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Vogel, E.

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ORIGINAL ARTICLE

Clinical Specificities in Obesity Care: The Transformations and Dissolution of 'Will' and 'Drives'

Else Vogel

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Abstract Public debate about who or what is to blame for the rising rates of obesity and overweight shifts between two extreme opinions. The first posits overweight as the result of a lack of individual will, the second as the outcome of bodily drives, potentially triggered by the environment. Even though apparently clashing, these positions are in fact two faces of the same liberal coin. When combined, drives figure as a complication on the road to health, while a strong will should be able to counter obesity. Either way, the body's propensity to eat is to be put under control. Drawing on fieldwork in several obesity clinics and prevention sites in the Netherlands, this paper first traces how this 'logic of control' presents itself in clinical practices targeted at overweight people, and then goes on to explore how these practices move beyond that logic. Using the concepts of 'will' and 'drives' as analytical tools, I sketch several modes of ordering reality in which bodies, subjects, food and the environment are configured in different ways. In this way it appears that in clinical practices the terms found in public discourse take on different meanings and may even lose all relevance. The analysis reveals a richness of practiced ideals. The paper argues, finally, that making visible these alternative modes of ordering opens up a space for normative engagements with obesity care that move beyond the logic of control and its critiques.

Keywords Bodily drives · Clinical practices · Control · Discourse · Modes of ordering · Obesity

E. Vogel (✉)
Amsterdam Institute for Social Science Research (AISSR), University of Amsterdam, Kloveniersburgwal 48, 1012 CX Amsterdam, The Netherlands
e-mail: E.Vogel@uva.nl

Introduction

One evening in 2012, a local debating centre in Amsterdam hosted an event with the provocative title "Obesity: your own fat fault?" ("*Obesitas: Eigen schuld, dikke bult?*"). Three medical students in white coats stood at the entrance, with pencils and notebooks and a weighing scale, enthusiastically asking the visitors if they wanted to apply for a discount. For people deemed overweight, 2 euros would be taken off the ticket. For the dozens of people not eligible for the discount, a consolation prize of a cream pie was offered. A nutrition scientist, a journalist, an industry spokesperson and the head of the patient organisation were invited to give their perspectives on the growing problem of obesity. The stunt at the start of the evening as well as the question mark in the title of the event underlined that the organization and the invited speakers were not going to settle for easy answers: obesity may be a person's own fault, but perhaps, as the presenters put it, the matter was 'more nuanced'.

How this debate was set up is paradigmatic of how obesity, and weight issues in general, receive attention in public debate in the Netherlands. What is at stake is unravelling the causes of obesity and figuring out who (or what) is to blame for its increase in recent decades, into the so-called 'obesity epidemic'. Since obesity and overweight are taken to cause serious physical, emotional and economic damage, the discussion of these causes is closely linked to questions of how to prevent and cure obesity: the solutions.[1] In this debate, positions move between two extremes. At one end, the overweight person is deemed responsible for his or her weight gain, and it is one's individual *will* that should have controlled one's (presumably) greedy body, for example, by carefully balancing the calories one ingests and burns. If this management fails (the overweight body being the living proof of this failure), the person is to blame. Here, individual behaviour, or one's lifestyle,[2] is cast as the cause of the problem and at the same time as the solution. Anne Mulder, member of parliament for the VVD, a right-wing, (neo) liberal party, argued in a newspaper article:

> "*Why should one hardworking, tax-paying Dutch citizen have to bleed for the lifestyle change of another? People are responsible for their own lifestyle and they themselves profit most from a healthier way of living*" [36].[3]

At the other end is the position that the causal *drives* of the body make the person gain weight. The body is enacted there as having needs that it will try to meet. Often

[1] In this debate, obesity, being overweight and weight gain are often used interchangeably as part of the same problem (e.g. [50]).

[2] The controversial concept of 'lifestyle' in relation to obesity can be considered as a linguistic move that, in itself, posits weight as the result of individual behavior [16] and can pave the way for *laissez-faire*, neoliberal public health policy [4].

[3] Anne Mulder made this statement in the context of a discussion on whether dietary advice—in the Netherlands the standard medical intervention for being overweight—should be covered by health insurance. In the Netherlands, health insurance is semi-privatized: although offered by private companies, 'basic insurance' is compulsory for all citizens and the contents of this package is decided by the government. In 2012, the government led by the VVD decided to take dietary advice out of this 'basic' package but this decision was overturned later. Currently, 3 h of dietary advice per year are covered.

the causal force within the body is combined with societal forces, the 'obesogenic environment' (for a critique, see [14]. The UK Foresight project report 'Tackling Obesities: Future Choices' offers a clear articulation:

> "*People in the UK today don't have less willpower and are not more gluttonous than previous generations. Nor is their biology significantly different to that of their forefathers. Society, however, has radically altered over the past five decades, with major changes in work patterns, transport, food production and food sales. These changes have exposed an underlying biological tendency, possessed by many people, to both put on weight and retain it. (…) The pace of the technological revolution is outstripping human evolution, and, for an increasing number of people, weight gain is the inevitable – and largely involuntary – consequence of exposure to a modern lifestyle. This is not to dismiss personal responsibility altogether, but to highlight a reality: that the forces that drive obesity are, for many people, overwhelming*" [13].

This position holds that obesity can be explained by forces outside people's will. Eating is posited as an act of compulsion. The "modern lifestyle" triggers an "underlying biological tendency". Hence, instead of weight gain being something that people *do,* it is something they *undergo* (cf. [5]. Accordingly, 'weight' also shifts from being simply the result of a balance or imbalance between input and output of energy to being the outcome of a more complex system. The solution is not an individual will that should work on an individual body, but a collective will that needs to intervene in the environment, for example, by removing candy bar machines from public space, making fast food more expensive, or replacing elevators with stairways. According to this argument, present day surroundings are ill-suited to people's naturally greedy and lazy bodies.

The two positions and their arguments do not fit together easily. The first position tends to be moral in tone—people *should* take responsibility for their lifestyle—while the second mainly makes use of scientific rhetoric, calling upon facts established in research that show that obesity *is* the result of an interplay between the biological dispositions of the body and the environment. At the same time, both positions figure in moral-political and scientific settings, as well as in juridical practices [17] and health promotion [6].

These positions, in all their versions and combinations, build on common theoretical assumptions about subjects, bodies and the environment. Together, they imply a reality in which the person as responsible *subject* is distinguished from the body as *object* embedded in causal relations—a classic dichotomy in the western tradition (cf. [20]. As obesity is attributed either to a subject's volition, or to causes located outside one's control in the combination of body and environment, the positions have in common that they enact the subject as something separate from the body and the environment. Their joint implication is that individual will may *support* a solution to weight gain (after all, even causal models posit that it is precisely a lack of a collective will that causes obesity) and that drives may *complicate* a solution to obesity (in the modern environment, the body naturally overeats). Thus, even though they seem radically different, 'will' and 'drives'

explanations of obesity are two sides of the same liberal coin. The dominant message in media representations and public debate is that in order to lose weight, in one way or another, whether through individual or collective will, the body needs to be controlled. This 'logic of control' structures possible positions in this debate.

It is against this background that medical philosophers and ethicists take obesity to invite important questions about agency and morality. Typically going along with the idea that there is an obesity epidemic, scholars in these fields engage with the above analysed logic by exploring the philosophical merits of different positions as well as explore the moral consequences of assuming such positions when allocating recourses in health care [43], in public health policies [37, 49] or doctor's practices [39]. In this literature, overweight tends to be posited as deriving from 'voluntary behaviours over which the patient has *some degree of* control' [38], my emphasis). In contrast to what often is the case in public debate, from this assertion it does not automatically follow that individuals are to blame. The moral arguments for adopting perspectives on obesity are different from the scientific-political reasoning that I laid out above in that perspectives are primarily appreciated in relation to values such as autonomy, equality and fairness. It is argued, for instance, that blaming people for the *onset* of their 'condition' has ethically unfavourable effects and should thus be avoided, whereas recognizing willpower as an important factor once medical treatment has started is likely to improve the success of interventions and therefore a good thing (ibid, 2010; [10]. Interestingly, however, these philosophical debates remain confined by the same liberal scheme that also infuses the logic of control: what is theoretically at stake is demarcating a line between (treating) the person as responsible subject equipped with volition and (excusing) behaviours that are determined by circumstances outside of the person's scope of influence.

The liberal scheme has been critiqued in the social sciences where poststructuralist scholars, often with feminist inspiration, have pointed out that control lies at the heart of the public concern with obesity. Rather than scrutinizing the ethical soundness of specific *positions*, these works focus on the *discourses* on health and weight that structure these positions and examine the notions of obesity, the body, the self and health that are embedded in them [7, 11, 18]. Their critical analysis is that the rationales underlying knowledge of obesity are linked to economic and moral projects. They argue that the obesity discourse works through contemporary neoliberal modes of governing that enlist and call upon a 'responsibilised self' to control and manage his/her own body [24, 32]. In this framing, discourse, political projects and health care practices are inextricably linked. The idea is that knowledge about healthy food, exercise and the body increasingly structures work, leisure, education and health care [8, 15, 19]. That medical knowledge has come to shape how people experience their bodies and identities becomes particularly salient in practices geared to normalising allegedly unhealthy or overweight bodies, critiqued as 'biopedagogies' [9, 51].

It is certainly important to critically engage with the dominant logics on overweight. However, in the poststructuralist analyses just mentioned, health care practices tend to figure only in as far as they are indeed structured by the dominant discourses and logics on obesity. But are they always, are all of them just the means

through which the regulating power of discourse is exerted? The present paper starts out from doubting that assertion. Inspired by earlier work on the creativity of care practices (e.g. [31], I have done fieldwork within such practices from the vantage point that they may well be productive and creative spaces where people, seeking to come to terms with a specific set of concerns, grapple to shape their own ethical engagements. I thus wish to engage in a kind of academic research that 'does not assess either theoretical notions in the light of empirical evidence or judge the practice in terms of the theory' but offers new ways of reflecting on current practice through re-description and articulation of logics or concepts-in-practice [44, p. 154]. This way of working allows me to explore what might be learned from professional ways of working that do *not* fit with the terms used in the media and in public debate. In various sites in the Netherlands,[4] I have done qualitative research into practices targeted at people with overweight with as a leading question whether, and if so, how, the logic of control is present within them. Between 2010 and 2012, I held in-depth interviews with dieticians, physical exercise trainers, nutritionists, and weight consultants, and observed some of these health professionals in their work with people who want to lose weight or change their eating habits.[5] In what informants relate and practices reveal, I draw out allusions to 'will' and 'drives'. These terms are framed in public debate in the way I presented above. But what are they made to be in practice, how are they called upon in the techniques professionals work with, and when are they not called upon at all? It is not my aim to argue for or against any position proposed in public debate. Instead, I seek to explore the diverse passages and translations of the various elements of the logic of control. Hence in my analysis, 'will' and 'drives' do not figure as entities that may or may not be present in people, but as terms that may or may not help to structure practices. They are fluid, analytical tools.

To draw out and learn from different *modes of ordering* [22], this paper articulates with the manifold relations and logics embedded in local practices [1, 23, 29, 33, 34, 41]. Attending to the intricacies and practicalities of health care in similar ways has allowed scholars to articulate alternatives to, for example, ideals of self-determination [45], the 'patient perspective' [40],'patient choice' [27] and 'scientification' of clinical practices [25]. These works have brought out the specificities of a practice of *care*, typically not governed by rules, but taking shape through processes of tinkering in relational ways. Consequently, a focal point in these analyses concerns the transformations that ideals, knowledges, and rules

[4] This study was part of a larger multi-sited ethnographic research on knowledge practices and different obesity interventions, ranging from dietary advice, fitness programmes, mindfulness courses and lifestyle coaching in the Netherlands. Field notes and interviews transcripts were translated from the Dutch. The study was undertaken following local ethics committee approval. To ensure anonymity, consent was verbally obtained and the excerpts from transcripts are not identifiable individual interviews or observations. The names I use for my informants in this paper are thus invented.

[5] These people, (called 'clients' or 'patients', depending on the setting) some of whom I also interviewed, usually came to the professionals on their own, or were referred by a doctor (usually a GP). Although some facilities, offering more extensive treatments such as bariatric surgery, were accessible only to people classified by a doctor as obese, the techniques and interventions of practices described in this paper made no other distinction relevant to the present analysis between overweight and obese people. Consequently, I mainly use the term 'overweight'.

undergo when they translate to clinical practices. In what follows, these transformations concern 'will' and 'drives' and along with that bodies, subjects, food and the environment. All of these emerge relationally in the work of the professionals whom I interviewed and observed. My analysis will help make alternative modes of ordering visible. In so doing, it opens up a space for interesting normative engagements. Rather than necessarily taking up a position within the logic of control, or critiquing from the outside, it becomes possible to move in more situated ways between practices, techniques and interventions.

Will and Drives in Practice

The figures of 'will' and 'drives' prominent in public discourses can also be found in the accounts[6] of professionals and clients/patients and in the realities performed in health practices that target overweight in multiple ways, taking different shapes and being reworked to fit local concerns.

Will Stimulates, Drives Complicate

In interviews, the professionals said that, indeed, someone who wants to lose weight needs to use their will. Stefan Halder, owner of a fitness centre for women:

> "*We will give you support, and of course we want to provide that for you, and we try to achieve a commitment, but yes, you're the one who is going to do it, you have to work hard here, I am not going to put those machines in motion. If you go out and stuff yourself… go to McDonalds in the mornings and afternoons and in between come to us… well, then it won't work.*"

Halder thus does his part to make weight loss easier by providing support and facilitating healthy behaviour; the women who come to his centre for a work-out have to do theirs. Here, their 'will' is mobilised as a relevant factor in the programme, as a way to ensure compliance to the programme or treatment [12] without which weight loss cannot be achieved. Furthermore, individual will is accepted to be partly independent from the intervention: it is the task of the women concerned to take the opportunity the gym offers to work on their bodies.

Just as proposed in public debate, the drives of the body often complicate matters and make healthy eating difficult:

> "*Mr Jansen, a middle-aged successful entrepreneur, enters the dietician's consulting room. Responding to the dietician, he says that he is doing fairly well, but that he eats out a lot for his work. In light of his goal to lose weight, this is not good, as restaurant food often contains fries and meat, and few vegetables. Last week he went out for dinner four times. And, he explains, as he works irregular hours, it is often difficult for him to have meals at regular times. During the day it is quite all right, but he often overeats in the evening.*

[6] Rather than the expression of individual *beliefs*, I take what professionals and patients/clients express to be *accounts* that 'link "things", concepts and practices together' [42].

His work also involves lots of get-togethers and coffee meetings, which come with so much tasty food that he cannot control himself. And, he adds, once he has given in a few times, he tends to give up for the whole week."

Mr Jansen may want to lose weight but he asserts that, in certain social situations, when tasty food is present, the drive to eat wins. The implication is clear: instead of being able to take control, to master his body, he feels his body's urges take over.

These are two possible ways in which the logic of control is present in the accounts of both professionals and overweight people whom I encountered in my fieldwork. The individual will may help the person to lose weight, and the drives triggered by tempting socio-material environments make it difficult to eat well.

Will Complicates, Drives Stimulate

Professionals working in care practices for overweight people do not, however, always frame individual will as being in line with health goals. To them, too much discipline is often a cause of trouble. Dieticians and weight consultants repeatedly mentioned that overweight people have a 'disturbed relationship' with food, usually due to a long history of attempts to lose weight through commercial diets. Sandra Peters, weight consultant:

"*What you see in the media, one thousand, twelve hundred calories a day, does not make sense. I had someone the other day, she started treatment with me, and it [weight loss] was not fast enough for her. It was very clear why, all these excuses and everything. Later she said, 'Sorry, but I've started on the 'Cambridge 500' [diet of shakes and soups]'. She lost ten kilos with that, but she quit because it was so expensive and she'd stopped losing weight. Then she came back to me. In the meantime, she'd really ruined her metabolism. This diet is five hundred calories a day, five hundred! […] Luckily, she's doing okay, still losing some weight eating healthy food, but most people gain weight rapidly. You read about people with permanent hair loss, really absurd*."

Here it is an excessive will that complicates treatment. In her desire to lose weight quickly on a diet of 500 calories a day, a person comes to neglect the needs of her body to the point that this is harmful for her health. Hence, people should not 'will' too much, lest their attempts to slim become destructive.

So while policies targeting the obesogenic environment operate on the assumption that weight management has to struggle with people's present-day surroundings because an abundant food-scape induces overeating, in this dietary practice a differently obstructive context appears: an abundance of 'crash-diets' fuels hopes and pressures to lose weight fast while encouraging people to exercise control. The proper response to *these* temptations is to attend to the mechanisms of the body. Suzanne Bot, a dietician in a multidisciplinary obesity centre, tries to see to it that her patients properly feed their bodies:

"*The patients we see here neglect themselves, they're totally out of balance. […] Most people eat very few basic foods, for example very little bread but lots of other high-energy products like cookies, crisps, or muesli bars, those*

kinds of products. And then they think they're healthy, and that they don't eat much at all, but actually they do. Because they compensate basic foods with these products. […] This is not a lack of discipline, I am deeply convinced of this, it is partly because when your body does not get enough energy in the right way, through carbohydrates, proteins and fats, it will beg for fast sugars and fats to meet its energy needs. […] So it is about healthy eating, and slimming down in the long run. This reduces the chance that you will gain weight eventually, because then at least you give the body what it needs, because then your body will not be difficult."

Bot insists that when you try to control the body, it becomes 'difficult'. Its energy needs will return with a vengeance, ultimately driving a person to overeat. However, even if bodily drives here are in conflict with the will, they are not a complication to losing weight. On the contrary, the dietician stresses that not taking the nutritional needs of the body seriously results in unhealthy eating and weight gain, whereas recognising and giving the body what it needs ensures that it will not crave unhealthy foods.[7] The dietician's patients thus need to eat enough of the right, healthy food. Consequently, the logic found in public debate is actually reversed here: drives are good, the will complicates.

Will and Drives Done in Practices: Progressively Transforming

Individual will is thus not always staged as conducive to the goal of being healthy, and not everyone frames drives as always needing to be controlled. At the same time, the examples above both posit will and drives as a *given*, functioning as *explanations* of what caused the person to become overweight: it was either the lack of will and the strength of the drives, or vice versa. In the accounts so far, will and drives thus figure as things inside people that interventions have to reckon with. However, when I attend to what is being done rather than said, it becomes apparent that will and drives may take other shapes.[8] Since clinical practices do not primarily invest in explanation, but in change (cf. [27, 28, 35], when will and drives figure as part of the intervention, they are amenable to *modulation*. They may transform.

In some cases the goal of an intervention is to strengthen someone's willpower in order to make healthy eating easier. Nelly van Dijk, a dietician, told me how she helps her adolescent clients:

"*If everyone buys a pink cake at break time, sure, you won't eat an apple because then you won't fit in. So you adapt. […] So I work on self-confidence, because this is often clearly not up to par. And on self-awareness, negative self-image. As a therapist, you work on a bit of resilience.[…] You have*

[7] A distinction is thus made here between the necessary, 'good' bodily drive of hunger, and a deceptive, 'bad' drive that is a response of the body to a lack resulting from overly restrictive eating. Cf. [52] on *ansiedad.*

[8] I do not separate the realm of words and materials here. Making the distinction between saying and doing rather communicates a difference between taking language as signifying a reality and as part of interactional work that goes on in practice, for example, in constructing weight as a moral issue in doctor's consultations [48] or in the achievement of satiety in a family meal [21].

different conversation techniques to get that on the table, so yes, you ask open questions, to find out what is important to someone, what motivates them. What do you want to change, how do you think you are going to do that, what if the whole group laughs at you? And pointing ahead to… so, what if you said you don't want a pink cake and everybody says: 'Whoa, you must be mad!' You know, that's how it goes! What would you do? When someone is prepared for that, you've made them resilient."

The technique of 'motivational interviewing', as in the above description, aims to strengthen people's will.[9] Significantly, this 'will' is different from the individual will mobilised in the logic present in public debate. The person is not expected to be in control: the dietician understands that succumbing to peer group pressure is natural. A wilful self is called upon, but it is not 'responsibilised'. Thus here the will of the person does not figure as an available recourse ready to tap into, instead it is performed as an outcome of the intervention, something that takes time and effort to achieve. Only through the treatment can the now-resilient client resist the powerful, tempting environment.

Similarly, the goal may be to work on (certain) drives, 'satiation training' for example, where people have to learn how to sensitise themselves to the feeling of hunger. If the physical drive to eat when the body needs feeding is (re-) strengthened, sudden cravings for unhealthy food can be prevented. Interestingly, the trigger to overeat in an environment full of unhealthy, processed food is staged here not as a natural causal chain, but as the result of a person not being able to *feel* bodily drives. Suzanne Bot explains:

"*If you are hungry, but unaware of it, you are more sensitive to outside stimuli. If you happen to walk past a fast-food shop, and you smell fries, you are likely to buy them not knowing that you are actually hungry at that moment. To regain this awareness, we often begin with eating six times a day, but (…) then clients are still dependent on an external stimulus, for example a clock. They set the alarm six times a day as an alert: now I have to eat. It can be an aid to getting there, and often we connect it to a thought. When the alarm goes off, take a second to reflect: what do I feel at this moment? I always give them cards with the hypo symptoms [hypoglycaemia: low blood sugar level] for diabetics, to show that when you are hungry you can experience any one of these symptoms: trembling hands, feeling faint, unable to think straight, dizziness, these kinds of things. And then when they… some people still don't feel it, but then it is a matter of practice, and the openness to learning, of course*."

Through the feedback from the hypo cards that describe hunger symptoms, people learn to feel a hunger drive 'from within'. This 'subjective' sensing of the needs of the body can be contrasted with a body that is known 'objectively' from the outside (see [30]. In a practice that foregrounds the latter, the will is mobilized to ensure that the body ingests the amounts stipulated by a daily menu. The use of the

[9] See for a discussion on empowerment as a technique/process and/or a goal, [46].

alarm clock in this practice still relies on some form of external control on the body. Bot stresses, however, that in her treatment the ideal is to eat well—both enough and 'healthily'—while being as 'unaware' as possible. It follows that ideally the will is not involved, at least after training. It is significant that by working on one's bodily awareness, the internal drive to eat is made to be a result of the intervention. And while satiation training strengthens *this* drive, it reduces the influence of elements in the *environment* that might make a person eat, such as the tempting smell of fries.

In practice, will and drives may thus arise from training so, in care practices for overweight people, will and drives are not enacted as given phenomena that work in opposition to each other but as entities that emerge and are modulated in different practices in different ways.

Practices Beyond Will and Drives

In the material presented so far, will and drives can still be distinguished as separate entities. This is, however, not self-evident. In some practices, will and drives are not only staged as transforming, but dissolve altogether.

Attention and Pleasure

The conflict between bodily drives and a controlling will is dissolved in interventions where people learn to care for themselves by feeling and *cultivating* their body. Take 'mindful eating', which claims that its non-judgmental, attentive attitude towards eating provides the eater with more room for choice and enjoyment. How two participants introduced themselves at the start of a 'mindful eating' course I observed illustrates the kinds of issues targeted in this practice. First, a 55 year old woman shared with the group that, all her life, she had been worrying about 'losing and gaining the same 10 kilos', a preoccupation which she experienced as severely obstructing the pleasure she took in eating. Second, a woman in her twenties stated that she felt her problem was that she did not think about food and treated it as mere fuel so she would often forget to eat during the day and serve herself ready-to-eat meals by night.

While one expressed the wish to become less obsessed with rules and regulations and the other hoped to take more time for eating, both participants came to the course for the same reason: to learn to become calmer when eating. The goal of this intervention, then, is not primarily to achieve weight loss. Here, healthy eating is about working on how to relate to the *act* of eating. People are taught to attend to how and why they eat, and to enjoy their food without worrying.

> "*Everybody sits quietly in a circle, eyes closed, and Lydia, the mindfulness instructor, rings a little bell to signal the start of our first exercise. She walks round, putting something in our hands. It is a raisin. Lydia leads us through the process. First, we feel it with our fingers. Then we look at it, we smell it, and put it gently on our tongues. After a while, we can chew on it and then*

finally, swallow it consciously. All in all, the exercise takes eight minutes. Afterwards, we exchange experiences. One woman mentions she had never noticed the sourness of raisins before. She had actually never really tasted them, but did eat them a lot. Never just a single raisin, but always a mouthful. Someone else is surprised that the raisin held so much flavour, and noticed the difference between having a raisin in your mouth and chewing on it. More women declare they had never tasted or noticed any food this way before: 'This experience is incredible!' 'Clearly, attention can turn an old or ordinary experience into a new and fresh one', Lydia concludes."

According to Lydia, paying attention to eating and appreciating the event itself change what eating is. Eating well, in this case, does not involve resisting the urge to eat bad food and choosing healthy food instead, it pertains to caring for and attending to food and yourself. To taste carefully, and be aware of how food affects you. Consequently, the 'self' that comes to the fore in mindful eating is not the same as the subject implied in the rationale of control. When cultivating the *awareness* of eating, neither a bounded will-subject nor an object-body come into play [47].[10] There is no conflict because, in this practice of attention, self and body are intertwined.

Support and Collectives

Some practices do not draw a sharp distinction between the will of the eating subject and others around him or her. In the logic of control, other people form a barrier to the individual goal of health. In the quote about the pink cake, the teenager's friends encourage her to eat unhealthy food. In the practices that I observed, however, healthy living is often not staged as an individual matter, but rather as a matter of *collectives*. Consequently, individual control moves to the background, and what becomes relevant is organising the support of others. Obviously, this already happens in the consultation with the professional, who carefully avoids all moralising and is always positive and understanding. Moreover, professionals often mobilise the targeted person's existing relationships. Dietician Pia Dorens calls her client's partner a 'super coach'. This next fragment makes clear why:

"*Jochem's partner Linda, a tall, slim woman, joins him [in the session] today. Linda does their cooking. In the past few months, the couple has used the Dutch Nutrition Centre's list [it classifies foods as 'preferable', 'permissible' and 'by exception only']. Linda takes the list very seriously, often tries out new recipes and tries to make them as appetising as possible to get Jochem get used to the new tastes. Jochem actually prefers standard Dutch cooking: potatoes, a few vegetables and lots of meat. This has to change if he is to lose weight. He says that he doesn't like most of the produce in the 'preferable' column, but does try everything Linda prepares for him. After all, she does the groceries and decides what they eat*."

[10] For an analysis of how (theorizing on) subjectivity changes when attending to eating practices, see [28].

Through Linda's efforts, the norms of the Dutch Nutrition Centre on healthy food can be reconciled with the normative evaluations of Jochem's palate. Here, neither the will nor bodily drives come into play. Instead, the collective is organised in a way that stimulates healthy living and motivates further engagement through positive experiences. For the same reason, new collectives may be organised, such as exercise programmes, walking groups and fitness clubs. These initiatives aim to provide people with a safe space in which they need not be ashamed of the size or fitness of their bodies. Thus, in these places, the overweight person is enacted as entangled in different sets of *relations* with others. When learning to eat healthfully is staged as a struggle for control, an individual should become free of the influence of other people. In contrast, here others provide support.

Other people are not only mobilised to support the individual's goal of healthy eating, sometimes a group of people, not an individual, is treated. Couples frequently come to the dietician or weight consultant together, and when children come in because of their weight, the care focus often shifts from the child to the family. Leontine Buijs, a nutritionist:

> "*If the rest of the family eats pizza and the child is served a bowl of lettuce, well, it won't work. But I have these families, that… well, this is extreme, of course, but the mother just eats crisps, and even though she waits until the child has gone to bed, children see right through this… Yes, I think the whole family needs to go for it. I don't believe that the rest of the family [can] have an unhealthy lifestyle and one child a healthy one, I don't believe that one bit. […] That's just not possible. You have to go down this road together.*"

The treatment targets all family members. Separating the individual here would not be helpful. Instead of positing an individual will in opposition to the influences of others, here the individual figures first and foremost as part of a collective. The interventions thus target the daily lives of all members of the collective that is most prominently involved.

Working with the Environment

The person is not always enacted as clearly separate from his/her environment. In discourses on obesity, the environment typically leads to the subject losing control, for example, when tasty food is available at work meetings. In some of the practices I observed, however, the environment helps to open up new behavioural repertoires, as people learn how to *work with* the environment. For instance, people can learn to acquire new skills. The following field notes were taken during an exercise in a gym as part of a multidisciplinary programme designed to encourage people with various physical and psychosocial problems to move more:

> "*Five women and one man are exercising in the small fitness room of the physical therapy practice. During the session, the clients switch between several cardio machines, while the coach walks round, making jokes and correcting movements. Sometimes, the coach urges someone to slow down, or she tries to motivate someone to put in a little more effort. One of the*

participants, Fatima, is a Pakistani woman who has lived in the Netherlands for seven years. A few years ago she broke her hip. She tells me that she never used to take exercise. In her country, nobody does, certainly not women. But it is good for you, she says. This is her second year in the programme. She likes it a lot. In the beginning, she was afraid of breaking her hip again. But here she is learning how to move properly. Besides doing the programme, she moves a lot more and goes for a walk almost every day."

In this intervention, the most important thing is to create an environment where Fatima can be healthy. The exercise class is easily accessible in the neighbourhood. The coach knows about the problems the participants are dealing with and encourages them to work at an intensity level that they can handle. In this environment, it is not willpower that has to be strengthened but rather the capacity of the person that has to be facilitated so as to live healthfully.

Apart from being encouraged to exercise, people are taught what food to buy, and how to prepare it well. Miranda Dekker, weight consultant:

"*People buy these ready-made sauces because they no longer know how to make them themselves, how to make food tasty with herbs, so they go for ready-made, but these often contain a lot more sodium, and they're more expensive… I work on this in the treatment, but not enough yet, I think. I try to make people cook, and go through the basic recipes together. There is a misunderstanding: it has to be quick, otherwise I will get fries. Yet it takes more time to go to the snack bar and come back than to peel a potato! So to make them aware of… the why, right? And to look at alternatives: supermarkets sell peeled potatoes. Sometimes we visit the supermarket, to show people what's there. […] And [I] try to get [them to] experience food, starting with: why don't you make your own smoothie, get fruit and yoghurt, and make yourself a nice smoothie*."

More than just knowledge is provided here, bodily dispositions are changed, and the way in which the person relates to the world around them. Here, the environment is neither complicating nor supporting, instead, the person actively engages with it. New skills, such as cooking and shopping for groceries, enable new ways of dealing with food in various contexts in ways that do not revolve around control.

The engagement of people with their environments is both fostered in acquiring these bodily skills and also in the way the professional and the person in treatment organise changes in daily life. Leontine Buijs describes some possible changes for the children she coaches:

"*Well, the dog has to be taken for a walk, so you can join [in that] once a day. And we are not going to grandma by car because it's an easy walk, so we walk. And well, to school, of course, but this is very obvious. […] I try to be creative, so I tell children: buy an exercycle and do your homework, the things you have to read or memorise, on the bike. […]They need to become creative thinkers, take [that creativity] with them in certain decisions. I now have a girl who needs to make a decision about high school. I told her: Well, you have to cycle a while to get to this school. Fifteen minutes there and fifteen minutes*

back, thirty minutes a day. You can take this into account, and take it very seriously. Knowing you are susceptible to becoming overweight, this may be a decisive factor for you, in choosing a school, a workplace, well, whatever. You can be aware of this in decisions you take in life, that this can be an issue."

Here healthy behaviour is not being staged as a matter of bending the environment to the individual's will, because it is acknowledged that the person is deeply embedded in socio-material contexts. What is (made to be) available in the environment impacts on people: certain things become easier to do. Both the person and the environment are *shaped together* in such a way that a healthy life is attained. Neither one is given to the other. Consequently, through this reorganisation of daily life practices, the task of healthy living is distributed to various elements.

Conclusion: Deliberation Discourses and Practices of Intervention

This paper departs from a dominant logic found in media representations and public discourses on overweight that stipulates that in order for people to lose weight their body needs to be controlled. This logic, depending on an implicit conceptualisation of a person characterised by a dichotomous relation between a responsible subject and a bodily object, structures possible positions in public debate. Extending previous work that critically engages with this dominant logic, I analysed where, how and to what extent this logic actually figures in various care and prevention practices for overweight people. I brought out how professionals and their clients make statements that fit the logic of control in which 'will stimulates, drives complicate', but that they also question this logic in their accounts. Dieticians, weight consultants and fitness instructors then argue that too much will may complicate matters, whereas attending to the drives of the body may be conducive to a person's health.

This apparent incoherency does not form a problem for the clinical professionals themselves. For professionals may engage with the logic of control in their verbal accounts, but their core practice is not to take on the philosophical task to think through matters of responsibility or the nature of the overweight body. Instead, it is to help people. Hence, I suggest that rather than 'reading' what professionals do as a *deliberation discourse* it deserves to be analyzed as a *practice of intervention*. Whereas professionals' deliberations are easily translatable to public debates, their practices don't travel so lightly. A logic of control, asking 'who or what is to blame for obesity?' requires methodical differentiation of entities and the separation of their respective powers. A practice of intervention, however, does not depend upon a coherent account of obesity from which statements on responsibilities ensue. Hence, terms found in public debate change when they enter these clinical practices. In techniques that are used, terms such as 'will' and 'drives' may be used in order to intervene into a specific situation in the hope of changing it for the better. I argue that the specificity of concerns in clinical practice should be recognized and is worth exploring.

Accordingly, by foregrounding what is *done* in clinical practices for overweight people rather than what is *said* by professionals, I have showed how will and drives may change entirely: instead of given entities explaining what causes unhealthy eating, they emerge as effects of certain techniques. 'Will' in clinical practice, might relate to the normative ideal of self-confidence rather than to responsibility and blame, and 'bodily drives' may arise in relation to practices of eating well rather than to compulsion and persuasion. Markedly, the liberal coin by which these figures are tied to each other in public debate is not translated to these practices.

Besides, in many instances, the concepts of 'will' and 'drives' do not suffice to describe what actually happens in clinical settings. The boundaries they imply between a subject and his or her body, relevant others and the environment dissolve in a number of ways. Other modes of ordering can be found that revolve around pleasure, collectives or skills. Ideals such as bodily awareness, attentive eating, collective eating and engaging with the environment then come into play.[11] Crucially, the clinical practices articulated in this paper have in common that success is not decided in discrete moments of exercising control as the entities in question and the stakes raised are not shared and stable, but appear fluid and emerge relationally. The richness of these practiced ideals is then all too easily subsumed under general headings such as 'health' and 'weight loss', as can be seen in public debate as well as in evidence based medicine (cf. [26, 35]. Only by resisting encapsulating these normative ideals into a dominant logic, they can be engaged with in scholarly debates on obesity.

In this way even the highly morally charged terrain of the 'obesity epidemic', may allow a space for normative engagements that do not stay confined in, nor just critique, the 'logic of control'. Rather than begging the question of responsibility for overweight, this approach invites care about locally relevant ideals such as feeling well, eating well and caring well. It thus becomes possible for critical scholars to move closer to what comes to matter within care practices. How might it be possible to strengthen, explore and improve these ideals on their own terms? The art is to analyze that even though, as specifications and translations are central to the clinical practice, generality cannot be found.

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[11] Paying attention to such clinical specificities reveals, among other things, that part of the concerns and models of healthy eating that fat studies scholars, in particular those involved in the Health At Every Size Movement [2, 3], advocate for may be said to be incorporated into this intervening practice, even though they are not prominent in public discourse in the Netherlands. For instance, the call of fat activists to focus on 'healthy day-to-day practices, regardless of whether someone's weight changes' [3].

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