such as diabetes, it is found to cause only osteoarthritis and uterine cancer (Oliver, 2006). With regard to the psychosocial comorbidities, evidence suggests that the stigma of obesity and the resulting repercussions may be manufactured by the same people who claim to fight against the perceived epidemic (Dalton, 2004). In Arkansas, for example, parents receive report cards that chart their children’s BMI scores. Thus far, no study evaluates the psychological effects of receiving such a report card, but anecdotal evidence suggests that BMI report cards may negatively impact children’s self-concept (Kantor, 2007).

In spite of the lack of evidence to substantiate the causal potency of obesity, stakeholders imply that childhood obesity has causal potency to inflict steep monetary and social costs. An influential obesity-related report, *The Surgeon General’s Call to Action to Prevent and Decrease Overweight and Obesity*

(USDHHS [U.S. Department of Health and Human Services], 2001), claims that obesity cost \$117 billion in 2000, an increase from \$99 billion in 1995. The calculated cost includes both direct expenses, such as those incurred by treatment, and indirect costs, such as wages lost due to premature death (USDHHS, 2001). Many of the costs are attributable to diabetes, heart disease, and hypertension (USDHHS, 2001). Medicaid and Medicare finance about half of medical expenditures related to obesity (Institute of Medicine, 2005).

The large cost attributed to obesity, \$117 billion, and the commitment of public funds through Medicaid and Medicare, suggest that obesity is a public problem requiring immediate attention. A close inspection, however, identifies egregious methodological assumptions in the research (Oliver, 2006). Oliver (2006) refutes the \$117 billion figure by noting that it was assumed that obesity, as opposed to poor diet and physical inactivity, is what had instigated medical costs. Additionally, it should be noted that obesity per se was not the cause of the health care expenditures. Rather, the expenses that the surgeon general's report attributed to obesity were mediated through other health conditions, such as diabetes (USDHHS, 2001). The report did not provide evidence that obesity was the causal mechanism for these health conditions. In fact, the report carefully noted that obesity was associated with these conditions, not the cause of them (USDHHS, 2001).

In another influential obesity-related report in the *Journal of the American Medical Association*, several authors, one of whom was the director of the CDC, claimed that poor diet and inadequate physical activity causes 400,000 deaths annually (Mokdad et al., 2004). The report measured poor diet and inadequate physical activity by the prevalence of obesity (Mokdad et al., 2004). It claimed that obesity, if left unaddressed, would soon rival cigarette smoking as a leading cause of preventable death. The CDC heavily promoted the findings, and the report received global media coverage (Basham et al., 2006). The report was shocking; it may have been “*the* crucial moment in the making of the obesity panic” (Basham et al., 2006, p. 61). Internal review of the methodological and political underpinnings of the report, however, cast doubt on its astounding claims (Basham et al., 2006).

The report is methodologically flawed. Although the report claimed that 400,000 deaths are attributable to obesity each year (Mokdad et al., 2004), the CDC deflated that figure to 25,814 after an internal review of the data and the methods used in initial calculations (Basham et al., 2006). Basham and associates (2006) assert that the report was based on data that was outdated

and cherry-picked. In fact, the CDC authors used a lot of data from studies funded by the weight-loss and the pharmaceutical industries (Basham et al., 2006); this could pose a conflict of interest. Oliver (2006) further notes that some of the report's calculations assumed that all deceased, obese people had died because of their fatness. If an obese person died in a car accident, for example, that death was attributed to obesity (Oliver, 2006). Although the estimates were later corrected, this article argues that public health officials and the media repeated the statistics frequently until the public took the existence of an obesity epidemic as a given. The subsequent retraction received no media blitz. The numbers circulated through the media flourish around the uncorrected report had already lodged themselves in the popular imagination. The stakeholders benefited from the erroneous statistics; once these findings were recognized as conventional wisdom, the public was more inclined to support obesity research (Basham et al. 2006).

In addition to citing methodological flaws, Basham and colleagues (2006) also intensely critique the political underpinnings of the initial publication of the report (Mokdad et al., 2004) and the subsequent internal review of its claims. They argue that the report is more aptly classified as science fiction than as hard science, because not only did good politics subordinate good science, but the report also cloaked policy as science. They support this claim with a quote from an internal reviewer who is reported to have noted: "The authors were under some political pressure to get this report out," and it "might have been better off presented as a policy exercise rather than a scientific study" (Basham et al., 2004, p. 62). Upon further analysis of the internal review, Basham and associates (2006) also note evidence that the authors of the report (Mokdad et al., 2004) knew that the report was flawed but proceeded to publish it anyway.

In sum, examination of constructs of obesity and epidemic reveals that both have methodologically flawed foundations. In spite of their limitations, they continue to be deployed in the construction of an ostensible public health problem. This article argues that the fatness construct underpins both the obesity and the epidemic constructs; that is, even though there is a lack of evidence, the childhood obesity epidemic construct continues to garner attention on the basis of the moral aversion to the fatness construct. The next section analyzes literature from academia and the popular media in order to substantiate this claim.

DEPLOYMENT OF THE OBESITY AND EPIDEMIC CONSTRUCTS

To write, to pass, and to implement childhood obesity epidemic policy entails the deployment of the two constructs: obesity and epidemic. The article asserts that both function to create a public health problem that allegedly can be addressed through policy solutions. In the words of Gard and Wright (2005, p. 1):

Characterizing obesity firstly as a disease and then one of epidemic proportions requires the immediate mobilization of resources to bring about change. In the context of the “obesity epidemic” this is translated into a sense that anyone might “catch it,” that people who are overweight or obese have already succumbed and are thereby dangerous “carriers” to be avoided. This permits their stigmatization and permits actions to be taken because of the “danger” to themselves and to society.

Many of those referenced by Gard and Wright (2005), the people who are already overweight or obese, are classified as having a low-SES or as being a racial or ethnic minority (Institute of Medicine, 2005). Thus, the obesity epidemic is a site at which policy makers can take actions on behalf of the so-called best interests of these traditionally marginalized groups. According to Basham and colleagues (2006), the obesity epidemic becomes a vehicle by which to express class- and race-based anxieties. Science thus provides the basis for policies to intervene into the lives of low-SES and nonwhite families to rectify their putative moral failings. Such failings are evidenced by a high prevalence of obesity, and that prevalence is established through the use of the construct.

Articles in academia (see Gordon-Larsen, Adair, and Popkin, 2003; Strauss and Pollack, 2001; Vieweg et al., 2007) are prone to listing the groups most vulnerable to the childhood obesity epidemic construct. Articles in the popular media (see Park, 2008; Santora, 2006; Weil, 2005) are quick to focus on the groups most vulnerable to said condition. According to results from existing measures based on the obesity construct, SES is inversely correlated to obesity, and nonwhite children are more likely to be classified as obese than are White children (Institute of Medicine, 2005). In light of the high incidence of obesity among low-SES and nonwhite children, the Institute of Medicine's (2005) report called for targeted attention to these two groups. Andrew Hill and Inge Lissau (2002) advocate directing special attention not only to the children classified as obese but also to their families. They note that families with obese children are more dysfunctional than families with nonobese

children. Families with obese children, according to these authors, define themselves as being less cohesive, less independent, and less interested in social and cultural activities.

Other stakeholders have advocated for interventions directed at families. Dalton (2004), for example, argues that entire families should change their lifestyles in order to curb the childhood obesity epidemic. She provides a list of recommendations for parents. These recommendations include such elements as listening, communicating, and helping children learn from their mistakes. She notes that families with few resources are susceptible to obesity. She also expounds on the cultural values of nonwhite families that increase vulnerability to the childhood obesity epidemic. According to Dalton (2004), Hispanic and Black families are more accepting of large bodies. Additionally, she argues that recent-immigrant parents are likely to restrict physical activity and to provide high-calorie treats to children. This article posits that a normative argument underpins her book; that is, she implicitly suggests that low-SES and nonwhite families should adopt the view that the childhood obesity epidemic is a problem, and these families should take her suggestions to eradicate said epidemic. The childhood obesity epidemic construct, however, does not provide evidence to support her underlying assumption that the construct is a problem. According to Glenn Gaesser (2002), the notion that thinner is better has nothing to do with health; healthy bodies come in varying shapes and sizes.

Journalist Elizabeth Weil (2005) provides an example from the popular media of the tendency to link the childhood obesity epidemic, a putative public health problem, to maladaptive social norms. She notes that 50 percent of the boys and 35 percent of the girls in Starr County, TX, a Mexican American community, are obese or overweight by the time they reach elementary school. After presenting these statistics, she proceeds to critique social norms. Weil details what she sees as the breakdown of self-reliance: “Now government assistance is a major part of the fabric of society. In addition to free meals for their children in school, many adults in Starr County receive food stamps, health care and utility and housing subsidies” (2005, p. 34). According to Roel Gonzalez, a school superintendent in Starr County, old norms were “eroding” (34). The article conveys the message that the obesity construct disproportionately impacts the Mexican American families in Starr County as a result of nature and, most chiefly, as a result of nurture. The current article presents Weil’s (2005) work as a case study to argue that the driving force behind the childhood obesity epidemic construct stems not from concerns about children’s health but rather from social anxiety directed toward poor and nonwhite families.

The childhood obesity epidemic construct provides a gateway for policy intrusion into the lives of low-SES, racial-minority, and ethnic-minority families. In both *Preventing Childhood Obesity: Health in the Balance* (Institute of Medicine, 2005) and the subsequent *Progress in Preventing Childhood Obesity* (Koplan, 2007), the authors of the two reports call for obesity prevention programs to be appended to various publicly funded programs that are geared towards low-income families (e.g., Head Start; Food Stamp Program; the Special Supplemental Nutrition Program for Women, Infants, and Children [or WIC]; Medicaid; and State Children's Health Insurance Program).

The 2005 report noted that an ecological perspective is necessary in order to combat the alleged childhood obesity epidemic. According to the report, the home is the most influential determinant of childhood obesity, yet it is also the most inaccessible (Institute of Medicine, 2005). The report thus advocates for seizing opportunities to influence nonhome settings in order to shape social norms within the home toward healthful lifestyles. Although the authors of the report remark that the childhood obesity epidemic places a collective responsibility on society, they maintain that special efforts should be extended to low-SES and nonwhite families. This article contends that implicit in the text is the notion that children prone to obesity, those from low-SES and nonwhite families, come from environments with maladaptive social norms. Within this is the idea that such norms must be changed in order to eradicate the childhood obesity epidemic.

The Institute of Medicine's (2005) report assumes an emotive tone, arguing for preventive action even though the authors explicitly acknowledge that there is a lack of scientific evidence to establish causality and to guide best practices. This article argues that the actions called for by the report should not be implemented without reflection. Indeed, Seid (1989) echoes the sentiments of Basham and colleagues (2006); she states that it is important to distinguish between health issues and moral issues because the current preoccupation with obesity is using illness as a metaphor for cultural prejudices. Without reflection, social workers might be complicit in perpetuating cultural prejudices through the childhood obesity epidemic construct.

IMPLICATIONS FOR SOCIAL WORK PRACTICE

The National Association of Social Workers' *Code of Ethics* (1999, sec. 5.02) mandates that social workers critically examine existing evidence. In whichever setting social workers may work, whether they draft policy founded on the obesity and epidemic constructs, whether they implement policies founded on

the childhood obesity epidemic construct, or whether they work with clients who are impacted by such policies. Current evidence does not confirm the existence of a childhood obesity epidemic. In fact, the current article argues that acting on the childhood obesity epidemic's flawed knowledge base may inflict harm. For example, Basham and colleagues (2006) review findings from several studies, arguing that controlling children's eating patterns may be ineffective, may result in children eating more than prior to the intervention, may distort body image, and may lead to eating disorders. To combat the medicalization of the childhood obesity epidemic, the authors sardonically remind their audience of the first principle of medicine: Do no harm (Basham et al., 2006).

The Institute of Medicine (2005) acknowledges that there is a lack of a robust evidence base to substantiate the childhood obesity epidemic construct, yet it maintains that there is an urgent need to respond to the epidemic. The popular media echoes this sentiment. In a recent article in *Time* magazine (Park, 2008), the reporter admitted that there are no existing studies on long-term consequences of childhood obesity, yet "doctors know enough from work on adults to be worried" (p. 90). The article suggests that the negative influence of obesity on health in children is commonsensical, yet the current article takes a different position: inferring that obesity has the same health implications for two distinct populations does not constitute evidence-based practice.

Social workers' commitment to evidence-based practice suggests that there may be a need for reflective and selective application of policies aimed at curbing the childhood obesity epidemic. Furthermore, a commitment to evidence-based practice signifies that social workers might play a role in ensuring that research questions are framed in an open-ended manner. Shiriki Kumanyika (2006) argues, for example, that an important question for research is: "Do minority populations simply have more problems and fewer safe neighborhoods?" (p. 18). Questions like this one preclude open-ended research that investigates whether obesity constitutes a bona fide health condition and whether the condition impacts health negatively, positively, or ambivalently. Finally, social workers can bring to light all available evidence. Often, the scientific community ignores evidence that contradicts the obesity epidemic construct (Cogan, 1999). Jeanine Cogan (1999) calls for parity and accuracy of information offered to the public, and social workers can play a role in responding to such a call.

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