Living Large

De Ervaring van Dikke Vrouwen

The experience of fat Dutch women

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AMMA Program Thesis
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ACKNOWLEDGMENTS

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Last but not least, I owe an immeasurable amount of thanks to my project sponsor, Jason Siegel. I could not have completed this process without his love, support, honesty, and willingness to help. It is a good thing that I married him.

-Amsterdam, August 2000
Ava Nepaul
INTRODUCTION

Overweight\(^1\) and obesity are increasing in prevalence across the globe. This trend is most marked in the industrialized nations of the Western Hemisphere. Increased wealth and food availability in combination with decreased physical activity contribute to this situation (WHO 1999). The prevalence of overweight and obesity in the Netherlands lies in between the high prevalence in the USA and the low prevalence in China (Mathius-Vliegen 1998a). Within the last decade, there has been an increase in the prevalence of fatness in the Netherlands. In 1998, an estimated 40% of Dutch men and 30% of Dutch women were either overweight or obese (Blokstra et al 1998).

Overweight and obesity are implicated in the etiology of ischemic heart disease, diabetes mellitus, and breast and cervical cancers. Excess body fat may inhibit respiration and contribute to clinical depression and social isolation (Carmichael 1998; Cohen 1985; Pauley 1988). According to the online resource Netherlands Statistics, the five leading causes of death in 1996 in The Netherlands were myocardial infarction, cerebrovascular disease, lung cancer, chronic obstructive pulmonary disease, and mental disorders\(^2\). This means that at least two of the leading causes of mortality in the Netherlands (i.e. myocardial infarction and depression) are related to overweight and obesity.

The increasing prevalence of excess body fat in industrialized countries should be the subject of more social research. Much has been written on the medical aspects of overweight and obesity, but comparatively little on their social aspects. Such research has been based on the idea that the primary solution to fatness is weight loss. This attitude neglects the reality of fat as a social subject. Ignoring this fact gives a skewed picture of the problem of overweight and obesity. It is no wonder that research focused on medical solutions to fatness have not proved to lessen its prevalence. Studies of the physiological correlates of human fatness in the absence of its social context and consequences are only one piece of the puzzle.

The study presented here gives insight into the physical, social, and psychological factors that accompanying being overweight in the Dutch context. Such insight may prove useful in the design of weight management, nutrition, and exercise programs. It may also serve to increase caregiver sensitivity to the fact that fat people are more than just their bulk and have concerns other than weight loss.

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\(^1\) In cases where medical and research views are discussed, “overweight” refers to people who are neither obese nor of ideal weight.

\(^2\) A variety of listings are available at http://www.cbs.nl.
Literature Review

Explanations of fatness

There are many explanations of human fatness. The most frequent one is that fatness results from eating more than one’s body can use (Mathius-Vliegen 1998). In technical terms, one’s energy intake exceeds one’s energy expenditure. This energy is expressed in terms of calories.\(^3\) To stay at a constant weight, one must ingest as many calories as one uses. For some people, it is not as simple as eating as many calories as you spend. Certain conditions like hypothyroidism (under-active thyroid gland) cause the body to store more fat than normal or improperly metabolize food.

Fat is a stored form of energy. This is useful in times when food is scarce and the body metabolizes fat to maintain vital functions. Fat storage developed as a human adaptation to starvation (Scrimshaw and Dietz 1995; Brown and Konner 1996). Another explanation of fatness deals with the Basal Metabolic Rate (BMR). This is the rate at which a person uses energy when at rest (i.e. number of calories burned per unit time). Though there are contradictory findings, it is generally held that obese people have low BMRs compared to non-obese people. In addition, researchers are examining the connection between increased consumption of refined carbohydrates (e.g., juice concentrates, white flour) and weight gain. In the psychobiological paradigm, obesity is the result of overeating prompted by neurotransmitter imbalance. This hypothesis is bolstered by findings that people who use selective serotonin re-uptake inhibitors experience less food cravings (Cohen 1985; Carmichael 1998).

Other explanations for fatness lie in the realm of psychology. Terms like “compulsive overeating” and the psychiatric diagnosis Eating Disorder NOS\(^5\) (not otherwise specified) capture the idea of the person who eats so much so often that it interferes with his/her social functioning. In the psychoanalytic view, food is a substitute for sex or aggression. It may also symbolize a mother’s love (Saukko 1999). In this frame, overeating means giving oneself the things one cannot have or was denied as a child. In the cognitive-behavioral paradigm, overeating is a way of coping with extreme emotions like anxiety, anger, and depression. The overeater finds food comforting. Another perspective is a radical one taken by the late feminist author and therapist Susie Orbach. She posits that the compulsive overeater is a rebel who protests against the restrictions placed on women by a male dominated society. Orbach submits that the compulsive overeater subconsciously wants to be fat because she gains some benefit from it (Orbach 1988).

\(^3\) A calorie is the amount of energy needed to raise the temperature of a kilogram of water by one degree Centigrade at one atmosphere pressure. Essentially, this is a just standard way of quantifying the amount of potential energy in a food source.

\(^4\) Serotonin (5-hydroxytryptamine) is a neurotransmitter implicated in the appetite and sleep irregularities associated with clinical depression. Selective serotonin re-uptake inhibitors (SSRIs) like Prozac (fluoxetine) are thought to help to increase the amount of serotonin available in the brain for electro-chemical processes that regulate the desire for sweet foods and sleep.

\(^5\) See DSM-IV for information on this diagnosis.
Biomedical aspects of fatness

Excessive fatness is referred to in medical text as “obesity”. The determination of obesity is made from calculation of the BMI\(^6\) (Body Mass Index). BMI is ascertained by dividing the body weight in kilograms by the height in meters squared (i.e. kg/m\(^2\)). Those with a BMI\(^7\) under 20 are underweight, those with BMI of 20-24.9 are at an ideal weight for their height, and those with BMI of 25-29.9 are overweight. A BMI of 30-40 indicates obesity and those who have a BMI above 40 are considered morbidly obese (Carmichael 1998). The BMI is not infallible and debate continues as to whether or not it should be the only standard for determining obesity. It accounts only for height and weight and does not consider the ratio of adipose tissue (body fat) to lean muscle. Other measurements of overweight and obesity include the waist circumference and the ratio of waist to hip circumference (Molarius et al, 1999).

So what does being overweight, obese, or morbidly obese mean biomedically speaking? The overweight person is viewed as having a tendency to become obese. The obese person is at higher risk for serious illness. The morbidly obese person presents a challenge that requires extreme measures in order to restore health. In itself, obesity causes damage to weight-bearing joints and reduces respiratory capacity. The reduction in physical activity can contribute to emotional distress and depression (Han et al, 1998). As a risk factor, obesity is implicated in the onset of cardiovascular disease, hypertension, non-insulin dependent diabetes, sleep apnea, depression, ovarian and prostate cancers, and osteoarthritis (Cohen 1985; Carmichael 1998). Overall, excess pounds mean a decrease in the quality of life and longevity.

Medically endorsed solutions to fatness range from advice like “take the stairs” to surgery. Restriction of caloric intake and moderate exercise for twenty minutes thrice weekly is usually the first line of action for fat people who are still moderately physically active. Fatter people who are restricted by their size, propensity to injury, or other medical complications, may be advised to reduce food intake and/or take a pill to suppress appetite or inhibit intestinal absorption. At some point, a clinician supervised high-protein liquid diet or fast may be recommended. One can even have one’s jaws wired shut to prevent chewing (the wires are loosened once a week to allow the brushing of teeth) (Carmichael 1998; Pinedo and Köhler 2000).

Surgery is the most aggressive fat reduction technique. There are two rationales for it. The first is that fat is unattractive and contributes to the psychological distress of the individual. Liposuction is a popular method of getting rid of unwanted fat. The liposuction procedure involves injecting saline solution into the fatty area to dissolve the fat and then sucking out the liquid fat. This type of fat vacuuming is used to contour the body into a desirable shape but is not without risks (Davis 1995).

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\(^6\) The BMI is also referred to as the Quetelet Index. Quetelet first described this method in 1869 (Carmichael 1999).

\(^7\) The BMI is endorsed by the World Health Organization (WHO 1990) and the NIH. The cutoff points provided here are used throughout the rest of this work.
The second surgical rationale is the inducement of weight loss to promote well being. The first weight loss surgery was developed in 1952. Called intestinal resection, it involved removing a large portion of the intestines. The techniques that followed like jejunocolic anastomosis and biliopancreatic by-pass\(^8\) resulted in significant weight loss of patients. Unfortunately, the procedures had nasty side effects like electrolyte imbalance, kidney failure, and numerous daily bowel movements. In light of such issues, the stomach became the focus of intervention. Considered the most successful operations for the treatment of obesity, vertical banded gastroplasty (VBG) and gastric bypass (GB) are currently used. Though the risks involved with these surgeries are high, they are considered to be necessary because they ultimately produce weight loss. Weight reduction translates to being less at risk for developing illnesses associated with obesity. Little mention is made of the fact that people with “successful” gastric bypasses tend to develop problems with eating, frequent episodes of diarrhea, and nutrient deficiency. Another possible outcome of VBG is re-operation should the stomach become distended and the band integrity compromised. Furthermore, some patients regain weight and others die from surgical complications (Carmichael 1998).

In summary, Western medicine views fat as a barrier to psychological well being, a danger to health, and an antagonist to longevity. To correct and/or prevent the problems of fatness or those associated with it, the fat must be removed. Removal methods include diet, drugs, exercise and surgical interventions. However, not all clinicians share these views. Paul Ernsberger and Paul Haskew challenged the prevailing clinical views of fatness in a 1987 publication entitled *Rethinking Obesity: An alternative view of its health implications*. Among other things, they point out that the majority of people who diet cannot keep the weight off and often end up weighing more than before dieting. These repeated cycles of weight gain and loss can contribute to poor health and cause people further distress. Moreover, with regard to the stigmatization of obese people, they state, “Many medical professionals, instead of recognizing and counteracting this discrimination, have allied themselves with it by emphasizing evidence which reinforces the dictates of fashion” (Ernsberger and Haskew 1987: 60).

**Social aspects of fatness**

Across Western cultures, ideas of the lean, fit and youthful body abound (Stearns 1997; Schwartz 1986). Media vehicles like fashion and fitness magazines are redolent with message that being thin and/or fit is highly desirable. Thinness is equated with attractiveness. To be attractive is to be happy. Being thin is being successful. These are messages from the “cult of slimness” (Germov and Williams 1999). The inference from such messages is that fat people are unhealthy, unattractive, unhappy, and unsuccessful.

\(^8\) See Carmichael 1998 for detailed descriptions of the surgeries mentioned.
“Fat” is a deviant identity. Emile Durkheim posited that deviance has five major characteristics (Conrad & Schneider 1992). Let us review these traits using fatness. First, deviance is universal and relative. There are fat people in every society, yet fatness is not regarded as abnormal in all of them. For example, the Naru of the South Pacific value the fat body (Pollock 1995). Second, deviance is socially defined. The notion that fatness is bad has been socially constructed by associations of fat people with negative ideas. It can be said that fat people are stereotyped in similar ways to people of color in societies dominated by whites. Third, deviance varies with the social context. A fat man dressed as Santa Claus is fine at a Christmas pageant, but the same fat man wearing swimming trunks at the beach is not well received. Fourth, social groups make conventions and impose them on others using social sanction. People as part of the collective make rules and define what is deviant. People influenced by public health information adopt the view of fatness as a bad thing. Coupled with the relative absence of real bodies in the media, people discern what is desirable (i.e. thinness) and hence what is not desirable (i.e. fatness). Fifth, defining what is deviant and enforcing such a definition involves power. The agents of biomedicine (i.e. physicians) label fat people as deviants. This view of fat people by biomedical institutions is incorporated in other societal institutions like insurance companies and employment agencies. The result is discrimination against fat people. Using this perspective, it follows that classification of fatness as a disease is a form of social control.

Fat functions as a master status meaning that obese people are seen as “fat” first and as possessing ancillary characteristics second (Degher and Hughes 1999: 13). When others view an overweight person, they may ascribe to him or her characteristics like jolly or lazy based solely on stereotypes that are socially created and endorsed. According to an individual in a study by Joanisse and Synnott, fat people “serve as society’s collective punching bag” (1999: 59). They are ridiculed by family members, teased in school, socially isolated, have difficulty maintaining romantic relationships, discriminated against in employment, unfairly evaluated by physicians, publicly harassed, and receive slower service in stores (Joanisse and Synnott 1999; Pauley 1988). They may also experience higher degrees of loneliness and lead restricted lives (Schumaker et al 1985; Zdrodowski, 1996). There are even reports of suicide among obese teenagers who can no longer cope with being teased unmercifully by peers (Joanisse and Synnott 1999).

Overweight people have different experiences than thin people that influence identity adoption. They manage their identities and reject deviant status in light of the negative consequences associated with being overweight. Fat people employ various strategies to cope with their marginal position in society. They use a variety of conscious and unconscious methods to either accept or reject the notions society ascribes to people of their deviant body condition. These coping mechanisms include internalization, over-compensation, distancing oneself from other overweight

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9 Degher and Hughes attribute this term to Becker.
people, flamboyance, and self-acceptance (Deghe r and Hughes, 1999; Cordell and Ronai, 1999; Joanisse and Synnott 1999).

In addition to coping with negative events, some overweight people attempt to transcend their experience. Ways of doing this include participation in the size acceptance and non-diet movements (Sobal 1999). The size acceptance movement is largely comprised of fat people making an organized effort to halt the perpetuation of discrimination based on body size. Two such organizations are the IASA (International Alliance for Size Acceptance) and NAAFA (National Association for the Advancement of Fat Acceptance). A related movement is non-dieting. This movement grew out of concern about the low success rates of diet plans and the recurrent dieting of women. Through organization around such beliefs, fat people may achieve acceptance of their bodies and challenge society’s concept of them.

In summary, being fat means being outside of societal norms while living in society. The life experiences of fat people are highly influenced by the ideas of others about their bodies as well as their own ideas. These ideas have been shaped in a particular cultural context with and associated with specific meanings. Though there is stigma associated with being overweight, fat people manage as well as challenge it.
RESEARCH OBJECTIVES AND METHODS

The original subtitle of this study was De ervaring van vrouwen met overweight. This literally translates to The experience of women with overweight. However, early in the collection of data, a woman remarked, “Overgewicht is mooi, but dik is what it is about.” Overweight is pretty, but fat is what it is about. I learned that in private, most people refer to their overweight situation by saying “Ik ben dik.” I am fat. “Being” fat is different from “having” overweight. This work aims to give insight into the physical, social, and psychological factors that accompany being a dikke vrouw (fat woman) in the Dutch context. It shows some aspects of the experience of being a fat woman in a society where fatness is not standard. However, this work is not about living outside of societal norms. It is about existing in a society whose norms and mores one has internalized and endorses while living with the fact that one’s body does not fit the norm. Essentially, I seek to uncover the meaning of dik for fat Dutch women. What reasons do they give for being dik? How do they feel about themselves in relation to their bodies and the bodies of other women? What do dikke vrouwen think the ideal female body is? What are their notions and feelings about food? What types of events constitute the experience of being fat? What are positive and/or negative aspects of the experience? What are strategies fat women use to manage their experience?

This is a qualitative, descriptive study based on data from tape-recorded, in-depth interviews with fat women living in the Netherlands. The areas assessed were body images, weight loss experiences, food and eating, and the social experience of being fat. I had hoped to conduct focus group discussions with non-fat individuals; however, given the short time for fieldwork and the failure of contacts to produce results, I was unable to do so. I sent out by e-mail a set of questions to four non-fat Dutch women to get non-fat opinions. One of these questionnaires was returned.

Five key informant interviews were conducted. Key informants were selected based on their expertise on areas relevant to the cultural meaning of fatness. I met with a medical anthropologist, a professor of Women’s Studies who has published literature on female body image, a fat activist, an active member of an obesity patient organization, and a prominent obesity researcher.

Snowball sampling was used to obtain informants. I employed this strategy in order to avoid classifying people based on employment of the BMI. Interviewees were referred to me by personal contacts (i.e. my own acquaintances and friends) who introduced the study topic to persons whom they thought might have an interest in participating. Interested persons were encouraged to contact me by telephone or I was given their telephone number by a personal contact. Using this method, thirteen possible participants were identified. However, due to life events and in two cases inability to contact, not all could be successfully recruited.

Before asking someone to participate in the study, I introduced myself as a graduate student from the Universiteit van Amsterdam and the purpose of my study. I discussed confidentiality. When

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possible, I sent an e-mail that reiterated points made in the telephone conversation. I arranged an interview time convenient for the informant. Interviews were conducted using an interview guide (see Annex 3). Eight interviews were conducted in informant homes. All informants were offered a copy of the final report and have been invited to give the author comments on the study results.

Nine in-depth interviews with female informants were conducted. Average interview length was 2.2 hours. All interviewees spoke English and had the equivalent of a MAVO degree or higher. Two participants were from the USA. The older one had lived in the Netherlands for twenty-four years while the younger had for three years. I included only the interview with the older woman in the study because she has spent almost half of her life living, working, and raising a family in the Netherlands. This makes the sample size equal to eight. The age of the sample used for analysis ranges from 26 to 52 years. Five informants were age 40 or older.

At the time of interview two women were actively dieting, two thinking about dieting again, one contemplating weight loss surgery, and three had stopped dieting altogether. Two women reported histories of eating disorders. Sample reported Dutch clothing size ranged from 41 to 60. BMIs were calculated using reported heights and weights. These ranged from 26.4 to 48 for seven of the eight women. One woman no longer weighed herself and did not give a response when asked about her weight.
FINDINGS AND INTERPRETATION

Obesity Research in the Netherlands

I met with Jaap Seidell, a well-published researcher on overweight and obesity in the Netherlands. Seidell is head of the Department of Chronic Disease and Environmental Epidemiology at the Rijksinstituut voor Volksgezondheid en Milieu (National Institute of Public Health and Environmental Protection) and an associate professor at the Amsterdam Vrije Universiteit. His group is most interested in the prevention of obesity and the prevention of weight gain. Seidell began epidemiological studies of obesity simply because there was no such data on the Dutch situation in the mid-1980’s. In addition to generating data on the prevalence of overweight and obesity, he has also published studies on the economic and personal costs associated with overweight and obesity, reasons for weight loss, and fat distribution and its measurement. He is one of a relatively small number of researchers in the Netherlands doing work in this area. He estimated that the number of people who are members of the Netherlands Association for the Study of Obesity is thirty-five, not all of whom are active researchers.

Seidell stated that obesity is a growing problem in the Netherlands. He estimated that one in ten Dutch people have a BMI over 30 (i.e. obese) and that obesity is “in the top league of chronic diseases.” In a 1995 article entitled Obesity in Europe – causes, costs, and consequences, Seidell reported findings by health economists who reviewed the Health Interview Survey. They calculated that the combined direct and indirect costs of overweight and obesity amount to one billion Dutch guilders or 4% of national health care expenditure each year (Seidell 1995). When asked how this compares to other conditions, he stated that cardiovascular diseases account for 4-5% of costs, cancer 5-6% and sport injuries around 20%. In addition, mental health care costs are higher than those associated with overweight and obesity.

The Central Bureau of Statistics reported that for the period of 1996-98, 7% of Dutch men and 9% of Dutch women were obese (see Table 1). The information in Table 1 is based on the responses of 10,749 Dutch men and 11,016 women. Note that the prevalence of obesity, defined as a BMI equal to or higher than 30, is highest in women aged 60 to 69 (14.4% of women sampled). Ten point two percent of the men in the 50 to 59 year old age group are obese. Note that most of the people in the sample fall into the ideal weight category. This represents 51.3% of the men and 52.8% of the women sampled.

Seidell points out that the data analyzed by the bureau is based on self-reported height and weight. Considering that height is often overestimated and weight underestimated, the BMI calculations based on self-reports would tend to be lower than they actually are. Based on his team’s

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10 Of the total 4%, 3% corresponds to overweight and 1% to obesity.
study of three Dutch communities, in which heights and weights of participants were measured by researchers, he estimates the current rates of Dutch obesity are 10% in men and 11-12% in women.

When asked about the BMI, Seidell stated that although it is used internationally, it is a problematic measure. It does not account for fat distribution, its interpretation is difficult because body proportions vary across different ethnic groups, and it is not a good measure for the bodies of children or the elderly. In the course of his work, he also found that waist-to-hip ratios are problematic because they not only reflect fat, but also pelvic width and muscle. He is interested in weight circumference as a measurement because he feels it probably truly reflects the abdominal adiposity that is most highly correlated with adverse health outcomes (Fogteloo and Meinders, 2000).

Table 1. BMI by sex and age class for the Netherlands, 1996-1998 (CBS 2000)

<table>
<thead>
<tr>
<th></th>
<th>BMI &lt;18.5</th>
<th>18.5 to 19.9</th>
<th>20.0 to 22.9</th>
<th>23.0 to 24.9</th>
<th>25.0 to 26.9</th>
<th>27.0 to 29.9</th>
<th>&gt; 30.0</th>
<th>Total n</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Men</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total (%)</td>
<td>1.2</td>
<td>4.0</td>
<td>24.1</td>
<td>27.2</td>
<td>21.2</td>
<td>15.8</td>
<td>6.5</td>
<td>10749</td>
</tr>
<tr>
<td>20-29 years</td>
<td>2.5</td>
<td>8.9</td>
<td>39.7</td>
<td>25.9</td>
<td>13.0</td>
<td>7.1</td>
<td>3.0</td>
<td>2203</td>
</tr>
<tr>
<td>30-39 years</td>
<td>1.4</td>
<td>4.3</td>
<td>26.6</td>
<td>30.7</td>
<td>18.2</td>
<td>13.1</td>
<td>5.6</td>
<td>2478</td>
</tr>
<tr>
<td>40-49 years</td>
<td>0.5</td>
<td>2.8</td>
<td>19.6</td>
<td>27.6</td>
<td>23.3</td>
<td>18.6</td>
<td>7.6</td>
<td>2201</td>
</tr>
<tr>
<td>50-59 years</td>
<td>0.7</td>
<td>1.1</td>
<td>13.8</td>
<td>25.3</td>
<td>27.5</td>
<td>21.3</td>
<td>10.2</td>
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<td>15.9</td>
<td>24.9</td>
<td>25.6</td>
<td>22.5</td>
<td>8.5</td>
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<td>70 years and older</td>
<td>1.3</td>
<td>2.0</td>
<td>20.7</td>
<td>26.2</td>
<td>26.2</td>
<td>17.7</td>
<td>5.8</td>
<td>984</td>
</tr>
<tr>
<td><strong>Women</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total (%)</td>
<td>3.1</td>
<td>7.7</td>
<td>32.3</td>
<td>20.5</td>
<td>14.5</td>
<td>12.9</td>
<td>9.1</td>
<td>11016</td>
</tr>
<tr>
<td>20-29 years</td>
<td>6.4</td>
<td>13.9</td>
<td>41.7</td>
<td>17.4</td>
<td>8.7</td>
<td>6.7</td>
<td>5.2</td>
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<tr>
<td>30-39 years</td>
<td>2.8</td>
<td>11.1</td>
<td>39.5</td>
<td>18.8</td>
<td>12.1</td>
<td>9.2</td>
<td>6.4</td>
<td>2334</td>
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<tr>
<td>40-49 years</td>
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<td>6.6</td>
<td>34.3</td>
<td>21.4</td>
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<td>12.1</td>
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<tr>
<td>50-59 years</td>
<td>1.2</td>
<td>3.9</td>
<td>26.2</td>
<td>23.7</td>
<td>17.7</td>
<td>15.0</td>
<td>12.2</td>
<td>1636</td>
</tr>
<tr>
<td>60-69 years</td>
<td>1.2</td>
<td>2.6</td>
<td>20.9</td>
<td>21.1</td>
<td>18.7</td>
<td>21.1</td>
<td>14.4</td>
<td>1287</td>
</tr>
<tr>
<td>70 years and older</td>
<td>2.1</td>
<td>3.2</td>
<td>21.2</td>
<td>22.2</td>
<td>19.1</td>
<td>19.6</td>
<td>12.5</td>
<td>1483</td>
</tr>
</tbody>
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I asked Seidell about Ernsberger and Haskew’s (1987) points in *Rethinking Obesity*. He agreed with the authors that the dieting advice currently offered to obese people is not helpful because diet results are of short duration and not evidence based. Moreover, he feels such treatments may actually do more harm than good. He concurs that “The prejudice, discrimination and stigmatization ©2000 Ava Nepaul
that people face in a society where thinness is the norm is problematic. I think they’re absolutely right in that” (40). However, he feels that Ernsberger and Haskew underestimate the health risks associated with obesity. Since the 1987 publication of *Rethinking Obesity*, meta-analyses of hundreds of studies have been performed which clearly demonstrate that increasing degrees of obesity are related to adverse health outcomes? In addition, overweight has been shown to be related to all cause mortality in all age groups. Increasingly, in addition to diabetes and cardiovascular disease, physical functioning and musculoskeletal problems are common correlates of obesity.

I also asked Seidell about who is most at risk of developing overweight and obesity in the Netherlands. He responded that the determinants of obesity include low socioeconomic class, ethnicity (particularly for women), a sedentary lifestyle, and being the child of obese parents, (this reflects both environmental and genetic factors). He said, “So that’s sort of the vague statements that you can make about this.” On the issue of an imbalance between energy intake and expenditure, Seidell pointed out that Dutch people cycle, walk, and use public transportation as much as they did about ten years ago. However, the total energy output of people in most Western countries has decreased by about 700 calories in the past 20 years (Köhler 2000). Seidell thinks that there has been less energy expenditure at home, school, and work. Schools have cut their athletic programs, labor saving devices decrease housework, and advances in technology have decreased energy expenditure at work. Information on food intake is suspect due to the problems associated with self-reports, so one cannot state that Dutch people are eating more.

When asked about the future of the Netherlands, Seidell said that a further increase in obesity is expected over the next ten years. About 15% of the total Dutch population will be obese and 50% will be overweight. There is increasing attention to this issue by organizations like the Dutch Heart Foundation, however, their efforts may not have a preventative impact over the next five or ten years.

**Stigma**

The stigmatization of fat people is based on the following notions. Fat people eat too much. Everyone knows that to get rid of fat, one should strictly control food intake and exercise routinely. Fat people are lazy and lack self-control, otherwise they would be thin. Fat people are dumb, otherwise they would know, as everyone else does, what to do to lose weight. Fat people are not attractive. They are ugly. They are unhealthy. These ideas are expressed in the response I received from the e-mail survey. These comments were made by a standard size Dutch woman in her early 50’s in response to the question, “What do Dutch people think of fat people?”

First of all, I do not like to see fat people. My first impression is: can they not control themselves? I know there are two possibilities: one, to be fat

11 Obesity prevalence was slightly higher in people with low educational levels (Seidell et al. 1995).

12 I interpreted this to mean that in general, one can state that these factors are associated with developing overweight and obesity. It does not mean that because you fall into one of the categories that it is inevitable that you will become fat.

13 See also Mathius-Vliegen 1998b for a presentation of the determinants of overweight and its prevention.
because of an illness, a physical problem. That’s terrible. The second possibility is the uncontrollable desire for food. For me, it is somehow ugly to see people constantly eating and being fat. The first thing is that it is very unhealthy and even risky. Second, the eating habit is out of control. On the whole, it is someone’s own responsibility and choice to become and stay fat. But I have to admit that there is a difference as soon as I know the fat people better. I forget about their being fat and enjoy their company. They way they dress is very important, because clothes can cover an awful figure.

Study participants were asked what Dutch people thought of fat people. The responses were: lazy, not in control, dumb, not responsible, unhealthy, and they drink a lot of alcohol (referring to fat men). The degree to which such attitudes are held is strong. The one woman in the sample who was gay stated, “It hasn’t been that difficult being gay. It was more difficult for me being fat.”(180).

Sara stated that Dutch attitudes toward fat people were very _afwijzend_ (unfavorable, rejecting). When asked why this was, she replied:

> Well, that’s the general way to talk about fat people. When you’re at an average birthday gathering and then the conversation can be about American people because they’re fat. That’s the image they have about American people. They are very overweight, about 200/300 kilos (laughs). I think it’s because of television programs we get here. Jerry Springer or whatever and there are major fat people really. And that’s the image of America and then they have something like an average town in America. They go to the street with cameras and then you only see fat people eating large packages (laughs) of chips, greasy hamburgers, large cokes and that kind of thing. And then they say, ‘Well, maybe I’m a bit fat, but I’m not as fat as they are in America!’ It’s also the image of fat people is that they’re lazy, they can’t control themselves, they don’t care for their appearance. Yeah, that’s the general theory I think (186).

Anne internalized these negative ideas. She stated that when she was “big”,

> I always thought then that people don’t want to speak with me and don’t want to be seen with me in town. And I also thought they would think I was very dumb or something. Strangers would think ‘When you’re fat, you’re dumb.’ It was the same in my mind. When you’re fat, you’re helpless. When you’re fat, you’re a victim (37).

In contrast, Therese responded:

> I think it also has to so with what’s in this year. Most are saying ‘Oh, you’re so gezellig.’ (Laughs)… You’re always smiling and okay, you’re

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14 American talk show, broadcast in the Netherlands by a Fox affiliate. This show is often referred to as an example of “trash TV”.

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I heard the adjectives *gezellig* and *sexy* used to describe fat Dutch women while watching a segment of the Dutch television show *Wat Recht Is* (What Is Right) broadcast on June 1, 2000. These adjectives give a positive spin to being a fat woman; however, neither of them directly refutes the numerous negative characterizations.

Two women reported that being fat can be advantageous. When Katia was a young, single mother, she found that being fat made her less attractive to men.

That was nice because then they would let me do my thing. They would let me study and then they would let me take care of my baby (56).

The implication here is that had she not been fat, more men would have been after her affections. This extra attention would have interfered with her primary duty, being a good mother. Sara felt that some people view fat people as being powerful.

I think people see you as a strong person. They see you as something like mature and grown up. The don’t treat you like a little child because you always look full and big (156).

In May 2000, I discussed the stigma of fatness with fat activist Marja Visser. She director of the Dutch organization for size acceptance called *Bond van Formaat*. She also runs a dating service for fat women called *Dik vor Mekaar*. Visser submits that the following contribute to the stigmatization of fat people in the Netherlands.

First, although less Dutch people are devout Catholics or Protestants nowadays, they have been imbued with Judeo-Christian ideas. The legacy of Christianity in Europe is that fat has become associated with sin. Gluttony and sloth, two of the Seven Deadly Sins, are readily associated with fatness. One is fat simply because one overindulges. The idea that suffering is good for the soul is exemplified by the life stories of saints that are redolent with fasting, self-denial, and physical tests. The discipline required to attain a sinless state is rewarded with veneration. In religious art, saints are gaunt while seductresses are plump. The flesh is sinful.

Second, a paradox exists in the welfare state. The Netherlands and other Western nations enjoy a large amount of wealth and access to resources relative to others. In countries where food and resources are scarce, fatness is prized state. A fat body is indicative of ample food and is thus a desired state. Visser cited the popular example of fattening rooms in African countries where a plump bride symbolizes and embodies wealth. In contrast, Dutch women often try to lose weight before they marry. Brown and Konner put it best. “In poor societies the rich impress the poor by becoming fat, which the poor cannot do. In rich societies, even the poor can become fat, and avidly do; therefore, the rich must impress by staying thin, as if to say, “We have so little doubt about where our next meal

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15 This means “fat for each other”. A Dutch proverb that means having everything in good order.
is coming from, that we don’t need a single gram of fat store” (Brown & Konner 1996: 410). In short, where there is abundance, fatness is seen as a misappropriation of abundance.

Third, the Dutch are fat phobic. Visser said, “Fat people are somebody’s walking nightmare.” She compared fat phobia to homophobia. Gay bashers beat up homosexual men in part because the bashers themselves have homoerotic feelings. By beating down the people who embody and openly express the feelings they cannot, the bashers reinforce to themselves the idea that they are “real men”. In the same way, women who restrict their food intake and/or exercise to keep their weight levels down, make negative remarks about fat women who are assumed to be overindulgent and lazy. Denigration of those who embody problematic issues justifies self-denial.

Fourth, increasingly, Dutch people form judgments about people based on physical and material appearances. Visser calls this “judging people by their looks and their haves”. This is the result of focusing alone on the accomplishments of individuals and not he process s/he employed to achieve. This concept helps to explain why people hold fat people in low regard. Regardless of the fact that most fat people have tried to lose weight using multiple conventional and fad therapies, they are still not thin. The effort is not appreciated. Only the end product is evaluated.

Visser posits that a fat person can mitigate the effects of stigmatization by employing four strategies. One, “I am trying a new diet.” Two, “I am a victim.” The person’s fat body embodies some physical or mental trauma (e.g., childhood abuse, loneliness). Three, “I am ill. It’s my glands.” The excess body fat is the result of physiological dysfunction. Four, “I have tried everything and nothing worked.” Visser points out that the fat person must always appear to be trying to do something about losing weight. Upon losing weight, the fat person is rewarded for discipline with praise. If s/he does not lose weight, s/he is still held in better esteem than those fat people who have not tried are.

Visser points out that the intractable nature of these notions is due to a misunderstanding of the mechanism of obesity. People simply cannot part with the idea that if you eat less you should lose weight. Fat is a form of stored energy to be used by the body in times of food scarcity. Famines no longer occur in post-industrial societies, save during times of war (e.g., Honger Winter). However, the biological mechanism remains in place. This explains why in countries that have experienced rapid increase in income and food availability, fatness in the population increases relatively quickly. Related to this fat storing mechanism is the difficulty that people with a long history of conventional, low calorie dieting have with losing weight. In fact, after losing a lot of weight, these people regain weight and additional pounds. This occurrence is referred to as the yo-yo effect or weight cycling.

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16 During the occupation of the Netherlands, an estimated 16,000 starved to death from Fall 1944 to Spring 1945. The situation was made worse by the bitterly cold winter of 1945 that caused waterways to freeze over so that vessels carrying food could not get to the areas in need. See http://www.lib.usc.edu/~anthonya/war for more information.
Living Large: The Experience of Fat Dutch Women

Why I am fat

When asked why they were overweight/fat, the women gave several responses. First, fatness runs in the family. Second, fatness is the result of having a metabolism that functions differently from that of most people. This is brought on by years of dieting and/or a medical condition. Third, food intake is too large. Fourth, food consumed is too fatty or too sweet, so-called “unhealthy” foods. Fifth, quitting cigarette smoking resulted in weight gain. Sixth, inability to lose weight after childbirth or weight gain at onset of menopause. Explanations can and often do coexist. For example,

…my father lost two nieces and an aunt at a very young age, at about 35, and then I know for sure ‘cause it’s in the family. It’s no excuse, you know. But I am very, how you call it? Over water. I get larger when I also drink water (72).
- Therese, age 33

… and I had a size 38/40 and well, it was perfect. But then, I had that weight for about a year and then I met my husband and he came to live with me. So my food habits changed because he liked to eat other things and before, I lived alone with my children and I was the one who did all the shopping and I decided what to eat and to cook. And when he came in, I liked to spoil him and I took also. We went for dinners outside and so along the way, I kept on gaining weight. And at one point I stopped smoking so that was very difficult and I gained five kilos. Then I got my driver’s license, and before that I cycled all the way everywhere and so I only sat in my car (laughs). So along the way, it’s about 12 years ago I think. Is that right? Ten years maybe. And well, 20 kilos gained again (81).
-Sara, age 40

Because I was dieting for 25 or more years of my life. I’m absolutely convinced that if they would have left me alone when I was a teenager, I probably would be a fat woman, but not as fat as now. But I’ve been dieting like they told me to. By that I destroyed my metabolism (100).
-Marianne, age 52

Several women expressed their concern about their daughters becoming fat. This yielded information on the personal notions of fatness etiology. Katia spoke of her relief that her teenage daughter was neither fat nor preoccupied with losing weight.
I said to her, ‘Listen,[daughter]. Don’t ever go on a diet because if you...pay any attention, it’ll be a habit. It’ll be the most important thing in your life. And you know, she doesn’t have that problem with overeating or whatever because she is happy (154).

Mina was concerned that her daughter will be fat like her.
[Mina]: ...I wasn’t fat as a child. It started much later. I was like [daughter] is now. I’m afraid she is going to be fat as well. [AN]: Why are you concerned about that? [Mina]: Because [husband] and I are both the short, fatty type. And this is our genes and she inherited it. And okay, we were both doing fine during our childhood, but we have this tendency to grow fat and I’m so afraid she will have that too. And she’s already complaining about her stomach. She says, ‘Oh, I’m getting a fat tummy.’ Already she’s seeing the problems and she doesn’t like having a fat mother. She doesn’t like to relate to that (327-329).

Sara commented on her teenage daughters:
…They both have a weight problem, by the way (short pause) they think they have...When you’re going through puberty it’s quite difficult. Sad to see, especially for me because I had the same problems and I wished for them that they shouldn’t have it. My former partner, their father, was a Hindustani. He is so skinny (laughs). So I hoped they would be too, but they came my physical appearance (152-154).

These three women share the concern that their daughters will be fat and suffer through the same things they have. These excerpts give some insight into what fat women think of the state of being fat and how one becomes fat. First, it is better to not be fat. Second, fatness is a heritable trait because it is in the genes. Thus, it is almost unavoidable to be fat if your mother or father is fat. It is likely inescapable if both of your parents are fat. You might have a chance at escaping being fat if one parent is skinny. Third, preoccupation with one’s body is inherent in being fat and the fear of becoming fat. Fourth, Mina’s comment that her daughter does not like to relate to a fat mother, reveals that Mina feels she is not doing right by her child. Her child does not deserve a fat mother.

Body Image
The term body image is used to refer to an individual’s subjective experience of her body, including its shape, size and proportions. The women interviewed were asked: 1) how they felt about their bodies, 2) to describe the “perfect” female body, 3) how they compared to their own ideas of the perfect female body and other women’s bodies, and 4) what influenced how they felt about their bodies.

Most of the women were dissatisfied with their bodies to varying degrees. For example, Therese described herself as a Ruben’s Woman, but,
I would like to be a little bit thinner. I think that’s better for my health. I know that for sure (70).

When asked what she would change about her body, she replied

Probably the weight, I’d say. But not my face or my breasts or anything (102).

Her statements reflect that her dissatisfaction lies with the weight of her body, not its appearance.

On the other hand, when asked how she felt about her body, Sara responded:

[Sara]: Ehmm… well, I don’t like it (laughs). [AN]: Why don’t you like it? [Sara]: Because it’s too fat. I don’t like my belly, and my upper legs because they have all kinds of holes in it. How do you call it? [AN]: Sinasappelhuid?17 [Sara]: The orange skin, jaa. [AN]: When you were younger, was it like this as well, or is it as you are getting older? [Sara]: Yes, as I’m getting older. [AN]: What do you like about your body? [Sara]: My breasts (127).

Sara states that she is “too fat.” As she has gotten older, the appearance of cellulite has increased her dissatisfaction. However, she is satisfied with her breasts that are comprised mostly of fatty tissue. For Sara, fat is acceptable if it is in the right place, her breasts.

The person most dissatisfied with her body was Mina. When asked what she would change about her body, she said:

Well, my stomach, my hips, my buttocks, my arms, and my legs (293).

This leaves her face, breasts, feet and hands. She admitted to avoiding full-length mirrors so that she would not have to look at her entire body. Two of the three women who currently accepted their bodies had reported histories of anorexic and bulimic behaviors. Marianne stated:

For myself subjectively, this is my body and I don’t find it a strange body because I have this body. I am used to it. I have no problems with my own body… I can only see that other people don’t have that type of belly. They don’t have the type of arms, thighs, face. They don’t have my body. And I can see with my eyes that my body is heavier, larger than theirs. I can see how they move and how I move. But to see differences is not bad. It’s the value you give to it (75).

Description of the “perfect” female body varied. Two women emphasized the softness and curves often associated with femininity. Mina stated,

Well, a waist (laughs) and okay, breasts and hips. It doesn’t have to bee too slim. I don’t like skinny bodies (laughs). Mollig18 (281).

In reference to a Dutch size 36 body, Mariolijn said,

I think it’s beautiful, but only when you still have the female roundings and you still have breasts (211).

Therese and Sara expressed ideas about not being too skinny:

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17 Refers to the similarity that cellulite has to the dimpled skin of an orange.

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[Therese]: Not too thin, not like a skeleton, ‘cause I think that’s very
[Husband]: Ally McBeal19. [Therese]: No! I think about a Dutch size
40/42 ‘cause they got a bit of meat on their bones. Just not too much, but I
think it goes with everything. With your whole, how do you call it?
Appearance. But not too thin. No. ‘Cause I think that’s not natural (114-
116).

Sara remarked,

Well, not skinny. Eh… not fat. A bit more full, but more to the skinny side
than to the full size. I think about a size 40. 38/40, something like that
(131).

Mariolijn also stated,

There’s no perfect body, I think. There’s the perfect body in the middle, but
there is a very big range above it, around the sides of it. It’s hard to say
because when you look at somebody, you can see that she is too fat or too
thin for her (199-201).

The last three statements contain the idea of a body in proportion. They exemplify the Dutch saying, niet meer nodig (no more than necessary). That is enough. There should be thinness, but not too much. There should be fullness, but not too much. There should be just enough. Also underlying these statements about proportion is the notion that one can look at another person and have an idea of what build the person should have versus the one the person does have. I wonder how such a determination is made.

Anne, who reported a history of anorexic behavior, gave this description:

Well, I think an ideal body is when it is feeling comfortable. Then it
doesn’t matter what size it is.

Marianne also gave a description that did not reference size or appearance:

A functioning female body which is healthy.

It is noteworthy that these two women are accepting of their size. Perhaps this is why they gave descriptions that did not reflect, as the others did, the parameters of a body. The body they describe is not of a specified nature. I draw from these responses that a body of a non-standard size or shape can be healthy and its owner/occupant can take comfort and pleasure in it, regardless of its appearance to others.

When asked how they compared to their own ideas of the “perfect” female body, the women who gave descriptions that emphasized appearance stated that they did not match these descriptions. I asked them how this made them feel. Mina responded that it was always “nagging” at her. Mariolijn felt that it was okay that she did not match the description. Her aim was to get to a weight and appearance that she felt comfortable with for herself and not for other women. Therefore, for some

\[18\] plump, chubby, soft

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fat women, not complying with the ideal is of greater importance than it is for others; however, approaching the ideal is desirable. This indicates knowledge that one’s body is not or does not belong to her own body. She also has become more aware of how some of her ideas contradict one another.

Anne noticed that there has been a change in how she views other women’s bodies since she came to a greater awareness and appreciation of her own body. She also has become more aware of how some of her ideas contradict one another.

Eh... well, there are very thin women and I don’t find it beautiful when they are too thin. But that’s weird because when I told you about Friends, they are very thin. And then I like women more fleshy, with some flesh on them. Don’t like them too skinny. Sometimes I feel envy, jealousy. Especially at the women who say they eat a lot and never get thick. But you know, now that we’re speaking about it, I almost, I don’t look at women that much anymore now. There was a time when I judged women by how they were looking, big or thin, whatever. But I don’t look at them like that anymore.

As Anne became less dissatisfied with her own body through participation in an eating disorders program, she became less preoccupied with the bodies of other women.

I also asked the women what they thought influenced how they viewed their bodies and other women’s bodies. The responses were general: television and other visual media, clothing fashions, and the appearance of others.

The television influence is evident in the references to shows like Friends and Ally McBeal. Two respondents mentioned the Dutch talk show Catherine. They considered it a program with positive themes about fat people in that it featured information on fashionable clothing for larger sized women and men’s comments on the attractiveness of women “with meat on their bones.” I contacted the network that carries the show, RTL-4, requesting transcripts of shows about dikke vrouwen. I received an e-mail informing me that transcripts were not available. Fortunately, while watching television one day, I came across a Catherine program entitled “Laat mij toch lekker dik zijn” (Let me be fat already!). From what I could understand, the fat women on the panel were explaining that they are happy with themselves just as they are and consider themselves beautiful. Two of the primary guests were a Surinamese mother and her daughter who was raised in the Netherlands. The two other primary guests were sisters. A standard sized woman from a research bureau presented information on a survey conducted by her organization. The survey results demonstrated that the majority of respondents found “large size” models more attractive than the “heroin chique” runway models featured in magazines like Vogue. A “large size” model was also on the panel. She was a size 46. In the audience, the husband of one of the sisters spoke about how he found his wife very attractive and

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19 Character in a popular America sitcom of the same title. The show is broadcast by the Fox affiliate in the Netherlands. Actress Calista Flockhart, who plays McBeal, has been criticized in the media for her thinness and is rumored to be anorexic.
had no problems with her body. Another audience member was a woman who had undergone weight loss surgery and had lost a dramatic amount of weight. She made the point that it is nice to be happy with yourself, *maar jouw gezonheid is belangrijkst* (but your health is most important). Another featured audience member was a thin female artist whose paintings, displayed all over the set, featured fat women. It was clear from the layout of the show that the message of fat women happy with themselves would not be diluted by the cries of a formerly fat woman who did something radical to be thin.

Clothing was an area of great importance to several of the women interviewed. According to the women interviewed, clothing in their sizes was available, but some found it expensive to get really nice clothing. They bought clothes at shops like H&M (with the Big is Beautiful collection), Tineke Mode, and M&S Mode. More expensive but higher quality clothing could be obtained at Ulla Popken. I was also told about catalog shopping through Ulla Popken and Neckerman. I have also seen clothing for larger size women on sale at a stall at the Albert Cuypmarkt.

I visited the H&M on the Kalvertore in Amsterdam. The Big is Beautiful collection features items from size 38 to 56. Most of the materials were soft, stretchable, and machine or hand washable. They were in a variety of cuts, colors and styles that were modern. I noticed that most of the size 38 to 44 items were either already sold or absent on the day I observed the store. The prices ranged from as little as 15 guilders for a T-shirt on sale to 175 guilders for an ornate, raw silk dress. I even bought several items.

Through her work as a psychotherapist leading a group for women, one woman I interviewed realized how important clothes are in the formation of women’s opinions about themselves. Being able to choose clothing that one liked and felt good in was significant. It was different from just buying an item just because it fit one’s body size. Recognizing the limited clothing options for “big size women” she started the first company in Europe dedicated to the clothing and the well being of fat women. It was called Fortissimo Services for Big Women.

I was still a single mother with two small kids and 20 years ago, women could never [rarely] get a loan from the bank. So I got a small loan because they said there are no fat women, and I showed that the average woman is over a US size 16 and the average woman is wearing an American size between 16 and 24... And I showed this to every bank in Holland and they didn’t accept it. They said “That’s America and Americans are al pigs and have no discipline whatever. But Holland is much better” (4).

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20 A popular American sitcom also broadcast by the Fox affiliate in the Netherlands. It features the actresses Courtney Cox Arquette, Jennifer Aniston, and Lisa Kudrow. The bodies of these women are tabloid fodder.

21 This woman and one of the primary guests had appeared on another Dutch program called *Wat Recht Is* (What is Right) that was broadcast on RTL-4 on June 1, 2000. They were debating whether it was right to have surgery to lose weight or live as a fat person who did not want to lose weight.

22 The business is now dormant.

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She recruited young designers through newspaper advertisements. Her models were everyday women she saw walking down the street. She would give them her card and ask if they would be interested in modeling clothing. All her models went through a training program with her that emphasized self-esteem and contained components of physical fitness and meditation. Her approach reflected the idea that if one feels good, one looks good. How one looks also affects how one feels about oneself.

This sentiment was expressed by other women in the sample. When asked what she thought influenced how she felt about her body and the bodies of others, Sara responded:

[Sara]: For other people’s bodies, it’s the way they present themselves, the clothes they wear. And whether I like them or not. Whether I find them sympathetic, I think. And for myself, also the way I look like when I’m dressed nice and my hair is nice an makeup and things. Then I can accept my body. But when I have to go to the beach in my bikinis or a swimsuit, then it’s (laughs) horrible, horrible. [AN]: Why is it horrible? [Sara]: Because everybody can see that my body isn’t beautiful or perfect or eh… I’m afraid that they’ll think ‘Woah. She’s ugly.” or fat or eh, something. [AN]: Why is it important what they think? [Sara]: Ehm… … because I’d like them to like me and I feel rejected when they don’t think me nice or beautiful. I think they judge me for my body and not for who I really am, my mind. Or their image of me stops with my body. So ‘Oh, she’s not nice or intelligent’ or whatever. She’s fat. Point. Dot (137-143).

Sara’s response says several things. First, the overall appearance of a person (i.e. how a person dresses and his/her personal grooming) influences self-opinion and he opinions of others. Second, the opinion one has of a person’s personality, his/her intrinsic qualities, affects how one perceives the person’s outward appearance. Third, clothing can camouflage things one thinks is amiss with one’s body. Fourth, people make a judgment about a person’s intrinsic characteristics based on evaluation of his/her external ones. The last point is important in defining the meaning of fatness in Dutch culture. Sara feels that if others find her body too fat, they will assume that she is neither nice nor intelligent. They will not look beyond what is “ugly” to what see what type of person she is and what her abilities are.

Two informants reported their lowest post diet weights. Using the reported height and lowest weight, I calculated the BMIs of these women at their lowest weights. The BMIs were 22.6 and 19.9. These figures placed one in the category of ideal weight and the other in the category of underweight. These women found these weights “just perfect” and were pleased with their appearances, despite the fact that one underwent breast reduction surgery to correct problems with loose skin and disproportionate breast size.
The Quest for Weight Loss

All of the women in the sample had attempted weight loss. Most succeeded in losing weight but eventually gained weight again. In most instances, they gained more than was lost. In investigating weight loss, I looked at why the women wanted to lose weight, motivation, goals, and the strategies they used.

Reasons for losing weight were improvement of appearance, health, and happiness. The first being very general, is not discussed. As for the second reason, several women endorsed it. Katia reported that she had been diagnosed with heart problems and sought to relieve the stress on her heart by losing weight. Therese placed herself on a waiting list for gastric banding to lose weight because she believed that her present weight places her at risk for the development of health problems. Mina also wanted to improve her general health. Her stamina is low for her age group and she reported suffering from leg and hip pains associated with carrying too much weight. The third reason, the idea that losing weight means obtaining happiness, is demonstrated in the following three reports.

And I would always say to my mother “I have a lot of problems.” She said, “No you don’t. The only problem is that you’re too fat. If you would only lose weight” (19).
-Maria

Because if I would be a lot skinnier, lose a lot of weight, I thought then I would be happier as well. That my happiness, every kilo of weight I lose, I got a kilo of happiness in return. And that is not true (67).
-Marianne

There was at one point, at what age was I? Twenty-four? I always thought when you’ve got the perfect body, then your life will be good. Because I am very shy and I had a lot of problems making contacts with people. I thought always it’s because I’m fat and it’s not good to be fat and when I’m slim or skinny, then I will be good and then I can make contact with people (4).
-Anne

The third excerpt demonstrates how an individual can think that the solution to her problems is a change in her physical appearance. This may be exemplified by something as benign as a change in hair color or a new outfit. However, for Anne, this rationale was the impetus for her twenty-year struggle with food restriction.

The women interviewed reported having employed or considered a variety of strategies to lose weight. They included pills, meal replacement products, altered eating of regular food, participation in a medically supervised program, surgery, and exercise. Two reported working with a dietiste (dietitian). Based on their enumeration of weight loss strategies, I calculated that each woman had on average employed five strategies. Strategies were sometimes combined.

On July 10, 2000, I went to the Etos apothek (drug store, pharmacy) in Amstelveen to see what types of nonprescription diet products are available to consumers. Upon walking into the entrance, I came face to face with a Profiel display. The five-day weight loss meal programs were
packaged in colorful cubes and presented at eye-level. To the left of the display was another arrangement of Profiel products: the pre-made, canned drinkmaaltijden (type of milkshake that is a meal substitute). I walked further into the store and found the major area for afvallen (slimming) products. They occupied approximately 25% of the row that also contained baby food, baby skin products, diapers, and contact lens care products. The weight loss aids one can purchase “over the counter” (without a prescription) along with their respective prices and claims are listed in Table 2.

Table 2. Over-the-counter weight loss products sold in a suburban Dutch apotheek

<table>
<thead>
<tr>
<th>NAME</th>
<th>DESCRIPTION</th>
<th>PRICE (fl)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Air Light Gum</td>
<td>kauw je slank (chew yourself slim)</td>
<td>12.95</td>
</tr>
<tr>
<td>Appelslank</td>
<td>40 units</td>
<td>24.95</td>
</tr>
<tr>
<td>Apple &amp; Citrin</td>
<td>Appelazijn (cider vinegar)+ HCA en Chitosan</td>
<td>unlisted</td>
</tr>
<tr>
<td>Etos slank druppels</td>
<td>50ml</td>
<td>19.99</td>
</tr>
<tr>
<td>Etos slank met appelazijn</td>
<td>45 units</td>
<td>19.99</td>
</tr>
<tr>
<td>Etos slankmaadkuur</td>
<td>90 units; sold out at time of observation</td>
<td>24.99</td>
</tr>
<tr>
<td>Etos vezeltabletten</td>
<td>250 units; sold out at time of observation</td>
<td>8.99</td>
</tr>
<tr>
<td>Gewichtsafname</td>
<td>20 bags kruidenthee (herbal tea)</td>
<td>6.95</td>
</tr>
<tr>
<td>Ideaal gewicht</td>
<td>100 fyto capsules</td>
<td>23.75</td>
</tr>
<tr>
<td>Komkommerslank</td>
<td>60 units</td>
<td>34.95</td>
</tr>
<tr>
<td>Limiet 65</td>
<td>afslank druppels (slimming drops)</td>
<td>unlisted</td>
</tr>
<tr>
<td>Lipidplex</td>
<td>60 units; vetblokker; 100% Natuurlijk</td>
<td>42.50</td>
</tr>
<tr>
<td>LucoVitaal Pu Erh Thee</td>
<td></td>
<td>unlisted</td>
</tr>
<tr>
<td>Minceur slank</td>
<td>150 units</td>
<td>29.95</td>
</tr>
<tr>
<td>Minceur slank druppels</td>
<td>50ml</td>
<td>30.95</td>
</tr>
<tr>
<td>Mincir Jour &amp; Nuit</td>
<td>weight loss while your are awake &amp; while you sleep</td>
<td>49.95</td>
</tr>
<tr>
<td>Minikauf deluxe</td>
<td>800 kcal per day for 5 days</td>
<td>47.95</td>
</tr>
<tr>
<td>Minikauf intensief</td>
<td>500 kcal per day for 5 days; package included a free, disposable 12 shot camera</td>
<td>39.95</td>
</tr>
<tr>
<td>Minikauf mild</td>
<td>650 kcal per day for 5 days</td>
<td>42.95</td>
</tr>
<tr>
<td>Modifast muesli</td>
<td>9 units</td>
<td>36.50</td>
</tr>
<tr>
<td>Modifast pudding</td>
<td>9 units; varieties: chocolate &amp; vanilla</td>
<td>36.50</td>
</tr>
<tr>
<td>Modifast shakes</td>
<td>9 units; varieties: strawberry, chocolate, orange, &amp; vanilla</td>
<td>36.50</td>
</tr>
<tr>
<td>Modifast soup</td>
<td>9 units</td>
<td>36.50</td>
</tr>
<tr>
<td>Modifast starter pack</td>
<td>6 low calorie meals</td>
<td>26.99</td>
</tr>
<tr>
<td>Pranavite Slank</td>
<td>120 units; kelp-lectine</td>
<td>15.95</td>
</tr>
<tr>
<td>Profiel 5-day</td>
<td>meal replacement program consisting of a shake, a soup, and muesli; varieties: Familie and Sportief</td>
<td>26.95</td>
</tr>
<tr>
<td>Profiel 5-day afslankkuur</td>
<td>met heerlijketussendortjes (tasty treats)</td>
<td>47.50</td>
</tr>
<tr>
<td>Profiel drinkmaaltijd</td>
<td>canned shakes; varieties: raspberry, orange, berry, &amp; lemon</td>
<td>2.99</td>
</tr>
<tr>
<td>Profiel maaltijdvervanger bar</td>
<td>Bars</td>
<td>4.95</td>
</tr>
<tr>
<td>Profiel maaltijdvervanger muesli</td>
<td>fruit muesli</td>
<td>7.99</td>
</tr>
<tr>
<td>Profiel maaltijdvervanger shake</td>
<td>3 sachets</td>
<td>7.99</td>
</tr>
<tr>
<td>Profiel maaltijdvervanger shake powder</td>
<td>varieties: strawberry &amp; vanilla</td>
<td>24.95</td>
</tr>
<tr>
<td>Pu Erh Thee</td>
<td>60 units; vermindert het hongervoel (lower hunger)</td>
<td>34.95</td>
</tr>
<tr>
<td>Riemini Extra Forte</td>
<td>40 units</td>
<td>29.95</td>
</tr>
<tr>
<td>Slank actief</td>
<td>84 units</td>
<td>39.95</td>
</tr>
<tr>
<td>Slank U Fit</td>
<td>40 units</td>
<td>19.95</td>
</tr>
<tr>
<td>Slankvitaal</td>
<td>90 units</td>
<td>34.95</td>
</tr>
<tr>
<td>Slim O Life</td>
<td>60 units; combustion accelerée des graisses</td>
<td>39.95</td>
</tr>
<tr>
<td>Topdieet</td>
<td>680kcal per day; advertised on television</td>
<td>49.95</td>
</tr>
<tr>
<td>Vezeltabletten</td>
<td>125 units; om af te slanken voor een regelmatige</td>
<td>9.95</td>
</tr>
</tbody>
</table>

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These products exemplify the range of beliefs that people have about weight loss and the nature of fat itself. The meal replacement systems are obvious in that they provide (usually) the daily amount of nutrients while delivering a small amount of calories. For convenience, they are canned or plastic wrapped forms. Products touting the weight loss properties of *komkommer* (cucumber) and *appel* (apple) derivatives appear to be a traditional staple of the Dutch diet product industry. Dutch friends told me that the *vezeltableten* (fiber tablets) are supposed to be taken with two glasses of water. Once in the stomach, the tablets swell up to help give one a feeling of fullness and helps with bowel movements. The Lipidplex fat blocker speaks for itself. I found the most interesting product to be the *ccelerate fat combustion*. This plays on the idea that body fat can be literally burned off just as if a chunk of *Croma* (popular brand of vegetable based cooking lard) was superheated and vaporized. In summary, these products represent the ideas that weight loss can be achieved by:

1) consumption of fewer calories;
2) intake of natural fruit and vegetable derivatives that contribute to fat catabolism;
3) creation of a feeling of fullness to discourage food intake;
4) encouragement of proper digestion and waste evacuation;
5) prohibition of the accumulation of new fat deposits; and
6) thermogenesis, generation of heat to melt away fat.

The dieting behaviors reported by the sample involved food restriction and/or reduction of calories from a specific nutrient group (e.g., fats). Anne’s experience exemplifies food restriction to an extreme.

Eh… it was always for months eating and eating so much and then I said, ‘Okay, this is it. I want to be skinny again.’ So then I stopped eating for six months, just taking some crackers, you know? And water. That was the only thing I did – eat and sporting a lot because that’s what’s good for you. That’s what everybody said, ‘You have to exercise a lot. So that’s what I was doing. And then I lost a lot of weight after six months and I was slim and then there was happening something… and then I had to eat again and then I gained. I was like a yo-yo: thick then slim (4).

The behavior reported by Anne, periods of increased eating followed by periods of extreme restriction coupled with increased exercise, resembles behaviors reported by people diagnosed with anorexia and...
For other women, food-restricting behaviors were not as severe as Anne’s were. However, they were just as unsettling.

Several women reported having tried the Bread Diet. According to their accounts, the plan required alternating one day of the consumption of only dry brown bread and calorie-free beverages like water and tea with one day of “normal” eating. A similar altered eating plan is the Apple Diet, which features apples instead of bread. Three had been on the Atkins’ plan, which endorses lowering daily carbohydrate consumption to less than forty grams per day (Atkins 1997). With such a low level of carbohydrates, one is left to consume high protein foods (i.e. meat and eggs). Mina reported that she lost seven kilograms in two weeks using this method, but they were back in three months when she discontinued the plan (47). Mina also reported using a Juice Diet. For two weeks, she consumed only fruit and vegetable juices.

Marianne reported having gone on a 1,000 calorie a day diet. She and other women also tried the Dutch Heart Association plan and Weight Watchers. These plans recommend a lower daily intake of calories from fat. Off all the plans they tried, the most positive remarks were given about Weight Watchers (WW). In general, the women felt that the WW portion sizes were reasonable and that the recipes provided by the organization were good. However, one woman did not like the way people trying to lose weight were treated in WW meetings. Based on her own experience at WW meetings in the South, Katia stated:

[Katia]: But what I also hated was that they had the opportunity for a life-long membership. A life-long membership!? God! It sound(s) like a cult, like a sect! I don’t want to be a life-long member. I don’t. Nope. Because I want to be able to choose myself and I didn’t agree with all those rules that they had. The evening that I decided to quit, I asked them, ‘Do you also have the donkey ears to put somebody in the corner?’ So I was just asking them because the way they put people on the spot. The way they treated people I thought it was very bad and I really was… in the end I wasn’t going to the meeting because of the weight loss problem anymore but just to observe people over there. [AN]: Entertainment value? [Katia]: Right. [AN]:So did they actually call people out? Or say things like ‘Why did you gain this week, why do you think you gained?’ [Katia]: Yeah. Yes sure. They did and people also had to tell if they had a party or if they had been to a birthday or whatever. So they were always asking “How come you didn’t lose weight?” “How come you gained weight?” I mean not having lost anything, okay. But gaining weight, oh my God that was bad (109).

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23 More information on the frequency and duration of these behaviors is necessary to distinguish between the two conditions as described in DSM-IV.
It is no surprise that Katia reported that she was referred to as *l’enfant terrible* by her WW group leader. Katia was reacting to the importance placed on weight loss rather than the feelings of the individual attempting weight loss. She also objected to the practice of weighing people in full view of others. The idea that others can see if you have succeeded (lost weight) or have failed (gained weight), suggests that one should care what others think. One should seek positive approval by being successful and avoiding failure and the shame associated with it.

Mariolijn was the only participant enrolled in a clinical weight loss and management program at the time of the study. The program is in Hilversum. She described it as having *drie fasen* (three phases). The *eerste fase* (first phase) lasts for 20 weeks. Participants go once a week to the program center for four-hour sessions during which their weight is measured and blood pressure monitored. Blood is drawn to test for diabetes and to obtain cholesterol levels. Each visit also includes a talk with a physician and group meetings with a psychologist. In the *tweede fase* (second phase), there is an initial phase that lasts for four weeks. During it, participants consume the low fat and low sugar Profiel bars, muesli, and soup. According to Mariolijn, this regime is supposed to help to stabilize the blood sugar. A program representative stated that the weight loss it induces helps to give a feeling of accomplishment (Poll 2000b). Following the first four weeks of the *tweede fase*, everyone is put on a diet made just for him/her. Mariolijn said that it is basically the same diet, but adjustments are made based on the participant’s preferences. For example, Mariolijn likes fruit, so she got more fruit in her plan than others. When I spoke to her, Mariolijn was in the second portion of the *tweede fase*. She goes to Hilversum once every two weeks for group meetings with a psychologist. This period will last for one year before she can enter the *derde fase* (third phase) in which one goes once per month for a year to the center.

Mariolijn also reported that in the past, both of her parents dieted with her. She and her father did a Modifast plan for six weeks together when she was a teenager. This demonstrates that Mariolijn’s parents were trying to be supportive; however, at the same time, they were impressing upon Mariolijn how important her being thin was to them. There was no consideration of what being thin or the cost of it meant to Mariolijn. The absence of consideration persists as exemplified by the fact that Mariolijn’s parents are financing the weight loss program. When asked why she is in the program, Mariolijn responded:

[Mariolijn]: That’s a hard question because...part of it because I think it’s not healthy the way I am...I am not feeling happy the way I am because I don’t want to get thin or something, but I just want to lose 20 [kilos] or something... But it’s also because of the pressure of my parents...I feel like there are more things from outside [influencing] me. [AN]: And how does that make you feel? [Mariolijn]: It makes me feel little and angry (107-113).
Two of the eight women included in this analysis mentioned weight loss surgery. Marianne underwent two surgical procedures to induce weight loss. She had her jaws wired shut and a gastric balloon inserted. Therese has placed herself on the waiting list for the gastric band. Her family is supportive of this decision. Therese maintained that their primary reason for supporting her is that they are concerned about her health. She reported a family history of obesity and that her father had lost two nieces to obesity related complications when they were about Therese’s age. Two of the women in the sample reported exercising specifically for weight loss. One was Anne and the other, Mina. At the time of interview, Mina had begun a fitness program at a sportschool (fitness center). She had managed to go there once a week. This amount was less than the trainers thought she needed to attend in order to improve her fitness level. Before going to the sportschool, she had been participating in a walking club that met two times a week.

[Mina]: And I thought, well, I will try something with movement because they all say it’s important to move. And I started walking and also trying to diet. [AN]: And how has it been working? [Mina]: Well, it worked fine as long as I kept walking. I lost 10 kilos, but then last year in June/July, we [referring to husband and herself] changed schedules (97).

Mina’s experience shows the difficulty some people have in taking regularly scheduled physical exercise. Her time is split between her job and her family. She uses the time left for herself, but she complained of feeling very tired most of the time.

Food and Eating

The women in the study were asked about food availability, what foods they considered healthy or unhealthy, foods associated with weight loss, and how they felt about food. I also asked them about what things contributed to their attitudes about food and eating.

Most women purchased their food at either a supermarket and/or specialty vendors like the slager (butcher) and bakerij (bakery). Therese reported receiving fresh fruits and vegetables from a relative’s garden or buying them from the groentenboer (vegetable man). Mina reported that her family preferred to purchase biologische (organic) products because she considered them more “biologically active” and better for the environment than non-organic products. The cost of food was considered reasonable, but healthier foods were considered more expensive than unhealthy ones.

Foods thought to be healthy were: salad, fruits, and vegetables. Unhealthy foods were: candies, fast food, frites (French fries), mayonnaise, spare ribs, chocolate, brownies, sweets, soft cheeses (e.g.brie, camembert), gravy, and creamy sauces. Foods associated with weight loss were: salad, “everything low fat”, mineral water, yogurt, carrots, cucumbers, and shakes. Note the overlap

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24 According to E. Jeurissen, a representative of the NOV, few weight loss surgeries are performed in the Netherlands because their cost is not covered by most health insurance companies. Some Dutch people go to Belgium for weight loss surgery.

25 A liquid-filled balloon is inserted into the stomach to reduce appetite. See Pinedo and Köhler (2000).
between healthy foods and those associated with weight loss. What is most obvious about the unhealthy foods is that they are high in either refined sugar or fat or both. Also noteworthy is the crunchy nature of the healthy and weight-loss related foods compared to the smoothness of unhealthy foods.

When asked how she felt about food, Mariolijn stated, “I think I’m just addicted to food”. She explained that food “has always been there for me.” Food served as comfort and as celebration. It became associated with pleasure, pain, and things quotidian. Sara stated, “With me, it is a friend and also an enemy. Love/hate.” She expressed the sentiment of most of the women interviewed that altering food intake is difficult because food is associated with so many things. Moreover, you cannot stop eating altogether lest you compromise your life. Anne spoke about “fighting with food”.

It’s like chocolate in the cupboard. I say ‘No. No. No. Don’t eat chocolate now.’ And then when I said the words, ‘No, don’t eat it.’, then I know I’m going to get it and eat it. So maybe I can hold out for a day or for an half an hour to let it [stay] there, but I know already that I’m going to eat it. Then it was a fight because I say ‘No, you can’t eat it!’; and the chocolate was calling “Eat me! Eat me!”; and it was always winning. The chocolate was always winning. So the chocolate got more power than I got. (20).

The more Anne tried to dismiss the chocolate, the more preoccupied with it she became until it gained prominence in her thoughts. This gives some insight into the difficulty dieting women encounter.

I asked Sara about her emotions related to certain foods:

[Sara]: I like whole-wheat bread. [AN]: When you’re eating that whole-wheat bread, what feelings are associated with it? [Sara]: Eh… comfort, pleasure, feeling full, warm, relaxed, happy (laughs). [AN]: So when you’re having that 220 calorie weight loss shake, what emotions surround that shake? [Sara]: Eh. It doesn’t taste good. It mostly tastes horrible, but I just have to go through with it because I want to lose weight. And it doesn’t fill me, it doesn’t do anything for me. It’s like torture (209, 217).

Mina reported having difficulty with throwing food away. After a family meal, if there is not enough leftover food to make a meal for another day, she feels compelled to eat it. I asked her why she held this attitude. She responded, “From home. Because I always had to finish my plate. Whether I liked it or not, I had to finish it. There was very much pressure. I think that was a result of the second World War because that was just passed and they had of course this awful honger winter. So they were focused on “Eat your food! Eat your food!” (107). Likewise, Mariolijn’s attitude toward food was influenced by childhood events.

But when I was young, I wasn’t this big because my Mom. She was obsessed with this. My Mom is very thin and she was always busy to keep me away from the food and to get low fat things. I can remember when I
was 3&1/2 years old. I was going downstairs and I was taking candies from the kitchen and my Mom was walking in and my Dad also and I was keeping like this (puts her hands behind her back to demonstrate how she hid the candy behind her back). I know it was wrong. It wasn’t wrong to take something, but it was wrong to take candies…. That’s what I remember like yesterday (97).

Mariolijn’s experience at such a young age demonstrates how quickly children can internalize their parent’s beliefs. Mariolijn learned quickly that sweets were bad and that she was not supposed to have them. To avoid punishment and/or removal of the candies, she hid them. For some reason, perhaps because she felt Mariolijn was too big for her age group or that sweets were unhealthy, her mother began restricting the consumption of sweets. This restriction caused Mariolijn to desire the prohibited foods even more.

[Mariolijn]: I remember that when I was playing with children my own age when we were at their homes, I always ate everything they offered me. And even they had a meal, I ate the meal and when I came home and my Mom was cooking something I liked a lot, I didn’t say “I had already a meal.” I was always trying to find out where I could get more food. I even said to my friends, “Ask your Mom if we can have another sweetie.” [AN]: Why do you think that is? [Mariolijn]: Because I didn’t get enough at home (263-265).

Social Interaction

Major components of the Dutch female fat experience are self-perception, the perception of others, and how one anticipates or expects to be treated by others based on shared cultural ideas about fat people. These thought processes occur in and are shaped by social contexts and physical spaces in the milieu of Dutch culture. In this section, I present information about several areas of experience. Specifically, I present material about the social domains of gezin (family), vrienden (friends), and andere mensen (other people or strangers). These experiences were significant in influencing how the women thought about themselves and other people.

Gezin

Events that occurred in the context of the immediate, nuclear family appeared to have the most impact on how the women in this study thought about themselves and their weight. Mariolijn’s story is a prime example.26 I gleaned from Mariolijn’s account that being fat is not desirable for females at any age. A child who is fat, or who is thought to have the propensity to be fat, is subject to regulation. When attempts at regulation fail, the child is encouraged to lose weight. Mariolijn did not report that her parents said nasty things to her about her weight; however, their repeated attempts to
entreat her to lose weight sent the message that it would be better for her and/or for them if she was thin. Possibly, Mariolijn’s parents are ashamed to have a fat daughter. The solidarity dieting she reported on the part of both of her parents demonstrates how much of an issue Mariolijn’s weight was for her parents. Rather than leaving her to her own devices, they intended to provide support, consolation, and role model with willpower. It is interesting how nurturing can couple with deprivation.

In the same way that interaction with immediate family members can be detrimental, they can also be of a positive nature. Therese, a lighthearted thirty-two year old, reported a supportive family environment both as a child and now as an adult. Therese described herself as a “large child”. When asked how her family reacted when she gained or lost weight, she responded,

Supportive, but when I gain weight, they say it’s better for you to lose some weight for your health. When I was eating, they did not say stuff like, “Don’t do that. Eat an apple,”(182).

Perhaps the support Therese received is because there have been more fat people in her family. Her family members were more accustomed than most people to fatter than standard bodies.

Little information on intimate relationships was gathered. Several women reported warm and loving relationships with partners who accepted them at whatever size they were. No woman reported to me that her body size caused the dissolution of an intimate relationship. When asked how her partner felt about Anne’s struggle with weight, Anne responded,

At first she didn’t know. And now she said, “I didn’t even see when you were fat. To me you were still the same”(171).

This statement may indicate that Anne’s partner was less focused on Anne’s body than Anne was. It could also be a demonstration of how a significant other maintains silence about his/her loved one’s weight changes to help her feel better about herself.

One woman, Marianne, spoke about her first husband. She ended up divorcing him, but remains grateful to him for accepting her size and acknowledging her beauty. He accepted her for who she was, body and all, and did not place demands on her to lose weight.

Here this guy comes along. He says ‘I love you.’ ‘I find you pretty.’ and God knows what else. And he brings me chocolates. He makes love to me. He says I’m okay. The first man in my life who acknowledged me. The fact that he was not okay and not loyal and all that see, doesn’t matter. I’m still grateful to him for that part, you know? And the others who were so wise to come to me and said ‘Don’t marry this [ex-husband’s name]! You know this [name] is a low life. You throw yourself away with him if you marry him.’ These guys who told me that, they nagged me all my life about being thinner and thinner and going on a diet (21).

See sections entitled “Food and Eating” and “The Quest for Weight Loss”.

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**Vrienden (Friends)**

All women in the sample reported having at least one friend with whom they were close. They socialized with their friends by telephone, at gatherings like birthday parties, and at informal get-togethers like at a café or bar. However, not all felt at ease talking with their friends about their weight issues. Friends may provide support in the form of making encouraging statements, validating the difficulty of the situation, and being accepting whether or not their fat friend loses or gains weight. Friends may also try to discourage the fat woman from dieting. This is exemplified by Katia’s account of her friends during her current weight loss attempt:

Some of them really encourage me and know that I…but the other ones think that its another useless attempt. But that’s not my problem. Who am I to convince them? They will see. It’s not my problem…Some of them say ‘Oh, yeah. Sure. You will have McDonald’s meals next month again.’, and I say, ‘No I won’t.’, (237).

On the surface, the friends who said that she will back to her old eating habits appear to be raining on her parade. However, over the years, they have watched Katia lose weight only to regain it. They may not be enthusiastic about Katia engaging in another attempt. They may not want her to set herself up for disappointment yet again.

Sometimes, a person whom you think accepts your size and cares for you, throws you for a loop. Sara did not realize, until she lost over 30 kilograms, how one of her close friends really felt about Sara’s fat body. Here is Sara’s account of the behavior of a woman she still considers a friend:

And what was also very hurting is that the moment I lost a large amount of weight, a good friend of mine said that, when I was overweight, well, she didn’t say anything about it. But I saw her looking, you know? And when I lost so much weight, she said, “Oh. You were really so fat. When I saw you walking and I saw your behind go like this (makes jiggling motion with hands) and you clothes were so tight. And oh, it was so horrible!” Well, that hurt. I think she thought it was safe to tell me now because then it was over. And one time I had to change my pantyhose with her and at that time I was also pregnant, I think. And I had a size 60 pantyhose because I had to put it on like this (demonstrates pulling the stocking top over a large pregnant belly). (Laughs) And when she saw the size on the package she said, “My God, 60!” She’s like this, you know (holds up pinkie to represent thin friend) and oh, it was so embarrassing. Yes, that really hurt me because she knows who I am and I always thought she accepted me for who I am in spite of my appearance, you know? And that made it clear that she obviously had a very eh… … [what] she thought about my appearance and talked about it with her friends and husband and children and family. Yeah, that hurt me very much (170).

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This excerpt provides powerful information about how fat women think they are seen and how others really see them. Sara assumed that her friend was someone who did not care about how Sara looked and liked her for her personality. Sara felt betrayed when it was revealed that her friend was horrified by Sara’s appearance. Sara thought she was cared for “in spite of” her appearance. The fact that Sara still remains friends with this woman is interesting. When asked if she still knew this woman, Sara responded,

Yes, I do and I want so much to tell her this, but it’s very difficult because I don’t want to hurt her” (172).

Why would Sara put up with a person who did not think enough of her to say something to her about her not looking her best in tight clothes? Why would Sara still talk to this woman, who now makes comments about other fat people to Sara? Why is Sara afraid to hurt her? The answer is that fat women agree with the idea that their bodies are “horrible.” In her own acceptance of this idea, how can a fat woman then negate the idea, especially when it is presented by a close friend?

Andere mensen (other people)

The following excerpts were selected to demonstrate interaction with andere mensen. These others include complete and familiar strangers, peers, and acquaintances that are not considered close friends.

Mina reported being on a tram and hearing someone say loudly, “Is that an elephant there?”

Her thoughts on this were,

It’s so hurtful and that doesn’t happen too often in fact. Mainly people keep quiet about it. It could be like that [mimes a person whispering to someone else]. You have the feeling all the time that (313).

When Mina went to the sportschool to exercise, she had an unpleasant experience in the personal trainer’s office.

And what I hate is you sit in a chair at the personal trainer and they feel that there’s not enough space because of you (laughs). I hate that! That’s some embarrassing (285).

Sara described what happened in the course of a normal conversation with a colleague.

I didn’t talk that much to him. He just visited us because he didn’t work at the same location. I came walking toward him and he looked at me, always looked in a very sexual way. And then he suddenly said, ‘Why don’t you go to the Weight Watchers?’ I was devastated! Because at that time I wasn’t fat at all really (11).

These experiences represent verbal and physical affronts. Verbal affronts are things said directly to the fat person or in the person’s vicinity and are heard by the fat person and others. Physical affronts occur when in close spaces, a person distances him/herself more than is necessary to maintain a comfortable personal distance. Though no one in the sample reported this, physical

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affronts also include things like unwanted touching and physical violence. Some affronts fall into the range of probable offenses. I call these unverified affronts. I use this term to refer to things like whispered insults wherein the only evidence of an affront is the belief of the fat person that it has occurred.

Just because an affront is unverified does not lessen its impact on the thought process of a fat person. Look at how Mina reacted when a person sat far away from her in a small office. Mina inferred from this action that the person perceived her as being so big that s/he had to make room for Mina lest s/he be touched by her. True, the person may be claustrophobic, but Mina does not know that. In the absence of an explanation for the person’s behavior, Mina found a plausible explanation given her prior experiences.

In Sara’s situation, a man that she did not know well felt at ease to comment on her body. Sara thought the comment was motivated by his desire to suggest that she change her body to better suit his preference. He had been looking at her in a sexual way. This verbal affront was particularly nasty because it happened in a work environment. She had to see this person during the course of her employment. Once can only imagine what it must have been like for her to have work-related interactions with her harasser.

The following three experiences are all examples of verbal affronts. I present them to demonstrate the range of social situations in which they occur. Mariolijn was called “Bessie” by the children in her school. Bessie was the sister of Billy Turf, a chubby boy featured in the comic strips of her childhood. She did not like being called Bessie or things like vetzak (fat bag).

[Mariolijn]: When I was younger, when I was about 12, they called me names. But it was a period of four weeks I think and two boys had been yelling things at me. I hit them (shared laughter) so very hard that they didn’t dare to say some things to me. I was coming home and I was crying, so angry, and I told my Mom and she said ‘Wow!’ and she was phoning the parents. [AN]: That’ll teach them to mess with you! [Mariolijn]: But I’m always op mijn huid. I am always aware that people can call me names. I’m always aware of my fatness. I’m always aware that I’m not normal (190-194).

Sandra’s experience with her health care provider left much to be desired. While getting a routine checkup, she noticed that her huisarts (general practitioner) wrote obesitas (obesity) on her chart.

I said to him, “What does that mean?” He says, “You are morbidly overweight.” I said, “I refuse! You take that off my chart!” He said, “But that’s what you are. Anything more than this,” pinching [his waist], “is morbidly overweight.” And I said, “I have here and here.” “Yeah. You’re a walking time bomb.” That’s my doctor! My GP! At which point I told him, “By this, I am leaving you as my huisarts”(24).

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Mariolijn put up with insults from her peers for a long time before she reacted in a physical expression of her frustration and hurt. The fact that the boys were teasing her makes a statement about how children express things that they acquire in the process of acculturation. Upon being assigned a label that she found offensive, Sandra protested. Her protest was met with a statement of the applicability of her physical characteristics to clinical criteria. There was no acknowledgment of her feelings, just a reinforcement of the biomedical truth. How often are smokers or workaholics told in plain language by health care professionals that they are “walking time bombs”? In protesting the attitude of her huisarts, Sandra discontinued her affiliation with him. Granted that Sandra has a lot of chutzpah, one is left to wonder how many fat women put up with caregivers that treat them similarly.

Marianne told the story of her unexpected experience at the birthday party of an acquaintance:

I remember I was once at a party and the lady came around with a plate of gebakjes and she offered me one like this (demonstrates a person holding out a tray). As I put my hands out to take one, she said very loudly in the room “Well go ahead! I suppose you have to grow from it still.” And I was more amazed by this remark than hurt and I went home thinking, “How come somebody is that aggressive with me?”... I gave her a present. I came on her birthday. We kissed. I congratulated her. She smiled at me [as if] nothing wrong. How come, why is it she made this remark the minute I want to take a gebakje which she is offering to me? I was more puzzled than I was offended.

Marianne explained to me that as she saw it, the woman who derided her was jealous of the fact that Marianne was enjoying herself. The hostess was a slim woman and Marianne felt that she had worked very hard, denying herself lekker (tasty, delicious) things to achieve a slender body. The hostess wore black at her party while Marianne wore a colorful outfit. Marianne, who did not deny herself and who was fat, was laughing with the hostess’ husband. The guests were laughing at Marianne’s stories. In short, Marianne’s body should have been disapproved by the others and in turn, she should not have been receiving positive attention. The hostess, who had worked hard to get approval, was not receiving the amount of positive attention she felt she deserved with her slim body. All of her effort was nullified by the positive interaction her guests and husband were having with the fat lady. By the statement she made to Marianne, it is as if she was attempting to remind the others that “Hey, this is a fat woman and she should be treated accordingly!”

Additionally, the hostess made the statement just as Marianne was reaching for a gebakje (small pastry usually topped with whipped cream). Never mind the fact that she offered the pastry or that social custom dictates that Marianne take one. The statement coincided with the sight of a fat

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27 Yiddish word use to refer to a person with a lot of spirit/pluck.

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woman reaching toward a tray of fat and sugar laden treats. The hostess could not have timed it better. She managed to join an admonition with the image of the stereotypical fat woman who eats sweets without a care.

*Watch out for maar*

On a routine trip to the University of Amsterdam (UvA) Library, I stopped in to see the Inter Library Loan clerk. I told him that I was interested in keeping the items I had borrowed for more than the month allotted. He told me that was fine so long as I renewed the items. “Maar (but), I might need them sooner. You have to always watch out for the maar in Dutch.” I kept his comment in mind and it has proved quite useful in elucidating another aspect of the meaning of fatness in Dutch culture.

I was discussing my project one day with a Dutch person and she said to me “I think you are beautiful, but you are also overweight.” I managed to spit out an awkward “Thank you.” It was awkward because while I heard her say the part about me being beautiful, I also registered that this positive statement was qualified with a statement following “but”. According to English grammar, the phrase after the conjunction “but” qualifies and sometimes negates the previous phrase. This was not a statement made with any bad intentions at all, but imbedded in it was the message that my beauty was imperfect. The fact that I am fat detracts from me being beautiful. Overweight/ fat negates the presence of true, unqualified beauty.

Because event occurred early in the research process, I decided to ask the women I interviewed what they thought of the statement, “You are beautiful, but you are overweight.” Here are three responses.

Therese said,

I don’t think that’s… if most people are saying “I think you’re beautiful” and have the “but” in their head, they won’t say the “but”. They keep the maar en het hoofdje (laughs), (275).

In essence, a person giving you such a complement would not ordinarily add the qualifier although s/he may think it. Perhaps the qualifier is omitted to allow the person receiving the complement the full positive intent of it. Of course, some people never think to qualify the statement. Sara agreed with the idea that most people would “keep the maar en het hoofdje” (keep the “but” in his/her little head). My inquiry about the use of “but” reminded her of a comment her cleaning lady made about her eldest daughter:

“Well, she is rather fat, but it’s becoming,” and that I thought that was a really nice way to put it. It’s not, “She’s is beautiful, but she’s fat.” “She is fat, but it’s becoming.” It sounded nice (152).

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28 I did not use the word “fat” because “overweight” is the polite term which most people would use in making such a statement.
The statement of the cleaning lady subverts the notion that fat is not beautiful. Fat can be “becoming”. A woman can look more attractive with extra kilograms. You do not have to be super slim to be pretty.

Since her more positive outlook on herself and her situation, Mariolijn has changed the way she interprets such statements.

I think when you look at the grammar in Dutch, the thing after “but” is more important, but when you ask me, “What do people think about you?”, I will say the first thing is yes, “She looks great.”, but the second thing is yes, “She is too fat.” Most of the time, after “but” is more important, but in my head, it isn’t because what they say at first is the most important thing, (326).

She admitted that before her involvement in group sessions dealing with being overweight, she too would have focused on the phrase after the “but”. Since talking and thinking more about herself in relation to her body, she has adopted a more positive outlook. This outlook accompanies the ability to focus on the initial statement that affirms her as being beautiful.

Organizing

In the April 27, 2000 edition of the NRC Handelsblad contained a section that dealt with overgewicht. Several organisaties (organizations) that deal with issues relevant to fat people were listed. I contacted two groups I thought could provide information on living as a fat person in the Netherlands. The goals and experience of these organizations are given in the following pages. I also present information about an issue on which the associations are united.

Nederlandse Obesitas Vereniging

I learned about the NOV (Dutch Obesity Society) through a conversation with Elly Jeurissen. She is an active member of the NOV who is currently working on a book about the experience of fat Dutch women. The Society was formed in Amsterdam approximately twelve years ago by Mathius-Vliegen, a professor of medicine at the Universiteit van Amsterdam, and her patients. The organization is now nationwide and membership is approximately seven hundred persons. The current chairperson is Mieke van Spanje (Klomp 2000).

According to Jeurissen²⁹, the purpose of the NOV is to support obese people in getting decent medical treatment and to help them receive fair treatment in society. The term obese is used rather than fat, reflecting the patient focus and medical orientation of the NOV. The original focus of the NOV was weight loss and increasing self-confidence. Presently, many people in the organization are into fat acceptance, including Jeurissen. She thinks this is not because members enjoy being fat. Rather, they recognize “Well, there’s no way we are going to be thin and we want to be healthy and

²⁹ Jeurissen is also a member of Bond van Formaat and NAAFA.
we want to be accepted” (29). However, there are those people in the group who still hope to be thin. Jeurissen said that there is a “fairly active” group within the organization who want weight loss surgery.

The NOV is supported in part through a grant from the Dutch government. The rest of its funding comes from membership fees and advertising in the NOV newsletter, *Infobesitas*. The NOV supports any treatment that it has determined, through research and interaction with medical professionals, to be reasonably effective and of low risk to health. No drugs are endorsed. Diets are not supported because they are ineffective. The only surgical procedure supported by the NOV is gastric banding (GB). The NOV currently is working to ensure that weight loss surgery (WLS) patients get decent aftercare.

Though GB is supported and a surgery group exists, not many people in the NOV opt for it. Jeurissen has noticed that more members in the Northern Region (Gronigen, Friesland, and Drenthe) have had WLS than those in the South. Jeurissen makes clear that those who are opposed to surgical interventions are not ostracized by the group. Jeurissen stated, “I don’t accept the surgery, but it does not mean that I’m not going to accept these people” (31). I asked her if those who had surgery remained members of the association. She explained,

> Yeah, they stay in the organization because they don’t lose so much weight that they are going to be thin. And a lot of people on the street, if you tell them that you have surgery to lose weight, you must be very weak because everyone can lose weight. Why did you need surgery? And then it didn’t work obviously because even though you’ve lost 20 or 30 good kilograms, people start out at 150 and they are still fat. Some people even say, “Did you really lose weight? How much, five kilograms?” People don’t know about it so the Society is one of the few places where they feel accepted (35).

The NOV sponsors many events. It held the second annual Anti Dieet Dag (anti-diet day) on May 6, 2000 (*NRC Handelsblad*). On Anti Dieet Dag, people are encouraged to abstain from dieting and weighing themselves. The event is aimed at combating societal messages that fat is ugly and unhealthy. The NOV also organizes weekend retreats and day trips. These more informal events provide the opportunity for fat people to meet, develop social networks, discuss issues, and participate in sporting activities. The most popular sport activity is swimming. It is favored as a family.

> It is being with your own kind of people where you don’t have to feel limited or apologize if you don’t fit in between two people and you can say, “Hey, move Fatty!”, because you can say that and they can say it to you and no one feels bad about it (laughs). If there’s a buffet, you’re not afraid to go up there again, or you can eat an ice cream without caring who is watching.

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You don’t care what the other people think. Of course, there are people who you don’t relate to, but they are part of the family.

**Bond van Formaat**

[Marja Visser]: Like why shouldn’t I be a fairy? Fairies don’t exist. So who told them that the fairies are only thin? I want to be Tinkerbell, you know? Who are you? You will never be able to be Tinkerbell because you are too heavy or [because of] your skin color. But why shouldn’t you be Tinkerbell? You were a little girl. Why shouldn’t you be able to do once in your life Tinkerbell? Somebody thought up this fairy tale…Why can’t you be a fairy once? The other kids are skinnier than me. They are also nice fairies. Why can’t we be fairies as well? Because when I was six they thought I’m too fat to be a fairy and I liked fairies myself. Is that fair? [AN]: It’s not fair. That’s just the way it is though. [Marja Visser]: Well that’s what I’m trying to fight against.

*Bond van Formaat* (Union of Size/Union of Stature) is run by Marja Visser.\(^\text{30}\) It is affiliated with the IASA. Visser started *Bond van Formaat* almost ten years ago to combat what she calls *diskriminatie* (discrimination against fat people) and to encourage size acceptance. *Bond van Formaat* is supported by membership fees and donations from people sympathetic with its goals. It does not receive a government grant because it is not a patient organization. The members of the *Bond* number far fewer than those of the NOV. Visser attributes this to the reluctance of fat people to organize minus the label as patient. “Fat people have learned from their youth that being fat is your own fault. So the tragedy it, that’s the biggest tragedy, that fat people in their hear believe that the ones who discriminate against them are right to do so” (89). Fat people share with their standard size counterparts the same *blauwdruk* (blueprint) that thin is good and fat is bad.

In comparing her organization to the NOV, Visser stated that the NOV is like Martin Luther King while the Bond resembles Malcolm X. Essentially, Visser elects to work outside of the institution of biomedicine. Visser’s biggest gripe is with the medical establishment.

I don’t know any other type of “patient” who gets as much wrong advice as fat people get; constantly the wrong prescriptions and the wrong advice. *Everybody* knows that dieting has the opposite effect. *Everybody* knows that 98% of diets will fail. *Everybody* knows that 98% of the dieters are back on the weight they had at the start of the diet and plus. This is common knowledge and still if you go to the doctor, the physician, he’s still going to tell you “You should go on a diet.” It’s criminal! And why? Because we have a multibillion dollar industry of slimming products (110).

\(^{30}\) Visser is a member of NAAFA and IASA.

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Visser networks with other fat activists in Europe and the United States. She appears whenever she can to speak on the behalf of fat people who have been denied employment, refused service, or otherwise mistreated on account of their size. She also mounts letter campaigns directed at companies and journalists who exploit and/or show fat people in a bad light. Visser makes it clear that size acceptance is not just for fat people alone. It is for thin people as well. If she would vilify thin people, it would be the same as a fat person being vilified. The mechanism of placing a lower value on people because of their personal characteristics is the same.

A Uniting Front: Xenical marketing in the Netherlands

Companies and individuals eager to make a profit have long targeted the overweight and those who think they are overweight, for a long time\(^1\). As my trip to the local Etos demonstrates, there is an abundance of supposed slimming solutions. In this section, I examine how one company is casting it’s net far and wide in the Netherlands with hopes of catching fat consumers and what organized fat people are doing about it.

On June 24, 2000, my husband and I attended Obesitas Dag (Obesity Day) in the town of Almere with fat activist Marja Visser. Visser had invited me to go along with her to what she thought would be a health fair. She had learned about the event from a brochure she found at the gezonheidscentrum (local health center). Before we left her home for the local high school where the event was located, Marja informed me that she suspected that the event was sponsored by the Roche pharmaceutical company. Earlier, she had received in the mail materials confirming our registration. The envelope in which the documents were enclosed were stamped with the Roche logo. She was puzzled by this because the information brochure contained no mention of Roche.

Prior to the Obesitas Dag, Bond van Formaat, NOV, and Stichting Obistat\(^2\) had brought the advertising tactics of Roche to the attention of the Dutch Health Inspection, Department of advertising control. The case was handed over to the landsadvocaat (State Attorney). As a result, Roche was fined 350,000 guilders. It is illegal to advertise prescription medications directly to the consumer in the Netherlands. Roche had broken this law by placing the full page advertisements in Dutch newspapers promoting it’s weight loss drug, Xenical (orlistat). The ad promotion was called “Het gevaar van te zwaar” (the danger of being too heavy) and was touted as an educational information campaign (IASA 2000). These ads featured a fat man with a large round belly. On his belly was stamped the international sign for danger, a large exclamation point painted on triangular shape.

Roche operates a number of web sites that promote Xenical. The Dutch version is located at www.overgewicht.nl. It features colorful, round representations of fat people that wave flags or jump

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\(^1\) For a cultural history of dieting in the United States, see Schwartz (1986).

\(^2\) Foundation Obistat. Promotes the interests of fat people and stimulates research about overweight and obesity (see NRC Handelsblad Tuesday April 27, 2000: 35.

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around icons that feature information on calculating your BMI, motivation, and eating. The web site is considered a “pull” marketing strategy and is therefore outside of the boundaries of Dutch law. “Pull” means that people find the web site on their own and read the general information about the health risks of obesity in addition to the product information. A “push” strategy, like the advertisement directed at the public, encourages people to ask their physicians to prescribe the medication for them.

The Obesitas Dag exemplifies a “push” strategy. I estimate that there were 188 people there based on a count of the chairs and information booth layout. Of this number, about 168 were fat people and a few of their relatives or friends who had accompanied them. Most of the fat people were women who appeared to be in their late thirties to mid fifties. Upon entering the high school gymnasium, we went to a line where our registration was confirmed and we received: tickets to be exchanged for two food or beverage items, two tickets for workshops, a risk test, a sheet advertising the Roche Nederland web site and telephone information line, and a prijswraag (set of questions which if answered correctly puts the respondent in the drawing for a prize). Information booths represented: Van Rheenen Sport, Ulla Popken, and Roche. There were five booths in total. One Roche booth featured a weigh-in after which the fat person would receive a few pamphlets and a handy BMI calculator. At another Roche station, I noticed that blood pressure readings were being taken. My husband said he saw small blood samples being taken, perhaps for blood glucose determinations. The last Roche booth consisted of people reviewing risk tests with the individuals who had filled them out.

The hard sell began with a slide presentation made by Lex Groeneveld, a physician. The slides all had the Xenical logo on them. Groeneveld was very quick in making his presentation of the fifty-eight slides. This may have been because Marja Visser had just finished having a lively debate with him in the presence of a reporter from a national radio station. The slide presentation was clearly skewed toward promoting Xenical. Because my understanding of Dutch is limited, I admittedly could not follow all that Groeneveld said. However, I took notes on the slide numbers and the corresponding slide title. When I received the presentation from Dr. Groeneveld, my notes matched very closely. What struck me about the presentation is that little time was spent discussing the side effects of Xenical. This is significant because these side effects are quite antisocial.

Xenical blocks the intestinal absorption of dietary fat by inhibiting the lipases that normally break fat down so that it can be absorbed. As a result, undigested fat is eliminated through bowel movements. Certainly, if one reduces fat intake, oily discharge is reduced. The average weight loss of people using Xenical in addition to a diet low in fat, is of 13.8 pounds (6.2 kilograms). The

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33 Groeneveld e-mailed the slide presentation to me at the request of my husband. I have not spoken with him in person. However, I did send an e-mail to thank him for the information.
34 In a way, Xenical may be viewed as a behavior modification drug as well. If one eats a meal with too much fat in it, one will reap the consequences of an undesirable, oily anal discharge.
35 Average weight loss information, orlistat mode of action, and side effects were found at an English language Xenical web site, http://www.xenical.com.
effects of Xenical on persons using it for more than two years has not been determined. This was not mentioned on any of Groeneveld’s slides.

After Groeneveld’s presentation, another physician gave a talk about a woman who had lost weight and the health benefits she enjoyed as a result. He had no slides, just notes written on a series of overheads. My knowledge of Dutch is not sufficient for me to state that I understood the majority of what he said. However, I didn’t have to know the language to read the body language of the people in the room. As he pointed to reducing numbers, people bobbed their heads up and down in agreement. Three fat women sitting in front of me seemed to hang on his every word. They turned to each other to say “Umhmm” when the doctor said something they agreed with. We decided to leave after the second presentation, so we were unable to attend the workshops.

When I asked Elly Jeurissen about the Obesitas Dag, she told me that the NOV, the patient organization, had no knowledge that such a day had been organized. As a result of Marja Visser’s vigilance, the NOV has taken action to answer the question: How could the national patient organization for obese people be uninformed about a day that was advertised as providing information on obesity and its treatment? Marja Visser contacted me on August 9, 2000 to let me know that she has sent off seven letters as a result of the Obesitas Dag. One of them was sent to Dutch Health Inspection. Roche will have many questions to answer in the months ahead.
DISCUSSION

These findings indicate that being a *dikke vrouw* means filling physical space in a particular social context, reacting to how others feel about that occupancy, and composing and implementing strategies to figure out how to occupy that space. In this section, I discuss several issues pertinent to the how the fat woman’s space is conceived, occupied, and managed. First, the explanations fat women give for becoming fat, divorced from their contexts, can be misinterpreted to the benefit of stereotype maintenance. Second, how does the notion of the ideal (perfect) female body become standard? Furthermore, what are alternatives to the thin ideal? Third, how do *dikke vrouwen* cope with living in a fatist society? Fourth, are women who want to lose weight really doing so for their health?

**Context please**

The explanations that fat women give for fatness demonstrate attempts to make sense of how they have arrived at their particular spaces. They are the basis for composing methods to determine how to be fat in a society where fat is bad and thin is good. Mariolijn’s food intake was tightly monitored by her mother. When she moved away from home, she splurged and gained a lot of weight. Sara recounted how she gained 20 kilograms after her significant other started living with her.

Degher and Hughes (1999) would refer to such accounts as “fat stories”. According to their definition, “fat stories” explain how or why the person is fat without the admission of responsibility for his/her fat condition. They are “accounts in which one admits that the act in question is bad, wrong, or inappropriate, but denies full responsibility” (Lyman and Scott 1970:113 qtd. in Degher and Hughes 1999:22). I do not consider these accounts “fat stories” by Degher and Hughes’ definition. The examples that Degher and Hughes give as “typical fat stories” do not convince me that the quoted women offer these accounts as reasons why they are not responsible for their fatness. The following three quotes are what Degher and Hughes call “typical fat stories”:

One of my problems is a hormone problem (Degher and Hughes 1999:23).

When I first got married I started using birth control pills. We didn’t want a child right away. I started to put on weight and have had trouble getting it off (Degher and Hughes 1999:23).

Last summer, I got back down to 185, and I was just real serious, practically fasted. I was going to the health spa, and then the next day I broke my arm. So really going to the health spa didn’t do a whole lot (Degher and Hughes 1999:23).

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In my interpretation of these quotes, devoid of context other than knowledge that these people are participants in a weight loss program, I do not see how one can say that they clearly demonstrate the abdication of responsibility.

The first interview excerpt is the report of a physiological condition that may interfere with weight loss and/or contribute to weight gain. If this is a “fat story”, the interviewee must be thought to be manufacturing the condition. S/he is not being truthful with the interviewer or him/herself. This may well be an example of rationalization, but the single sentence, stripped of context, does not convince me of it. In the second excerpt, the interviewee states that she gained weight after starting birth control pills. This can in fact occur. Again, devoid of context, this is a “fat story” if the interviewer has information to indicate that the respondent was on a medication that was not associated with weight gain. They key element of the second quote is that the respondent uses “I” when talking about weight gain and the attempt to lose weight. In the last example, the individual reports being “serious” about weight loss before and injury. After breaking an arm, how many people would go back to the gym immediately?

I do not mean to imply that Degher and Hughes (1999) are completely wrong. There are people who will rationalize that they must be fat because they have gland problems, even when they do not. My point is that presenting examples of “fat stories” devoid of their contexts is inappropriate. They leave the reader to assume that the fat person is not able to look honestly at why s/he is fat. This implies that fat people are dumb, dishonest, and are victims rather than powerful individuals in their own lives. In effect, decontextualizing the experience of fat people to such a degree assists in reinforcing stereotypes of fat people.

In order to avoid doing so, I will give the context to the examples from this study with which I began this discussion. Mariolijn, conditioned to restrict herself from sweets, splurged when she got out of the food-restricted environment. She stated, “I enjoyed being in the supermarket buying food. It was great!” Mariolijn selected food, prepared, and consumed it. She does not blame her parents for her weight. They contributed to how she feels about food, but she is the one who operates with those feelings. Mariolijn recognizes that she has to unthink certain things in order to achieve her goals. In Sara’s case, her romantic relationship affected how she did things. She prepared foods that she thought her partner would enjoy. Sara knew they were different from the foods she had been eating to maintain her 63 kilograms. Yet, she was the one who made the decision to change her eating habits and found enjoyment in it. As Sara’s activity level dropped after getting her driver’s license, she gained 20 kilograms. She stated that this was a result of her no longer cycling. In summary, both women see how their actions contributed to their weight gain. They are not shirkers, but one would not know that from looking only at the information presented initially.

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The thin ideal

Doe maar gewoon, dan doe je gek genoeg. Just act normally, that’s crazy enough. This proverb is a call to conformity or at least, the appearance of conformity. So what is acting normally? As one can see in the experience of dikke vrouwen, being a fat woman is not viewed as normal in the context of Dutch society. If fat is not the norm then it’s opposite, thin, must be. However, even thin must be defined. As the responses of the women I interviewed demonstrated, the ideal is not exact. There is a thin ideal and a functional ideal.

I address here the thin ideal. The women interviewed identified the ideal Dutch female body as being anywhere from a clothing size 36 to a size 40. At the same time, they stressed the importance of things in proportion, not being too full and not being too thin. Several mentioned that some women were too fat or too thin for their body structure. How do they know what looks right and what does not?

To understand the thin ideal and why women seek to conform to it, Germov and Williams state that we must start with the notion that women’s bodies are gendered. This means that cultural ideas of what is attractive reflect normative expectations of female and male bodies (1999:118). Simply stated, this means that the way men and women are expected to look is attached to what their gender roles are. For example, the “traditional” woman is a docile object of male sexual desire. In Western societies, thinness has become equated with beauty. Thus, the ideal female body is a thin one which men (supposedly) find most attractive. The thin ideal is reinforced by industries which benefit from its promotion (e.g., fashion and food) (McKinley 1999). Women are sent messages via magazines and television that thinness is more attractive than overweight or obesity. Even health care professionals encourage pursuit of the thin ideal by refusing to treat their fat patients until the patients lose some weight or admonishing overweight patients each time they come for a visit (Joanisse and Synnott 1999).

Women know what looks right (i.e. what approximates the ideal) because they scan their environment. They watch other women and are aware that they are being watched. In effect, they are their own “body police”, keeping track of those who transgress and meting out punishment in socially accepted ways. Germov and Williams (1999) call this occurrence the body panopticon (all seeing). The panopticon concept was coined by Foucault who based it on an eighteenth century English prison of the same name. The prison is a metaphor for social control that does not require coercive force. The physical prison was comprised of cells arranged in concentric circles with a guard tower at the center. In this way, the guards could observe the inmates at any time. Aware of this fact, the inmates constrained their behaviors. Likewise, women who assume that they are being constantly looked at, seek to conform to the societal norm in order to avoid sanction. As we have seen in the experience of dikke vrouwen, sanction comes in the form of affronts.

Germov and Williams are quick to point out that the body panopticon is escapable. To think that women are endlessly caught up in pursuit of the thin ideal renders women “cultural dupes” of a

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“patriarchal system” (Germov and Williams 1999:127). Women are able to break free of the body panopticon using an alternative discourse, size acceptance. Women are not simply docile creatures caught up in perpetuating their own oppression. They have the ability to act. They are agents who “give power to the relations that “over-power” them (Smith 1990 qtd. In Davis 1995:61). As such, becoming accepting of one’s size is a form of female agency that resists the thin ideal.

Three of the women in the sample had adopted such a strategy. All three have stopped dieting. Marianne did so as a result of experiencing years of weight cycling. Fed up with the adverse effects of years of trying to approximate the ideal, she found that becoming accepting of her own body’s shape and size left her with less torture and more happiness. She does not need social acceptance to sustain her self-acceptance, but she wants it for herself and others. Marianne wants the stigmatization of fat people to stop because she does not want others to endure the suffering she has. Moreover, while she has come to size acceptance, she is not immune from the impact of the social sanctions. She admits that there are some days when it is hard to endure the stares of others at the public swimming pool.

Another size accepting woman, Anne, recognizes the contradictions in her thinking on female bodies. On the one hand, she states that she can look at fat women and think that they are beautiful. On the other hand, when asked what representations depicted ideal female bodies, she cited the women on the sitcom *Friends*. As she spoke to me, she recognized the contradiction between her thought and her actions in the real world. She subsequently stated, “There was a time when I judged women by how they were looking, big or thin, whatever. But I don’t look at them like that anymore.” I infer from this statement that Anne can see women of whatever size as beautiful without referencing the thin ideal as a standard. Thus, fat and thin can be beautiful.

**Coping**

The women in the sample reported that rarely were they insulted in the form of a direct verbal comment regarding their fatness. The most public incident was Marianne’s experience at a birthday party. Nonetheless, fat women are aware that they are being talked about, thought about, and judged (Zdrodowski 1996). Mina and Mariolijn reported that they are always aware that they can be commented upon because of their body size. Imagine the insecurity some fat women feel daily. How do *dikke vrouwen* cope with knowing that their bodies are seen as “not normal”?

In a study of fat people’s reactions to the stigma of obesity, Joanisse and Synnot (1999) interviewed “large” Canadians. They identified several forms of reaction and resistance to stigma. These are: internalization, anger, verbal assertion, physical aggression, flamboyance, activism, self-acceptance, enlightenment and fat power. Joanisse and Synnott state, “These eight types of reaction

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36 Davis discusses using agency to circumvent the notion of the “cultural dope”. See how this applies to the case of cosmetic surgery in Davis1995:60-62.

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and resistance to sizist oppression are important components of personal change and also, to varying degrees, of social change” (Joanisse and Synnott 1999: 67).

An internalizer is a person who had bought into the idea of the cultural norm/ the thin ideal. In the case of the Dutch, this norm is a thin woman who still maintains feminine curves. Not too thin, but not too fat either. Once the norm is internalized, the desire to lose weight in order to conform results. All women I interviewed were internalizers at some point in their lives. This partially explains their attempts at weight loss. Two women in the sample, Marianne and Sandra, were openly angry about the way fat people are treated and viewed by society. Both reported instances of verbal assertion. For example, Sandra let her huisarts know that she disagreed with him and took action. These women were also self-accepting and no longer dieted. They were active in combating sizism through independent and collective work. They both came to the realization that they were not going to be thin and that they did not want to continue waiting for their lives to begin once they lost weight. Flamboyance describes when a person flaunts his/her size. This may be achieved through the use of colorful or revealing clothing. None of the women reported this behavior or the use of physical aggression.

In their study of a national weight loss program’s participants, Degher and Hughes (1999) identified avoidance, reaction formation, compensation, compliance, and accounts as coping strategies used to decrease the negative traits associated with fatness. Avoidance includes avoiding situations where being fat can be problematic and not thinking often about one’s fatness. I did not ask the women in the sample about the latter form of avoidance. Concerning the former, however, Sandra reported not eating frites in public. She would do so in Israel or the US, but not the Netherlands because she is aware that she would be looked at and judged. Mina reported avoiding going to the beach because she felt “embarrassed.” She preferred to stay at the beach café with a cup of coffee while her family played on the beach without her. She cannot overcome the feeling of shame at the thought of other people looking at her body. It does not matter to her that other fat women, even women fatter than her are on the beach in bikinis. Mina also avoids full-length mirrors. She does not want to look at her fat body.

Reaction formation describes when a fat person reacts to a negative comment by doing something to exacerbate their situation like eat more. Degher and Hughes (1999: 20) found that reaction formation was a short-term strategy used when people could not deal directly with a situation. No one I interviewed reported such behavior. The strategy of compensation was employed by Mariolijn and Katia. It appeared to me that they were trying to make up for being fat by becoming over-achievers. Mariolijn reported being an excellent student as a child. At the time of interview, she was working an academic degree and a professional certification simultaneously. Katia was an active volunteer, a language teacher, and an extremely active parent.

Compliance has two forms. Face compliance occurs when the fat person agrees to try to lose weight because of demands from loved ones. The fat person is not committed to trying, but says that

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s/he is in order to avoid problems with the loved one (Degher and Hughes: 21-22). Mariolijn’s experience of going on diets as a child may exemplify this. Stereotype describes how the fat person fulfills a stereotype of fat people in order to increase the chances of being acceptable. For example, a fat person may make a fat joke mixed (thin and fat) company. Stereotypes endorsed by Degher and Hughes’ study groups were the “jolly” fat person, the “faithful sidekick”, and the “bully” (Degher and Hughes 1999: 22). None of the women I interviewed reported instances of stereotype compliance.

In addition to using strategies identified in the existing sociological literature, the dikke vrouwen employed what I call “standing by”. “Standing by” is used when the fat person feels s/he does not want to confront a negative idea about him/herself or another fat person for fear of further social exclusion. Sara’s story of not wanting to tell her friend about how much the friend’s comments hurt her, exemplifies this. Sara does not want to confront her friend about the hurtful comments. Saying nothing is the equivalent of agreeing with the hurtful comments. The friend’s idea that a fat body is “horrible” is never challenged. The friend is never forced to look at the damage her statement caused. Moreover, Sara maintains a friendship with this person that could be endangered by Sara expressing her opinion.

The dikke vrouwen also dealt with the negative ideas about them in society by living well. Sandra made a point of buying beautiful clothing that fit her personality, sense of style, and her body. Mariolijn stated that she was “not ashamed of my body” and went to topless beaches. Marianne rode her bicycle to the train station. Katia took walks along the beach. In their enjoyment of life and non-avoidance of events, these women combat the notions that fat women are unattractive and that they are not physically fit.

Is gezonheid belangrijkst? (Is health most important?)

In her study of the correlates of fatness and lifestyle, van Otterloo (1995) interviewed working and professional-class Dutch women. In addition to collecting information on what attitudes toward food, she also solicited attitudes on body appearance. “The possession of a slim body is evidently a prescription for women which is independent of class. Moreover, there is an obvious shift in motives and arguments for ideal slim-but-not-too-thin body shapes moving from working class to middle-class groups, from beauty and shame to health” (van Otterloo 1995:121). Van Otterloo also noted that the there were four types of motives for being dissatisfied with a fat body. She referred to them as practical, social contempt, health, and aesthetic. The upper class women in the sample most frequently endorsed health as a weight loss motive. This was also the case with the women I interviewed. The three women actively engaged in weight loss attempts stated that improving their health was primary. Van Otterloo comments that indeed, the non-working class women were not fat compared to their working class counterparts. She speculates that this is the result of being “propelled” by internalized motives of health instead of external appearances of social shame (van
Otterloo 1995:123). I disagree with this reasoning. I submit that the internalized health motives are enmeshed with the desire to avoid social shame.

I began to question the ready endorsement of health as the primary reason for weight loss after compiling informant demographic information. Mina and Sara reported their lowest post diet weights. Using their reported heights\(^37\), I calculated the BMIs of these women at their lowest weights. The BMIs were 22.6 and 19.9. These figures placed one in the category of ideal weight and the other in the category of underweight. These women found these weights “just perfect” and were pleased with their appearances, despite the fact that one underwent breast reduction surgery to correct problems with loose skin and disproportionate breast size. This shows how the pursuit of the thin ideal has a lot more to do with appearance than health.

The women I interviewed employed weight loss strategies which clearly contradicted an interest in improving health. These women had tried highly questionable weight loss methods like the Bread Diet. One consumed nothing but vegetable juice for two weeks. Why would these women subject themselves to the sheer nonsense of these methods? The answer lies in the social reality that being fat is such a bad social experience that a fat person will rationalize employing any method to lose weight. I do not mean to imply that fat women are simply “cultural dupes” in a fatist society. The truth is, they exist within a society where the person trying to lose weight is held in higher esteem than the person who is not. But why is this the case? Why is there preferential treatment for people seeking thinness?

The answer may lie in looking closely at ideas about health. Germov and Williams (1996) discuss medicalization and healthism in relation to health promotion. Medicalization is a form of social control in which medical solutions for a deviant condition are sought. It is the process by which a societal occurrence that deviates from acceptable norms is transformed into a disease. “Medical intervention as social control seeks to limit, modify, regulate, isolate, or eliminate deviant behavior with medical means and in the name of health” (Zola qtd. in Conrad & Schneider 1992: 29). Clearly, fatness has been medicalized. Biomedicine offers pills, regimes, and surgical interventions to remedy bodies out of control. Interventions are made under the assumption of recovering and/or enhancing health.

The offshoot of medicalization is healthism. Germov and Williams use Crawford’s definition that healthism is the belief that the highest human value is health maintenance and the avoidance of illness. “Healthism is a new form of morality, where notions of good or bad behavior (as evidenced by individual lifestyles) are popularized in a paternalistic and patronizing fashion” (Germov and Williams 1996:102). Fat people bear the brunt of this new morality in which health equals thinness. Fat people are viewed as leading inactive lifestyles that are more sedentary than the rest of the population. Their food choices and eating patterns are scrutinized to identify where they go wrong.

\(^37\) Admittedly, this data is suspect because it is self-reported.

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and make inappropriate choices. Hereditary reasons for getting fat and staying that way are no excuse. The fat person is ultimately responsible for his/her own body.

Yes, everyone is responsible for his/her own body; however, the social, economic, and political resources available to the individual are often predetermined and individual choices can be influenced by powerful interests. Take the cases of smoking and fatness. That smoking is detrimental to health is acknowledged but not acted upon in the Netherlands. This may be because it is the best interest of larger powers, like the tobacco industry, to make sure that the situation stays this way. In the same way, fat is attacked because it is in the best interest of powerful industries. Consider the fact that in the same day corporate giant Unilever purchased Ben & Jerry’s Ice Cream, it also bought SlimFast. This acquisition of products to both fatten and slim the public is the perfect marketing strategy to ensure lifetime consumers. It is not unlike to strategy of tobacco companies to get people hooked and then keep them coming back for more.

If everyone is ultimately responsible for his/her body, why is the responsibility of fat people focused on so much? I submit that it is because fat people are easy, large targets. The importance of the visual image in impressing to other people the nonstandard nature of the fat body cannot be overemphasized. Dutch people have adopted very well public health messages that excess pounds are detrimental to health. In a system where fat is a health risk, the fat person is the embodiment of that risk. People want to avoid risk because they want to be healthy. Not surprisingly, they have prejudice toward fat people to mitigate their own fears of becoming fat (Cash and Roy 1999).

The application of healthist attitudes is selective. In the Dutch case for example, smokers are not subject to the prejudice fat people are. Why is this? It has been established since the 1950’s that tobacco smoking is directly linked to lung and oral cancers and emphysema. Public health officials in the US, acknowledging the possible risks of second-hand smoke (the smoke from the burning cigarette) encouraged smoke-free environments. As a consequence, the majority of office buildings, hospitals, and restaurants are partially or entirely smoking restricted areas. The same cannot be said of the Netherlands.

From my experience in the Netherlands, it is apparent that cigarette smoking is widespread. In my talk with him, Seidell stated that the smoking rates in the Netherlands are around 35-40% in men and women. There are a small number of smoke free public spaces. As a person from the East Coast of the US, I have become accustomed to smoke-free environments. I am not a smoker and have no intention of starting up the habit. The smell of cigarette smoke makes me nauseous. I am happy that there are places where I can breathe relatively freely and keep my lungs healthy. When I see a smoker lighting up in my general area, I move because I don’t want to inhale the smoke. If it is a smoke-free zone, I might even remind the person of this fact. Yet in the Netherlands, despite knowledge that smoking is “risky”, I can rarely find a smoke-free eatery. Even the public buildings

38 The newspaper de Volkskrant reported on Tuesday April 13, 2000 that Unilever paid around 500 billion guilders for Slimfast and 750 million for Ben & Jerry’s.
are not really smoke free. Before entering the main library of the UvA, I have to navigate through a sea of people puffing away on cigarettes. The Dutch people I know who do not smoke also put up with these situations. They are not upset as I am to be subjected to something that they don’t want. They accept that part of their environment includes people who smoke. They are tolerant. Thus, there is no outrage at the sight of an infant caught in the second-hand smoke of its parents.

Smoking places people at risk for the development of health problems, yet smokers are rarely discriminated against. In the Netherlands, excess body fat is a risk factor for developing health problems and fat people are stigmatized. In general, smokers are accepted but fat people are not. This contradiction indicates that there is more to the idea of health than the prevention of a disease condition. This element is the appearance of health. Dutch smokers do not look “unhealthy”. The diseases they are at risk for rarely produce external signs until they are fully developed. The fat person on the other hand, wears his/her risk on the outside. Fat is a badge of dishonor, marking the bearer as an accident waiting to happen. Thus, people who cite health as the primary reason for weight loss seek to escape the appearance of being unhealthy and its inherent ascribed guilt in addition to improved health.

A Note About Americans

My interest in examining the experience of dikke vrouwen is a result of my personal experience as an American fat woman living in the Netherlands. Therefore, I received the comments regarding Americans with great amusement and interest.

Sara spoke of the images the Dutch have of Americans as extremely fat people who eat lots and lots of high fat and high sugar foods. In a conversation with the young American woman who has lived in the Netherlands for almost three years, she confirmed that Dutch people think Americans eat too much and lack self-control. Americans are a convenient target for because they are distant others, yet they are admired by the Dutch. There is little risk of sounding racist if a Dutch person says “those fat Americans.” The Dutch have an affinity for things American. This is no surprise because they are bombarded with American culture via television, radio, computer, and print media.

It is true that North Americans eat too much. The US is the home of multibillion-dollar fast food restaurants that offer to “supersize” already large portions of food. As a result of decreased physical exercise and consumption of larger portions of food, US residents have become some of the fattest people in the Western Hemisphere. According to the US National Institutes of Health (NIH 2000), over 50% of Americans have a BMI equal to or greater than 30. This fact, combined with interactions with Americans and viewing syndicated talk shows like Ricki Lake and Jerry Springer, lead the Dutch to associate American fat with lack of self-control.

But as the Netherlands becomes more and more Americanized, there is an increased chance that the Dutch will pack on pounds and look very much like fat Americans soon. Dutch people are astute enough to notice that they are not too far away from being in the same situation as their cousins.
across the Atlantic. By calling Americans pigs who lack self control, the Dutch are simultaneously expressing their fear of becoming fat ("At least I’m not as fat as them.") and their national identity ("We are able to control ourselves.").
CONCLUSION

The stories told by *dikke vrouwen* are poignant and inspirational. Their experiences of are relevant to all women who are locked in the “body panopticon”. They closely resemble other stories of fat women in the West (Bovey 1991; Wiley et al. 1994); yet they are unique in that they occur in a culture that is tolerant yet not accepting.

I set out to identify elements of the Dutch cultural meaning of fatness through analyzing the experience of fat Dutch women. I found that fat ultimately means the appearance of the loss of self-control. Weight and thus health is perceived as a controllable entity. Fat people are viewed as failures because they embody a health risk. Health in the Netherlands and other Western countries has become “an achieved rather than an ascribed status, and each person is expected to ‘work hard’ at being strong, fit, and healthy (Scheper-Hughes and Lock 1987). This is the result of the medicalization of human conditions like fatness. In the Dutch case, healthist attitudes are coupled the desire of Dutch people to conform (*Wij doen normaal, dan doen we gek genoeg*). Thus, fat people are maligned. The prejudice they encounter is the result of the fear of becoming fat, an ever increasing fear in the West due to decreased physical activity and increased intake of refined foodstuffs.

Despite the negative attitudes toward fat people and the negative attitudes about themselves that they have internalized, *dikke vrouwen* do manage to live full lives. In the US, the expression “living large” means leading a successful life, full of wealth. I selected the expression “Living Large” as the title of this thesis to convey what I felt in speaking with the women who contributed their experiences. The wealth of happiness and self-knowledge was tremendous. Some were survivors of years of battle with themselves and their bodies. These women are helping others, either through fat activism, launching a clothing line, or speaking about eating disorders to *middelbaar* (high school) students. Others seek to change the size of their bodies. Regardless of their reasons for wanting to doing so, this too is part of living large.
RECOMMENDATIONS

In conducting this study, I accumulated a large amount of information and have come to an appreciation of what may be done to better understand and improve the situation of fat people in the Netherlands.

First, the promotion of size acceptance is the most cost-effective and long term method. This is especially important given the projections for an increase in overweight and obesity over the next decade. The emotional damage fat people can suffer as a result of prejudice and discrimination can be lessened by encouraging their abilities and not making their bodies the focus of their existence. If size acceptance is practiced in schools, perhaps fat children will not grow up socially isolated. Perhaps they will not be the last people selected to play on the football squad. Perhaps little fat girls can play Tinkerbell in the school play. Perhaps then, they will not grow up feeling that have to limit themselves because of their body size.

Second, the design and implementation Fat and Fit initiatives in communities. As the NOV demonstrates, fat people like sporting activities. Exercise programs for fat people should be designed that have minimal risk of joint injury like water running. Participants in such movement programs would benefit not only from the exercise, but the ability interact with other people in a fat-friendly environment. Moreover, this a kind of “kill two birds with one stone” approach. The same low joint injury risk programs could be used for elderly people as well.

Third, a study of huisarts attitudes about and treatment of overweight and obese individuals should be conducted. In my experience of the Dutch health care system, I have recognized that an individual’s relationship with his/her huisarts is essential to getting good and appropriate care. If fat people are reluctant to go to their huisarts because of the practitioner’s fatist attitudes, their physical and emotional health may suffer.

Fourth, greater attention of regulators to the weight loss products industry. As the information in this report demonstrates, corporations can and do circumvent existing regulations to get to fat consumers. As the US experience with Redux (dexfenfluramine) demonstrates, people not originally indicated as candidates for certain drug therapies are prescribed them (Kauffman and Julien 2000). Of course, Dutch people may think “That kind of thing doesn’t happen here.” The point is it hasn’t happened yet. The tactics of Roche may indicate a new aggressivity in the market for “lifestyle” drugs. Thus, the Dutch government should be forewarned and forearmed.

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ANNEXES

Annex 1. List of abbreviations

BMI: body mass index
BMR: basal metabolic rate
DSM-IV: *Diagnostic and Statistical Manual of Mental Disorders, 4th Revision*
GB: gastric bypass
IASA: International Alliance for Size Acceptance
NAAFA: National Association for the Advancement of Fat Acceptance
NOV: Nederlandse Obesitas Vereniging
SSRI: selective serotonin reuptake inhibitor
VGB: vertical banded gastroplasty
WLS: weight loss surgery
WW: Weight Watchers
Annex 2. Interview Guide

Demographics
1) Please tell me a bit about yourself like your age, where you were born....
2) Who do you live with?
3) Describe your social network; who are the people you can confide in or receive emotional support from?
4) How has your health been? How is your health currently?
5) What is your current weight and height? What is your clothing size?
6) What is the most you have ever weighed?

Self Image/Body Image
1) Describe yourself.... How do you feel about yourself? What do you think of your abilities? What do you think other people think of you?
2) How do you feel about your body?
3) What are you satisfied with about your body? What are you unsatisfied with?
4) What do you think influences how you feel about your body?
5) How do you think losing/gaining weight would change this?

Ideal Body Image
1) What do you think the ideal/perfect female body is like?
2) How do you think you compare with that?
3) How does that make you feel?

Experience of being overweight/fat
1) Why do you think you are overweight/fat?
2) When did you first consider yourself overweight/fat?
3) What has been your experience of being overweight/fat?
4) How do you feel about being overweight/fat?
5) What about the reaction and behavior of family...friends...partners...people at school...work...?
6) Does being overweight help you or hinder you? Please tell me ore about this.
7) What are the difficulties you encounter being overweight/fat?
8) What are some positive things about it?
9) How do you deal with the negative things?

Size acceptance
1) Do you accept your size/feel comfortable with it? Why or why not?
2) Are you involved in any organizations that promote size acceptance and/or non-dieting? Please describe it/them to me.
3) How did you arrive at this?
4) How do you deal with people that challenge your acceptance of your body size?

Food and Eating
1) How do you feel about food and eating?
2) What are your favorite foods? What tastes do you prefer (sweet, salty, bitter)?
3) What do you consider healthy foods?
4) What foods do you consider unhealthy?
5) What foods do you associate with weight loss?
6) What foods do you associate with fun?
7) What foods do you associate with social gatherings like birthdays? Are you able to eat what you want at such gatherings? Why or why not?
8) Where do you usually get your food? How much do you buy (enough for one day)?
9) What do you think about the price of food? Are certain foods cheaper than others are?

Weight loss experience
1) Tell me why you want/wanted to lose weight.
2) How many times have you tried to lose weight? What strategies did you use and when? Tell me about them.
3) What do you take into account when deciding on a strategy (e.g., health care coverage, cost)?
4) Are you currently/have you tried in the past to lose weight? Please tell me about those experiences.
5) Why are you/did you try/ing to lose weight? What is your goal?
6) Tell me about the weight loss plan that you are on now. How long have you been (....)?
7) Take me through a typical day in your strategy.
8) What do you like least/like most about it?
9) What has been easy? What has been hard?
10) How do/did you deal with failures/successes?
11) What who motivates you?