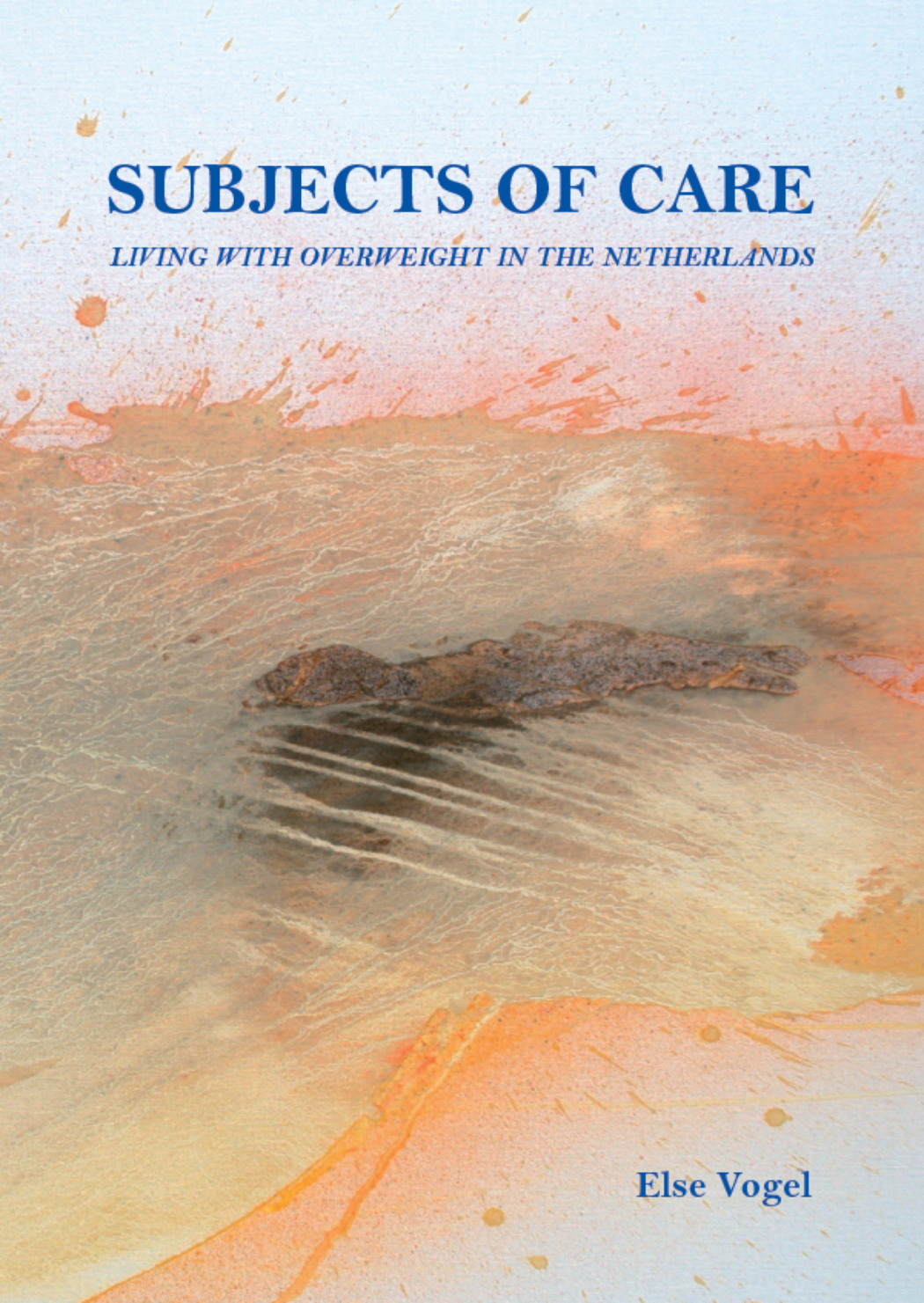
Subjects of care: Living with overweight in the Netherlands

Vogel, E.

Publication date
2016
Document Version
Final published version

SUBJECTS OF CARE

LIVING WITH OVERWEIGHT IN THE NETHERLANDS



Else Vogel

SUBJECTS OF CARE

LIVING WITH OVERWEIGHT IN THE NETHERLANDS

By Else Vogel

Amsterdam, the Netherlands

October 2016

ISBN: 978-94-6233-391-8

Printed by: Gildeprint – The Netherlands.
Cover: Henrie Vogel, *Fragiel lichaam.* 135/135 cm, gemengde techniek.

The research and writings that form the basis of this dissertation were executed within a larger research project - The Eating Body in Western Practice and Theory (ERC Advanced Grant AdG09 Nr. 249397) – headed by Prof. dr. Annemarie Mol. The project ran from March 2010 to February 2015 at the Amsterdam Institute for Social Science Research (AISSR) of the University of Amsterdam. It was funded by the European Research Council. The research further benefited from the 2012 Spinoza Grant for Annemarie Mol.

SUBJECTS OF CARE
LIVING WITH OVERWEIGHT IN THE NETHERLANDS

ACADEMISCH PROEFSCHRIFT

ter verkrijging van de graad van doctor aan de Universiteit van Amsterdam
op gezag van de Rector Magnificus prof. dr. ir. K.I.J. Maex
ten overstaan van een door het College voor Promoties ingestelde commissie,
in het openbaar te verdedigen in de Agnietenkapel
op donderdag 6 oktober 2016, te 14.00 uur
door Else Vogel
geboren te Kampen

Promotor:	prof. dr. A. Mol	Universiteit van Amsterdam
Promotor:	prof. dr. A.J. Pols	Universiteit van Amsterdam
Overige leden:	prof. dr. R. Reis	Universiteit van Amsterdam
	prof. dr. A.P. Verhoeff	Universiteit van Amsterdam
	prof. dr. D.L. Willems	Universiteit van Amsterdam
	prof. dr. G.C.G Dehue	Rijksuniversiteit Groningen
	prof. dr. H.A. Paxson	Massachusetts Institute of Technology
	dr. A. de Bont	Erasmus Universiteit Rotterdam

Faculteit der Maatschappij- en Gedragswetenschappen

Dedicated to my parents

TABLE OF CONTENT

LIST OF FIGURES AND TABLES

Chapter 1

INTRODUCTION

Caring about weight

It is a Thursday evening in the south of the Netherlands, in a room in a local healthcare center. Janneke, the dietician who allowed me to observe her course on 'healthy eating', is waiting for the two participants to arrive. As soon as Suzan enters, she declares that she did not want to come. Things are not going well. But she came anyway because Janneke had emailed that I would be attending – and she did not want to disappoint me. Janneke had already told me that Suzan is in the process of her second divorce. During the previous divorce, she gained 30 kilos. Taking this course should prevent that from happening again. The other day, Suzan shares, she ate two bags of ginger cookies [pepernoten] *instead of dinner: 'I am such an emotional eater. At such moments, eating is a comfort, and I just cannot stop'. Then she turns to me and says: 'Take this for your research: the more you worry about your weight, the more you want to eat!'*

Janneke asks her if she wants to weigh herself. Suzan is reluctant. Her own scale at home told her she had gained weight. Then she decides to 'get it over with' anyway. To her relief, she has only gained 0.5 kilos. Overall, she lost 2.5 kilos during the course. But with her 72 kilograms Janneke still considers Suzan 'not too heavy'.

The other participant in the course, Laura, enters. Laura counts calories. A self-defined 'Burgundian', she is not yet keen on her recently started project of weight loss and healthy eating: she feels it forced her to ban 'all fun things from life'. This week she and her husband went out for dinner, which was nice. At her husband's encouragement, she 'sinned' and ordered an apple pie for dessert. Janneke asks if she at least enjoyed it. 'If you do take something, make sure to take pleasure from it, too.' Laura laughs.

Introduction

In this dissertation, I study the practices and techniques through which people who consider themselves *te dik* [fat] or classify as *te zwaar* or *obees* [overweight or obese], or feel they are at risk of becoming so, care for their bodily weight. To do this, I draw on ethnographic fieldwork on practices through which various practitioners and people care for bodily weight by means as diverse as dietary recommendations, exercise regimes, meditation, tasting, diet shakes and surgery. Such techniques, I stress, not only intervene *on* the body, but reconfigure the lives of the people involved. As the above vignette indicates, they change the practicalities and meanings of everyday life – of cooking and eating, of pain and pleasure, of shopping, of raising one's children. And as we learn from Suzan, people's desires, hopes and fears affect how weight manifests as a problem and may be managed. In this dissertation, I demonstrate how these processes unfold in locally specific ways. As my focus is on care practices, I ask such questions as: Towards which desired practices is care directed, and how? Who/what is mobilized in the changes deemed necessary? And what kinds of ways of relating to oneself, one's body, other people, food and one's surroundings do these eating and exercise practices foreground? Specifically, my quest is to explore the subject engaged in (self-)care.

The chapters that follow variously elucidate how people relate to their bodies – how they control, listen to, enjoy, care for, and try to change their bodies, how they are taught to do so, and why. In these practices, different modes of living with overweight emerge. I approach each mode of living as a certain *staging* of the world. That is, I analyze them as theatre performances, in which particular versions of food, bodies and subjects play their part. As I will elaborate further, this staging is not simply a particular way of *knowing* or imagining obesity: it comprises actual world-making.

Chapters 2-6 are in the shape of journal articles. Each contains its own theoretical discussion and argument and is readable independently from the others. But as the article format necessitates brevity and focus, I take this introduction as an opportunity to further explicate my theoretical commitments and analytical strategies. I situate this study in relation to the

literature that has engaged with concerns of overweight, nutrition and health. I tease out the specificities of the field of my study and the questions that guided me throughout my analysis. The introduction ends with a discussion on methods and a brief outline of the articles that comprise the subsequent chapters.

How big is the problem?

Exploring how people, with the help of health care professionals or their significant others, live with overweight requires a focus beyond individuals and their behavior. Discourses in politics and public health, and the ways in which body weight is known, problematized and handled, shape what modes of living with overweight become available and desirable. As it happens, those whom it concerns now find themselves part of an urgent societal problem. According to the World Health Organization (WHO), overweight and its more severe form, obesity, are among the biggest health problems the world faces today. In the last few decades in the Netherlands, the population's body weight has increased to such an extent that, along with others, the Dutch nutritional agency, the *Voedingscentrum*, says overweight is now a true 'epidemic'.[1] For body weight to be measured on a population level, the numbers on weighing scales, whose fluctuations can be monitored by people at home as well as by General Practitioners and dieticians in their offices, are converted through the formula Mass (kg)/(Height (m))^2, which has since 1970 been known as the *Body Mass Index* (BMI). Thanks to this simple metric, large datasets can trace changes, compare groups and visually represent the problem of overweight (Fletcher, 2014). The Dutch Statistical Bureau (*Centraal Bureau voor de Statistiek, CBS)*, for instance, can thus report that compared to 27.4 percent in 1981, in 2014 43.8 percent of all men and women aged 4 or older were by present standards 'overweight' (Body Mass Index = 25-30). In the same year, 12.2 percent fit the category of 'seriously

[1] http://www.voedingscentrum.nl/encyclopedie/overgewicht.aspx. Last accessed May 16, 2016.

overweight' or obese (BMI>30), compared to 4.4 percent in 1981 (see Figure 1).

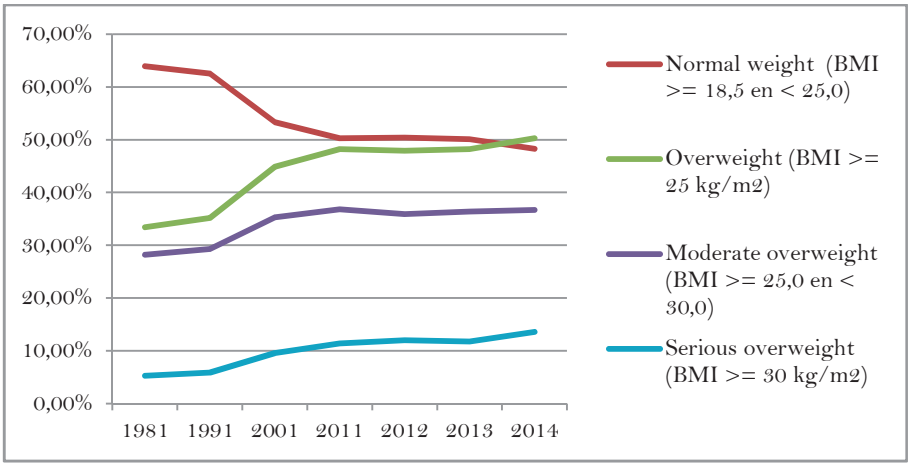


Figure 1. Percentage normal weight and overweight in Dutch population 20 years and older, 1981-2014. *Source: CBS (2016).*

When the BMI metric was first developed in the nineteenth century it was not used in medicine or public health, but in anthropometry (Hacking, 2006). In developing his theory of the 'average man', the famous Belgian statistician Adolphe Quetelet proposed it as an elegant measure to study human variation (Hacking, 2007). Nowadays, certain levels of BMI gain their qualification as *normal* or *abnormal* through links with epidemiological research that ties weight to health risks (Jutel, 2006) and not through their placement in relation to a larger population. After all, with almost half of the adult population in the Netherlands now being overweight, overweight is the new 'average'. The difference between normal and overweight designates a higher prevalence of diabetes and elevated blood pressure in populations with high BMI scores, as has been found in epidemiological studies (Fletcher, 2014). Likewise, such studies found a spike in mortality rates at a BMI of around 31. Epidemiologists rounded this number down to 30 for convenience, thus becoming the BMI score indicating 'obesity'. These labels became

standardized ways of categorizing bodies in relation to health, are included as variables in countless scientific studies, serve as admission criteria for certain treatments and increasingly indicate disease in themselves (Jutel, 2006). Considering the risks of diabetes, arthritis and cardiovascular problems, general practitioners (are urged to) tell their patients in the overweight or obese category at a consultation that they should 'consider losing some weight' even if at present, they have no complaints. Information on these risks, coming from various governmental and non-governmental organs, also aims to convince people to attempt to lose weight.

From data sets we also learn that body weight is distributed unevenly across the Dutch population. Indeed, public health statistics show that rates of overweight in the Netherlands are correlated with socio-economic status, level of education and ethnicity (de Wilde, van Dommelen, Middelkoop, & Verkerk, 2009). Gender plays a role too: in 2013, more women than men qualified as obese, but men are in the majority in the overweight category (*Centraal Bureau voor de Statistiek*, 2016). From these numbers, and the knowledge they are part of, we learn many things about overweight: that the problem grew in recent decades, that it poses several health risks, and that if 'we' as a population would lose weight, 'we' as a population would be healthier. But these numbers tell us little about *how* to care for overweight and how it should be targeted. Health risks, moreover, give urgency to intervention; however, knowing about them gives little direction as to how people might live with and address their overweight, or how body weight might be targeted in care practices.

How to care about fat?

The question of how to live with overweight cannot be answered by focusing solely on the effectiveness of 'interventions' or weight loss treatments. Who or what should be the focus of intervention, and what its desired effects should be, is anything but straightforward in this case. Social problems and political dynamics are folded into the concern with overweight throughout: from the ways in which it is known to how it is targeted. This makes the concern a

potent subject for social scientific inquiry, but also makes the question of how to *care* for overweight a loaded one. For one must first ask: who should do this caring?

In the 2013 royal address, Dutch Prime Minister Mark Rutte proclaimed that given the scarcity of public money, the Dutch welfare state must transform into a 'participation society', in which 'it is asked of everyone who possibly can to take responsibility for his or her own life and environment' (2013, my translation). One commonly voiced critique to such rhetoric is that in the current neoliberal climate, the burden of the 'crisis' is wrongly placed on the shoulders of individual citizens. This bypasses or even aggravates larger structural problems that can only be addressed collectively, such as social inequality and modes of food production. In the last couple decades, nutritional concerns in the Netherlands, as in many other places, have shifted from overall scarcity to caloric abundance and from availability to quality of food.[2] Although such abundance is the reason that in the Netherlands obesity is sometimes labeled a *welvaartsziekte* [prosperity disease][3], one of the leading Dutch public health experts and a prominent public figure when it comes to obesity, Professor Jaap Seidell, recently started calling obesity 'the cholera of the twenty-first century'. In an interview in the daily newspaper *Het Parool* (2015), Seidell stresses that, like cholera in the nineteenth century, obesity is often used to stigmatize the poor for supposed amoral choices, while it is a condition caused by the lack of a healthy environment. His point is that for those in the lower social strata, the stress of their daily lives as well as limited access to health care, healthy food and exercise opportunities foreclose the path to healthy ways of living.

Others have argued that neoliberal politics permeate the very way in which the problem is constituted. For instance, geographer Julie Guthman (2011) argues that the notion of energy balance central to public health

[2] This does not mean access to food is no longer an issue. According to their latest assessments, 94,000 people apply for food assistance at the *Voedselbank* [Food Bank] on a weekly basis (see http://voedselbankennederland.nl/nl/feiten-cijfers-en-filmpjes.html, last accessed 3 August 2015). For research on food insecurity among this group, see Neter et al (2014).

[3] The English term used in public health is *non-communicable disease*. Both terms are contrasted with infectious diseases, but with different implications.

discourse on obesity conveniently makes health about *food* and *exercise* rather than about food production, toxins or the harmful effects of capitalist modes of production. Despite occasional calls for fat or sugar taxation or bans on marketing to children, the present approach to industry seems to be that as long as standardized and regulated information is available to ensure consumers can make 'informed choices', markets and intensive food processing may run free.[4] Industry may even profit from the concern with weight by marketing 'health' or 'light' foods and stressing the importance of exercise over diet (Gard & Wright, 2005; Herrick, 2009; Ibáñez Martín & González García, 2010; Sanabria, 2016).

In this context, rather than solving a problem, public health campaigns that target people's food choices risk creating 'yet more anxiety about a food system gone awry, concomitant with the sense that there is diminished capacity to do anything about it' except carefully choosing what to eat (Guthman, 2014: 2). Stressing the adverse effects of fatness on health may have unexpected social and cultural effects. For instance, critical clinicians and scientists worry that having weight loss as a therapeutic goal brings along body dissatisfaction and disordered eating rather than health (Bacon & Aphramor, 2011; Nicholls, 2013). The field of Fat Studies, identifying a societal 'fat phobia', warns that pathologizing and medicalizing fatness through obesity may further fuel stigmatization, discrimination and the moral blaming of fat people and their family members (Cooper, 2010; Murray, 2007; Rothblum, Solovay, & Wann, 2009).

The various points raised in this literature highlight the socio-political salience of my field from the start. Rather than examining the 'Dutch case' and the extent to which this case differs from how the problem of obesity emerges in other countries, I instead take care practices *themselves* – and the people, bodies, techniques and knowledges figuring within them – as exemplary social sites in which the problem of obesity emerges and is handled, both practically and ethically. 'The social' emerges in professional and client/patient interactions, group sessions, and as family and friends are

[4] Although, as David Schleifer (2012) shows, the effects of labeling may go beyond the governing of consumers' choices and also structure the way food is produced in anticipation of consumers regulating their food choices.

mobilized – or not – in projects of healthy living. It emerges, too, in the relations between self, body and food. These relations are charted in care practices, but their socio-material conditions of possibility – the knowledges, normativities and technologies that embody them – may be traced far outside them. In examining these care practices, then, I focus on the problems they foreground, and the realities and normativities that come with them.

Biopolitics of weight and appetite

The work of Michel Foucault (1977; 1998; 2003) on power, the constitution of modern subjects and the centrality of the body in contemporary governmental control, and the works inspired by his theories, make pertinent how concerns with body weight helped moralize people's relation to their bodies. They further situate my focus on ways of living with overweight in social and normative contexts. Foucault traced how the relation between citizens and government changed over the course of the nineteenth and twentieth centuries, as the power of the sovereign was supplanted by *biopolitics* working through discipline, regulation and normalization of its citizens. Foucault asserted that the scientific measures and standards embedded in discourses, rather than being oppressing or coercive, make a certain way of doing/being appear desirable. The BMI has been analyzed as an important standard in this way (B. Evans & Colls, 2009), but as anthropologists, feminists and cultural scholars have argued (Gremillion, 2005), normalization also works through, for instance, popular media including celebrities, fashion magazines and cosmetics commercials that present beauty ideals privileging ever thinner bodies, especially for women.[5]

Following Foucault, contemporary scholars analyze discipline and regulation of weight and appetite as a contemporary technology of biopower, which works through (the encouragement of) *self*-control rather than external control from the prison or workplace (Coveney, 2002; Heyes, 2006). They recognize a strong imperative for modern 'bio-citizens' in contemporary Western societies to 'take responsibility' for their health: they should become

[5] Although such ideals are not universal (Davis, 2003; Popenoe, 2012).

productive and refrain from incurring health care costs, therewith burdening society (Guthman & DuPuis, 2006; Lupton, 2012; Rose, 2007; Wright & Harwood, 2009). Part of being a good citizen entails regulating one's weight and making sure not only to become better once sick, but to prevent the onset of (further) disorder and disease by making healthy choices and engaging in good behavior.[6]

Foucault's later work inspires attention to the ways in which individuals may care for themselves while navigating certain norms. In following how people live with overweight, I am interested in what Foucault called 'technologies of the self', which he defined as permitting 'individuals to effect, by their own means or with the help of others, a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality' (Foucault, 2000: 225).

Scholars inspired by Foucault emphasize the rationalist and calculative logic built into the techniques that currently shape ways of living with overweight. Such techniques appear as a *recipe*, a set of rules and advice on food and eating in which nutrients and calories are key ingredients. For instance, philosopher of science Gyorgy Scrinis argues that current approaches to healthy food and eating are infused with an ideology of 'nutritionism'. Examples are the use of food labels and food pyramids. Nutritionism holds a reductive account of the nutritive qualities of foods and the evaluation of their effect on the body, for instance by quantifying the nutritional content of food while designating some macronutrients such as protein 'good' and others such as fat or carbohydrates 'bad' (2013).[7]

In turn, calories, converting food and exercise into energy intake and expenditure, communicate that 'what must go in, must go out'.[8] The

[6] See Trudy Dehue (2014) for an analysis of Dutch 'lifestyle politics' in which health is presented as a choice, obligation and product.
[7] Geographers Hayes-Conroy and Hayes-Conroy likewise criticize 'hegemonic nutrition' (2013) and its focus on metrics and standardization.
[8] The history of the science of caloric requirements and nutritional needs has been well-described – in particular its emergence from late nineteenth- and early twentieth-century concerns with managing and controlling the health and morals of specific populations such as workers, patients, inmates or soldiers (Biltekoff, 2013; Cullather, 2007; Duff, 2004; Landecker, 2013).

accounting practices calories are part of, John Coveney (2002) asserts, carry a protestant appreciation of prudence and ascetic aversion to 'bodily sins'. They promote a self-conscious 'sovereign' subject capable of making informed food choices. It is in these self-controlling practices themselves, then, rather than only through the (possible) *outcome* of weight loss, that one develops oneself as a (good) person. Susan Bordo (1993) shows how dieting and the required attention to every minute detail of what one eats constructs a 'docile body', a body tamed and trained by the powers of normalization. She argues such contemporary ideals of bodily control paradoxically combine norms of consumption with the imperative to master such consumption through dieting and exercising.

Foucauldian scholars with an interest in the power dimensions of obesity argue that public health, medicine, education, industry and popular media are all complicit in the same neoliberal normalizing political and social projects (Greenhalgh, 2012; Guthman & DuPuis, 2006; LeBesco, 2011; Lupton, 2012; Mayes, 2014; Monaghan, Colls, & Evans, 2013; M. Warin, 2011; Wright & Harwood, 2009). Particularly fields such as 'critical weight studies' or 'critical obesity studies' tend to present a unilateral condemnation of everything infected by the 'anti-obesity discourse'.[9] Analyses may even take the form of 'unmasking' a hidden plot. Deborah Lupton, for instance, states:

> 'In the case of fatness, medical practitioners and public health researchers and policy exponents have tended to unquestionably take up various belief systems and discourses which give meaning to fat bodies, just as do the mass media, the education system and lay people, including many fat people themselves.' (Lupton, 2012: 33)

These 'belief systems', for Lupton, include the ideas that thinness is the body's 'natural state' and that weight control is an individual responsibility. The

[9] See also the recently coined field of 'Critical Nutrition'. Coming from a concern with the moral underpinnings of dietary projects, one of the aims of this field is to shake the tacit assumption of nutrition science that 'good eating' and 'good digestion' are conscious acts carried out by a sovereign body, suggesting instead that these are issues that may be difficult to manage at an individual level (Guthman, Broad, Klein & Landecker 2014: 46).

problem with such little regard for differences between practices and concerns, however, is that it leaves all critical engagement to the social scientist, while ('lay') people are left to either 'internalize' norms or resist them.

The critique of the construction of obesity as a 'problem of the body', moreover, focuses primarily on the effects of scientifically prescribed food norms and what they moralize and encourage. In its assertion of biopower's dominance, this analysis risks closing off ways of thinking beyond that which it critiques. Focusing on (the power of) control of 'input' prominent in dietary recommendations and nutrition science, for instance, leaves other practices of eating that complicate rationalistic approaches to food, such as cooking, tasting and socializing, out of sight. These more marginal practices, or practices that do not easily travel through talk, might yield interesting alternatives to the technologies of control that scholars describe.

What about the body?

The poststructuralist focus on the political and social underpinnings of discourses on obesity has created a division between social scientists who believe 'the obesity epidemic' that gives urgency to the problem of overweight is 'real', and those that take it as a 'social construction' (Moffat, 2010). Dissatisfied with both these positions, Megan Warin (2014) argues that the way forward is to engage with the 'biological reality' of fat bodies. Anthropologists have long argued that analysts cannot revert to 'nature' and 'culture' as foundations of, or resources for, explanations or arguments, as the dichotomy that underlies them itself originates in modern Western thought and practice (Rabinow, 1992; Strathern, 1992). Feminist scholars further politicized projects of drawing such nature/culture boundaries, pointing out the dividing, hierarchizing and othering they do (Butler, 1990; Haraway, 1991). The recent '(re)turn to materiality' in the social sciences and humanities (Alaimo & Hekman, 2008; Bennett, 2009) that Warin is part of, aims to escape such dividing by shifting the attention from the body as an object of knowledge/control to its lively materiality.

Warin suggests the life sciences such as epigenetics may be an ally in the project of debunking common obesity myths of individual responsibility and the stigmatization that results from those myths (Warin, 2014). As she and her colleagues argue, far from being reductionist, 'epigenetic theories bring to the fore what anthropologists have known for decades': that bodies are embedded in material, social and economic contexts across time and space (Warin, Moore, Davies & Ulijaszek, 2015). The problem with new materialists' approaches to materiality is that they, however carefully, still grant (social and natural) science exclusive access to what the body 'is' and what constitutes its 'agency'. In Warin's analysis, for instance, materiality, following Elizabeth Wilson, amounts to that which is 'physiologically, biochemically or microbiologically constituted' (Wilson, 1998: 14–15, quoted in Warin, 2014: 12). As others have argued, this approach risks universalizing materiality and taking scientific data at face value (Abrahamsson, Bertoni, Ibáñez Martín, & Mol, 2015; Paxson & Helmreich, 2014). It also misses the chance to follow the socio-material practices through which materiality comes into being. The focus on scientific texts, 'data' and theories, then, suggests that rather than escaping discursive renderings of the body, one discursive signification is replaced by another.

Indeed, like sex or race, overweight is a case where the biological and the medical come to matter politically. Biological accounts of the body and overweight serve as ammunition in all kinds of debates around obesity. For instance, at the 2014 North American 'Obesity Week' conference in Boston, representatives of 'The Obesity Society' (TOS) distributed flyers with the 'Obesity Pledge' (see Figure 2) which features a call to subscribe to the idea that obesity is a medical concern and a *disease* that deserves to be treated as such. In a debate I went to in 2012, journalist and feminist Asha ten Broeke, in her argument that obesity is not someone's individual responsibility, cited studies showing that sugar is as addictive as cocaine. TOS lobbies for the availability of obesity treatments and their inclusion in medical insurance packages, while Asha ten Broeke points to harmful food production processes that need political intervention. TOS's rendering of the reality of overweight is not more complex or reductionist than Ten Broeke's; it is in contrasting these versions that complexities come to the fore. Consequently, they do not

just reveal controversy over the 'truth' of obesity; what comes to 'matter' too is what should be done about it. Different accounts of the body support or imply different moral and political positions and interfere with what living with overweight might be. A social scientific engagement sensitive to the politics of overweight allows for different ways of knowing bodies, including those emerging in more marginal practices.

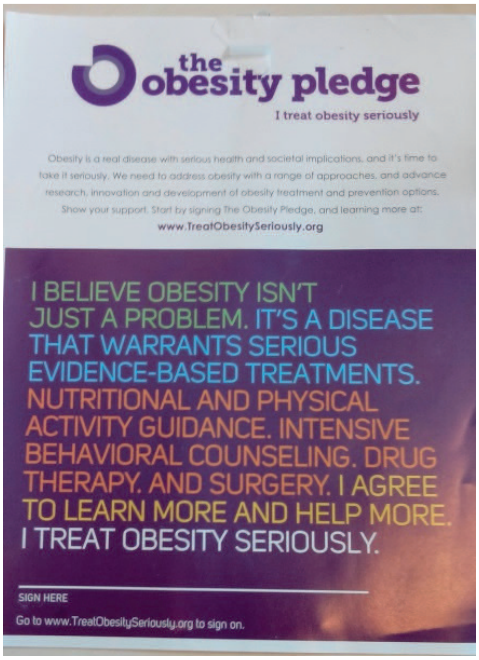


Figure 2. The Obesity Society's 'Obesity Pledge'. ***Photo by the author.***

Engaging with modes of care

To escape normalization and look for different practices of self-care, Foucault delved into antiquity (Foucault, 2012 (1984)). But those interested in alternative ways of living with overweight need not go that far. Despite body weight's relatively clear-cut measurements, care practices do not target a well-defined condition. Instead, being informed by various therapeutic

concerns, they work on altering a wide array of modes of doing, being and relating. It is my contention that by contrasting the different forms of care that come to matter in these practices, we may explore anew how people may craft themselves as bodies and persons through eating and exercise when weight is a concern. These, then, are the research questions that animate this dissertation:

What forms of care emerge in these practices and how do they configure the body and the environment? What may subjects become as they engage in these forms of (self-)care?

In my analysis, I take on sensitivities characteristic of 'actor-network theory' (ANT) and 'material semiotics'; to difference and multiplicity; to techniques, practices and materiality; and to the relations through which entities are enacted and enabled as actors (Latour, 2005; Law & Mol, 2008; Law, 2009; Mol, 2010a). Rather than seeking to identify one totalizing ordering apparatus, I look for *modes of ordering* in care practices (Law, 1994). This term highlights how care depends on a practical arranging of people and things – of subjects, bodies, environments, techniques, professionals and activities. In a particular ordering, certain problems are attended to and particular normative ideals are pursued, while others are left out. I investigate the differences between these orderings, and how they depend on, include or exclude each other.

Different modes of ordering overweight, I maintain, are not just different ways of imagining or approaching overweight. As I said in the opening paragraphs of this introduction, I take each form of care as a particular staging – a way of 'enacting' the world – of bodies and selves, food and eating.[10] Thus, I take from the aforementioned literature the importance of social, political and material environments, but I do not give them causal

[10] The term *enactment* differs from earlier terms used in STS such as *construction* (Latour & Woolgar, 1979) as it does not give powerful and preexisting actors such as scientists the credit of world-making. Instead, it emphasizes the ongoing, mundane work of putting realities into being. Moreover, enactment contrasts with *performance* in as far as the term removes all suggestions that there is a pre-existing doer behind the deed and a (more real) backstage to the performance (Mol, 2002).

force. Instead, I will explore which environments are staged in care practices, and how people's relation to these environments emerges in modes of doing. Moreover, we know the body 'matters', but in my analysis I do not presume the body is a given 'material' entity that precedes practices. Instead, I will study the techniques and procedures through which in care practices particular bodies come to matter. I am not talking about acting *with* the body, or of using the body as a 'prop' (see Goffman, 1959; Zimmerman & West, 1987). Neither do I claim bodies 'have' agency. It is in practices that both bodies and subjects may be *enacted as actors* and gain agency – or not (Law & Mol, 2008). What is enacted changes from one setting to another.

The term enactment emphasizes the performativity of knowledge, what it *does*, what it makes of bodies, of selves, and of the world. But knowledge is not coherent and different kinds of knowledges contribute to different modes of ordering. In her analysis of different forms of dietary advice, for instance, Annemarie Mol (2013) shows that food pyramids or healthy eating plates target the problem that people eat *unhealthy* food as they follow cultural or social routines. To eat well, they should eat proper nutrients and for that they have to take cognitive control. Counting calories, by contrast, addresses the problem of *too much* eating; the practice also requires control, not in shifting routines, but to contain a pleasure-seeking body. Both forms of advice call upon the subject to 'mind' her plate, to moderate and control, and yet they enact different bodies and environments.

In line with Foucault's analytical focus on self-care, here I will trace the various logics that modes of care for overweight are based on, and the subjects they enact. These subjects are neither figures of social construction nor ontologically given. Foucault insisted that the self was a form, not a substance. This form does not remain unchanged, but changes depending on the situations and concerns in which it is relevant. Emerging in diverse techniques such as diary keeping, exercise and meditation, the subject relies on discursive and practical conditions in which it becomes possible to 'concern oneself with oneself'. Crucially, I attend to the *differences* in these conditions rather than to their similarities.

Technologies of the self always have a normative dimension, a 'telos', which is often related to the norms embedded in scientific truth discourses. It

is in this way that self-care can be linked with technologies of power and domination. However, following the specificities of 'care in practice' (Mol, 2008b; Mol, Moser, & Pols, 2010), I explore how in daily life, self-care techniques encounter a range of 'goods' and 'bads'. In the chapters that follow, I look at how a concern with weight comes to affect care practices, is negotiated with other normative ideals – such as self-care, pleasure, sociality and practical considerations – and how it might be transformed by these ideals.[11]

Finally, I hold that engaging with 'matters of care' requires a responsiveness to the complex normativities 'within the very life of things' (Puig de la Bellacasa, M., 2011). Instead of analytical distance, such responsiveness invites 'situated participation' (Haraway, 1991) in a field that is continuously evolving. By analytically contrasting normative ideals I do not deny (neoliberal) power, but I do employ a different normative strategy than external critique in the face of responsibilizing and disciplining apparatuses. To be precise, I engage in a strategic *articulation* of the messy socio-materially embedded relations in practices through which living and caring is done. To study the realities of overweight without reverting to or 'believing in' physiology or medicine is as much a political as a theoretical intervention (Mol, 1999). If reality is done and not given (for instance, if the 'lived body' – the body we come to live in and with – is variously enacted, cultivated and shaped in practices), then in contrasting practices, we may gain new imaginations of living with overweight. Along the way, we may gain new

[11] My interest in eating was able to develop in a thriving scholarly context. The doctoral research this dissertation presents is part of a research project led by Annemarie Mol based in the University of Amsterdam, bearing the title 'The eating body in Western theory and practice'. Studies emerging out of this research project have used eating - a practice that enrolls, incorporates, organizes and transforms food, the body, material surroundings, other people and animals in such profound ways - to theorize, to name but a few, modes of doing and agency (Abrahamsson et al., 2015), relating (Bertoni, 2013; Bonelli, 2014), subjectivity (Mol, 2008a), nature/culture dichotomies (Yates-Doerr & Mol, 2012), and bodily sense and sensitivity (Mann et al., 2011; Mol, 2009). See also the website www.whatiseating.com (last accessed 30 June 2016). The project happened to line up with a renewed interest in eating, metabolism and food practices elsewhere in the social science field (e.g., Abbots & Lavis, 2013; Hillersdal, 2013; Ibáñez Martín, 2014; Just Christensen, 2014; Landecker, 2013; Paxson, 2012; Strathern, 2012).

terms and coordinates with which to value the subjects, bodies and environments that are enacted.

Specifying the field

In order to engage in this research, I conducted ethnographic fieldwork in various sites and situations in which eating, (over)weight and weight loss were a concern. I started with seeking out dieticians, as these professionals play a key role in the shaping of weight care in the Dutch health care system. Dieticians are paid for 3-6 hours per year by the insurance company of the client, depending on the coverage of the client's policy.[12] If a person goes to his/her general practitioner because of their overweight, diabetes or cholesterol, the doctor is likely to refer him/her to a dietician or perhaps to a weight consultant. A weight consultant is, compared to a dietician or nutritionist, a less-trained expert/coach who seeks to help people achieve moderate weight loss without weight loss products or meal replacements. Like a dietician, he/she may work independently with his/her own practice or be part of, for instance, a health clinic, community center or hospital. If the person qualifies as 'morbidly obese' and all else 'fails', or has comorbidities such as sleep apnea, a GP may suggest bariatric surgery, which is a range of procedures on the intestinal system meant to reduce food intake and uptake to induce weight loss.

Most of the people who go to these practices are not just judged by clinicians to be too heavy, but are themselves bothered by their body weight. They may experience pain in their joints or wish to reduce their diabetes medication. Because they have learned their weight might make them sick and cause them to die younger, or because their weight interferes with, for instance, the ability to play with their children, they worry about the consequences of their health for them and their family. In addition, particularly women feel their fat makes them 'ugly' or 'unfeminine'.

[12] For statistics on weight and health problems in the part of the population that sees a dietician in the Netherlands, see Govers et al. (2014).

However, weight care in the Netherlands is not confined to the clinics and consultation rooms of doctors, dieticians and other clinicians. These health care practices, though important, are but a fraction of the range of possibilities offered to people who want to, or feel they 'need to' lose weight. It is, for instance, very likely such people will try one or more of the many commercial weight loss products promising swift weight loss, often with little effort. In 2011, the books of diet guru Sonja Bakker were so popular in the Netherlands that the verb *sonjabakkeren* was added to the dictionary. Other big diet books include those of low carb advocate *Dokter Frank* (2010) and Kris Verburgh's *De Voedselzandloper* (2015). People try mindful eating, opt for shake diets, attend programs like Weight Watchers, start with various exercise regimes or watch and learn from celebrity chefs on television. There are community programs that facilitate exercise in the neighborhood and local gyms that offer nutritional advice and help their members reach their 'goal' of weight loss.

In the field that I ended up studying, then, various credentialed and non-credentialed forms of expertise circulate, including the knowledge and methods people themselves develop in their attempts at weight loss or healthy living. I summarize the practices of the people I worked with broadly as lay and professional *care practices that address issues with bodily weight.* This term helps me to highlight how, in various proposed solutions to overweight, different problems of eating in its relation to body weight are foregrounded. Its looseness allows me to explore anew what is at stake in them.

Methods and analysis

The empirical material that I draw upon results from ethnographically studying contrasts and tensions between and within settings. My research is geographically located in the Netherlands, the place where I grew up and currently live. In contrast to an ethnography in a strange place, where the researcher needs to immerse herself in the new surroundings, an ethnography 'at home' requires the researcher to shift between several sites in order to stay sensitive to, and actively craft, strangeness (Marcus, 2009). In order to be able

to tell surprising stories about familiar practices, the task thus consists of bringing out and articulating contrasts, through the method of *involved* description and re-scription (Harbers, Mol, & Stollmeyer, 2002).

An important part of the empirical material gathered for this project comes from participant observation. I did not deem long-term participant observation in one particular clinic or research center suitable for this project for both practical and theoretical reasons. As the goal was to see tensions and differences between various settings, moving around allowed me to learn more. I observed and attended meetings, joined in on exercises, and sat in with consultations in various settings. Among the interventions that I studied are diets, fitness programs, lifestyle coaching, and mindfulness courses.

In addition, I conducted over 20 formal and informal interviews with dieticians, weight consultants, coaches, doctors, nutritionists, psychologists, physiotherapists, fitness trainers and one surgeon. These informants were initially recruited through a call on the website of the professional society for dieticians, and then through snowball methods. In addition, I interviewed 20 people who have tried to lose weight in various ways, most of whom were recruited through an obesity clinic that also offers bariatric surgery. The interviews took place in various parts of the Netherlands, in clinical settings or in the homes of the informants.

The questions I asked were concerned with the knowledge that informants have about the practices they are involved in. Simply put, I asked what they do and why. My questions focused on bodily practices – what the informants say they do to make themselves healthy, slim or satisfied or to understand their body's workings; and what problems or difficulties they find with their specific approach, often relating to concrete situations that happened recently. In this way, I listened to my informants as if they were their 'own ethnographer' (Mol, 2002: 15). I taped these interviews and transcribed them.

I did not select informants on the basis of pre-set categories such as class, urban/rural, education, ethnicity, and except for stating their gender, I do not categorize my informants accordingly. In doing so, I wish to avoid giving the impression that by reference to these categories I might somehow explain the complex practices people engage in (cf. Akrich & Pasveer, 2004).

In this sense, I follow the rationales of care practices themselves: while people and their clinicians may think epidemiologically about disease, they also always start with the particularities of their own or their client/patient's situation, concerns and capacities. For instance, a dietician, when encountering a client, may realize that gender, class or culture 'matter', but *in what ways* remains to be explored: Does the client have a restricted budget? Who does the cooking in the family, what kinds of food are preferred and what is the level of culinary skill? How do work schedules affect eating patterns? To what others does a person compare him/herself and his/her body to? In a different vein, for some of these care practices, in which a 'service' such as an exercise program is offered, inclusion criteria may implicitly or explicitly privilege or invite certain kinds of people over others, but then, the program is the same regardless of the client's specificities. These practices thus make social differences and coherences in their own ways – ways that shape which and how problems are worked on. These differences may or may not line up with epidemiological and sociological distributions of people (Latour, 2005).

To learn more about how care practices differed from other settings in which obesity is a concern, for instance in how they enact bodies, translate norms or address people with overweight, I also visited research facilities, including an experimental setting in a department of human nutrition and a psychology laboratory studying self-regulation. I went to scientific conferences, visited public health interventions and kept track of discussions of obesity in the media. In addition, I took into account written material and images such as flyers, scientific articles, programs and websites, obtained through both asking my informants for recommendations for these sources and searching myself. Documents, graphs, diaries and other tools that professionals use in their practices also contribute to the enactment of certain configurations of eating, bodies, subjects and food. My task in analyzing them, then, was to tease out the kinds of techniques that were included, what realities they created and how bodies and subjects figured in them.

The chapters

Chapter 2 explores the diverse ways in which dieticians, weight consultants and other health care professionals address their clients. I compare them, and the realities they enact, to the ways public discussions around obesity depict certain subjects and bodies. The goal of this chapter is to open up a space for a productive normative engagement with obesity care that attends to 'clinical specificities', while moving beyond dominant logics in public debate and the critiques against them. **Chapter 3** draws on exercise practices in the Netherlands in which there is a primary concern with weight. I contrast a metabolic logic that premises metrification of bodies, exercise and food with a logic that aims at activating the body's metabolism and increasing vitality. What becomes apparent is that how knowledges, metrics and techniques narrate eating, bodies and moving together variously shapes what constitutes 'healthy living'. In **Chapter 4**, which I co-authored with Annemarie Mol, we aim to learn about bodily sensitivity from the practices of professionals who critique the idea that healthy eating implies practicing self-restraint. They instead work to cultivate their clients' capacity for pleasure. Here we explore the conditions of possibility for feeling the body 'from within'. **Chapter 5** is about a mindful eating course that in order to address problems with eating, engages with hungers that are not fed by food. In doing so, its practitioners interestingly shift therapeutic goals from a normal body to a good life. The aim of this chapter is to articulate an alternative normative register to normalization. **Chapter 6** interferes with the assumption that self-care and support are opposites. It draws on fieldwork in an obesity clinic in which patients who are deemed 'morbidly obese' undergo bariatric surgery. I analyze the ways through which these patients seek to become active subjects capable of self-care, paradoxically by arranging support and subjecting themselves to treatment. Lastly, **Chapter 7**, draws together theoretical insights from the empirical chapters to engage anew with the question laid out in this introductory chapter of how to care for overweight. It thus forms the conclusion of this doctoral work.

Chapter 2

CLINICAL SPECIFICITIES IN OBESITY CARE[13]

The transformations and dissolution of 'will' and 'drives'

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*

[13] Originally published as: Vogel, E. (2014). Clinical specificities in obesity care: The transformations and dissolution of 'Will' and 'Drives'. *Health Care Analysis*, 1-17. doi:10.1007/s10728-014-0278-3.

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.[14] 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,[15] is cast

[14] In this debate, obesity, being overweight and weight gain are often used interchangeably as part of the same problem (e.g. WHO, 2010).
[15] 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 behaviour (Howell &Ingham, 2001) and can pave the way for *laissez-faire*, neoliberal public health policy (Cannon, 2005).

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' (Mulder, 2011).[16]

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 the causal force within the body is combined with societal forces, the 'obesogenic environment' (for a critique, see (Guthman, 2013). 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

[16] 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.

> highlight a reality: that the forces that drive obesity are, for many people, overwhelming.' (Government Office of Science, 2007: 5)

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. Chang & Christakis, 2002). 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 (Van Hoyweghen, Horstman, & Schepers, 2007) and health promotion (Dougherty, 1993).

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. Latour, 1993). 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 (Sharkey & Gillam, 2010), in public health policies (Muroff, 2011; Womack, 2012) or doctor's practices (Persson, 2013). In this literature, overweight tends to be posited as deriving from 'voluntary behaviours over which the patient has *some degree of* control' (Pearce & Pickard, 2010: 1, 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 (Feiring, 2008; ibid). 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 (B. Evans, 2006; Gard & Wright, 2005; Inthorn & Boyce, 2010). 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 (LeBesco, 2011; Monaghan, 2007). 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 (Evans & Colls, 2009; Henwood et al. 2011; Knutsen & Foss, 2011). 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' (Evans et al. 2004; Wright & Harwood, 2009).

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. Mol, Moser & Pols, 2010), 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 (Struhkamp, 2004: 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[17], 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.[18] 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* (Law, 1994), this paper articulates with the manifold relations and logics embedded in local practices (Akrich & Pasveer, 2000; Law, 2009; Mol, 2013; T. Moreira, 2006; Moser, 2005; Pols, 2013a). 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 (Struhkamp, 2005), the 'patient perspective' (Pols, 2005),'patient choice' (Mol, 2008b) and 'scientification' of clinical practices (Lettinga & Mol, 1999).These works have brought out the

[17] 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.

[18] 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'.

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 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[19] 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

[19] 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' (Prior et al. 2000: 836).

> 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 (Gingras & Aphramor, 2010) 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. 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.[20] 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.

[20] 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. Yates-doerr (2012) on *ansiedad*.

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.[21] Since clinical practices do not primarily invest in explanation, but in change (cf. Mol, 2008b; Moser, 2010), 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 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.'

[21] 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 consultation (Webb, 2009) or in the achievement of satiety in a family meal (Laurier & Wiggins, 2011).

The technique of 'motivational interviewing', as in the above description, aims to strengthen people's will.[22] 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

[22] See for a discussion on empowerment as a technique/process and/or a goal, Tengland (2008).

> 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 Mol & Law, 2004). 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 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 (Vogel & Mol, 2014).[23] 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

[23] For an analysis of how (theorizing on) subjectivity changes when attending to eating practices, see (Mol, 2008a).

> 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.'

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 analysed 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.[24] 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. Mol, 2006; Moser, 2010). 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

[24] 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 (Bacon & Aphramor, 2011; Burgard, 2009), 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'(Burgard, 2009: 42).

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 analyse that even though, as specifications and translations are central to the clinical practice, generality cannot be found.

Chapter 3

METABOLISM AND MOVEMENT

Calculating Food and Exercise or Activating Bodies in Weight Management

Abstract

In the Netherlands and elsewhere, exercise is increasingly the means to compensate for an otherwise sedentary lifestyle. In this article, drawing on ethnographic fieldwork in weight management practices, I argue that how knowledges, metrics and techniques narrate eating, bodies and moving together profoundly shapes what constitutes 'healthy living'. Some bodily metaphors used by health professionals premise *calculating* food and exercise to ensure energy balance, while others point to eating and exercising as ways of *activating* the body's metabolic rate. I show how the first approach incites a desire and sense of responsibility in people to have control over and correct their bodies, while the second, foregrounding less measurable forms of health, hinges on a person's responsivity and trust in other active entities. The differences between these 'metabolic logics' matter, I argue, because they shape how, in the context of the 'obesity epidemic', people may live with and value their bodies.

Keywords: *exercise, eating, metabolism, health promotion, food, body*

Introduction

How do eating and moving relate? In the context of the reported 'obesity epidemic' in the Netherlands, in which health is increasingly equated with 'a healthy *weight*', their relation seems straightforward: people are getting heavier because they eat more and move less. It follows from this apparent lack of movement that people need to exercise more. The idea that 'exercise is good' fuels many health care practices, diet and exercise regimes, and obesity prevention programs. Likewise, the concern with weight, strengthened by both health and cultural/aesthetic norms, contributes to people's attempts to make 'healthy changes' in their lives.

While recognizing the seriousness of the health issue (Moffat, 2010), anthropologists have also expressed concerns with the hidden perils of individualizing, calculative strategies to health proposed in public health agendas (Greenhalgh, 2015) and in commercial weight loss programs (Darmon, 2012; Heyes, 2006). However, careful not to analyze 'biomedicine' as a monolithic set of normalizing practices and discourses representing 'health according to science', others have shown 'nutrition-in-action' (Yates-Doerr, 2012b) and 'practice-in-the-making' (Ferzacca, 2000) allow for alternative, idiosyncratic strategies and modes of relating for both professionals and patients/clients. Moreover, in practices we see that *what* facts and sciences are drawn upon also turns out to be of pivotal importance in what constitutes 'healthy living' (Mol, 2013).

In this article I focus on exercise practices in which there is a primary concern with weight.[25] My concern is with the modes of relating to one's body that are offered in these practices. I contrast two 'metabolic logics' with each other: two more or less coherent, but strikingly different notions of how eating and exercise may change bodies and lead to health and weight loss. One emphasizes '*calculating*', the other '*activating*'. I investigate how the knowledges, metrics and techniques that come with these metabolic logics both transform practices and are transformed there in situated ways.

[25] Thus not taking into consideration other concerns that come up in exercising, including personal achievements, competition, sociality etcetera, though all these may go together with a concern with body weight.

As is well described, dietary management emerged out of typical industrial concerns with productivity and labor. For governments and employers, the measurement of the calorie presented scientific 'standards of living' that contained wage levels while maintaining a healthy, productive workforce (Cullathar, 2007). Recommended dietary intakes (RDI) have their origin in a similar early nineteenth century context where such 'dietaries' had to ensure that the nutritional needs of inmates and patients were met (Mudry, 2009). The industrial metabolism of a 19th century biology concerned with labor and efficiency models the body after the factory (see also Rabinbach, 1992). As science historian Hannah Landecker (2013) details, it mirrors a theory of value in which raw materials are converted into manufactured goods, presenting pathology as disruption due to broken parts in the productive machinery.

Recently, anthropology, Science and Technology Studies (STS) and other social sciences have seen an increased interest in 'metabolic relations' (Abrahamsson et al., 2015; Bertoni, 2013; Cousins, 2015; Guthman, Broad, Klein, & Landecker, 2014; Kendrick, 2013; 2013; Levin, 2014; Solomon, 2014). This interest emerges from concerns with ecology and food production as well as with the politics and effects of the increase in 'metabolic ailments' of the modern world, such as obesity and diabetes. Current social scientific attention to metabolism, moreover, runs parallel to changing ideas in the field of biology on what metabolic processes are and do. As Landecker argues: concerns have shifted from how *matter transforms through bodies* to how *bodies transform through matter*. Rather than broken parts, postindustrial pathologies are regulatory crises (2013: 496). New scientific understandings of food and bodies complicate the values embedded in industrial models of metabolism (ibid, 2011). Part of the current appeal of 'thinking metabolically' is its challenge to Western assumptions about embodiment, cognition and control (Kendrick, 2013; see also Wilson, 2015).

In this article, my concern is with the ways that certain accounts of metabolic relations, in relation to certain health concerns, shape consumption. Even in postindustrial times, figures of bodies as factories and food as building blocks are built into techniques of knowing, shaping and restricting the contemporary foodscape and its effects on the body. In the process, exercise –

a substitute of labor – became a part of metabolic practices. 'Working out' is a way to intervene in the conversion of food into matter and energy. It is thus not just food that has been grown and bodies that have been fed by such metabolic logics, but also people's desires and hopes for their bodies and the techniques that are made available to them. In the health practices I study, these feelings are central.

In my analysis, I approach the two metabolic logics as particular 'modes of ordering' (Law, 1994; Moser, 2005) people, bodies, food, exercise and the environment. These modes are also different modes of doing *good*, as facts and knowledges inform and are weighed with certain ideal bodily states and effects. Because although the basic idea that 'moving is good' was usually taken for granted in my fieldwork, there were different accounts of what good it does and for what.

As the concern with an 'active lifestyle' is taken up in health care practices, moving is predominantly put forward as an important compensation for excess ingestion. In the first part of this paper, I further investigate how this logic shapes practices and orders moving in a certain relation to eating that premises calculating as a strategy to ensure energy efficiency and weight loss. I contrast calculating with another practical logic, one aimed at activating people's metabolic rate in order to enhance the body's vitality. In the first, exercise is foregrounded for its ability to burn energy; in the second, it is mobilized for building vitality. These modes of ordering are not just two alternatives, but relate to each other. As will become clear, the second, foregrounding activating, responds critically to the first, which is more dominant. I stress that these orderings are achieved in health practices and that people are not caught up in one of them, but may move between both and many others in their lives. Nevertheless, by contrasting their characteristics, and by showing how their ordering is achieved in practice, this analysis offers insights into the multiple ways concerns with body weight may be embodied and expressed.

Health care professionals I met used metaphors such as battery, fire and organism to talk about the body. Though metaphors of the body and illness have been analyzed as representations with a certain symbolic power in society (Martin, 1987; Martin, 1994; Sontag, 1978), I will analyze these

metaphors as part of health practices in which they contribute to the modes of ordering I describe. I suggest these are more than projections *onto* metabolism; metaphors change what metabolic processes are and how they may transform. Particularly as the body and its weight become in need of correction or intervention, the meaning of metaphors lies in their *presentation* of certain 'modes of action or ways of life' (Kirmayer, 1992: 323). Drawing 'on salient features of the vehicle to make latent features of the topic more salient' (Kirmayer, 1992: 332), metaphors configure the body as having certain properties as well as foreground certain valuations of these bodies.

Methods and analysis

This study was part of ethnographic research in the Netherlands between 2011 and 2014 on sites and situations in which the concern with obesity is somehow present, ranging from dietary advice, fitness programs, mindfulness courses, obesity surgery and lifestyle coaching. I conducted over 20 formal and informal interviews with a number of dieticians, weight consultants, coaches, doctors, nutritionists, psychologists, physiotherapists, fitness trainers and one surgeon. Central to these interviews was the professionals' way of working, the techniques they use in their work and their strategies to help their clients or patients. A number of these professionals were also observed in their work with individual members, clients or groups. In addition, I interviewed 20 people who were striving to lose weight in various ways, inquiring about their attempts to lose weight or get healthy. I recruited these people through snowball methods or through the clinical sites where I did my fieldwork. Informants were anonymized and field notes and interview transcripts were translated into English from Dutch. I also read and analyzed policy documents, public health research, popular publications and books of several professionals, and other relevant written material.

Metabolic logic 1: Calculating input and output

Pieter is a cheerful, light-spirited 19-year-old student. After he quit his teenage fencing career because of an injury, he gained 40 kilos in six months, which he attributed to a lack of exercise and his newly adopted 'student lifestyle'. When just paying attention to his own eating habits and adding a little exercise to his daily routine did not result in losing the weight he gained, he followed a rather rigorous diet. For two months, he ingested only 500 calories a day by means of special banana- and strawberry-flavored diet shakes. Compared to the recommended dietary intake for adult men (2500 kcal a day), Pieter's daily calorie intake was very little. He complemented his diet with working out, using the gym's 'cardio training' machine that had him move his arms and legs diagonally and forward and backwards. Combining these two techniques of bodily control, diet and exercise, Pieter quickly lost 27 kilos. He was excited to share his success with me:

> 'If you are on a cross trainer, well you see you have burned 500 calories at some point, so then I didn't eat anything that day, net. So I worked out, and then I effectively didn't eat! This probably sped up the process (of weight loss).'

Striking in Pieter's weight loss project is the clear presence of the notion of zero-balance. When he effectively 'doesn't eat' by burning these calories in the gym, his body will start using up the excess stored energy and lose weight – or so his logic goes.

Pieter is joined in this reasoning by many others who use similar strategies of weight loss, but also by the Dutch national nutrition center, the *Voedingscentrum*, an important source of information for both citizens and health care professionals. I often encountered the 'wheel of five', the Dutch equivalent of the food pyramid published by the *Voedingscentrum*, in my fieldwork with health care professionals. On their website, what constitutes and leads to a 'healthy weight'[26] is a central theme. Under the heading 'My

[26] Defined as a Body Mass Index of 18,5-25 kg/m^3.

weight' and then 'Energy balance', the reader is encouraged to look at their body as if it were a battery:

> 'The battery charges with food. It depletes by using that energy from your food. Someone who moves a lot uses up a lot of energy. But when you eat more than you use up, your body will store the unused energy as fat. You will get fatter. When you eat less than you use, you lose weight.'[27]

Moving is thus put forward as a possible *compensation* for ingestion. Pieter and the *Voedingscentrum* configure body weight as a matter of energy balance in which eating and moving can be captured by the same measure: energy. Foods can be measured according to the amount of calories they offer to a body, a measure of the kinetic energy of heat inside a foodstuff.[28] The exercise metric equivalent of the calorie is the MET, the Metabolic Equivalent of Task. One MET is defined as 1 kcal/kg/hour and corresponds roughly to the energy cost of sitting quietly for one hour.

With these measures, activities and foods can be made equivalent to each other: Fries contain 20 times as many calories as boiled potatoes. Walking up the stairs for five minutes equals the energy spent watching television for an hour. Likewise, food can be converted to moving and the other way around: In 96 minutes of moderate walking, one burns the energy one took in with a portion of fries. In the equation of energy balance, then, food and exercise are quantified, and moving is the 'other' of eating: they can even each other out.

The arithmetic activities of exercise regimes and dieting depend on further sociocultural structuring. In many places, 'western' and otherwise, food already enters people's food practices as 'measured' (Mudry, 2009): through conventional units of food and exercise; store packaging; and displays on machines, lists or apps (cf. Lave, 1988). Counting is further facilitated by

[27] (Last Accessed February 26, 2016, http://www.voedingscentrum.nl/nl/mijn-gewicht/gezond-gewicht/energiebalans.aspx)
[28] One kilocalorie stands for 4.18400 kilojoules of energy. 1 calorie equals the amount of energy needed to heat one gram of water with one degree Celsius.

the fact that packaged foods usually bear food labels indicating the amount of calories per portion or 100 gram. With regard to exercise, the Compendium of Physical Activities, developed in the 1980s and updated every few years, indicates the energy expenditure of a large number of activities, as diverse as light bicycling, crab fishing and tap dancing (3,5; 4,5 and 4,8 METS, respectively) (Ainsworth et al., 2011). Originally developed for standardizing self-report physical activity scales of people participating in epidemiological studies, it is now used for exercise and weight management programs across the globe. In gyms, the calorie counters on apparatuses that show the amount of calories burned after a workout, as well as those on apps and websites, are based upon this compendium (and are thus not a reflection of a person's actual energy expenditure). The *Voedingscentrum*, Weight Watchers and many other organizations and companies, offer apps and 'activity trackers' that allow one to keep 'diaries' of weight, exercise levels and how much and what has been eaten, thus making healthy living a matter of bookkeeping in which 'credits' and 'debits' have to be balanced together (Yates-Doerr, 2015).[29] This particular project of weight loss, then, is part of, and draws upon, a vast network of knowledges, techniques and standardization that spreads out far beyond the Netherlands where the *Voedingscentrum* is operative.

The power of black-boxing

With its metaphor of the battery, the *Voedingscentrum* aims to make the logic of the energy balance intelligible for a large audience. In so doing, it evokes what has been described as a decidedly modern, mechanistic vision of the body that can be understood in input/output terms (Turner, 1982). When one moves, one 'uses up energy' that once came in through food, much like a car uses up fuel. Indeed, in my fieldwork, I witnessed professionals draw upon the figure of the car to explain a similar logic of efficient energy use. It is interesting to compare these metaphors of the battery and the car. Whereas a

[29] Wearable technologies such as watches and apps track much more than input and output of energy. According to Natasha Schull, they open up a particular form of self-care that she calls "data for life" (2016).

dietician would use cars to bring into view the qualitative *variety* of bodies and food – saying, for instance, that a diesel car cannot drive on gas, and a jeep needs more fuel than a mini cooper – a battery presents no such particularities. Further, while a driving car brings out the productivity of the body's labor and has an implicit notion of needs (diesel or gas), a depleting battery evokes the body as a passive resource for use, a mere storage of energy.

Unlike the battery or car, which cannot charge or fuel further when full, a body will grow to accommodate excess energy. 'Unused' energy is not excreted, but will sediment in the body. As portrayed here, then, it is not bodies that (should) balance, but people. Energy balance moves from being a mechanism that explains weight gain, to a technique. To be clear, many professionals would assert that strict calorie counting runs the risk of missing important nutrients. Adding the requirement that the food that is eaten contains enough nutrients, however, need not fundamentally alter the calculating scheme; it merely complicates it. The purpose of exercise is still the burning of calories. Moreover, the efficient use of energy and the aligning of input and output is foregrounded as a *project* of the person, rather than a capacity of the body. After all, if the body could balance 'on its own', weight would not be gained.

When the capacity of the body to 'energy balance' *is* foregrounded, it is as a complication: in my fieldwork at scientific conferences, several presentations on the health benefits of certain dietary or exercise regimes discussed the problem that people compensate 'on the other side'. For instance, when on a diet they will move less, or when exercising more they will eat a few bites more. This type of behavioral compensation may happen outside people's awareness and thus often escapes self-report questionnaires, to the frustration of researchers.

Rather than describing the body *as* a battery, then, the reader is encouraged to treat his/her body *as if* it were such a mechanical object. This metaphor is thus not only indicative of the symbolic power of cultural and technological contexts, but also brings certain things and practices into view while foreclosing others. The equivalence of food and exercise has the advantage that counting is generally applicable to all food and exercise, and to

all people and bodies. Much is ignored in the process. As bodily needs are reconfigured to quantitative measures, the quality and peculiarity of what one eats can no longer be part of the equation. Foods grown and processed in very different ways are made equivalent to each other in terms of their nutritional content. In addition, records of intake and expenditure are based on population averages and do not take into account the individual and temporal fluctuations of uptake, processing and storage caused by, for instance, cooking techniques and bodily processes. In targeting all people, then, this information is not for anyone in particular.

This elegant generality, however, is ideal for health promotion campaigns. Energy balancing can be done without knowing much about what calories or METs are and how metabolic processes work. Anthropologist Emily Yates-Doerr, borrowing a term from Bruno Latour (who in turn borrowed from cybernetics), points out that these mechanisms are often 'black-boxed' in nutrition education (Yates-Doerr, 2012a). Latour describes a black box as 'a piece of machinery or a set of commands' deemed 'too complex' to grapple with; as soon as it works, 'in its place they draw a little box about which they need to know nothing but its input and output' (Latour, 1987: 2-3). As long as the strategy of counting does what it needs to do – as long as it has decisive *effects* – it is not deemed necessary, and may even be very inefficient, to attend to the precise mechanisms involved.[30]

People's weight loss strategies are often characterized by a similar pragmatism. Pieter's practice of balancing energy required him to know only two things: how many calories he ingested and how many he burned. Thanks to his diet products offering standard packaged portions, he did not have to calculate exactly how many calories the 'food' he ingested contained: this was always 500 kilocalories. On the display of this machine, he could see how many calories he had burned so far – or rather, what the average person of his height, age and weight (variables he inserts beforehand) will burn on that machine in that time.

[30] Here, metabolic processes are not just too complex to understand; measuring individual food expenditure and intake is also practically impossible in daily life. Currently, such precise measurements can only be done by confining a subject to a 'calorimeter' where his/her food intake is controlled and carbon and oxygen emissions are measured.

As Pieter tells me, he had to start eating 'normally' at some point again. Since he stopped drinking his shakes two months ago, watching his 'energy balance' every day became more complicated. Now, practical considerations play into his everyday calculations:

> 'So I eat three sandwiches, maximum four sandwiches a day. And in the evening just a piece of meat with vegetables. And if you add that up then you will not go above the 1500 calories so I will at least have some space for when someone comes by with cookies or something, then at least you can have something, at least you have a buffer. And with sports, if I eat a lot, most of the time I will work out a lot the next day. To strive to burn as many calories as possible. (…) Strive to, I don't know, burn 1000 kilo calories in an hour (…) And if you take in only 1500 calories for dinner and bread on one day then you ingest actually only 500 calories, that is not such a big deal.'

In this logic, possible events causing fluctuations on one end of the equation, such as friends offering food, can be compensated on the other end – one snack 'stands for' an hour of exercise, exercise can leave space for a cookie in the evening. In other words, working out becomes 'working off'.

In her study of how people enrolled in a Weight Watchers program count, Jean Lave (1988) notes that measurements and their meanings are variously transformed in practice. For instance, the more expert the dieter, the less calculating is necessary. She describes two possible approaches for counting calories in practice: people either meticulously control food portions or go with the idea that 'as long as I feel hungry I must be losing weight'. Pieter's strategies show similar, but slightly different creative adaptations to the arithmetic logics implied in calorie counting. He stays well under the norm, for practical reasons. He will eat fewer calories during the day to ensure that he will not get into trouble later on. Further, he only takes into account how much he has burned in the gym, and not all the other ways in which he moves throughout the day. What matters to him is the movement that is counted (e.g. I burned *at least* 1000 kcal today). How much he moved exactly is

not relevant as long as he stays within safe margins and keeps his ingestion under control.

Control

This metabolic logic stressing calculating comes with a mode of ordering that stages exercise as the 'other' of food, as the means to 'spend' the calories ingested. The body is portrayed as a vessel storing or using energy, and metabolism is black-boxed as the mechanism through which food is processed and neutralized. Exercise is here foregrounded for its ability to diminish and shrink the body's fat and weight or to prevent the body from growing and storing energy in the first place. For this project, both exercise and food *have* to be made knowable for you to know what you are allowed to eat, or whether you undid the 'damage' caused by eating. By staging input and output as in need of balancing, activity becomes something that can be isolated, calculated, monitored, and accounted. Movement is to be counted: what matters is *how much* you exercise.

An industrial model of metabolism, described by Landecker (2013), stages food as the raw material of labor. The knowledges and techniques it emerged from stressed a concern with how much one should eat in order to *work*. Exercise is wasteful, as energy could instead be spent on useful labor. In this metabolic logic, on the contrary, exercise is undertaken to (be allowed to) eat or to undo the damage done by eating. Rather than a concern with production and working bodies, there is a concern with consumption and its excesses. This metabolic logic fits a context in which most people are no longer engaged in manual labor but spend most of their days at a desk, in a 'sedentary' lifestyle, in which using up energy is no longer taken for granted. Overweight is evidence of indulging in food while failing to compensate with exercise, a situation to be corrected by proper bookkeeping.

In the 'calculating' mode of ordering, then, losing weight, both as a population (in obesity prevention policies) and as an individual (in commercial diets and health care practices), is the main concern. What Pieter and others like him value in this practice of counting is exactly this

manageability of the problem. The 'starve and sweat' mantra that aims at minimizing food intake and maximizing expenditure has a specific temporal ordering too, playing out on the daily cycles of input and output. Built into it are promises of both immediate successes (burning 1000 kcal!) as well as considerable results in a short period of time (losing 40 kilogram in 4 months!). Of course, there are more modest versions of accounting strategies as well. The point is, however, that counting enacts these successes as within the control of the person, who can decide how much effort and suffering one is willing to put into it. On the website of the *Voedingscentrum*, the reader is explicitly interpellated as responsible for his/her weight:

> 'Whether you are energy balanced [*of je in energiebalans bent*], is mostly up to you. You, after all, decide how much you eat and how active you are.'

This mode of ordering thus responds to and incites a desire and sense of responsibility in people to have control over and correct their bodies. This resonates with Lee Monaghan's observation, based on his fieldwork in a fitness center, that 'constructing fatness as a correctable problem entails calculability, efficiency, predictability and technological control' (2007: 70): a body shaped according to principles of rationalization.

The pitfall of this project of weight loss, however, lies in this ability to remain in control. Practically, control is often not 'really' possible; practices are made knowable, but they also seem to only count when they can be counted. This is not just evident in how Pieter pragmatically uses his calculations, but also in how the metaphor of the battery itself is a technique rather than an explanation of one's bodily workings. This elusive and requisite ability to remain in control resonates with a growing concern in the obesity field with the notorious ineffectiveness of weight loss and exercise regimes, especially in the long run (Douketis, Macie, Thabane, & Williamson, 2005; Gudzune et al., 2015). Typically, participants are able to 'keep up' with the schedule for a few months, lose some weight, then 'succumb to temptation' (food, the couch), gaining what they lost and more. Usually, then, another

cycle, played out over a longer period of time, can be observed, in which periods of control are alternated with periods of release. It is precisely this ability to stay in control – to keep one's hands on the wheel – that a calculating strategy hinges on.

Metabolic logic 2: Activating metabolism

Some of the caring practices that I encountered in my fieldwork that were explicitly concerned with exercise similarly put forward the ingestion and expenditure of calories. Like the *Voedingscentrum*, these practices proceed from the knowledge that if one moves more, one uses up more energy. But rather than directly linking to weight management through energy control, this knowledge is mobilized as part of quite a different logic that I saw emerging in my fieldwork with trainers and dieticians. As an introduction to this second mode of ordering, consider the approach of Sarah de Hoop, who has a private practice as a weight consultant in a small town in the northern Netherlands.

> 'In classes I give at a local gym, I try to get women to do strength exercises. They are always afraid they'll turn into body builders, but then I explain that won't happen that quickly, but that it is very good because muscles will use up much more, even while you are sleeping. This thought usually appeals to them [laughs]. Losing weight while sleeping? A lot of people do cardio training, because that will make them lose weight. Sure, true, but it works only for a short time, while if you build muscles you will profit from this for 24 hours.'

Fabian and Christel, a couple running a franchise of an international circuit training program for women, work on building muscles too: workout sessions in their gym consist of 30 minutes, in which 1-minute strength exercises on hydraulic pressure machines are alternated with exercises on aerobic steps.

They stress that they aim to improve health and achieve weight loss for their members by activating the body's metabolism. As they welcome me in their fitness club, Fabian talks a lot while Christel occasionally interjects. They tell me that when the goal is to activate the body's capacities to transform food into energy, eating and moving are not each other's opposites, but have to work together:

> Fabian: 'So exercise is key to losing weight and keeping up the burning, but good eating is key to having energy and building muscles; it is an inextricable combination. You can show people that when they eat well, their energy will increase substantially. And then sport starts paying off too.'

Here, metabolism, understood as the process that ensures the release of energy in the body, is the object of intervention and care itself. It is presented as a fire that can intensify or diminish. Not only is food presented as building blocks, fuel that can feed this fire in order to increase energy, but exercise is also enacted as a way to keep energy expenditure going, much like oxygen does for fire. In order for sports to 'pay off', then, people who increase their exercise should eat more. Both need each other.

Recently, Fabian and Christel started collaborating with a dietician to incorporate advice on food and eating into their program, because they noticed this was often 'an issue'. In order to give an indication of bodily needs, the fitness center uses the 'basal metabolic rate' (BMR) to measure the energetic needs required to keep the vital functions of the body going when it is in rest. In order to accurately measure an individual's BMR, one would need a laboratory – however, formulas are available that approximate this BMR, varied by age, gender, height and weight.[31] For the average person, the BMR amounts to around 1500 calories a day. Fabian stresses that regularly active people may even need around 2800 calories a day. Christel shows me menus that make up 2000, 2300 or 2800 calories, which are meant to give their

[31] For instance with the Mifflin St. Jeor Equation: For men: BMR = 10 x weight (kg) + 6.25 x height (cm) – 5 x age (years) + 5; For women: BMR = 10 x weight (kg) + 6.25 x height (cm) – 5 x age (years) – 161.

members an idea of how much food that is. The selection of food, moreover, takes into account nutritional content and the proportions of carbs, fats and proteins in one's meals. Such menus are a common tool for dieticians, through which they translate the meaning of calories and nutrients to conventional meals and food items. One such menu, adding up to 2615 calories, includes:

> Breakfast: 2 slices of whole-wheat bread with diet margarine, egg salad, a slice of aged cheese and 1 glass of semi-skimmed milk.
> Snack: 1 currant bun with diet margarine and 2 mandarins.
> Lunch: 3 slices of whole-wheat bread with diet margarine, with diet spread cheese, a fried egg and a slice of lean meat.
> Snack: 1 fruit, a glass of semi-skimmed milk, one cup-a-soup, 2 slices knackebrod, diet margarine and 50 grams of smoked salmon.
> Dinner: 125 lean meat or fish, 15 ml of oil/butter, 200 grams of potatoes or 100 g pasta/rice and 200 grams of vegetables.
> Snack: 1 piece of fruit, 1 bowl of vanilla custard, 2 crackers, diet margarine, aged full fat cheese and raw ham.

These lists stage food such as bread, potatoes, milk, and vegetables as the norm, as opposed to, for instance, fast food or cookies and crisps, which according to Fabian are not very helpful. These lists are not to be followed rigorously, and members are not encouraged to do calorie counting, but they are distributed to help people 'get it': when moving, one needs to eat *well*. Food, in this logic, is potentially a facilitator and activator. So not only are eating and exercise no longer each other's opposites, they also change character: in this mode of ordering, what kind of moving you do (muscle building instead of cardiovascular training) and what kind of food you eat, matters.

Conditions for thriving

Often, this message that one should eat more is met with joy and amazement: 'Am I allowed to eat all that?' In their practice, however, Fabian and Christel

also encounter one major obstacle for this activating project: out of a desire to slim down fast and a fear of gaining weight, their members often do not eat nearly enough to be exercising. According to Fabian and Christel, this behavior risks jeopardizing the health of their body and is counterproductive in the long run.

> Fabian: 'I try to confront my members: so how long do you think 1200 calories is healthy for your body? Isn't that just bad for your organs? That is just crashing. [...] If you give the body too little, the body will slim, because... it is just a natural organism responding, and it thinks like: I am ingesting too little, I need to respond. But it will slim down where it should not; it turns down the fire. [...] So you lose muscle tissue and keep the fat protecting the body, because that is its reserve. [...] The effect food has when people consistently deprive their body of it... if you give it enough for once, all kinds of things start happening.' Christel: 'Hair growth, glowing skin... Their digestion and bowel movements normalize, really: unbelievable! You think, man! And all this reveals itself when you start caring for it.'

Christel points out that if moving and exercise are seen in combination, they may do great things to the body. If one stokes the fire in the right way, one might even start glowing. Further, Fabian makes a distinction between *kinds* of weight loss: one made possible by bad, unhealthy 'crash-dieting', the other by 'caring', healthy practices. The first kind causes people to quickly gain weight as soon as they start eating again – leading to the notorious 'yo-yo effect' – but also makes all kinds of processes in the body function less well; their skin turns pale, their mood goes down, energy is low and digestion falters. Metabolism will slow down and go into 'saving mode': muscles, a readily accessible energy storage, will be eaten, while fat, the body's 'reserve' and insulation, is retained. Once the body has received enough food again – and the dietary intervention aims to ensure this – it will be able to take on its full range of functions, and thrive. As the bodily processes between the 'input' and 'output' of energy are thus foregrounded, evaluations shift: when stressing

that the body does something *valuable* with food, low-calorie food is not 'good' because it does little 'damage', but 'useless' because it gives the body nothing.

In order to bring out all these processes, Fabian calls the body an organism, an entity outside of 'we' or 'you' that eats and does certain things in response to our actions. This organism interprets little food as a crisis. It will slow down and go into 'survival response', protecting itself against scarcity. Food, then, is here not only enacted as a source of energy and a building block for the body, but also as providing cues from the external environment, mediating how the body regulates its internal functions. Though this is a helpful evolutionary response in *actual* times of hardship, here it is understood as a false alarm. It is an 'unnatural', forced scarcity that the person will not be able to uphold, which will eventually lead her to start eating. Weight gain is portrayed as a consequence of this process: once the person starts eating again, the body will not burn everything that comes in; whereas without this period of forced fasting the metabolic rate would be higher and this energy would be burned and put to good use. In this mode of ordering there is thus still a possibility of eating in excess, of unused energy with weight gain as a result. But how much food is *enough* or *too much* is not general and static, but is instead dependent on what the body has gotten used to in the past. This means that someone who has been dieting cannot immediately adapt to 2600 calories, and would need to, with supervision, carefully build up eating in combination with exercise. The body may then slowly 'learn' that food is available and can be invested elsewhere. It is thus endowed with both a memory and a forward-looking capacity, and this is something a person can play into in order to get in synch with the body.

Importantly, through this focus on regulatory crises, other possible causes of disturbance come into view. For instance, sleeping was a concern in many of the dietary practices I observed. Clients were told that respecting circadian rhythms was important to keep metabolism going, and that if they did not sleep enough their body would start looking for energy elsewhere, e.g. in food. Likewise, the troubles and frustrations of everyday life, often summarized under the term 'stress', were considered detrimental to proper functioning of the organism.

> Fabian: 'We measure every month, and when there is no improvement, people get very frustrated. Some try real hard for a short time, but then quit… yes, stress has an impact. They are all so busy, busy, busy. And stress sets off processes in the body that have a negative impact on weight loss. It stimulates hormones that make the body go into 'saving mode'. And sports are of course a good countermeasure for that; endorphin is produced which makes people feel good, it suppresses things, but still stress is an important factor.'

As stress puts the body into 'saving mode', thereby actively countering the 'good' kind of weight loss, relief of stress is necessary. Like the battery, this notion of 'saving mode' presents the body as an apparatus, but interestingly, here it is a 'smart' technology that 'knows' how to maximize the available energy, invest in certain parts and tissues and adapt to perceived changes in the environment. Like a computer, it may 'crash'. This notion of the organism is thus itself inspired by information technology and the feedback loops and signaling pathways of computer models (Sanabria, 2015).

Along the way, another advantage of exercise is foregrounded: it counters frustration. This does not only play out on a physiological level; an important part of the appeal in this approach is its immediate sensorial effects:

> Fabian: 'There are measurable results, but we don't like to focus on those. Because we are in very close personal contact with our members, we can discover the… mental advantages too. We notice people saying; I feel so good, I am so happy this gym is here for me in my neighborhood.'

In the mode of ordering premising calculating, whether one feels good or not because of exercise is made irrelevant for projects of weight loss. But here, 'feeling good' figures as a stress-countering, vitalizing effect that encourages a fully functional, active metabolic system. It is added to the range of things that matter.

Dispersed coordination

In this second metabolic logic, then, the concern is with 'healthy' weight loss, where health is understood as the thriving of an organism and its functions. Whereas in the first, metabolic processes deplete the battery, in the second, metabolism is a fire that, burning fast or slow, conditions the body's vitality and abilities. The speed with which the body can put food to good use is thus configured as a moving target that is open to modulation by both (certain kinds of) food and (certain kinds of) exercise. The use of the Basal Metabolic Rate informs the importance of this activation mantra, while the image of the organism foregrounds the valuable functions of food and muscles and the active responsivity of the body. The temporal scope of this mode of ordering is longer term; beyond a single workout, one's metabolic fire can stay high for an extensive period of time – as long as it is consistently fed. Weight loss takes longer too, but is presented here as more durable.

Like that of the battery, the metaphors of fire, organism and saving mode help reconfigure how people are encouraged to affect and tinker with their body and metabolism through eating and exercise. It presents a range of possible effects they might value in relation to it: importantly, vitality, but also relaxation and a general 'feeling good'. Rather than mere added benefits to projects of healthy living, these feelings are central to it. In other words, the relation between these effects is not hierarchical, but one of equivalence. The balance strived for relates to the extent to which all kinds of energetic activities – exercise, eating, sleeping, and the demands of daily life – are in synch with each other. What emerges is the need for dispersed coordination and the flow of proper communication: between resources, different bodily functions and the person and his/her body. The person and his/her body affect each other such that one does not have complete control over the other. The person may only stoke the fire, nudge it in various directions, while conversely, the workings of the body may make him/her feel better or worse.

As my informants tell me, however, it is difficult for people to accept that though such an active metabolism may prevent weight gain and even lead to weight loss, such change does not happen overnight. This practice of activation depends on the person's motivation and inclination to trust the

processes in the organism without being given measured feedback to keep it 'in check'. The fire needs to be stoked in the trust that one day, it will work wonders. This long process is not what Fabian and Christel's members, who generally go to the gym to lose weight *fast*, want and are willing to accept. Though one may experience immediate effects of hair growth and enjoy the feeling of vitalization that food and exercise may bring, the desirable number on the weighing scale may come too slowly, and the ideal dress size may never come. Failure to meet their expectations thus leads people to frustration and disappointment. Where counting input and output is solely in the hands of the person, relating to a body-as-organism hinges on responsivity and trust in other active entities.

Conclusion

In this paper, I laid out two metabolic logics that stage some things as movable and some things as fixed. The two modes of ordering, and the modes of doing 'good' that come with them, do not merely exist next to each other; they are in tension. In my material, the tension between the two emerged most prominently in the differences between the approaches used by professionals, and the ideas, wishes and techniques their members or clients engaged in. The second mode of ordering presents the use of the energy balance equation for controlling weight as a harmful and counterproductive strategy for weight loss. The body – staged as a self-regulating organism – will face long-term disturbances and neglect from daily input/output equations. Whereas in the first mode of ordering the (in)ability to stay in control is at stake, in the second, the logic of activating is haunted by rigidity and system shut-down. Pieter's strategies, then, as told through the logic of activating, are no good at all: his efforts and motivation become a harmful excess of will. They are a disturbing mediator between the body and the environment, failing to adequately fit his body's needs and mechanisms.

Landecker's (2013) 'postindustrial' metabolism emerges from a concern with the processed foods and metabolically morbid bodies that industrial metabolism has produced. The logic aimed at activating metabolism

described in this paper seems rather to respond to the calculating strategies of healthy eating that were put forward for remedying industrialism's pathologies. It thus prompts us to question not what and how fat is known, but how fat is dealt with in practice, in relation to specific concerns, techniques and contexts. In the situated health projects that emerge, some things are valued, while some are left out.

To explore these valuations, I focused on the metaphors of energy balance, battery, metabolic rate, saving mode and organism, which, rather than models or representations of what the body *is*, direct to ways of *working with* or *on* it. The metabolic logic premised on counting, which equated health with weight loss, is most available to people as it is part of socio-material orderings of food portions, exercise apparatuses and fits with the presentations of commercial diets, advertisements and other aspects that fuel beauty ideals. The other, premised on activation, is emerging: the pleasures and desires for the right conditions for the organism to do its job in the best way possible perhaps fit with an emerging food culture in which 'good', natural food is popular, and in which 'health' in less measurable forms is celebrated.

In many ways, the modes of ordering in these exercise practices reveal the limits of education about food and the body. These are evident in Fabian and Christel's confrontation with their members' fears of eating more and gaining weight. They are not only confronted with *ideas* about what is or is not healthy, but also with calorie lists, food packaging, weighing scales and commercial diets that convey these norms. Rather than take these processes as emerging 'in' the body, those of us who are interested in 'thinking metabolically', can address metabolism as part of socio-material practices that narrate eating, bodies and moving together in particular ways. It is from the tensions that emerge within these practices that we may learn about what people face in their efforts at becoming healthy.

Chapter 4

ENJOY YOUR FOOD![32]

On losing weight and taking pleasure

Abstract

Does healthy eating require people to control themselves and abstain from pleasure? This idea is dominant, but in our studies of dieting in The Netherlands we encountered professionals who work in other ways. They encourage their clients to enjoy their food, as only such joy provides satisfaction and the sense that one has eaten enough. Enjoying one's food is not easy. It depends on being sensitive. This does not come naturally but needs training. And while one kind of hunger may be difficult to distinguish from another, feeling pleasure may open the doors to feeling pain. What is more, sensitivity is not enough: enjoying one's food also depends on the food being enjoyable. A lot of care is required for that. But while engaging in such care is hard work, along the way clients are encouraged to no longer ask 'Am I being good?' but to wonder instead 'Is this good for me?' Both these questions are normative and focus on the person rather than on her socio-material context. However, in the situations related here the difference is worth making. For it entails a shift from externally controlling your behaviour to self-caringly enjoying your food.

Keywords: *behaviour, self-care, food, pleasure, sensitivity*

[32] Originally published as: Vogel, E., & Mol, A. (2014). Enjoy your food: On losing weight and taking pleasure. *Sociology of Health & Illness, 36*(2), 305-317, and Vogel, E., & Mol, A. (2014). Enjoy Your Food: on Losing Weight and Taking Pleasure. In S. Cohn (Ed.), *From Health Behaviours to Health Practices: Critical Perspectives* (pp. 145-157). Oxford, UK: Wiley Blackwell.
Co-authored with Annemarie Mol, first author.

Introduction

In an interview shortly after she had managed to lose 15 kilos, Isa, a 25-year-old Dutch woman, told us that she had achieved this feat with a low carbohydrate diet and a range of additional strategies:

> I now drink water. It's a great trick. If I get hungry I drink a large bowl of coffee and then I am full again… I have cut a fat index out of a magazine and hung it up in my food cupboard. It says how many calories a snack contains and how many minutes you must walk to lose those calories.[33]

Strategies like these are widely used by people who want to lose weight. They relate to food as energy and help people to absorb less energy than they burn. But despite the ingenious character of the tricks, it is not easy to shift one's energy balance. A year after the interview Isa had regained her original weight, plus a bit more. This happens to many people who diet. All too easily the conclusion is drawn that those concerned are not strong-willed enough to give up the gratification that eating and drinking offer. That they live in an obesogenic environment does not help. Jointly, or such is the argument, weakness of will and the abundance of readily available calories cause an increase in overweight and obesity. In response to this problem public health advocates seek to address the obesogenic environment. However, it appears to be difficult to achieve a world with fewer adverts, fewer fatty foods outlets, smaller servings of soft drinks and better access to healthy food. Working towards these goals clashes with the market organisation of food production and consumption and with the interests of the food industry. What remains is the possibility of addressing consumers and urging them to make healthy food choices. Hence, the public is provided with information about food (its calories; its carbohydrate content; its fatty acids and so on) and warned that

[33] The study was undertaken following local ethics committee approval. Consent was verbally obtained and to ensure anonymity the excerpts from transcripts used in this paper are not identifiable individual interviews or observations.

overweight and obesity cause health problems (diabetes, vascular disease, osteoarthritis and so on). Such campaigns target what public health research calls health behaviour. They admonish us to behave, that is, to take control over what we eat and abstain from excessive food pleasures.

It is not just nutrition scientists, government officials, healthcare professionals and diet gurus who sing this song. In the social sciences the tension between health and pleasure tends to be taken for granted as well. There are social scientists who explore how people negotiate their concern with health and their desire for pleasure in their daily lives. Some wonder how people's ability to exercise control might be strengthened (Coveney & Bunton, 2003; Jallinoja, Pajari, & Absetz, 2010; Rozin, 1999; Williams, 1997; M. Wilson, 2005). Others argue that siding with 'health' is disciplining or normalizing and go on to suggest that, instead, we would do well to give free rein to our desires (Smith, 2002). While these views are in opposition to one another, a similar scheme is at work in both: rationality and control are disentangled from, and contrasted with, desire and excess.

It was against this background that we started our ethnographic inquiries into care practices in The Netherlands for people who want to (or, as they often put it themselves, have to) lose weight. One of the present authors, AM, while wondering about possible escapes from the 'control versus excess' paradigm, was being interviewed by an online journal for dieticians. She used the occasion to ask for volunteers willing to participate in a further inquiry into weight loss in practice. Starting out from these volunteers, and then adding others through the snowball method, the other author, EV, was able to conduct twenty formal interviews (with dieticians, weight consultants, coaches, doctors, nutritionists, psychologists, physiotherapists, fitness trainers and a surgeon). In addition we did ethnographic observations. AM with a general practitioner, a dietician and a coach; EV with two different dieticians, two movement support groups, a weight loss training group and various professionals in an obesity clinic. In addition EV participated in a mindfulness training as a trainee. It turned out that in practice things are more complex than we had been led to expect. Firstly, we found that the control versus pleasure paradigm comes in strikingly different variants.

Secondly, some professionals appear to work with it in interestingly creative and innovative ways.[34] And thirdly, we came across professionals who did not fit into the control versus pleasure paradigm at all. The present article is based on the work of the latter group. Drawing their inspiration from a variety of resources, these professionals are experimentally developing practical alternatives to the control versus pleasure paradigm. Intrigued, we sought them out. They readily gave us access to their work, pleased that someone wanted to learn about it. Their clients agreed to our presence as well, either because they were generally in favour of openness or because they hoped that this would help others to get the kind of care that they were receiving themselves.

The practices analysed here do not seek to strengthen people's will-power. Instead they try to cultivate their capacity for pleasure. The ideal at their horizon is not self-control, but self-care. Self-care is not easy. In this article we draw out a few techniques for fostering it. They involve feeling pleasure and pain, sensing one's needs and crafting situations and meals that give joy. The goals of self-care are varied. They include not just health and weight loss but also joy, pleasure, satisfaction, ease and calm. As we analyse what is at stake in the practices that we studied we do not claim that they lead to paradise. They have blind spots, hit up against perplexing resistances and generate new and difficult dilemmas. But while the logic of control has been reiterated over and over again, the intricacies of self-care have so far received less attention. They deserve to be brought out into the open, discussed, amended and tinkered with. We hope that our articulations will strengthen and sharpen the theoretical creativity of our informants and help their insights to travel beyond their daily practices. As we address what public health calls health behaviour we argue that this term is not simply a label pinned to something going on out there. Instead, it

[34] For our work on dieting variants and creative uses of the control/pleasure paradigm, see Mol 2012 and Vogel, 'Clinical specificities: will and drives in obesity care', submitted. Heretic professionals have made themselves heard in self-help or popular science and semi-scientific books with titles like *The Slow Down Diet* (David, 2005) *Intuitive Eating* (Tribole & Resch, 2003) and *Savor: Mindful Eating* (Nhat Hanh & Cheung, 2010).

indexes the paradigm in which control contrasts with pleasure. Self-care is better served with other words.

Productive practices

As the alternative practices we present here go against the received wisdom that weight loss crucially depends on taking control over one's appetites, the first task that our informants set themselves is to spell out the fact that such control may not be all that helpful and may even be counterproductive. This is the idea: if people succeed in controlling their food intake the result is not simply that they come to absorb less energy than they burn. Their bodies are affected in other ways as well. They get hungry.

> Annette is a coach and her practice is called *Liever slank*. This Dutch phrase translates as preferably slim, but also as slim in a way that is kinder. On a fine evening in autumn 12 people have gathered to learn more about this. They exchange experiences. At one point, Kees (as we call him here) says: 'If I am hungry, I immediately feel like *yes*, I am going to stay hungry for an hour, because then I will lose weight'. His hunger gives Kees a sense of achievement. Tanja adds: 'If I don't eat, I feel I'm on the right track.' The drawback, however, is that such happiness doesn't last. Annette uses a moment of silence to ask: 'But is this really a good idea, to suffer so heroically? For you won't be able to sustain this. Eventually you will eat, because your body wants it. And then you will feel bad. Angry with yourself. Or guilty.'

The tables are turned. If the hunger that follows from heroic attempts to control one's body undermines one's ability to stay in control, it may well be that the gluttony that conventional wisdom takes to precede dieting, rather follows from it. This is one of the reasons that successes tend to be

short lived: dieting practices produce what they seek to counter. In addition, they also produce bad feelings:

> Tessa: 'Then I eat something and I think, oh, that's another 200 calories. Too bad.' Everybody nods. Annette nods, too. And then she counters: 'How can you enjoy what you eat once you start thinking 'that's another 200 calories'? While you feel bad, too bad, you do not taste'.

While Tessa-in-control counts calories, Tessa out-of-control consumes them. The 'too bad' indicates that she lives this as a failure. But where does this failing originate? The control paradigm suggests that the origin lies in Tessa's uncontrolled desire to eat. Annette, by contrast, suggests that the very attempt to take control is to blame because it drags a person into a vicious circle.[35] As control kills pleasure it precludes satisfaction. And as long as a person is not satisfied, she will want to eat.

What emerges here is that there is no such thing as the body. Instead, there are two ways of configuring bodies, two versions of the body and these are in tension. In the first, external control (provided by a set of rules or a mind) is needed to stop a body from absorbing more energy than it burns. In the second, bodies are taken to have an internal feedback system that keeps them in balance. Pleasure is a crucial part of this feedback system because it signals 'enough'. Thus, when there is no pleasure – as a consequence of guilt, or haste or a list of other intervening factors – the feedback system does not get its crucial feedback. Hence no balance:

> Annette takes it that people who want to lose weight would do well to enjoy their food. She talks about her own experience. At one point she had put on weight and started to complain about it. A colleague advised her to not start dieting but to try to take more

[35] Psychologists who study disordered eating have long since argued that restricted eating and a lack of pleasure have psychologically harmful effects. See Lindeman and Stark (2000) or Westenhoefer and Pudel (1993).

> pleasure from her food. And indeed, as she began to shift her attention to what she ate, things started to change. Instead of finishing a box of chocolates in one sitting, she would indulge in one or two pieces. She began to take more effort with her cooking. She sat down whenever she ate and concentrated on it. After her story, Annette challenges her clients who have just admitted to all kinds of binge eating incidents. She says: 'When you really take pleasure in eating, you can't eat an entire pack of cookies. You only ever do that when you gobble them up thoughtlessly'.

Like the body, the subject also comes in different versions. In the logic of control, the subject is a cognitive centre making decisions. It receives advice about what to eat (a diet plan) or it gathers information (for instance, about calories) that will allow it to make its own plans. In addition, it must somehow muster the motivation to act on these plans. In the self-care logic that informs Annette's way of working, the subject starts out by feeling. It feels hunger, guilt, a sense of failure. It feels like being slim or in need of comfort. It may feel a sense of achievement or of calm and satisfaction. These two subjects have different relations to their body. For the first subject the body is an object of knowledge and control. For the second the body is a locus. It is one of the sites where feelings reside and emerge. In this site so-called emotional feelings such as fear or joy encounter (hit up against or get confused with) so-called physical feelings, such as hunger or cold. Disentangling these feelings is not easy. Even feeling itself appears difficult to do.

Feeling pleasure

The practices we studied share the idea that feeling, even feeling pleasure, does not come naturally. As long as people are busy counting calories, running around or reproaching themselves, they are unlikely to feel the gratifications that eating and drinking potentially provide. Feeling depends on being attentive. You better attend, is the idea, to what you taste.

> The conference is on healthy eating; there are lectures and workshops. Guido gives one of the workshops and starts by handing out crisps and nuts. 'You might want to taste both, first one, then the other. Then, make a few notes. What did you expect and what do you experience? Is there a difference? And what happens to the flavour as you are eating, does it build up or fade away? Once you've swallowed, what do you feel then? For now don't talk, please, first concentrate'. A bit later everybody's notes are compared and they appear to be strikingly similar. The crisps are covered with salt. They mainly taste of salt and, though they are not particularly good, they induce a craving for more, perhaps due to the initial intense sensation provided by the salt. The nuts are completely different. They have been roasted but they are not salted. Their flavour increases as you chew, there is substance to them, they feel nutritious. A small handful is good; nobody wants more.

Here Guido tries to convey the fact that sensing what one eats depends not just on eating but on stopping short, turning inwards and protecting one's sensations from being overrun by the talk of others. What emerges is that if she is not attentive a person might be inclined to eat more and more crisps, not because they are particularly enjoyable but rather because they are not. This comes as a surprise to most participants and that is the point of the exercise. The moral is that you may hope to feel what is truly satisfying by tuning in on your food.[36] However, satisfaction depends on more than good food and attention alone. It may be tied up with endless other intricacies of life.

> Maria is a dietician working in what she calls a holist way. In her consulting room Helen, one of her clients, says that things are improving. In last few weeks she no longer overate every day.

[36] For the analysis that affect is not a natural phenomenon but that people may gradually learn to be affected see Hennion (2004) and Despret (2004). For an interesting note on this see Latour (2004a).

> However, things still 'go wrong' three nights out of seven. Then she gets takeout food, for example, from the Chinese restaurant on the corner. She knows that home-cooked food would make her feel better and taste better, but there it is. Maria asks about cooking. If that is the problem, it might help to cook two or three meals in energetic moments and put the spare ones in the freezer. Helen says no. 'When I'm tired I am not just lazy, but also crave for salty and fat stuff. For junk food. Even after dinner I dive into the fridge for cheese or salami'. Maria nods. 'It's very good that you are at least able to notice this. That's quite a big step already. So, now, let's see. It is when you are tired that you eat more than you would like to. Is there something you are trying to keep at a distance? Something you do not want to feel?' Helen pauses to think. Then, slowly, she nods.

Since she started visiting Maria, Helen has gradually learned to recognise that feeling tired may go together with feeling the need for salty, fatty foods. Now the next step is to learn that the comfort that food provides may help to keep other feelings at bay, nasty feelings that are more difficult to face than tiredness. Maria does not explore what the feelings are that Helen might be pushing aside. She takes this to be a task for a psychologist. However, she does insist that learning to feel threatening emotions may be a crucial step towards losing some weight. Another client, Stella, has picked this up and is learning to give her unwelcome feelings a name.

> Stella talks about a day at work. She was hungry and once she had eaten the food she had brought from home, she ate a few of the sandwiches that had been laid out for a lunch meeting. Even then her hunger did not go away. Her surprise about this made her stop and think. And only then did she realise that it was not exactly hunger that she felt, but rather frustration. 'And then it didn't take me long to realise why I was frustrated. And that was okay, it had to do with a situation at work that was, well, frustrating. So I

> allowed myself that feeling. And the urge to keep on eating disappeared'.

Maria's work is based on the experience that if eating is done out of frustration, to keep threatening feeling away, food pleasure has no chance. If, by contrast, an emotion such as frustration is simply allowed to exist it does not have to be driven away by eating. All this means that in treatment practices different kinds of feelings, emotions and bodily sensations need to be attended to together. This idea also informs the psychomotor therapy given to people with obesity as part of their follow-up treatment after bariatric surgery.

> Mariette, the therapist, hands out balloons and asks all six members of the treatment group plus the ethnographer to stand up and place a balloon on the seat of their chair. 'Push on it, go ahead, as much as you dare, go!' There is some giggling, but not a lot. After some pushing time Mariette wants to know what we feel. She writes the answers on a whiteboard. Petra is 'afraid the balloon will burst'. 'Where do you feel this fear?' 'Well, just fear,' Petra says, shivering a little. 'But where do you feel it *in your body*?' 'Ehm … well, in my chest, my heart rate'. Rinse suggests: 'In your breathing?' More sensations appear on the white board: 'get hot', 'belly pain', 'have to pee'. Anja proclaims: 'I do not feel anything. What should I feel?' 'You may have to push harder,' says Mariette. Anja tries. She pushes the balloon into the chair as hard as she can. '*I* feel something just by looking at you!' Petra sighs. Anja shakes her head and looks around. Is this a defiant look or is she excusing herself? 'No, still nothing.' BANG! The balloon bursts. A little startled, Anja admits that yes, finally she feels something: her heart is beating faster. At the end of the session Mariette talks about homework. She asks the members of the group to think about how they deal with tension in their everyday lives. 'What do you do when you are put under pressure, when you are stressed, do you hide feelings away, rationalise them, look for distractions?'

A body can only hope to feel pleasure if it is able to feel in the first place. Thus Mariette creates situations in which feelings are likely to arise, and encourages her treatment group to attend to what occurs. Focusing on their bodies should help people to feel something, anything at all. Seeking words for these feelings and relating to what others say – recognising it, being surprised by it – should help them to explore their sensations further. And all this comes with the hope that in real life participants will get better attuned to their physical and emotional sensations.

Feeling needs

In the control paradigm losing weight depends on abstaining from food even if one feels like eating. One's food intake should not be based on feelings, but on dieting guidelines or a proper calculation of nutritional needs. Self-care, by contrast, includes learning to feel what you need.

> The workshop again. Now two kinds of orange juice are passed around. They look the same. Guido, the workshop leader, asks: 'Note down how they taste and what effects they have on you'. People take sips and make notes. Once we are allowed to talk the agreement is striking again. The first juice has hardly any taste. Someone calls out 'sugar water!' General acclaim. At the same time, most participants report that they felt the urge to keep on drinking. The second juice, by contrast, has a rich taste. There are layers in it: sweet, sour, a tinge of bitter. It is good, but a small glass is enough. Only after this has been collectively established do we learn that juice number one was the light version of an expensive brand and juice number two was freshly squeezed. Guido: 'Isn't it strange that when our bodies ask for juice, we trick them with something light? Why not give them the nourishment they need?'

Guido is convinced that it is not despite its rich, layered taste, but because of this, that freshly squeezed juice does not urge a person to keep on drinking. It is satisfying. Guido contends that light food is a trick, and a bad trick at that, because a body is not so easily deceived. If only people can learn to feel them properly, their desires will appear to be in line with their needs. This confidence in the body's potential to sense its needs is striking in most of the practices that we studied. It may confuse clients who in the past have been given rules (this is what you should eat) or information (this is how to calculate your needs). Things do not necessarily get easier without such handholds.

> As a part of her attempts to lose weight Melanie, who is in her twenties, goes to the gym. But what to eat after the gym? Melanie: 'If I have rules, I'll be fine, I can follow rules'. But Janet, the dietician, tries to take another course: 'That is very good, that you can follow rules. But what about trying to feel what you might best eat? There is a difference between hunger and craving for something sweet, you know. Are you hungry? Then you want proper food, soup, a sandwich, something filling. Do you have a craving? Then you have some of what you crave for. The difference is important. Would you like be able to feel what you need, instead of thinking: what are the rules?' Melanie hesitates. Janet continues: 'This is hard, we have to take it step by step. Let's start from an example'. Yesterday after her gym, Melanie first had yogurt and then crackers with chocolate spread. Janet asks whether she was still hungry afterwards, but Melanie cannot tell. 'This is the kind of thing you might want to become aware of,' Janet says. 'To get there, it may help to sit down and make notes. Not about what you eat, but about what you experience. How your food becomes you'.

Feeling demands training. Time and again clients are asked to attend to such things as 'how your food becomes you'. What becomes them today may well do so again tomorrow and in this way one's past experiences may come to

inform one's future eating patterns. But patterns should not crystallise into fixed rules. Bodily needs may vary from one day to another. While rules seem to offer a stable kind of control, there is no end to the tinkering self-care that involves feeling.

> Melanie says that, okay, she will try. But for now she has one last question. She often eats currant buns. Are they allowed? She looks at Janet almost apologetically, realising that she has not quite got it yet. Janet smiles and says: 'That is a good question. You know what? Next time you have a currant bun, try to feel that for yourself. Or you may want to buy a few different kinds, from different bakeries, and try to feel which one satisfies you most. What I encourage you to do, is not to ask 'am I being good?', but rather 'is it good for me?'

While rules may be stabilised and carried along between moments, sensing has to be done in the here and now. While rules that stipulate healthy behaviour are based on measurements done on a population level, sensing has to do with the effects of food or drink on a specific body. Experimenting with different but comparable kinds of food or drink may help in gradu ally acquiring the ability to feel these effects. In the end, this should allow people to feel and feed their own particular needs.

> A mindful eating course. We learn that mindful eating distinguishes between no less than eight kinds of hunger. Joyce, the course instructor, shows a list of them in her PowerPoint presentation. The group has to think up fitting examples. In this way, we come to talk about eye hunger (seeing food makes you want it), nose hunger (walking past the bakery), ear hunger (the cracking of crisps, the sizzling of oil), mouth hunger (sweetness, taste), belly hunger (rumbling stomach, 'real' hunger), body hunger (vague feeling of distress), mind hunger ('I can't eat this, I should eat that, if I don't eat this I can eat that') and heart hunger (warmth, rest, acceptance, cosiness). Then we start an exercise. As we sit in a circle, Joyce

> invites us to relax and then hands out coffee biscuits with mocha glazing. First we have to rate how much of each kind of hunger this biscuit makes us feel. Then we may choose whether or not to eat it. Only one out of the 12 people present actually does. Then we talk again. 'It looks like plastic, really.' 'The smell is good.' 'Is it? I think it isn't.' 'Once you start thinking about it, you realise: I don't want this cookie!' Most of us say that if the biscuit had been presented during the tea break we would have eaten it without thinking twice.

Even though only belly hunger is granted the adjective real, the point of an exercise like this is not to forbid foods that cater for what, by implication, are unreal hungers. Instead, the idea is that if you realise that, say, you are seeking comfort from a piece of cake, it becomes easier to leave it alone and look for comfort of another kind or, and this is at least as important, to actually find comfort in it. For rather than feeling bad about yourself, you may then enjoy your food. Making the different kinds of hunger explicit helps to open up different perceptions. Food may look appealing, smell lovely, have an interesting texture, a rich taste or provide a gratifying belly feel. Some people even appreciate the sugar rush that follows from their cookie. And as your needs are met and you register your satisfaction, your desires calm down as well. For at least some time all your eight hungers are quietened.

Crafting conditions

The professionals whose work we present here tell people not to forgo bodily pleasures but to cultivate them. As a part of this, people are encouraged to feel their sensations and emotions, rather than to eat them away; and to attune to their various needs and desires so as to better meet them. All this is work on the self. But caring for pleasure does not stop at the boundaries of the self; it also includes care for one's surroundings.

> I tell the adults about the hypothalamus, I explain that this is the satiety centre that regulates how much you eat and makes you stop eating. And then we talk about how this may become dysfunctional. And they get the assignment to give it stimuli again, to start tasting. So we discuss how to do it, this tasting. How to become an aware eater? It starts with sitting at a table, a nicely set table, with flowers, a nice table cloth. Eating with cutlery. Switching off the TV, the radio, putting away the newspaper. Just sitting and tasting. Trying to chew 15 times. Often clients will look at me, like: where's the fun in that? But it does help you to eat more consciously. For if you eat in front of the television, you tune out from your hypothalamus, you do not listen to it anymore. But it tells you exactly when to stop. (Martine, weight consultant)

Care for the self depends on care for the context in which this self is situated. The problem that is tackled here is not an obesogenic environment that induces eating but a distracting environment that shifts attention away from eating. The environment of an eater should not be distracting, but attractive. It should foster pleasures that underline and add to the pleasures provided by food – flowers, a table cloth. It should index care – hence the cutlery.[37] An attractive environment will not alter the flavour of the food but turns the activity of eating into a pleasure in and of itself. And as the body gets pleasure, it registers that it is eating and at some point will signal that it has had enough to eat.[38]

This 'enough' is not a set quantity, like the '2000 calories a day' that results from research done on groups of other people under other

[37] What does and does not index care for one's surroundings is replete with class and cultural markers. In our Dutch materials the norms at work are middle class, though not those of, say, arty or academic elites, who would not care about table cloths. And while in the USA, for instance, eating with only a fork would be acceptable, in The Netherlands this signals a lack of cultivation or of attentiveness. That one might eat as well, and well, with one's fingers, is not considered here. But see (Mann, Mol, Satalkar, Savirani, Selim, Sur, and Yates-Doerr, 2011).

[38] In nursing homes, where people risk eating too little, caring for attractive surroundings is celebrated as it incites people to eat more. Hence, there too, pleasure is supposed to help in balancing the amounts people eat. See Mol (2010b).

circumstances. Instead, it is a locally relevant amount of food that suits your particular body here and now. This body is not caught in a causal chain: the food on offer does not cause your body to eat. Instead this food is, or is not, inviting.[39] You may either respond to this invitation, or not. Such responses are not fixed, they may change over time, they may be tinkered with.

> Amanda, a dietician, encourages Johan, a man in his forties, to try new things. She explains that taste buds only get used to something after at least three weeks. Then they respond with an 'oh, carrots.' It takes another three weeks of tasting before the brain is able to shift to: 'yummy, carrots!' 'So keep trying. Taste a little piece, again and again, and you'll be fine.'

Here, then, pleasure is not enacted as a natural effect, but as a cultivated response. It depends on committed efforts. By attentively tasting new kinds of food one may learn to like them. But while our informants say 'try carrots, they might be good for you', they never say 'you should like carrots'. Luring a body into liking carrots is worth trying, but such self-care techniques do not offer control. In the end pleasure may emerge – or not.

> For children Amanda uses a form that has a long list of vegetables followed by two columns. In the first of these, a child may put a tick every time she tastes the vegetable in question. After 15 ticks she is allowed to rate the vegetable's taste in the second column. The scores are like those of the Dutch school system: 1 for truly bad (or disgusting) and 10 for could-not-be-better-so-very-good (yummy). This form tries to turn appreciating food into a game. Once they have 'done their best' and tried a vegetable 15 times, children are allowed to judge for themselves and score it.

[39] For the material aspects of hospitality, see also Candea and da Col (2012).

The context in which one eats may be attended to; new flavours may be tried. But caring for pleasure also depends on caring for the food itself. For food is not naturally given, it is grown and transported and sold and bought and cooked. The attention of our informants tends to focus on the last stages of this process. How to prepare food in an enticing way?

Susan works as a dietician with overweight children and their families:

> It strikes me that many of my clients eat very plain food, nothing imaginative. They hardly use herbs or spices. Spicing things up a bit might make meals more appetising. And then it all has to be quick, quick, quick, easy and ready. Of course it then gets boring, especially if it also needs to be healthy, because they all think that's vile. So how to make healthy stuff more appetising? This is difficult, because in practice … we can cook with the children, but with the parents it is difficult to organise. Because the parents … you can present them with information, but that doesn't work. They have to experience it. Often they think that they don't like something, but if they make it in a slightly different way, they will experience a different taste. And fun cooking is not necessarily all that difficult or time consuming. (Susan)

Crafting pleasure takes effort. It depends on skills and imagination. While telling people to take control of their food intake presupposes that the food to be taken in is present already, fostering self-care includes paying attention to the work that goes into selecting, buying and preparing good food. This does not easily fit within consultation rooms and current financial regulations, if only because self-care is not a just cognitive task, but involves the entire body. It depends on developing skilled eyes, noses, tongues and hands. It is only by training in practice that a person may become capable of caring.

Conclusion

In public health the concern is with what is called health behaviour. In the research that backs up this concern, 'behaviour' is configured as something observed from the outside. It is what one person (the researcher) may see another person (the research subject) do. The researcher-outsider may then seek out the explanatory variables that cause this or that behaviour and hope that interfering with these explanatory variables offers the possibility of changing the behaviour in question. But what if one is the person doing the behaving? Then such knowledge from the outside makes little sense and neither does trying to alter the causes of one's own behaviour (Despret, 2008). The professionals whose work we have presented here therefore try to go in other directions. They do not address behaviour observed from the outside but the feelings that, as a person, one may come to sense from within. They do not encourage people to put themselves under their own control but to caringly tinker with themselves, and tinker again, all the while seeking to actively and appreciatively take pleasure from their foods and drinks.

The ideas embedded in these caring practices resonate with phenomenological theory. Phenomenology, likewise, calls for attention to how a body feels from within. However, in a lot of phenomenological studies feeling one's body from within appears to be a naturally given and universally available ability. The practices we studied suggest instead that it is a demanding local achievement. It is not something that 'the' body does, but rather something that some people may learn to do under some circumstances. Hence, rather than a general truth that needs to be theoretically defended, the lived body of phenomenology here emerges as an empirical configuration that may or may not be realised in practice.[40] The professionals who were our informants work to realise it in, with and for their clients, in various ways.

[40] See notably Csordas (1993). In parts of phenomenology the fact that conditions of possibility are precarious, is acknowledged. See Varela's note that being a lived body is not something everyone can easily do, but requires cultivation (2001). For the shift from having/being to doing also see Mol and Law (2004) and Law and Mol (2008).

Firstly, they encourage people to feel. The idea is that it is only if people attend to how their food affects them that satisfaction may ensue. One of the complications is that different bodily sensations may intertwine with each other and with a plethora of emotions. As positive and negative feelings are not easy to keep apart, avoiding all forms of feeling may sometimes seem safer. This is a problem: taking pleasure depends on also being able to experience pain. A second set of repertoires addresses the feeling, not of one's responses, but of one's needs. Rather than calling upon nutritional science to stipulate these needs whilst mistrusting one's desires because they know no bounds, in the practices we studied needs and desires are explored together. The ideal is to learn to feel the difference between needing/desiring nourishment, a treat, consolation or something different yet again. A person able to do this will find it easier to meet her needs, fulfil her desires and achieve satisfaction. But satisfaction does not just depend on being able to feel but also on organising one's food world in satisfying ways. Therefore, a third repertoire foregrounds caring for one's eating environment, attuning to different foods, acquiring diversified tastes and, crucially, learning to prepare attractive meals.

Satisfaction, then, is crucial to the practices we studied. The idea is that satisfaction serves weight loss as satisfied bodies send out the signal: 'enough'. But while weight loss is important to both professionals and clients (who, after all, seek help because they hope to lose weight) it is not the ultimate parameter of success. It may be even more important to learn to take pleasure and then being satisfied once in a while; or to be able to feel what you need and which foods and drinks are good for you at which moment.[41] This, then, is how we want to summarise the work of the professionals we studied. While public health messages insist that we should take control over our food intake, here the message is to attend to what we

[41] Healthcare practices have to be justified by proving in clinical trials that they are able to effectively improve a given relevant parameter of success. If a practice has a range of goals, its effectiveness becomes more difficult to prove. For some of the many complications involved, see Mol (2006) and Struhkamp *et al.* (2009) and, for an alternative way of working, Moser (2010).

eat. Rather than repeating the admonition, 'mind your plate', these professionals give the encouragement to enjoy their food.

None of this is beyond criticism. 'Enjoy your food' resonates with the advertisement messages of food industries, which makes it easy to be misused. What is more, not all possible food pleasures are being endorsed. Calm enjoyment is being fostered, and wild ecstasy is not. Ignored are the pleasures of transgressing, forgetfulness or, say, of stuffing oneself with fast food while watching a B-movie with friends.[42] There is little about sharing food, feasting, or acting as a generous host or a grateful guest. In addition, the self-care being propagated is demanding. Our informants want their clients to show curiosity by seeking out new food experiences and experimenting with new habits. They risk turning a gourmet model of eating into an ideal for everyone. They hardly attend to money. They work largely through education, like almost everybody else in contemporary public health. And while they give support, once again the people who have the problems have to do most of the care work themselves.[43] All in all, there is a very thin line between liberating the pleasures of the body and imposing yet more obligations on the caring self. Say you find yourself trapped in the station at 5:30 in the evening after a busy day at work. You are hungry, have a long way to travel ahead and little money left. Your food choice then and there is between an expensive luxury salad and cheap, filling chips. Yes, of course, you might have anticipated this moment and brought your own food from home. But you did not. Here yet another sense of failure looms. If only you had taken better care of yourself!

As it happens, our informants know all too well that they are not in the business of creating a paradise. They also know about the socio-material circumstances of their clients. As we talk, they deplore the fact that they cannot change the marketing strategies of the food industry, school canteen policies, supermarket layouts, social inequality, the kinds of skills

[42] See also the aesthetic regime of comfort, that celebrates the paralysing pleasure of fatty, high-caloric food in Christensen, 'Aesthetic regimes: how good food is crafted through connoisseurship', forthcoming.

[43] On possible problems that extending the care-space from the clinic to self-care can bring about, see Miewald (1997). For another discussion on self-care see also Kickbusch (1989).

children are being taught (or not) in schools and so on. Every day again they learn from working with their clients about the structural problems that interfere with eating well. But what can they do from where they stand? Taking their situatedness seriously, we suggest that it is just too easy to write in a social science journal that encouraging people to take pleasure from their food is nothing but another neoliberal disciplining strategy. Once you have heard Annette's clients tell stories of bingeing and feeling miserable; or pushed a balloon with the therapy group of Mariette; or witnessed Maria attending to the details of Helen's responses to foods and feelings; once you have transported yourself to these sites, the conviction imposes itself that paradise may have to wait. It is urgent enough to attend to the question what to do in these sites. What is better rather than worse in a situation where a person wants to (or has to) lose weight (Yates-Doerr, 2012b)? Is it obligatory to learn to control your eating behaviour while asking yourself the question: am I being good? Or might it also be possible to learn to take more pleasure from your food, while wondering: is it good for me? This is our conclusion: pointing to the difference between these two ways of working is important. It is a difference worth making. Enjoy your food.

Chapter 5

HUNGERS THAT NEED FEEDING

On the normativity of mindful nourishment

Abstract

Drawing on participant observation in a 'mindful weight loss' course offered in the Netherlands, this paper explores the normative register through which mindfulness techniques cast people in relation to concerns with overeating and body weight. The women seeking out mindfulness use eating to cope with troubles in their lives, while at the same time they are hindered by an unhelpful preoccupation with the size of their bodies. Mindfulness coaches aim to help them let go of this 'struggle with eating' by posing as the central question: 'what do I *really* hunger after?' The self's hungers include 'belly hunger' but also stem from mouths, hearts, heads, noses and eyes. They cannot all be fed by food. The techniques detailed in this paper focus on recognizing and disentangling one's hungers; developing self-knowledge of and a sensitivity to what 'feeds' one's life; and the way one positions oneself in relation to oneself and the world. The paper argues that in this course, rather than introducing new norms, normativity is configured differently altogether, and so are the worlds people come to inhabit through engaging in self-care. In particular, the hungering body is foregrounded as the medium through which life is lived. Drawing on material semiotic work in Science and Technology Studies, this paper makes an intervention by articulating this normative register as an *alternative* to normalization. Thus I highlight material semiotics' potential contribution to different ways of doing normativity and the development of better ways of living with overweight.

Keywords: *mindfulness, obesity, care, material semiotics, normalization*

Introduction

'Mindful Eating is the New Diet', reads the headline in the Dutch daily newspaper *Trouw* (2012). 'The Netherlands keep getting heavier', the article cautions. 'To lose weight you must change your eating patterns. But this is easier said than done.' Mindfulness, we learn, is nothing like the usual 'crash diets' that aim at weight loss through restrictive calorie counting or set menus. The key to changing one's figure, these days, is changing one's mind.

Mindfulness, as it is sold (or oversold) (Brazier, 2013) in today's fast-paced, technological era, allegedly fixes a plethora of ailments, from parenting difficulties to crime to burnout. As the newspaper article quoted above illustrates, mindfulness is also often adopted as a promising new 'treatment' for obesity.[44] But the concern with whether mindfulness 'works' to counter the nation's expanding waistlines glosses over the interesting ways in which this practice reconfigures the ways this problem is understood and targeted. This paper explores the normative register through which a particular version of mindful eating, shaped by psychological knowledge and techniques, casts people in relation to concerns with (over)eating and body weight. To do so, I give an ethnographic account of a 'mindful weight loss' course, offered in the Netherlands, advertised as helping participants 'develop a healthy relationship with your body and yourself'. I show how the course shifts therapeutic goals from having a normal body to having a 'nourishing' life.

In public health circles, the relation between health norms and happiness is predominantly cast as one of mutual enforcement: being healthy will help one lead a happier, more productive life; being happy, in turn, leads to better health. In the mindfulness course I participated in it is precisely the conflict between health norms and happiness that is at stake. As it is articulated there, participants use eating to cope with troubles in their lives, while at the same time they are hindered by a unhelpful preoccupation with the size and shape of their bodies. Mindfulness coaches aim to help people let go of this 'struggle with eating' by posing the question: '*what do I *really**

[44] Thus figuring in Randomized Controlled Trials (such as Dalen et al., 2010; Tapper et al., 2009). Paul Grossman (2011) argues such studies do not test mindfulness but rather psychology's 'positivist' re-inventions of this practice.

hunger after? A focus on the physical characteristics of the body is replaced by an orientation towards desires. The shift, I suggest, lies not in the fact that mindfulness practices make people strive for different norms. Instead, normativity is configured differently altogether through these practices, and so are the worlds people come to inhabit through engaging in self-care. Drawing on material semiotic work in Science and Technology Studies, my aim in this paper is to articulate this normative register as an alternative to normalization. Along the way, then, I address how a material semiotic approach to analyzing these practices can contribute to a different way of *doing* normativity. This means that I am committed to learning from the specificities of this therapeutic practice rather than reporting on, critiquing or explaining its workings.

'Mindful weight loss'

In 2014, I participated in a course entitled 'Mindful weight loss'. It was publicized as focusing on 'learning how to look differently at, and get a different taste of, food and eating'. The course, set in a medium-sized city in the Netherlands, is taught by Karen, who, as she puts it, 'long struggled with [her] relationship with food and eating'. Mindfulness helped her to work through this struggle. Next, she became an independent coach to help people with similar problems. Karen was trained by three coaching programs in the Netherlands that explicitly contrast themselves with 'regular' dieting approaches, which they claim not only lead to bodily neglect but also cause disordered eating in a psychological sense. The course comprises a mindfulness focus on relaxation and attention, with psychological techniques borrowed from eating disorder treatments, Acceptance and Commitment Therapy (ACT), and a metabolic nutrition approach. The course itself is a fortnightly program of a total of eight sessions. No diagnosis is needed; everyone who pays can participate, although Karen might refer someone to a psychologist if she suspects an eating disorder.[45]

[45] The normativities of such a diagnosis are interesting in themselves, but lie outside the scope of this paper.

In my ethnographic studies on overweight care practices in the Netherlands, I became interested in mindfulness as I saw its techniques make their way into diverse treatments, ranging from consultations with dieticians to clinical treatment before and after bariatric surgery. I was particularly intrigued as some clients and patients I met in these settings enthusiastically told me that it made them experience food as a substance to savor and enjoy rather than battle with. I wanted to know more. After meeting with Karen privately to discuss my interest in mindfulness, she invited me to join her course. I started by participating in an evening workshop introducing mindful eating, during which three other Dutch women (ages 27-60) and I subscribed to the more in-depth course. At the first meeting, I introduced myself as a researcher. After explaining I was eager to learn what benefits mindfulness might bring to people, I asked whether the other participants consented to my using their and my own experiences with the course in my research. Everyone readily consented and my position as a researcher did not explicitly come up again.

In contrast to typical practices in the consulting rooms of many doctors, weight consultants and dieticians, being weighed was not a part of these meetings. Obesity and overweight were not mentioned. Though some participants continued to weigh themselves at home, in Karen's therapeutic practice, overweight, as a particular condition to be measured and corrected on the body, is an 'absent presence'. It is absent because it is explicitly set aside as an object of intervention, but it is present as a concern of the participants who consider it detrimental to a good and healthy way of living.[46]

The normative engagements of practitioners like Karen and those who trained her come strikingly close to points made in psychology and beyond on the harmful effects of contemporary norms of bodily control. For instance, Karen would not disagree with feminist cultural scholars who emphasize that eating disorders differ only in degree from more culturally accepted forms of dieting (Bordo, 1993; Greenhalgh, 2015; Gremillion, 2003), or with scholars in the fields of fat studies and critical dietetics criticizing the harmful effects of conflating health with weight (Rothblum et al., 2009).

[46] For a discussion on the normativities of using the *word* 'obesity' both as researchers and care practitioners, see (Warin & Gunson, 2013).

Likewise, if this literature were more readily available to her, she would concur with Bryn Austin who calls eating disorders 'the blind spot in the drive for childhood obesity prevention', and may go along with his bold statement that 'science', with its calls for monitoring food intake and monitoring weight, is 'complicit in a culture of disordered eating' (2011). Mindfulness practitioners also hold that privileging biomedical norms of health risks obstructs interpersonal and embodied realities of eating (Yates-Doerr, 2012a) and ignores the ways in which eating is *not* about food (McIver, McGartland, & O'Halloran, 2009). Although for admitted commercial reasons the course title suggests the *goal* is losing weight, Karen often stressed that weight loss might be one of the *consequences* of developing a renewed relationship with food and eating, but should not be an aim in itself.

Bodies, norms and practices

In the Netherlands and elsewhere, metrics such as the Body Mass Index (BMI) not only construe, but materially constitute certain bodies as normal and others as abnormal and in need of intervention (De Laet & Dumit, 2014; Fletcher, 2014; Nicholls, 2013). Since Foucault, social theory has come to view such medical norms as proceeding from an interplay among social, technological and political imperatives that reflexively structure a particular kind of social order (1973 (1963)). The logic of adhering to bodily normalities or, for that matter, optimality (Rose, 2007)
holds that attending to bodies and their diseases will eventually lead to a better life, both individual and collective, as more productivity and lower health care costs ensure a better society (Foucault, 2014 (1979)). Thus, to be good citizens, people must engage in healthy eating, diet and exercise. This, to Foucault, is the role medicine plays in the governing of contemporary society: by foregrounding *normality* as something that everybody ('every *body*' (Mol, 1998, 280)) wants to strive for.

The social account of these norms may be (and has been) read as increasingly taking precedence over and structuring clinical encounters, people's own evaluations of their health and bodies and the organization of

society. Here, I will relate to this admittedly brief account of normalization in two ways. First, I want to learn how people, with the help of others and by means of various knowledges and techniques, give shape to such norms in situated ways. I am concerned with what Foucault in his later work termed 'arts of existence', what he defined as 'those reflective and voluntary practices by which men not only set themselves rules of conduct, but seek to transform themselves, to change themselves in their singular being, and to make their life into an oeuvre that carries certain aesthetic values and meets certain stylistic criteria' (Foucault, 2012 (1984), 10-11). These practices, he explains, are characterized by on the one hand, a focus on *training* – what the Greeks called *askesis* – and on the other, an orientation to something one deems *valuable*, a 'telos'.

In the provocatively titled paper 'Foucault goes to Weight Watchers', Cressida Heyes suggests that women try diet after diet, despite their evident failure, not (only) because they strive to reach a social ideal, but because they are attracted to the way of working on oneself that emerges in the day to day moments of dieting (2006). Specifically, meticulously attending to one's food and exercise enables capacities such as self-development, mastery, expertise and skill. Heyes argues that commercial weight loss organizations appropriate the *askesis* – specifically, working on self-knowledge, pleasures, capacities and self-care – to hide their complicity in normalizing webs of power. If these self-care practices are employed in a different context than Weight Watchers, however, they may have different effects and do more than reify or internalize subject positions of an order of the normal. The focus on training indicates that disciplinary techniques are productive; they reveal and multiply new competencies and ways in which it is possible to be a subject or a body. Through these self-cultivations, people may shape certain dominant discourses in situated, creative and relational ways of living. I show how in the mindfulness course people are taught to negotiate between and give shape to norms that they encounter, and to develop their own normative engagements. What is then worked on is the self's mediating and form-giving capacity under 'conditions that are not of one's choosing' (Brown & Stenner, 2009).

Notwithstanding the norms that are handed down to us and shape us in a variety of ways, I deem it important to appreciate that people have a

heartfelt affinity with what they deem 'good', to things they value or are passionate about. This affinity suggests that what Antoine Hennion terms 'those things that hold us together' (2007: 98), are not (just) the norms through which we are *ordered* simultaneously as individuals and as part of a collective. They are also the ways we *organize* around common values, passions and concerns, and the way these passions organize *us*. Hennion positions himself against the sociological inclination to analyze taste, passion or value as a marker of social difference or as a product of social construction or false consciousness (2004). Instead, he invites us to follow the practices through which people express and develop their attachments to such diverse 'goods'. He describes the subject of such passions with the French term *amateur*, meaning 'any lay-person engaged in a systematic activity, which makes them develop, in various degrees, their sensitivities or abilities in that domain' (2007: 112). In these activities, people use different knowledges and techniques and try out various methods. I suggest mindful eaters may also be understood as amateurs. In their practice, they attach themselves not just to food or other 'objects' but also to themselves as bodies and selves. As a result, these entities variously reveal, multiply and transform themselves (Hennion, 2007: 101).

Second, then, my question is whether, and how, the worlds people come to inhabit through such practices may subvert the order of the normal and create alternative orderings in which people come to live with their concerns about body weight and eating. The mindfulness course I attended is interesting in that it explicitly positions itself against dieting and a focus on body size and weight. At the same time, it addresses the ways in which its participants are oriented towards these norms, and offers a new normative register through which each participant can concern herself with herself. The most relevant 'practice-specific alterities' (Van de Port & Mol, 2015) of mindfulness, I argue, lie not in the way it enacts, for instance, different versions of what the body is, but in the way it shifts normativities and activities around eating. In the course I participated in, activities and techniques are oriented towards the nourishment of hungers. Here, I will articulate this normative register of nourishment as an *alternative* to a normalizing order.

In my analysis, I use the tools developed in Science and Technology Studies (STS), and specifically in material semiotics. A material semiotic approach studies ordering not as a monolithic apparatus but as something that emerges through practices, requires *active* associating, and results in not just one distribution but instead in *multiple* realities. Ordering as a practical endeavor, moreover, emphasizes its precarious and *emerging* nature (Law, 2002; Moser, 2005). Orderings, in this reading, always have partial connections to other orderings (Strathern, 2004). But attending to differences rather than coherences, and to process rather than product, also reflects a political commitment and normative engagement on the part of the social science analyst. To make this clearer, I repeat Ingunn Moser's important question: 'How can we avoid colluding with and adding to the power and dominance of an order of the normal?' (2005: 668). If we take up the old STS insight that to study the world is to change it (Hacking, 1983; Latour & Woolgar, 1979) the question of whether we read practices such as mindfulness as complicit in a normalizing ordering is not only an important empirical question. Rather, articulating it *as* an alternative becomes an active intervention.

The 'struggle with eating'

Every other week, Karen welcomes us into a cozy, high-ceiled room overlooking a park. One by one we enter, leaving our coats in the adjacent marble-floored foyer. As we sit down at a large oak dining table carrying tulips and candles, Karen pours us herbal tea. A whiteboard and two comfortable armchairs are placed in front of two bookcases displaying a range of psychological and coaching literature. Among these are publications of people involved in the coaching programs Karen is trained in, notably, 'Get rid of the Scale!' by nutritionist Meijke van Herwijnen (2012); 'Eat more! Feeling good with pure and healthy food' by dietician Karine Hoenderdos (2014); and 'Mindful weight loss' by Joanna Kortink (2015).[47] The latter book forms the core of the course and outlines its program. Every week we read a

[47] The English titles are my translations.

chapter of Kortink's book and do the exercises that the book contains. Its language evokes inspirational self-help literature and a wellness culture that mixes Buddhist traditions of meditation and mindfulness with more 'Western' values of empowerment and authenticity.

Like Karen, Kortink comes out as having struggled with weight and eating problems all her life. It is this atmosphere of shared suffering, care and understanding that characterizes the meetings. In the book, readers are addressed in a didactic, but empathetic 'you', and Karen frequently says things like, 'Yes, that is what we do!' For instance, 'we' always prioritize everything but ourselves and our own bodies. The collective thus staged, that engages in dieting and suffers from certain self-defeating emotions and inclinations, is decidedly gendered (Bordo, 1993; Stinson, 2001). It may not be surprising that although the course addresses both men and women, the vast majority of participants are women.[48] These women, moreover, are able to spend time and money on diets and are accustomed to concerning themselves with their ways of eating and the particularities of their bodies. On Karen's website and in the books, there is talk of cycles of control and release and of love-hate relationships with food and the body. In the introductory workshop, the participants discuss what this troublesome relation with eating and one's body brings to bear: tension, low self-esteem, feelings of guilt and failure, overeating, weight gain and tiredness or stomach pains.

At some point during the introductory meeting, a 50 year old woman whom I call Margaret, shared, with the trust that comes from assuming to be amongst likeminded others, that she had tried almost every diet out there: low carb, Weight Watchers, even hormone therapy (which according to her was an excellent way to *gain* weight). Not so long ago, she was on a diet that restricted her to only eating dairy; she just couldn't stand the sight of yogurt anymore. Margaret proclaims that whenever she is on a restrictive diet, she only wants to eat whatever she is *not* allowed to eat at that point. And though she usually loses some weight initially, she always ends up gaining much more than she lost. Margaret concludes by saying she is tired of it and hopes that mindfulness will give her some relief.

[48] And because in my course, there were only women, I will speak of women from now on. All names are pseudonyms.

Figure 3. The room where the course was held. *Photo by the author.*

These practices of sharing around 'the struggle with eating' perform the women's life histories as strikingly similar. Even though no diagnosis is made, this common struggle provides points of engagement. In the course, the women will work on relieving this struggle to make way for better forms of self-care. The course is said to provide a 'tool box': in the meetings, people can explore which tools do something for them, and which do not (but might work later!). In line with this tool metaphor, what was drawn upon was not a coherent repertoire of knowledge, but various techniques that a person may value on the chance they help bring change in their lives.

I could relate to most of the everyday life struggles that were shared and, as a (middle class) woman, experience the norms and values that pose a problem here in my own life. However, I did not experience the severity of the suffering around eating and body size much in the same way. But since forms of self-care, rather than body size and weight loss, were the points of engagement, this was not an obstacle to joining exercises and discussions. Yet, my double role as researcher and participant had other effects. Whereas most participants were oriented to their own problems and therapeutic needs, I listened to the other women's stories with a different ear. I was there not to

find sympathy, but to sympathize and understand what they wanted mindfulness to do for *them*. By participating in the course, I let myself be affected by the normativities of my field, by what Karen and the course participants deemed 'good', worthwhile and beautiful – and what they worked against. My notes, written down in a notebook Karen handed out to us, were *field* notes, which after class I would write out further.

However, instead of suggesting that I was radically different from the others, perhaps it is more on point to say that all participants had partial connections to the 'common struggle'. For instance, not all participants' concerns with weight were the same. Catherine, a sixty year old woman, expressed her wish to no longer spend her life worrying about gaining and losing the same ten kilos. Meanwhile, before coming to the course, thirty year-old Anja's obesity made her concerned about her health and led her to seek out a gastric bypass surgery. After conversations with Karen, she ended up trying mindfulness first, persuaded by Karen's suggestion that any medical treatment 'would not fix the real issue'. Anja, then, was happy she was losing weight. Her weight loss was staged as a result of other changes in her life: regular meals, more exercising, different foods, a better job. She might have quit the program and opted for surgery after all without this result – but at present, her projects of weight loss and changing her life could combine in one program. In the following sections, I discuss how in the course what Karen called 'the real issue' took shape, and how in response, a particular orientation to a fulfilling life, modelled after eating, was proposed. I analyze how, as participants attempted to put this orientation into practice through exercises, reading and sharing, bodies and selves were configured in particular ways.

What do you *really* hunger after?

In Dutch, the object food and the verb eating are the same word: *eten*. And in fact, this conglomerate Dutch word *eten* accurately expresses the focus of the mindfulness course, as the what, when, why and how of *eten* are all enacted as intertwined and important. Mindfulness practitioners set themselves apart from common ways of addressing healthy eating by not focusing on *food* and

its quantities and qualities, but instead starting out with and exploring ways of *eating*.

At the introductory meeting, the group came up with a wide range of reasons for eating: 'I eat when I'm not allowed something because of my diet', 'I always give in when I pass a lovely-smelling bakery' and 'I eat when I'm bored'. Karen categorizes these as 'hungers'; respectively; 'head hunger', 'nose hunger' and 'heart hunger', adding 'eye hunger', 'ear hunger', 'mouth hunger', 'belly hunger' and 'body hunger' on her whiteboard. The idea is that without drawing attention to them, people tend to confuse different hungers so that they have started to, for example, crave food when they feel lonely. This is unhelpful, or so Karen tells us, because food can only ever really satisfy the belly, through its nutrients, and the mouth, through its taste. Ultimately, Karen promises to work through eating to explore the question that she deems 'both profound and beautiful': what do you *really* hunger after? In this new framing, eating becomes evaluated differently.

This became evident when, at the beginning of each meeting, Karen asks us to reflect on what went well in the past weeks. On one such occasion, with an expression of resignation on her face, Suzan shares with the class that after talking with her ex, she went on an eating binge for the whole weekend. She says she realizes what a shame it is that her sense of failure about her binge and her worries about what it might do to her weight further burden her already pressing sadness about her divorce. Rather than a body out of bounds, it is these kind of situations, and the feelings and thoughts that are accompanied by them, which are the subject matter of the therapeutic practice of mindfulness.

The problem, as it is staged here, is not an abnormal body but an unhappiness of the person, in relation to her body or whatever else comes to bear in the course. The first contrast with an order of the normal, then, is that it is not the size of one's body that warrants participation in the course, but one's lived experiences and strategies of self-care. The stories of women like Margaret and Suzan draw out the plethora of ways in which people act on, with and from their bodies in relation to food and eating, and how the admonition to control one's weight interferes with them. Thus, although *eten* is explored in considerable detail, in many ways it is made peripheral to the

core of the course. Often, subjects of an entirely different nature were discussed, such as Suzan's recent divorce, Catherine's unhappiness with her job and Anja's wish to make more time for herself. All kinds of daily life troubles, traumas and events came to the fore. The problem encountered in the course was that currently, participants live their lives with certain hungers unsatisfied.

Through hunger, Karen and the book reconfigure the problem away from food and body weight, towards a concern with self-care, taken here as various forms of *nourishment*. Living is modelled after eating throughout. Often, Karen insists, *eten* is not only burdened with problems it cannot solve; it is itself made into a problem that has gained too much weight. As Suzan's story illustrates, the struggles with blaming oneself for failing to lose weight, uncontrolled eating episodes or an 'obsession' with one's weight are staged as important factors in obstructing nourishment and therefore in need of attention. Mindfulness brings about new patterns and new ways of ordering in how a person concerns herself with herself.

Filling versus feeding

Whereas in dieting, hunger is something to suppress, the mindfulness course makes different kinds of hunger explicit and helps to create a space in which strategies of nourishment can be developed. The goal of the course is for participants to feed all the different hungers on their own terms. This means, first of all, to disentangle them. In the introductory workshop, we sit in pairs and discuss what it means to be 'really' hungry. Your stomach growls, headaches ensue and you lack energy. Then we think of examples when we eat but actually have a different need than belly hunger. Natalie says: 'at work, I sometimes eat to allow myself a break. I might just take a walk instead'. Lisa eats when she fights with her teenage son. When asked, she acknowledges that what she really *hungers after* is a good relationship with him, so Karen suggests she might think of better ways to work on that.

These insights depend on one's ability to recognize and act on one's hungers. Kortink's book asks its readers to consider whether, at a particular

moment, they crave eating because they are truly hungry or because they want to fill up something else. Eating as 'filling' [*vullen*] happens when one eats without attention, gulping down food and feeling bad about it afterwards. Eating as 'feeding' [*voeden*], on the other hand, is a way of eating that becomes available through mindful eating: eating food that is nourishing, because you have belly hunger and not for some other reason. In class, we often sat down together with a small piece of food such as a nut or raisin, and were instructed to carefully feel, look at, smell, taste, chew and swallow the food item, calmly, with attention. We were encouraged to do the same by ourselves at home. This small socio-technical 'dispositif' has generative power (Gomart & Hennion, 1999). The logic of mindful eating is that attention builds in a pause between picking up a foodstuff and eating it. It does not make any food forbidden, but makes space to realize *why* one wants to eat it; and to question whether eating is actually the best way to feed one's hunger. The technique should allow for several insights about *eten:* what it is exactly that food and eating *do* - and what they do *not* do.

Faced with the task of taming bodily urges that are perceived to be threatening and out of control, then, the strategy mindfulness proposes is not to discipline the act of 'filling' by force (mental or otherwise), but to slow the body down. Thus the body emerges as the home of various hungers, ranging from hunger and sleep to a need for social contact and a sense of self-worth; a home that participants are encouraged to slowly start inhabiting and caring for. Such inhabitation was further cultivated through techniques like meditation and the body scan, in which participants are encouraged to 'travel' with their attention through every part of their body (guided by Karen, a recorded voice on a website, or by oneself). Slowing down, however, was far from easy. Even though all participants were positive about the *idea* of mindfulness, and experienced its soothing effects in class, the small techniques proved difficult to incorporate into daily life. In one meeting, our homework consisted of keeping a 'mindful diary' (see figure 4), in which we should note down, among other things, what we ate, where we were and how we felt when eating it, rate seven types of hunger, and note down how satisfied we felt after eating it.

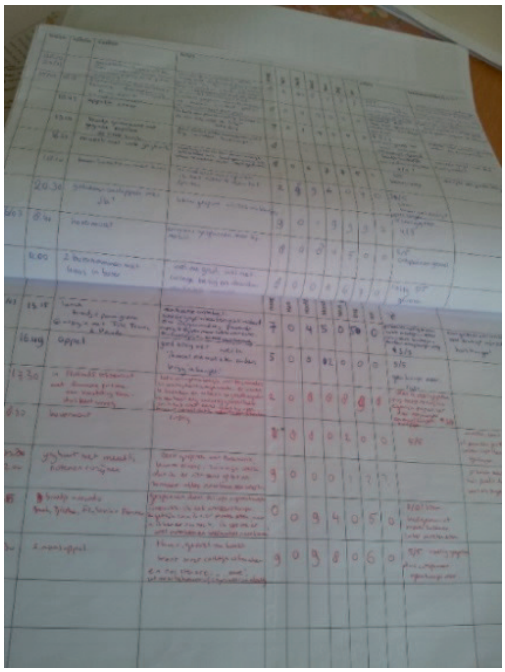


Figure 4. The mindfulness diary. *Photo by the author*.

Full of (auto-)ethnographic commitment, I started filling out the form, putting it next to me on my desk or dinner table so I would not forget. I still did not manage to fill out all the days. The next meeting, I turned out to be the only one who filled in the diary at all. It was not (just) the formal, school-like activity of the diary that prevented the other women from completing it; remembering and then taking the time for introspection during the day was experienced as too hard. This was also acknowledged by Karen: 'If you take *one* bite with attention, this is already an improvement'. What participants worked on most of the time, then, is not how to respond to hungers, but on their ability to recognize them in the first place. Far from being indulgent, this embodied mode of living that values calm, well-fed pleasures becomes available through *askesis*, practical training. Knowledge provision resembles what psychologist James Gibson called an 'education of attention' (Gibson, 1979: 254) where 'placed in specific situations, novices are instructed to feel

this, taste that, or watch out for the other thing' (Ingold, 2000: 22). Learning about oneself and the world takes shape through evolving sensorial engagement with the world, while sharing and discussing such feelings with others.

In seeking nourishment, this practice does not perform a boundary between the physical, the feeding of one's body, and the spiritual, the feeding of one's soul. That is, the hungers described here should not be read as metaphorical.[49] Though not all of the hungers can be fed by food, they are staged as bodily and soulful at the same time. Hungering is not an act of a free will, nor is it a command; it is something a person must give shape to in her life. Only *as a body* can one experience pleasure, satisfaction, calm and comfort. In doing so, the hungering body is foregrounded as the medium through which life is lived.

Nourishing values

Taking hungers as a departure point rather than a notion of 'bodily needs' that could be generalized to all humans, serves to personalize care. Besides attending the course, Anja goes to a dietician who put her on a diet that does not allow her to eat dairy. Anja said she decided to divert from her dietician's advice because she likes yogurt in the morning so much. Karen compliments Anja on this decision. Approvingly, she says: 'always keep feeling what works for you. Remember, what we are offering are handholds, but it is *your* path, it has to work for you!' Handholds may help one to develop nourishing strategies, but lessons are always both specific (for 'my body') and processual (situated in daily life).

Whereas bodily norms such as weight draw human bodies under the same metric, then, an orientation to nourishment allows for differences between people. This does not mean, however, that while the medical and

[49] I owe this reflection to François Jullien's *Vital Nourishment* (2007). It must be noted, however, that Julien decries the co-optation of Chinese thought in wellness and health magazines, which he describes as 'the troubled waters in which "self-help" propagandists fish for the easy profits to be reaped at the expense of indolent minds' (21).

dietary practices that mindfulness contrasts itself against are normative, in mindfulness the question of what to do is left to the subjective, private considerations of the person. This practice is not *less* normative; it just does norms differently. This became evident when Suzan expressed her wish to 'be strong' for her teenage daughters. Karen shows concern: 'I don't mean to… correct you, but why not let your children be part of your life and your difficulties? They can learn from you that they are allowed to show feelings and take up space when they are in pain. Practice what you preach!' The idea that *hungers need feeding* comes with an acceptance of one's own vulnerability. One might say that what is at stake is a conflict between the two norms of 'good motherhood' at play here. I would like to stress, however, that Karen's emphasis on self-compassion makes a crucial difference in the practices through which women are encouraged to *give shape* to such norms in their lives.

A normalizing order implies the 'bad' of pathology and abnormality, of not living up to a norm. The normative register of nourishment, by contrast, works against a different 'bad': the 'too bad' of a life that leaves hungers unfulfilled. Often, women were disappointed that they were still so far away from their goals, still struggling with the demands imposed on their bodies and themselves. But limits were never seen as fixed and always explored. Often, Karen urged us to be generous: 'remember that you have been doing it for so long! It is your process, you take on whatever you are ready for. Focus on the good: failures will come, but also see the growth!' In the fifth meeting, then, the practice of awareness allows Catherine to proudly tell her fellow course participants that that week, after work, instead of going about her usual routine of snacking in the car on the way home, she recognized that her actual ('heart') hunger was for a moment for herself, in a quiet space. To respond to that hunger, she took a detour through the countryside, enjoying nature, and arrived home with a clear mind and without the guilty feelings she would have had if she had eaten snacks. Getting away from a preoccupation with eating is valued not (only) for its eventual expression on a scale, but for its immediately nourishing effects. Such small successes are strived for. Rather than a possible outcome of a therapeutic practice, these are taken to be therapeutic and a source of nourishment in

themselves. At one meeting, we celebrated that Catherine faced her husband and made clear that what she needs for a holiday is not an active hiking program but instead a quiet space to relax. Suzan proudly related her decision to take a few days off from her job to have time to grieve over her divorce, and Anja is praised for daring to engage in, and actually enjoying, workouts in a public park.

The attention to hungers requires acknowledging the 'edibility' of the world and the nourishment that may be brought by the activities one engages in, the people one meets and lives with and the food that one eats. It also requires recognizing that some activities, people and foods provide more nourishment than others. Mindful eaters work to become sensitized to such differences. In doing so, they cultivate the way one 'eats' the world.

Self-knowledge is an important component of the techniques of the self, developed through mindfulness. Specifically, we studied what 'feeds' our life. In the first meeting, Karen handed out little notebooks which, as she explained, would be our 'happiness diaries'. Every day before going to sleep, we were encouraged to write down one positive aspect of our day: a nice moment with a friend or partner, something beautiful we saw, a compliment we received. We put the notebooks in our purses, while Karen explained that an orientation to positivity would itself bring positive change. Throughout the course, we were encouraged to reflect on what gives joy and purpose to our lives and link this to the values we hold dear. Part of our homework was to formulate goals for the next five years of what we wanted in life. The goals we articulated included things such as, 'At least once a week I will spend some quality time together with my partner', or 'I want to be less controlling when it comes to my job'. The 'telos' of these self-care practices lies as much in the here and now as in the future. Orienting towards 'truly valuable' goals makes space for better forms of nourishment. As Karen repeatedly said, these reflections prevent one from 'being a floating boat lost on the ocean' and instead allow one to 'take charge' of one's change instead.

Examining what one hungers after is a pursuit without end. Mindfulness therefore engages with goods (and 'bads') which do not take the shape of (ab)normalities. Instead, personal (and highly gendered) notions of a valuable life are implicated in what counts as appropriate change. These

norms are not prescriptive, but permissive, opening up ways of living and being. That is, Karen presented her norms not as admonitions ('you should'), but as encouragements ('wouldn't it be nice if…'). All the exercises reconfigured life away from fruitless efforts to lose weight, commitments to keep in busy lives or admonitions about what is good or bad to eat, instead focusing on what is 'truly' nourishing and valuable. Throughout this process, one could experience personal growth. Karen talked, for instance, of 'blossoming', understood as bringing out the unique capacities that already lie within a person. Rather than *being* appreciated as the object of a normative judgment, mindfulness works to nurture the person's active appreciations, of one's food, one's life and of oneself.

Minding one's selves

In one of the exercises that was part of our homework, we were invited to write a 'letter to your body' indicating 'why your body is important to you'. Next, we had to write 'a letter from your body to yourself'. Some dared to share their letters with the group, others deemed them too personal. For Suzan, the exercise brought to the fore how she always thought of her body as an unattractive, good-for-nothing obstacle. It took her a month to write the letter in which she expressed her wish to leave this pain behind. Her voice broke as she read: 'I always put the bar so high. And when I finally achieved my weight goal, I still wasn't happy'. In the letter she wrote impersonating her body, Suzan wrote: 'It hurt me to see you hurt yourself. I am happy you decided to come home'.

In the mindfulness course, it was explicitly not the body's constitution, size and shape that was problematized. Rather, the way a person concerned herself with herself emerged as problematic. The body came to the fore as this problem expressed itself in a struggle with eating. It was caught up in unhelpful strategies of self-care. 'Putting the bar high' was a common theme for all of us. In one meeting, Karen asked us to pair up and write down what we saw as the qualities of our partners. Catherine blushed and could hardly listen as I read out to her what I wrote down: that I was impressed by

her ability to keep an fulltime job while caring for her husband, children and her handicapped sibling, and that it appeared to me as if over her years Catherine has learned a lot about herself. Expressing such appreciation of others, Karen pointed out, 'shows how unforgiving we often are with ourselves. The nasty things we say to ourselves, we would never dream of saying to anyone else'.

Slowly, we were encouraged to take up positions that have 'our best interests at heart'. In her ethnography of an inpatient treatment clinic for anorexia, Helen Gremillion describes how psychologists encourage patients to make a distinction between their 'self', who knows what would truly be beneficial, and the 'anorexia' part of themselves that makes them want to lose weight in unhealthy ways (2003). Similarly, in the mindfulness course, an authentic self was staged and appealed to for engaging in better forms of nourishment. This 'real self' was contrasted with so-called internal critics, several of which are laid out in Kortink's book: the perfectionist, helpless, insecure, limitless, bossy, or lazy parts of a person that have emerged and became powerful somewhere during one's life. They are old strategies of feeding oneself that risk stagnating, obstructing nourishment in the here and now, causing someone to engage in cycles of release and control in relation to eating. They were discussed by zooming in on the cacophony of voices (dialogues, reflections, admonitions) that existed in the women's thoughts. Karen explains that every new fact on 'healthy food this, *bad* food that' provides the critics with ammunition. We learn there is a critic at work in the thought, 'you worked so hard today, you deserve that bag of cookies', but also in 'from tomorrow onwards, I should cut off half my calories'.

By writing out dialogues, women learn to position themselves alongside the critics, in the role of their 'true self'. 'The trick is to engage your critic in a way so that it dares to look at alternative strategies', Karen explains. At some point during the fifth meeting, when we have practiced with these dialogues for some time, Suzan confesses: 'Before, I wanted to subject myself to a strict shake diet, get rid of a bunch of kilos, and then start this mindfulness thing. I still have this thought sometimes, but now I see the saboteur in it'. It is sabotaging, she elaborates, because she has tried diets on and off for all her life to no avail, in an effort to feel worthy and beautiful. Co-

opting the mindfulness course as just another diet means doing little to change to more nourishing strategies. So as she writes out the dialogue, she answers her critic: 'I know you want the best for me, but I have tried that road so many times, now I want to try something different'. The critic may then negotiate about what is acceptable change. It appears that feeding hungers was the modus operandi of the subject all along. The critics also respond to (heart) hungers: they try to find fulfilment for the hunger for acceptance, contact or comfort. It was their strategies to do so that were harmful. By focusing on nourishing the hunger at stake, both the real self and its critic (as played out on paper, anyway) may, as allies, come to realize that neither imposing harsh rules on the body nor taking refuge in food will be of much help.

It is worth noting that Suzan describes herself as *having a thought*. This is in line with the phrasing proposed in the course. Instead of being a form of narration or expression, thoughts become 'events', to which more than one response is possible. In these psychological techniques these events were framed as the voices of internal critics. Alternatively, in line with meditation practices, we learned we could distance ourselves from thoughts through attention, as in one exercise in which we were to imagine our thoughts 'drifting by as clouds in our head'. With this exercise, Catherine noticed how liberating it can be to observe, 'oh, I notice I have the thought again that I am fat', without having to take the thought seriously. Kortink, in her book, proposes that rather than listening to them, one may evaluate them: 'Does this thought further a valuable life?'

Through the externalizing techniques I described, the subject emerges as a composite of conflicting positions and incoherencies, full of anxieties, perfectionism and temptations, but also more caring, self-compassionate voices. Though only one of these is designated as the 'true self', I argue that what is shaped here is not an identity. Rather than the occupation of a fixed position, it is the activity of *positioning*, in relation to one's body, oneself and the world, that is transformative.

On several occasions, the exercises were difficult to complete. Catherine, for example, after trying to write out dialogues at home, sighed that 'her' internal critic desperately shouts 'No, No, No!' every time she tried

to reason with it. On another occasion, after a meditation exercise in which for a few minutes we had to imagine opening a door to a different life, Anja said she did not see any door and was not comfortable with such exercises. The internal space that is or is not conjured up, is thus not in our heads, but emerges in an activity, in *minding*, and is made possible by the concentrated class setting, the notebooks, the other participants and the examples in the books. Only then is it possible to concern oneself with oneself. The promise of these exercises is that the participant's way of eating-the-world is reconfigured to the effect that self-neglect makes way for self-care, opening up to a healthier, more fulfilling life. This reconfiguration also moderates how, to what extent and for what purpose societal and scientific norms about a good body and good eating are 'internalized'. What is internal and external, moreover, shifts: as we share and respond to one another, the self comes to be (in) the other, while the attention to critics and thoughts-as-events stage others within our own selves. The unravelling of these is what constitutes the art of mindful living.

Conclusion

Judging is after the fact, distanced, a separate activity. Appreciation emerges in the doing. In this paper I have explored how people, in their self-care practices, give shape to and mediate norms that are posed to them. I have also explored different ways in which normativity is done. I argue that the techniques described in this paper shift the normative register in which eating and living well take shape. Mindfulness is not a practice of *norming*; of taming variety in bodies, subjects or behavior by means of metrics, standards or categories. Neither is this practice geared towards the recovery or appropriation of an identity, for instance a 'thin self' or 'new me' that one can then try to live up to (Heyes, 2006; Throsby, 2008). Instead, it orchestrates a different form of change altogether: one that is not enacted as a correction on a body out of bounds, but as a search for nourishment. While engaging in nourishment, what is 'good' to do cannot be found in measuring oneself against general rules of conduct or advice. Instead, one may sense and

appreciate such goods from inside oneself. In this sense, the hungering body is foregrounded as the medium through which life is lived.

How to best feed hungers? Karen emphasized that the previous strategies of self-care women engaged in led to tension, feelings of guilt and failure, weight gain, tiredness and stomach pains. As it was staged in the course, these strategies kept hungers unfulfilled, leaving the body frustrated, full of anxieties, perfectionism and temptations. Mindful living, then, is not a readily available way of living. Rather, it requires training. In this training, I highlighted three steps. First, the normative register of 'hungers need feeding' depends on *attention* to one's hungers, achieved through a slowing down of the body. Only through attending to them can they be disentangled, recognized and fed on their own terms. Second, feeding hungers begins with a search for what one finds nourishing. Here, it is not only nourishment itself that is considered valuable; the process of searching for and orienting towards what one finds nourishing is appreciated as transformative in itself. Third, the self is staged as composed of a collection of conflicting positions and incoherent thoughts towards oneself and the world. Given this, one tries to first find and then live from that position that has one's best interests at heart. All of these steps re-organize daily life, and the ways in which one positions oneself in relation to events internal to the subject and in outside encounters with the world.

The subject of this mode of ordering learns to 'feed' herself and orient herself towards what she finds important, beautiful and pleasant. Instead of aiming to conform to norms imposed on her by society, she learns to concern herself with herself in a different way. Mindfulness practitioners attend to *their* hungers, *their* path. What is developed is the self's mediating and form-giving capacity under 'conditions that are not of one's choosing' (Brown & Stenner, 2009). Such mediating and form-giving depends on continuous minding of tasting, feeling and observing what one hungers after, and of the nourishing qualities of such diverse things as food, the countryside and friends. This way of living with overweight is not easy – and it is precarious. At any moment, the techniques could fail, because they were too threatening, too laborious, or too unusual. The steps through which the women nourished their lives were always small.

Material semiotic approaches typically study the *how*, rather than the *why* of ordering. They analyze practices and the emerging multiple realities they enact. The implication is that norms – notions of bodily needs, a normal body size, a good person – do not do their work automatically. They must be continuously remade in practices – scientific, medical, political and everyday. This means that sometimes, even in therapeutic practices that concern themselves with overeating and body weight, they can also, if only temporarily, be *re*done or even *un*done. The alterity I attended to here, I underline, is not pure and beyond criticism. It is interspersed with partial connections to processes of normalization. The co-optation of mindfulness as a promising new weight loss intervention attests to that. With my articulation, then, I do not claim that this course breaks free from or has the potential to overturn an order of the normal. But the realities enacted in this course cannot be reduced to normalization either.

How can we, as scholars, appreciate this difference? If ordering is a practical endeavor, then, to use Donna Haraway's words: 'it matters what stories we tell to tell other stories with, it matters what knots knot knots, what thoughts think thoughts, what ties tie ties' (2013: 3). It is precisely in emphasizing, and exploiting, the researcher's involvement in how ties are tied that material semiotics contributes to different ways of doing normativity. In my analysis, in a classic material semiotic move, I have emphasized the contrasts and conflicts with normalization, in the hope of thus strengthening the invention and fostering of better ways of living in situations where overweight is a concern.

For this, or so is my risky assertion, is what we learn from this therapeutic practice. Its techniques, materials and exercises facilitate taking different subject positions, opening up the possibilities of action, and ultimately developing different ways of being. The normativities implied in mindfulness techniques shape processes of becoming. The limits and shape of what is cared for do not precede these practices, *nor* are they enacted *in* them. Their open-endedness, the 'not-yet-enacted', is exactly what characterizes them. This openness is what feeds the hope of alleviating the suffering in everyday life that motivates self-care practices.

Chapter 6

OPERATING (ON) THE SELF

Transforming agency in obesity surgery and treatment

Abstract

In this article, I describe the processes through which patients diagnosed with 'morbid obesity' become active subjects through undergoing obesity surgery and an empowerment lifestyle program in a Dutch obesity clinic. Following work in actor-network theory and material semiotics that complicates the distinction between active and passive subjects, I trace how agency is configured and re-distributed throughout the treatment trajectory. In the clinic's elaborate care assemblage – consisting of dieticians, exercise coaches and psychologists – not only is the person actively involved in his/her own change, the subject of intervention *is* the 'actor': his/her material constitution, inclinations and feelings. The empirical examples reveal that a self becomes capable of self-care only after a costly and laborious conditioning through which patients are completely transformed. In this work, the changed body, implying a new, potentially disruptive reality that patients must learn to cope with, is pivotal to what the patient can do and become. Rather than aiming to become disembodied, self-contained (neo)liberal subjects that make sensible decisions for their body, the difficult task patients face is how to become active subjects through submission and attachment and by arranging support.
Keywords: *care, patient empowerment, embodiment, bariatric surgery, agency, obesity*

Introduction

Hans is a 43-year-old security officer who has been 'big' all his life. As he recalls, he grew up in a family in which abundance of food and drinks was the rule, a standard which continued in his own household where his wife does most of the cooking. Hans feels that his impressive body grants him a certain authority at work. For a long time, he tells me, he 'denied' to himself that his body weight posed a problem. But a few years ago, he suffered whiplash complaints after a car accident, gaining more weight and developing diabetes. At the same time, he saw both his parents die of cardiovascular diseases, and his son was becoming overweight too. '*Something needs to change*', he thought. Through playing squash and controlling his diet, he managed to lose 40 kilos and get his blood sugar levels under control. But keeping the weight off proved to be difficult. Periods of substantive weight loss were always followed by weight gain. Over a period of eight years, he calculates, he lost a total of 208 kilograms, gaining 280 kilogram back.

Recently, Hans decided in consultation with his doctor to opt for bariatric surgery. When we meet he is three weeks away from having 'gastric bypass' surgery in a Dutch obesity clinic, which I will refer to here as *clinic Q*. In this procedure, a surgeon will reduce his stomach to ten percent of its size and re-attach the new stomach to the intestine about 150 cm further up (see figure 5). A large part of his small intestine will thus be circumvented, a rearrangement that if successful should result in a substantial loss of weight. But whereas surgeons determine a surgery to be either successful or unsuccessful based on weight loss and reduction of comorbidities such as diabetes, in the clinic the substance of therapeutic intervention extends far beyond the body as revealed through the 'anatomo-clinical gaze' (Foucault, 1973) of the surgeon. Prior to and after the surgery, patients at clinic Q go through an elaborate clinical program meant to help them engage in better forms of self-care. Self-management and personal responsibility are key goals in this clinical treatment.

At first, gastric bypass surgery may seem to be at odds with such calls for responsibility, as the procedure suggests a surgeon relieves the patient of the difficult task of controlling his/her behavior. This framing may

invite a sense of comfort to the patient as finally, normalized notions of body weight may be in reach (Felder, Felt, & Penkler, 2015); however, patients also risk accusations of having 'cheated' their way to health (Throsby, 2008). My fieldwork, however, suggests that in practice, support and agency are not mutually exclusive. In this article, I describe the processes through which patients diagnosed with 'morbid obesity' become active subjects through undergoing obesity surgery and engaging in an empowerment lifestyle program. As I will show, in the clinic's elaborate care assemblage – consisting of dieticians, exercise coaches and psychologists – the self-actor is not only actively involved in projects of healthy eating; their wishes, feelings and appreciations are the very subject of therapeutic intervention.

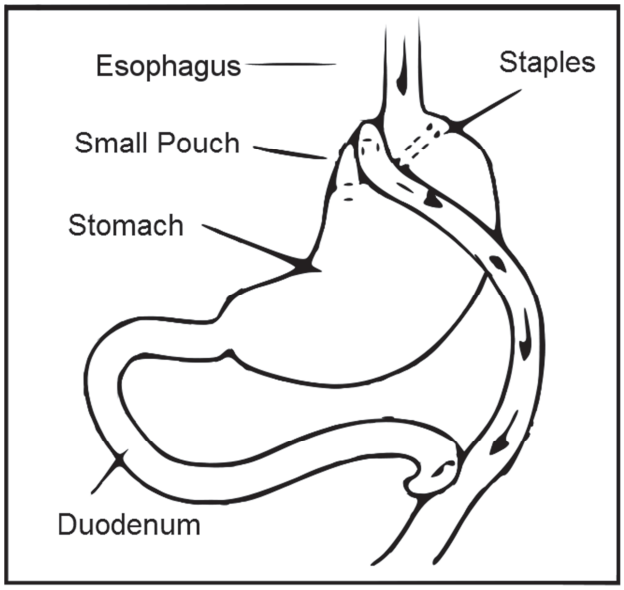


Figure 5. Model of a Roux-en-Y Gastric Bypass. *Source: Wikimedia Commons.*[50]

[50] https://commons.wikimedia.org/wiki/File%3ARoux-en-Y_gastric_bypass.png, available under a CC BY-SA 3.0 license. Author: NIDDK. Derivative work: Steven Fruitsmaak. Last Accessed: June 19, 2016.

Following scholars inspired by post-ANT and material semiotic work that complicate the distinction between active and passive subjects (Gomart & Hennion, 1999; Thompson, 2005), I trace how agency is configured and re-distributed throughout the treatment trajectory. In clinic Q's medical and psychological treatments, the qualities and abilities of the self, and the socio-material conditions through which they come to be, are rearranged. This rearranging, moreover, is to an important extent done by the patients themselves, who willingly submit themselves to objectification (by surgeons) and subjectification (by psychologists) in order to craft themselves differently. This agency, however, does not lead to liberation or control. Patients make things act on them that in turn make them act in certain ways, and that transforms them in the process. In this work, the changing body, implying a new, potentially disruptive reality that patients must learn to cope with, is crucial to what the patient can do and become. My argument is that rather than striving to become disembodied, self-contained (neo)liberal subjects who make sensible decisions for their bodies, the difficult task patients take on is how to become active subjects through submission and (re-)attachment and by arranging support. The empirical part of this article articulates how this struggle plays out in eating practices. The examples reveal a self that is capable of self-care only after a costly and laborious conditioning through which patients are completely transformed.

Obesity surgery in clinic Q

Between 2012 and 2013, I conducted fieldwork in clinic Q. While regular public hospitals in the Netherlands offer few meetings with a dietician and a psychologist to guide patients through the surgery, this private clinic makes surgery part of an extensive clinical program.[51] After screening, patients are put into groups of 10 and attend seven three-hour preparatory meetings led by dieticians, psychologists and physical therapists. The post-surgery trajectory consists of meetings every three weeks in the same group

[51] In the Netherlands, treatments such as these are fully funded under a system of obligatory health insurance, provided by private health insurance companies.

composition for the first 18 months. Yearly follow-up meetings last up to seven years. To be eligible for treatment by both medical and insurance standards, adult patients need to have a Body Mass Index (BMI) above 40 kg/m^3, or 35 kg/m^3 with comorbidities such as diabetes or sleep apnea (Fried et al., 2014). The most common surgery practiced in the Netherlands and in clinic Q is the *gastric bypass*. On average, gastric bypass patients initially lose 85 percent of their 'excess' weight, with losses stabilizing over the years at 60-75 percent (Sjöström et al., 2007). Another common procedure is the *gastric sleeve mastectomy*, in which a large part of the stomach is removed, leaving a stomach the shape of a small banana. Sometimes these surgeries are performed in order to supplant a *gastric band:* a restrictive ring around the stomach that is now largely considered as an ineffective and outdated treatment.

During my fieldwork, I observed clinical meetings and various surgeries and had informal conversations and formal interviews with clinicians. In addition, I interviewed 15 patients about their history with being overweight and their decision to go for surgery.[52] I asked them about their experiences with the clinical and surgical trajectories. They told me about their routines and strategies for dealing with the effects and demands of treatment in their daily lives, thus giving insights into how they live with what some called 'their overweight', and the ways in which the clinical treatment informed these practices.

Bodies, selves and agency

These days, with the increasing prevalence of chronic diseases, politicians and health policy workers often call for active patients. The new healthy citizen is informed about and actively managing his or her own treatment – indeed, preferably working to prevent the onset of illness to begin with. Given talk of

[52] Interviews were conducted with patients, enrolled in different stages of the clinical trajectory. These patients agreed to the interview after being asked by the clinic personnel or they responded to a flyer that was put in the waiting area. Interviews were transcribed, anonymized in line with local ethical guidelines and translated into English. Names in this paper of both patients and clinicians are pseudonyms.

how the 'obesity epidemic' is burdening nations with mounting medical costs, such calls for self-management often take on a sharp moral tone. A fat body is said to bear the mark of an out-of-control subject – boundless, spineless and gluttonous (B. Evans, 2006; Murray, 2007; Schwartz, 1986). By contrast, its desired alternative resembles a disciplined, self-contained (neo)liberal subject who makes sensible decisions for his/her body (Guthman & DuPuis, 2006; Throsby, 2008).

Given these pressures, social scientists are often wary of empowerment discourses in health care. They read them as a 'responsibilizing' mode of governing: enlisting the individual in its own controlling, thus placing a 'burden of freedom' on him/her (Rose, 1999). Often, the analytical stress is on what these institutions and programs 'make' people do. Muriel Darmon (2012), for instance, in stressing the drastic transformations that 'bodies and souls' undergo in a commercial weight loss group (a 'people-thinning institution'), presents individual motivations, will, and self-constraint as functions of external control and surveillance.

Bariatric patients' empowerment has likewise been discussed through such a lens. Knutsen, and colleagues describe the tensions that arise as 'caught between conduct and free choice' (Knutsen & Foss, 2011), patients struggle to navigate the tensions around control and credibility (Knutsen, Terragni, & Foss, 2013). As surgery in these programs is staged as a mere *tool* for weight loss, depending heavily on lifestyle change by the patient, others worry the patient now carries the burden not only of the effects of surgery but of its very success (Groven, Råheim, Braithwaite, & Engelsrud, 2013).

I contend, however, that the fact that people actively seek treatment invites a more complex analysis of agency and control that investigates what these programs make available to patients, given their motivations and options, and taking into account clinicians' notions of 'good care' (Mol, 2008b). Scholars inspired by actor-network theory and material semiotics typically attend to the ways in which situated relations and concerns might mediate institutional, cultural and medical norms. Through a focus on practice, such work does not take bodies, subjects and selves as pre-existing entities endowed with inherent capacities and qualities, but rather explores the processes through which they come into being relationally (Akrich &

Berg, 2004; Danholt, 2013; T. E. Moreira, 2004). These analyses contrast with calls for self-management. While the latter often dream up a world of stable objects and relations in which only the decisions and actions of a pre-given subject (should) change, the former attend to the socio-material conditions for self-care and agency.

This approach depends on a particular way of studying action. More than just applying humanistic models to heterogeneous actors – stating that nonhumans and bodies *also* have agency – post-ANT work typically uncouples action from the (more or less distributed) actor(s) involved. As Antoine Hennion and Emilie Gomart (1999) stress, asking 'who acts?' is in these analyses, at least temporarily, no longer appropriate. A focus on enactment, multiplicity and marginality opens up agency beyond the managerial model of translation for which early day ANT analyses were criticized (Lin, 2013; Star, 1990). Only sometimes is an 'actor-enacted' (Law & Mol, 2008) and can action be circumscribed to a particular source. Indeed, it appears practices may not stage clear actors at all. Eating and digesting, involving semi-permeable entities that mutually transform and incorporate each other, are a case in point (Abrahamsson, 2014; Mol & Law, 2004; Mol, 2008a).

In her studies of women undergoing infertility treatments, Thompson (2005) questions the assumption that subjects are *either* active or passive. Instead, she argues, objectification through reproductive technologies is by no means antithetical to agency and personhood. Whether women experience the interventions as alienating, or as reconstituting their agency, depends on whether it was successful in achieving their goal to become parents. She describes how women actively submit themselves to these procedures, analyzing the process that structures the (dis-)alignment of treatment and women's experiences as an '*ontological choreography*': a dance between self and environment in which what parts the women are built of, what and how many descriptions they fall under and how integrated they are or need to be, changes. Through maintaining a synecdochal relation between self and parts of the body throughout interventions such as the pelvic exam and the ultrasound, women produce a desired long-range self (Cussins, 1998).

In their studies of the passions of music lovers and drug users, Gomart and Hennion theorize a similar mode of doing, which they term

'attachment' (see also Latour, 1999). They argue that being affected (by drugs or music) is not an automatic effect of substance or sound, but depends on a 'making oneself available'. The 'competent amateurs' they study use techniques to make a set of heterogeneous entities such as drugs and music act on them in a way they desire (1999). They make choices, negotiate competing demands and exercise judgment, but they never master. Instead, their manner of proceeding is characterized by an obligatory pragmatism which permits 'not a liberation, but partial substitutions' (qtd. in Danholt, 2013: 378; Hennion, 2010: 1).

To these rich analyses of the agency of medical subjects and amateurs, this article adds a case in which the person is not only actively involved in his/her own change, but is also the subject of intervention – his/her material constitution, inclinations and feelings. As I will show, departing from a dissociation between one's wish to change and one's inability to do so, the subjects of this study move through the world making and breaking attachments. The network in and through which patients move and are moved includes surgeons, the surgically altered stomach, food, social relations and the clinical treatment. These attachments transform them, as embodied self-actors, in the process. They attachments change how patients feel, how they know and respond to their bodies and themselves, and thus open up ways of becoming while closing others. Although the effects of surgery are far-reaching, I will limit my analysis to practices of and concerns related to eating.

The promise of surgery: anchoring the will

> [*fieldwork excerpt*] Mrs. Jansen, the second patient of today, enters the surgical room. She is asked to take a seat at the chair and place her calves in the holders. As she settles in, the surgeon and anesthesiologist explain to her that they will try to perform a gastric bypass, but that given her high BMI this might be too dangerous. If so, they will go for the gastric sleeve procedure, a procedure that is quicker and has less risk of complications. Mrs. Jansen knows all of

> this already. After the check, she gets an oxygen mask and the anesthesiologist administers the anesthetics. Mrs. Jansen is a bit restless, breathing heavily. 'Just let go,' says the surgeon as he strokes her arm, 'it's all good'. The next moment, Mrs. Jansen falls asleep [...]
>
> After the procedure is done, the surgeon cuts the intestine where it attaches to the new stomach pouch, and checks one more time if all organs are in the right position and no bleeding is left. Once all instruments are removed from the belly, the medical resident and surgical nurse stitch the incisions for the trocars. The anesthesiology assistant stops the flow of anesthetic, slowly waking the patient. Due to the anesthesia, she will not be able to remember these moments in the OR. As soon as Mrs. Jansen wakes up, she asks: 'Did it work??' Busy cleaning up in his corner of the OR, the anesthesiology assistant mumbles, 'Yes, we did it.' A few minutes later, as Mrs. Jansen is still half asleep, she asks again. 'Yes, we were able to put in a bypass,' someone else confirms. 'Oh, great!!!' Mrs. Jansen moans.

The idea of bariatric surgery might suggest that the doctor comes in and corrects from the outside, thus relieving patients from the difficult task of taking control over their behavior. This framing privileges the situation in the surgical theatre as the relevant site for action, in which surgeons and equipment mechanically act on organs while a patient is anesthetized (Hirschauer, 1991). By the time the patient wakes up, the surgeon has done the work for him/her. But on closer look, a more complex interplay of doing emerges. Importantly, undergoing surgery does not necessarily imply passivity on the side of the patient. This is true when considering the practice of surgery itself – as Goodwin (2008) shows, the technological augmentation of the body in present day anesthesia provides the unconscious body with possibilities to convey its needs to the doctor – but particularly when considering surgery in a broader therapeutic trajectory. Patients actively commit and submit themselves to the interventions of the surgeon and his/her medical colleagues, making themselves a body that can be handled in the operating theatre.

Indeed, becoming eligible for surgery is for many a task on its own. This is due to, for instance, the admission criteria for clinic Q. Sometimes people are referred to extensive psychological treatment first if their psychological problems are expected to interfere with the medical treatment and its effects. Patients who are dangerously overweight or present serious cardiovascular risks may have to stop smoking or lose a certain amount of weight to be eligible, lest they have to opt for a safer but less effective surgery. Sick leave needs to be negotiated at work, household and care tasks need to be delegated to others. In addition, patients have to be on a very strict diet for two weeks before surgery, in order to decrease the size of the liver, thus preventing complications during surgery.

Patients have good reasons to make this effort. For them, body weight incorporates such diverse concerns as immobility, pain, illness, and fear of health risks, but also feelings of intense shame and guilt. Moreover, dieting experiences were familiar to all of the patients I interviewed, who had often tried to lose weight by different means, sometimes continuously throughout their lives. In fact, to be eligible for bariatric surgery according to guidelines by the European Commission, patients should have tried and 'failed' to lose weight 'by other means', surgical or non-surgical (Fried et al., 2014). After this history of 'failure', the procedure holds the promise that an overwhelming and persistent problem – their body weight – will become (literally) graspable and solvable (Felt et al, 2015; Solomon, 2014). Not only will they get a 'normal' body, but they will have help getting there too:

> Beth: 'Surgery seemed to me the only way to lose weight and then keep that [lower] weight. Losing weight is not such a problem. I diet, and I pay attention. Now, because I know what I am like, to protect myself, I have this stomach reduction. Of course, at some point you will have a bit more cravings, but because of this stomach [pouch] you cannot eat that much anymore.'

Whereas Beth's history of dieting locates the means to moderate consumption in her willpower and ability to 'pay attention', surgery allows her to bring forward the new stomach as an alternative route to success. Finally,

restriction becomes possible and 'pays off': weight is lost. As anthropologist Harris Solomon phrases it in his study of metabolic surgery in India: 'Aided by surgery, the body takes over and becomes its own instrument of therapy from the inside out. [...] Postsurgery, a person could enjoy loosened ties to the diets and medication that led nowhere and could instead invest in intimate attachments elsewhere.' (2014: 71). One such new attachment surgery allows Beth to make is to her new stomach, a rearrangement that she says 'protects' herself.

Through mobilizing the surgical network, Beth makes certain parts of her body act on her in a way that she wants. Beth's narration of the surgery begs the question: who 'does' what happens through surgery? Is it the patient, the surgical team, the rearranged organs, or the countless other entities involved in the trajectory? The answer is: none and all of the above. Even more interesting is what is made available through all this action. The procedure, I argue, anchors her will in her body. The promise of this materialization is that her body no longer needs to be the site of a struggle in which discipline is necessary to counter cravings. Instead, in the embodied self that surgery makes possible, will and cravings are in line with each other. The new attachment, then, does not only change *what* the patient can do, it opens up the possibility for a different *kind* of actor altogether: a willing embodied self, capable of moderately incorporating its surroundings. But as we will see, although in themselves, gastric bypasses or sleeves can be fixed in under an hour, these single attachments do not fix patients' problems. Rather, they shift them.

Obesity in the clinic: staging problems, scripting solutions

Body weight and eating are already highly problematic for patients prior to entering treatment. But in the way obesity emerges in clinic Q, the 'problem' and what is necessary to counter it, becomes legible in a particular way. Through the surgery, the organs comprising the digestive tract, often referred to simply as 'the stomach', are brought out as, in a sense, more concrete – not only because they are literally made visible and manipulated by the surgeon,

but also because they now display certain properties that were previously not specified to a particular body part, for instance, the (in)ability to limit food intake. As the stomach enters 'the scene of action'(Thompson, 2005) of treating and causing obesity, it takes on new meanings.

For instance, the possibility of an 'active' stomach makes visible how the body before surgery was not present in quite the same way. Consider Hans, who describes how after years of defying feelings of fullness when eating, he lost touch with his bodily signals:

> 'I am rarely hungry, but when I start eating it's as if a beast comes out. [...] Feeling satisfied, I don't right now - I'm never full. This is something that is not right…. here [points to his head]. So I look forward to it, because one of the effects of surgery is that you do feel satisfied. From a big plate full of meat dangling over the edge, you will go to this small piece. Well that will affect your eyes, your senses… with the huge bites I take, my brother always said when I eat a sandwich: I pity your sandwich, please act normally! So to listen to your body again, to not ignore it because then you will keep eating and eventually [the new stomach] will stretch again, one has to prevent this from happening.'

Like Beth in the previous section, Hans implies that surgery creates a new kind of embodiment which allows a moderate mode of consumption. In a very real way, then, patients' lived bodies, and their agency, come to life in the attachments made through these medical practices. A possibility emerges to become 'normal', to recreate what was somehow lost or never there to begin with. At the same time, however, in pointing to his head, Hans suggests the core of his problem lies elsewhere. Circulating 'horror stories' about what may happen after surgery revealed that in relation to the psychological problem, surgery might be disruptive, rather than helpful:

> Hans: 'In the post-surgery treatment we will discuss lifestyle change. Like, how you will organize it. And yes, especially prevention, that you won't do crazy things. I hear stories about people blending big

> macs, just to be able to eat. I cannot imagine anything like this happening to me, now, but I haven't been operated upon yet!'

Hans gives little impression of seeing surgery as a 'quick fix'. He anticipates a change after which he might not recognize himself. As his own inclinations and habits become part of what is taken up in treatment, he poses the time after the surgery not just as a recovery period, but as central to the change he sought when coming to clinic Q. As he indicates, surgery's effect on the amount he eats is not automatic: in order to 'work', the change requires him to adopt new strategies, to 'listen' to his body so as to prevent hitting upon and stretching the limits of the new stomach. In line with this idea, the clinic's motto – included in the very first information meeting and often repeated by patients in interviews – is that only 20% of the change comes from the surgery, and the rest 'you have to do yourself'.

Patients are not always inclined to accept this active role in their treatment. Especially in the past, clinicians faced 'resistance' to the post-surgical clinical program from patients who were only interested in getting the surgery and 'losing weight fast'. Now, patients sign a contract stating that they will attend most meetings; if they do not hold this agreement, they will have to pay a sum of money to the clinic. At stake is the very success of treatment. As my informants in the clinic tell me, although surgery kick-starts weight loss, letting the surgery 'do its job' without changing self-care practices may not prevent a person from overeating in the long run – a risk that fuels Hans's fear of stretching his stomach. Moreover, surgery's effects are not all positive. Patients can experience intestinal and digestive problems, and the pain and deformity of excess skin can make patients feel like they are worse off than before (cf. Throsby, 2012). Medical research reports a high risk of malnutrition, disordered eating and even alcohol addiction after surgery (Ertelt et al., 2008; Kalarchian, Marcus, & Courcoulas, 2008). In order to prevent these issues, clinicians in clinic Q ask patients to profoundly change the practices of self-care they engage in.

They do this through a number of therapeutic interventions and exercises. During a group session with a dietician, around eight months after surgery, the list detailed in table 1 was collectively established on the

whiteboard. It was the result of an exercise asking patients to think about which changes in their lives were caused by surgery and which were caused by their own actions. It took a while before the group started talking, but after a bit of awkward silence, the discussion began. As the list continued, the dietician listened, summarized and paraphrased strategically to make things fit boxes or create clarity. The list demonstrates that surgery's effects do invite certain types of behaviors (eating smaller portions) but that a surgical procedure may not change that behavior completely ('deliberate choices' still need to be made).

Table 1. Depiction of the whiteboard at the end of the session with the dietician.

Self	**Surgery**
Healthy choices for products	*Dumping*
	Feeling full sooner
Eating pattern	*Amount you are able to eat (first year)*
Deliberate choices (saying yes/no)	
Losing weight	*Start losing weight*
Health…	*… improvements*
More physical activity	*Different uptake of food*
Better fitness	*Smaller portions*
More self-confidence	

Part of the discussion was on 'dumping', the process of solid parts of a meal going directly from the stomach (pouch) into the small intestine, causing very uncomfortable bouts of cramps, sweating, nausea and diarrhea. Dumping, it was established, might be caused by the surgery – some people experience this while others do not – and is in this sense considered a helpless consequence of the body. But if one is susceptible to it, *choosing* not to eat candy because it *leads* to dumping is considered an *act*. Some people, after all, do 'accept' these effects and eat on anyway. Surgery thus merely creates situations that afford change. Some changes, such as increased physical activity, are facilitated by

the weight loss the surgery induced but still depend on oneself to do it, and are thus put in the middle.

Clinicians thus make use of what Cheryl Mattingly (1994) called 'therapeutic emplotment', the production of narratives that makes surgery and what happens within the therapeutic process intelligible as leading somewhere. As talking was the main activity in the pre- and postsurgical trajectories, such narratives and exercises serve as powerful therapeutic techniques to involve patients in the treatment. These therapeutic plots also contains *scripts*. It is important to the collectively established performance of care around bariatric surgery to clearly indicate what should be done, and who or what plays which part, and when. Not only does this exercise elucidate the diversity of effects of surgery, it also makes visible certain important activities and tasks: managing complications, engaging in healthy activities, eating in a certain way, and dealing with the emotional and social consequences of bodily change. In this clinic, the message is patients cannot and should not delegate the task of managing their obesity to the surgeon, nor should they 'accept' dumping or find themselves doing what Hans called 'crazy things'. Instead, they should actively take on the work of getting in sync with, and adjusting to their new body. I will now discuss two ways in which self-care after surgery becomes a matter of concern for patients: in adjusting the socio-material practices of eating, and in arranging sources of self-care away from food.

Experimenting with unpredictable bodily limits

Many patients hope surgery will provide an opportunity to learn to eat differently, or rather, *better* (cf. Hillersdal, Just Christensen, & Holm, forthcoming). The new stomach, through radically reshuffling the sensorial qualities of eating, gives urgency to this learning process. If they fail, patients worry, they might 'stretch' their stomach again in the long run by forcing it with too much food. For some patients, post-surgery eating comes with the threat of dumping and other uncomfortable sensations. The new connection to the stomach thus does more than loosen the need for self-discipline. Bodily

limits, and the effects of hitting them, are unpredictable, shifting. Care is in order:

> Hans: 'Some things you will have to try out, there are also things you just don't want to try. White bread is a no-go. When I hear how much trouble this causes others… and for me it's easy to leave, so I won't even try. What I will do is a sandwich with aged cheese, because I think there is no point in punishing yourself your whole life. So I want to see if that works. I would rather have aged than soft cheese, it has a stronger flavor. But perhaps my taste will change too after surgery? You never know.'

In his elaboration of his plans to experiment with the limits of his new stomach, Hans highlights that he does not just ingest food (or not), but also chooses and enjoys it. He considers it important to take pleasure into account, to make life after surgery 'livable' – weighing potentially troublesome food based on what he can do without (white bread) and what he wants to keep enjoying (cheese). But nothing is set, as changes in the metabolic system may affect his food preferences.

Tastes, hungers, pains and pleasures were not just a topic in my interviews with patients, but are discussed at length in the clinical sessions, even before surgery. Moreover, clinicians encourage a specific eating technique borrowed from mindfulness practice, which should assist patients in experimenting with what 'goes down well' or not. Slow, attentive bites, according to dieticians, allow food to be better absorbed by the body and afford feelings of fullness. But such eating is not straightforward at all (see also Just Christensen, 2014). Halina, 14 months past surgery, explains:

> 'Old habits will present themselves soon. For example… If you eat a sandwich, and you cut it in 8 pieces. This was the advice from here [the clinic]. And eat it calmly, at a table, not in front of the TV. But then you eat 7 pieces, you're full. But you have one left, then I think: "Food should not be thrown away". It is a piece of 2 by 2 cm, it will fit. You come back from that immediately. It doesn't fit. Having a

> sleeve, it means I get symptoms like puking, sweating, being out of breath… So you notice that a small piece can be way too much. And that is how you learn. You have to try. I am at the end of my trajectory [of the clinic] now, so I kind of know what I can and cannot eat.'

Halina has to deal with a conflict between her stomach's limits, and her old habits and moral inclination: 'food should not be thrown away'. The new mode of eating, set up to help her recognize her limit, merely brings this conflict to the fore. The new stomach speaks loud and clear, but fails to be binding. Only because the effects are so severe did she eventually, through trial and error, learn what and how much she can eat. It is for this reason that some patients call 'dumping' a blessing and a curse: though very unpleasant, it will force them to eventually eat better and sync up with their stomach in better ways.

Amy, a few months after surgery, also finds it difficult to eat well as stipulated by the clinic. For her, the conflict emerges not from her moral evaluations but in her relation to the social world:

> 'What I now do is put down the cutlery, and chat during dinner. You need to dare to recognize when you are full. […] You have to learn to not be bothered by anyone. Full is full. […] You have to keep focusing on yourself if you are conversing with people. It can be very difficult, and often I'm still nauseous afterwards. One bite too much and you're done for the night. That really sucks. I have to say I get better at it, when I have the feeling I'm full, I cover the food in salt so I really won't touch it anymore. But yes, it is a matter of recognizing and some practice, but it is still tricky.'

Surgery is not enough to anchor the will to the stomach. Amy uses salt to strengthen the bond. On its own, a compact stomach size can only overrule social interactions and plate-size conventions when it is too late. Changing one's inclinations and behaviors requires more than a rearranging of the digestive tract; the socio-material practice of eating should reorder with it. The clinic offers mindful eating as a point of engagement to help fit a post-

surgery body in daily life practices. Either patients actively link to their stomach by eating in a certain way or risk the forceful bond of dumping.

In everyday practices such as these, being an embodied person is a matter of doing (compare Mol & Law, 2004). It entails keeping a body together that is full of internal tensions, including that between a person's unruly bodily movements and his/her attempts at control. The surgically altered body is in tension with the body that enjoys food and conversation, as well as with the body that habitually and morally engages with food and eating. Eating after surgery entails learning, through effort and trial-and-error, how to reconcile these with one another. Attending to how bodies are done reveals that unity and harmony are hard-earned temporary achievements. The task patients at clinic Q face, then, is not making better decisions *for* their body, but learning how to *be*, and act as, a different eating body altogether.

Rearranging food and other sources of self-care

In clinic Q, it was frequently stated that though the patients' condition resulted from overeating, the cause of this eating is mental – Hans staged this mental realm by pointing to his head. Through the narratives and techniques offered by clinic Q and previous psychological treatments, patients thus learn to localize 'the problem' – the obesity – inside themselves. Accordingly, surgery is clearly not enough: as patients phrase it, surgeons only operate on their stomach, not on their head. Proper treatment for obesity addresses the latter too. In group sessions, the psychologists urge patients to explore what parts of themselves food and eating link up with.

For instance, they discuss words referring to ways of eating, like 'internally/externally triggered' (denoting a split between body and environment), 'restrained' and 'emotional'. Patients describe themselves as 'addicted'. Rather than analyzing how psychology constructs the 'eating mind', my focus here is on the clinic's language for what it does in directing patients towards certain forms of self-care rather than others. These categories invite patients to sketch out certain kinds of work they have to do

in the clinical trajectory. Consider Julia, a 27-year-old woman five months after surgery:

> 'Everything that is wrong here [points at head] is still there. But I learned in psychological treatments to leave problems where they are. So if someone does not do right by me, I am much more confrontational, I tell them what I think. I used to swallow [accept] much more. It's not easy, because I'm still the same person, so my first inclination is still to take it home and eat it all away. So I have to take good care to be clear to that other person, to say: man that is not cool.'

As Julia starts relating to herself as an 'emotional eater', a particular form of 'good care' opens up. The surgery problematizes continuing old patterns – what Julia refers to as 'being the same person' – at least right after the procedure. One can no longer 'eat it all away'. The terms introduced in treatment thus reveal a necessity for the head to catch up with the stomach's changes. As both patients and clinicians tell me, the surgery will impact everyone differently. This makes the evaluation of, and work on the self, more pertinent: Being 'me', as this kind of eater, what will I have to face over the course of treatment?

Karin, a 45-year-old woman who underwent surgery eight months ago, mentions how in a pre-surgery meeting with the psychologist, the group was asked to explore the advantages and disadvantages of surgery. Pointing out that surgery has disadvantages underscores that the procedure is not a quick fix, but also asks patients to explore the work that still lies ahead. For Karin, the exercise made her anticipate losing a 'good friend':

> 'I have a very busy life. I work, I have two children that I raise by myself, so I rarely leave the house on evenings. So if something happened at work, I used to think: which crisps will I buy? Cozy on the couch in the evening, with crisps, in front of the TV, that gave me a good feeling. So for me a disadvantage of the surgery was that I do not have the comfort of that food anymore. [...] I was very aware

> that I was saying goodbye to the crisps and that abundance of food. I experienced it as a kind of mourning process. It may sound very strange if you are not familiar with this… but I had the feeling you might have when ending a relationship with someone. You know you don't make each other happy anymore, and it's good like this, it wasn't right, but you still miss him. Sometimes.'

Both Julia and Karin maintain intimate relations with food, causing them to overeat. These relations risk interfering as the body's attachments to food have changed through surgery. They need to be released and rearranged. Paralleling Thompson's agency through objectification (2005), this way of dealing with oneself, I suggest, can be read as an agency through subjectification. As part of their attempt to change themselves, patients actively submit to the clinicians' psychological knowledge and techniques that, in addressing their 'head' (or psyche/mind), enact them as particular kinds of eating subjects. Despite the Cartesian distinction that talk of heads and stomachs suggests, in the problems that are talked about and dealt with, stomach and head are rather two active components of the same emerging embodied self-actor that need reconciling. This self-actor is affected by its surroundings, experiences anger, grief and loneliness, and organizes its forms of self-care accordingly. Speaking out when mistreated or letting go of crisps in the evening are not 'just' changes in behavior; both Julia and Karen work to transform their very way of being in the world. Julia makes new connections in the world and 'leaves problems where they are' instead of eating them, whereas the practice of mourning is a way for Karin to move on. In these ways, the semi-permeable boundaries of the embodied self may, for a moment, be self-caringly protected.

Conclusion

In this article I have argued that rather than taking over the task of managing one's behavior, surgery operates on the self as actor, thus offering patients a possibility to become self-caring. The transformations through treatment do

not just make available a particular kind of agency; they change the patient as actor altogether. The self-actor patients aspire to become is able to eat moderately and experiences no internal conflict between their motivations and bodily drives. It is true that this focus on achieving moderation reinforces the image of obesity prior to surgery as a state of being out of control (Murray, 2010). The alternative that is strived for and practiced after surgery, however, is no in-control, free actor.

The self of bariatric surgery care that I analyzed is not opposed to the body, but moves with and in it; it is not engaged in choice and autonomy, but comes to act by the various relations it is part of. I have described patients' activity not as mastered choices, but as, following Gomart and Hennion (1999), the pragmatic constituting and substituting of attachments, both within the skin and outside of it. Self-care emerges as a matter of doing, aligning, adjusting, organizing, attaching and detaching. One change invites another, and in the process, patients do not only *act* differently, *they* (their feelings, inclinations and appreciations) come to *be* different.

I suggested that the way in which the clinic plots the therapeutic trajectory and scripts problems and solutions shapes how patients come to feel, know and respond to their (old and new) bodies and selves, thus opening certain forms of self-care and closing others. Rather than foregrounding the clinician's power, I stressed patients' active involvement in such constructions. Clinicians' ideas about what 'proper' self-management is do not always correspond to the patient's valuations of how much dis- or aligning one can handle, nor to how livable tensions are, or what connections one is able to make. The normative evaluations involved in the self-care practices I articulate here, however, are not static, tied to the subject positions of 'clinician' and 'patient', but emerge in the nonlinear, unpredictable process of transformation.

'Bad' and 'good' attachments present themselves and are continuously sorted out, leading to changes in the way the self hangs together. The attachment to the stomach that surgery makes sets itself apart for its particularly transformative effects. But like Hennion and Gomart's drugs and music, to be helpful, the surgery's powerful effects require a laborious and costly conditioning. In the shaping of everyday eating after surgery, and

through the subjectification of psychological techniques in treatment, yet other attachments open up to forms of self-care. But at any point in time, attachments may fail too: stomachs block or stretch, awareness falters and old habits take over. Still, every attachment makes a difference, even if only temporarily.

Finally, this paper shows that calls for patient empowerment need not always be seen in light of neoliberal political or economic rationales, in which health is considered one's individual responsibility while self-care is the cheapest and thus most desirable option (LeBesco, 2011). The embodied self enacted in the practices I describe does not carry a 'burden of freedom' to choose (Rose, 1990) as it struggles to adhere to biomedical regimes. Enacting the patient as an actor did not result in less support or care. The question of who or what should take up the task of caring for obesity thus turns into: how might self-care practices be supported? Patients struggle, not because they are left to their own devices, but because living through transformative procedures, and living with chronic conditions, *is* a struggle.

Chapter 7

CONCLUSION

Modes of care

This dissertation has engaged with the problem of overweight through a study of care practices. This was not a straightforward choice. The question of *how* to live healthy and *what* to do is one generally left to scientists, where the problem of excess body weight is a puzzle that, however complex, has a solution. The task is to find out, once and for all: what is healthy? Capable researchers have studied various aspects of food, bodies and their environments to identify 'contributing variables' connected by causal relations and feedback loops to well-defined entities such as the body and food. The idea is that all of these relations not only add to our understanding of obesity and its causes, but also offer points of engagement for intervention. Ideally, the findings of such research are handed down to nutritional agencies, health care practices and the public, where they may be applied.

This 'science-based' approach to healthy eating presents education and the supply of up-to-date information as the main tasks of professional care. In this way, care practices come to figure as 'interventions' on pre-given bodies, subjects and problems. But as the preceding chapters have shown, prescriptions for health emerging from laboratory research do not land in a social vacuum. In 'the wild', people grapple with often contradictory messages embedded in cooking traditions, printed on labels and spread through popular media. Even insights from different scientific disciplines do not add up and may inform contradictory advice. The advice is furthermore directed at people who have already been sensitized to particular things and have acquired certain capacities rather than others, while cooking, tasting and eating together.[53] There are several ways in which care practices may relate to

[53] These points are beautifully illustrated by the work of both Bodil Just Christensen, who traces the meaning of nutrients and healthy eating advice in the lives of conscripts and bariatric surgery patients in Denmark (2014), and Rebeca Ibáñez Martín (2014),

suchcomplexities, which this dissertation has addressed as the practices in which caring about weight is *done*. My particular concern was with the subject engaging in (self-)care. I asked what it may mean in practice to 'take up' the task of living with overweight. What are people encouraged to do, and strive for, when caring for their weight? How do these practices configure the bodies and environments they come to live in? In what normative relations are the subjects of self-care bound up? Rather than exploring who is called upon to participate, I asked what subjects may become by engaging in (self-)care.

Although my focus was on care practices, I do not wish to suggest that overweight is a problem for dieticians and other professionals to address with individual clients, thereby ignoring more 'structural' factors. My informants faced a multitude of situations that were largely beyond their influence. But however aware they were of the obstacles they faced, they also had the astute insight that food environments, political climates and cultural body norms are unlikely to change overnight. In the meantime, they had to give shape to their lives with overweight in one way or another.

Not all overweight people partake in the care practices I studied. They may not see their body weight as a problem, or stigma may be preventing them from seeking help; they may lack the time and money to pursue diets or mindfulness courses and gym subscriptions. Nevertheless, they, too, are often caught up in the ways of thinking and doing 'healthy living' that this dissertation interferes with. As the preceding chapters have shown, while relations between self, body and food are charted in care practices, their socio-material conditions of possibility – the knowledges, normativities and technologies that they embody – can be traced far outside of them. In this sense, I do not approach care as a set of micro-practices in a larger society that some engage in and others do not, but as practices that contain the social world within them and have effects beyond themselves. The possibility of obesity surgery, to name but one example, shapes how obesity is understood, targeted and judged, thus influencing the lives of people considered obese beyond those who opt for the procedure.

---

who describes the relations and misfits between nutritional recommendations and cooking practices in Spain.

CONCLUSION

So what, then, matters in care practices? By attending to what was done rather than said, and by unravelling professionals' and peoples' creative and idiosyncratic strategies, I found that those directly involved were not primarily interested in explanation, a coherent account of problems and solutions, or accountability, but in improvement. That is, professionals and people engaged in care focused on what is amenable to transformation. Rather than deliberating on what causes obesity or who is to blame for its increase, professionals and their clients, members or patients were concerned with 'what works' to achieve their goals.

For the people I interviewed and encountered, weight loss was a crucial good to strive for, although their concern with weight was not always medically informed. In the sites I visited, not all people seeking weight loss were obese in a medical sense, although many were concerned about the health risks that come with being overweight. Often, aesthetic and social concerns played secondary or even primary roles. Although weight loss was the ideal that led people to seek out care practices, what were meaningful changes in care practices often had little to do with numbers on the scale. Starting an exercise routine, taking a walk instead of eating candy, or learning to savor food were positively valued changes in themselves. The emphasis on ideals other than direct weight loss may be read against the (notorious) difficulty of actually achieving weight loss over longer periods of time. Most of the professional care practices I studied aimed to strengthen client or patient motivation to change by creating possibilities for success. In contrast, striving for weight loss could set one up to fail.

The focus on 'meaningful changes' also highlights how techniques and operations in care practices should first and foremost be seen as interventions within *lives*, and not on isolated bodies. Care practices intervene in specific situations to alter them for the better. This begs the questions: What are these situations? What is the 'better' sought after? Instead of distinguishing between people who are serious about maintaining a healthy weight and those who are not, what emerges from my analysis are different ways of caring for (over-)weight in daily practices, each with their own understandings of what constitutes 'better'. Crucially, the conditions of

possibility for these forms of care are always and already collectively shaped and done.

Engaging with matters of care

The social scientific literature seems to be divided between authors who 'go along' with the problem of obesity as a health crisis and those who critically analyze its construction (Moffat, 2010). I found myself uncomfortable with both positions. In the morally charged arena of the 'obesity epidemic', I deemed it more fruitful to show alternatives rather than unmask the ever tightening webs of normalizing (bio)power. My research therefore focused on the care practices where living with overweight is *done*. From the outset, I found that although nutritional guidelines and measures such as the BMI stabilize overweight and the problem it is taken to be, in practice these issues come in many guises. The 'condition' and problem at stake, its proposed remedy, the knowledges that inform and shape its normative realities, and the medical, political and cultural sites and situations in which it comes to matter, are all contested. That the issue has no clearly articulated core leaves space for new articulations. To trace what is at stake in this complexity, I did not focus on a dominant thread, but contrasted different coherences found within the broader field. I therefore asked:

What forms of care emerge in these practices and how do they configure the body and the environment? What may subjects become as they engage in these forms of (self-)care?

I traced how various modes of care become thinkable and 'doable' through the alignment of social and material elements, including people, bodies, food, techniques, professionals and activities. These elements are ordered in relation to each other, and moreover take shape in these very relations. Along the way, I articulated many ways in which living with overweight currently takes shape in care practices in the Netherlands.

CONCLUSION

As I mentioned in the introduction, my aim to contribute to the articulation of care practices signals a particular normative engagement with my field, an engagement that foregrounds the performativity of research practice. If we take the performativity of research seriously, why should we only analyze discourses without participating, contributing to them as well? The realities this research presents I may travel, helping us to rethink the problem of overweight and how it can be targeted. This participation required that I be attentive to my informants' concerns and include them in my audience. The way I 'did' normativity, then, was not tied to pre-established loyalties but emerged from what Teun Zuiderent-Jerak (2015) describes as an '*artful contamination*' between field and academic training. There was thus a productive exchange between my fieldwork, where I allowed myself to be 'contaminated' by my informants' concerns, and the discussions I had with colleagues and the critical social scientific work I read. While the latter alerted me to the political and social stakes of calling for bodily discipline and responsibilizing individual subjects, the realities enacted and the concerns addressed in care practices allowed me to explore alternatives to the neoliberal discourses these social scientists critiqued. By drawing distinctions I deemed worth making, I aimed to 'come closer to what comes to matter within care practices' (Vogel, 2014: 15). Such a 'politics of care' (Puig de la Bellacasa, 2011) does not forego critique but engages in what Latour (2004b) calls 'proximal critique' – inviting concern, hesitation and praise too.

In the dissertation's chapters, I analyzed practices of living with overweight as a specific staging or 'enacting' of the world. Modes of care in which nutrients or calories are prominent, for instance, stage overweight as a problem of eating too much of the wrong food and taking too little exercise. But care practices mobilize more than just calories and exercise; psychological techniques and labels, cooking and exercise skills, coaching techniques, meditation, tasting exercises and surgery all shape the realities enacted in care practices, staging other mind-body-life configurations. In my analysis, I aimed to learn from differences emerging within and between practices. By way of conclusion, this chapter clusters them in four modes of care. I articulate the bodies staged in these forms of care and the environments they engage with, in particular through eating and taking exercise. Finally, I relate these modes

of care and the realities they enact to the question of the subject engaged in (self-)care. I discuss these configurations of body, environment and subject here in relative isolation of the practices they emerge in, so as to further highlight the contrasts between them.

Four modes of overweight care

Taken together, the chapters makes it possible to cluster together four modes of care. These modes attend to different problems and have different ways of doing so. The first is care through the *control of input and output* by a rational mind. Here, the overweight body is foregrounded as the problem, the result of eating too much and exercising too little. In the practice of calorie counting, for instance, care takes the form of proper bookkeeping, in which exercise 'works off' the food one has ingested. Through counting, caring about weight emerges as a manageable problem that allows for calculable results and successes, staged as being to the credit of the individual. With a zero-balance of energy 'in' and 'out', the threat or damage done by food can be neutralized by exercise, and weight loss may be achieved by lowering what goes in while increasing what goes out.

The second mode of care works through *changing the embodied self by reconfiguring its anatomy*. Patients undergoing bariatric surgery engage in such care. The problem here does not lie in the imbalance of input and output, but in misalignments in the constitution of the embodied self, rendering patients incapable of moderate consumption. In clinic Q, weight loss was an important good, but one that could not be managed by control. Drastic changes were seen as necessary, with equally drastic effects that work out in unexpected ways. Alongside a smaller stomach, a socio-material process of manipulations must lead to the desired outcomes of responsibility and self-management. In the self-care practices of gastric bypass patients, this means getting in synch with one's body, a process which, crucially, includes surgery. As patients depend on others to realize forceful changes in themselves, this is a mode of care that aligns support and submission with activity.

The third mode of care works through *cultivating the tasting body*. The goal here is eating enough and healthy in ways that do not rely on the will, but on a sensitive embodied self. This mode of care addresses the problem that the body does not express itself, or is not listened to. Practices of proper feeding or activating metabolism are premised on the normative ideal of giving the body what it needs. These needs comprise healthy, nutritious eating and exercise as well as sleeping, 'feeling good' and experiencing pleasure. We thus see a subtle shift in focus from body *weight* and behavior as the object of concern to caring for the body's *vital activities*; from processing input and generating output to building, feeling and thriving. Slow, 'healthy' weight loss is contrasted with fast, 'bad' weight loss. Conversely, more immediate sensorial effects are valued alongside measurable results and physiological changes. Through a number of techniques aimed at sensitization, such as satiety training, the cultivation of pleasure and the training of taste, the body becomes expressive and its preferences healthier.

Finally, a fourth mode of care is premised on *feeding the hungry self* in fitting ways. The self's hungers include 'belly hunger' but also stem from mouths, hearts, heads, noses and eyes. These cannot all be fed by food. This mode of care shifts from a focus on bodily norms to nourishment, exemplified by the absence of weighing or mentioning weight or body size. The problem is a struggle with eating, which is said to stand in the way of leading a valuable life. Rather than truly nourishing themselves, people binge on bags of cookies or pursue weight loss. Coach Karen emphasized that while weight loss might be a *consequence* of letting go of this 'struggle with eating', the number on the scale is not a worthwhile goal in itself. Through the normative register that 'hungers need feeding', this mode of care focuses on distinguishing between hungers and fulfilling each on its own terms, fostering appreciation for the immediately nourishing effects of, for instance, taking a trip to the countryside when one is tired, and growing more self-aware and having self-compassion in the process.

As I have argued throughout the chapters, these modes of care should not be read as different ways of dealing with the same reality. They configure different realities for people to inhabit. Below, I draw out a few of these realities: those to do with bodies, environments and subjects.

Bodies

The 'nature of the body' does not precede care practices, but is variously enacted in them. What, then, were the bodies people came to live in as they engaged in various modes of care? In the mode of care centered around control, the body figures as naturally greedy and lazy. Unless restricted from the outside or 'put to work', this body will keep eating or stay on the couch. Given postindustrial work patterns and the ubiquity of cheap and processed products, it emerges as inherently problematic: what the body wants – its *causal drive* – conflicts with its 'needs' stipulated by dietary standards. These needs are conveyed through care practices in different ways. The body may be depicted as a battery, charging and depleting as calories are ingested and burned, or as a car needing 'fuel' that fits its engine. What these metaphors share is a mechanistic notion of energy that allows calculating input and output, where food must equal exercise. But this simple formula leaves much out: the leap from population values of energy needs to the individual, food preparation, and the fluctuations of energy uptake and expenditure within individual bodies. As pragmatism rules over precision, these more complex processes are 'black-boxed'. They did not affect how my informant Pieter 'did' his body – although as 1-1 hardly ever added up to zero, they did complicate it.

In the mode of care premised upon reconfiguration of the embodied self, bodies are again problematic, but in different ways. The body here *makes one do* – for instance, overeat. Surgery stages the body's material constitution as open to intervention; the body undergoes objectification by surgeons and subjectification by psychologists. Nevertheless, such manipulations, rather than being reductionist, do not dispense with lived-in bodies that can feel full and satisfied, experience nausea, and seek comfort in food; rather, they come to life *in* the treatment. Pre-surgery, this body harbors a conflict between the will to change and the impossibility of doing so. The procedure allows patients to anchor their will in the body's anatomy, permitting a mode of embodiment in which one's will and cravings are in synch. While the transformation harbors great potential, it can also disrupt. An active stomach enters the scene, changing how the body feels, knows and acts, demanding

other changes. New tensions emerge between the post-surgery body and the body that enjoys food and conversation, between the hassles of new self-care techniques and one's habits or moral engagements, and the active forces of the 'head' and the operated upon 'stomach'. These tensions express themselves in powerful ways, with possibly harmful effects, constantly requiring reconciliation. Unity and harmony are hard-worked achievements.

The needs and desires of the body enacted in the third mode of care do not emerge as inherently problematic. Here, the body emerges as 'smart', sensitive and responsive, a potential ally rather than an obstacle to health. It only becomes 'difficult' if it goes unattended and untrained. Bodies are taken to have internal feedback systems that keep them in balance. Food and physical activity emerge alongside other energetic activities that matter for the body's functioning, such as sleep and relaxation. When all of these needs are met, this body may thrive. But under stressful conditions, this 'natural organism' goes into 'saving mode', slowing the body's metabolic rate. This rate fluctuates according to what the body has previously gotten used to. A 'smart' technology, the body remembers, learns from and prepares for adverse conditions. The body also emerges as the home of both physical and emotional feelings. These feelings, not always clearly discernable and sometimes difficult to access, may be painful and come from experiences that have left their marks in complex ways. Part of cultivating the body is allowing all of these feelings to emerge. As the tastes of the body are developed through tasting, chewing and engaging with food, the body learns to appreciate other foods and sensorial effects, and becomes more articulated, more sensitive to differences. Disciplining the body emerges here as 'bad'. While a body might absorb less energy than it burns and lose weight when people limit their food intake, restrictive strategies have other effects as well. For one, bodies get hungry. The guilt and frustration that come with peoples' attempts at restriction moreover block the crucial pleasure that signals 'enough'. What emerges here, then, is that the greediness of the body is not the reason for, but the *result* of, controlling it.

Finally, in the mode of care aimed at feeding hungers, it is not the body's constitution but how a person concerns herself with herself that is the problem. Expressed as a struggle with eating, the body is caught up in

unhelpful strategies of self-care, the consequences of which are tension, feelings of guilt and failure, weight gain, tiredness and stomach pains. To heal, the body is foregrounded as the medium through which life is lived. It is enacted as the site where hungers for comfort, pleasure or acceptance reside and arise, but also become confused. Unfulfilled hungers leave the body frustrated, full of anxieties, perfectionism and temptations. By feeding particular hungers properly, mindfulness aims to slow down and appease the body, nourishing it and making it happy. One may thus engage in self-care rather than self-neglect, which opens up to living a healthier, more fulfilling life.

Environments

The four modes of care are enabled by specific conditions and engage with different environments that pose different problems. In the world conjured by the control of food intake, a person moves through the world by making (ir)responsible *choices* for (certain kinds of) food or (refraining from) exercise. It assumes an environment in which choices are available; the person is staged as *in* this environment but not affected by it. This figure is in tension with but also depends on a body configured as an object that stands in a web of *causal* relations with its environment. Given the ubiquity of food, elevators and cars, and the steady replacement of manual labor with computer work, this environment is 'obesogenic'. Overeating and 'sedentary behavior' – and in an environment set up differently, healthy eating and physical activity – are staged as acts of compulsion. In this environment, conscious compensatory acts are necessary. The challenge, then, is how to intervene in the causes that determine one's behavior while resisting their power. For this to be possible, the environment needs to be knowable and calculable. The eater who counts calories or makes healthy food choices draws on a whole infrastructure of food labels, pre-packaged diet products, displays on machines or apps and other nutritional advice. Without them, this form of care cannot be enacted.

In the mode of care that changes the embodied self, people do not emerge in isolation but as entangled in webs of emotional, moral and sensorial

relations. For instance, Hans traced his inability to feel satisfied to his growing up in a social context in which food abundance was the rule. Here, the environment is not something people find themselves in, but something that makes them be. This being-in-relation becomes particularly pronounced following surgery, when the post-surgery body interferes with food preferences, and social conventions of going out for dinner with friends must be negotiated with the limits of the new stomach. As patients say goodbye to their emotional connections to food, eating appears as a well ingrained source of self-care. These complex realities are not just the variously complicating or facilitating 'contexts' in which healthy living takes place; they are its very substance. Neither inviting the despair of inevitability nor the dream of malleability, changing the embodied self requires a pragmatic constituting and substituting of attachments (Gomart & Hennion, 1999). Self-care becomes a matter of organizing social relations and finding support – from surgeons, objects, techniques, understanding practitioners, creative spouses and fun exercise classes. The environment enacted in this mode of care is far from static as people change and seek out others. Moreover, one's relations to others, or to eating itself, may change as people work with their surroundings.

Care through training bodily taste and sensitivity engages with yet another environment. This environment emerges as problematic when it *distracts* attention from the sensorial experience of eating, such as when eating in front of the TV. Here the environment does not make one do anything; instead it poses invitations to which a person may respond. What is inviting or not changes over time and may also be tinkered with, for instance by developing a taste for liking carrots, cooking nice meals or by setting up a cozy table. The person is disposed to her environment through affective relations. In practices such as satiety training, a body is enacted that overeats not as the result of a natural causal chain but because a person is unable to *feel* bodily drives. But in the process, another environment emerges that adds to the difficulties: one in which people are tempted to try 'crash-diets' promising swift weight loss, or to buy deceptively marketed 'light' foods in which fats have been replaced by sugars. This environment leads people to practices that disturb their internal balance. Feeling, then, is not a given mode of being in the world, but needs to be called upon by techniques. Rather than slimming

down, the transformation that is worked upon lies in the aesthetic quality of these relations, between body and self, self and world. A body must learn to become affected (Despret, 2004). This form of care arranges situations such as tasting sessions that draw feelings out and sensitize persons to their environments, providing vocabularies that facilitate attuning to one's physical and emotional feelings in daily life.

In the mode of care focused on feeding, everything can be approached as potential nourishment for one's hungers. Living is modeled after eating. The attention to diverse hungers brings to the fore the burden of all kinds of daily life troubles, traumas and events: divorces, busy work schedules and care obligations. The mindful eating course foregrounded that peoples' lives contain unfulfilled hungers. Care through feeding the right hungers, then, depends on situations in which other sources of nourishment can be sought. This not only implies that such sources are available, but that people configure their lives and ways of being in the world accordingly. Specifically, this mode of care requires recognition of the 'edibility' of the world and attention to how one feeds one's life. Here, too, social norms of bodily control and body size emerge as damaging, leading people to develop a 'disturbed relation' to their bodies. In the mindfulness course, externalizing techniques, mental body scans and diaries engaged with particular events in women's lives, be they courses of action (such as binge eating) or thought patterns ('from now on, I will no longer eat more than 500 calories'). These are taken to be self-care strategies relating to different hungers and accordingly emerge as more or less nourishing.

Subjects of care

What kinds of subjects were enacted in the care practices I studied? I analyzed subjectivity as related to situations rather than individuals (Pols, 2005). In the mode of care that works through control, weight gain is attributed to a person's volition, in particular lack of volition. The subject thus enacted can be held responsible for its actions and lifestyle; if it is not in control, it should take control, for instance by calculating food and exercise to ensure energy

balance. The point of departure of my analysis has been that judging and being are not opposites – one the task of a liberal subject, the other of a biologically determined body – but merge in the body-in-practice. But in this practice, the subject is configured as separate from the body: with the ability to act *on* the body and to bend the environment to its will. With this mind/body split, a person can intervene in the conversion of food into matter and energy by putting his/her body 'to work' or by 'putting it on or off' certain (amounts of) food. This subject thus enacted treats its body as if it were a mechanical object. *As if*, because the reality control builds on is, in daily life, only partially 'doable', only partially able to be performed. My informant Pieter, for instance, 'knew' food and exercise through calories, but in his daily strategies had to contend with the limits of what can be counted and with situations that were out of his control. As the subject is advised on what is good to eat or gathers information on food and exercise, it is performed as a *cognitive center making decisions*. Such difficulties notwithstanding, this subject, motivated to do 'the right thing', will engage in control and forego pleasure. Through its actions and 'lifestyle', it proves herself as worthy, responsible or 'healthy' to society.

The second mode of care works with an *embodied subject seeking to transform itself*. It is subject to other norms than health, for instance the social norm that one eats with or as one's significant others. For this social subject, acting for the good of one's health emerges not as a natural given ability that one may or may not make use of, but as a carefully crafted possibility that needs to be enabled. This subject works on its own socio-material conditions for self-care and agency by submission (to surgeons, psychologists) and by arranging support. Its empowerment derives not from independence, but from the surgeon's support and that of rules and advice that confirm that despite the mocking of one's friends, the apple is indeed the better choice. Whereas in the first mode of care one's subjectivity stays the same, in the other modes of care subjects alter their feelings, appreciations and ways of knowing themselves and the world around them. This change is not about doing different things; it is about *being* different altogether. This happens through various attachments inside and outside the skin. The embodied self strives to get in synch with the body, first by changing its anatomy through surgery

and then by adjusting the socio-material practices of eating and by arranging sources of self-care away from food.

In the third mode of care, an embodied subject is encouraged to listen to what is felt 'from within' – to its feelings, needs and desires. It shifts from self-control to self-care, from asking 'am I being good?' to 'is it good for me?' What emerges is not a quantified self, but a *sensitized self*. This subject works to cultivate appreciation of oneself, one's body and one's life. While cultivating tastes and bodily sensitivity, the person cannot control her body, but only nudge or train it. Hunger, guilt, disappointment and frustration, and conversely, relaxation, satisfaction and 'feeling good', were staged as directly affecting the body's functioning. This subject enacted relates to its body as a responsive entity. Affective relations go both ways: it feels better or worse depending on the body. In lieu of handholds such as rules or advice, this subject tinkers with feelings in the here and now. While doing so, people may have to deal with threatening emotions or with the endless intricacies of daily life that get in the way. But while engaging in feeling, tasting, table setting or cooking, this subject attends to one's own aesthetic sensibilities, cultivating them, committing to them in ways that involve hands, eyes, noses and tongues.[54]

Finally, in the fourth mode of care, a *'hungering' subject* is enacted who 'puts' a lot of things in *eten* that food can never satisfy, such as hungers for acceptance, comfort or joy. This subject seeks to nurture hungers for acceptance through reaching social ideals (dress size 36) and hunger for comfort through overeating. Rather than being called out on its decisions, through asking 'what do you *really* hunger after?' this subject is encouraged to search for true nourishment. This begins by developing self-knowledge of

[54] In my use of aesthetics, I draw on Jeannette Pols (2013c) who states that in mundane situations, 'aesthetic values [...], refer to different conventions of what is proper, tasteful, stylish, or pleasant.' (187) Pols (2013b; 2013c) thus aims to 'rescue' aesthetics from a Kantian understanding that, by contrast, links it to the arts and sublime, makes it individual, and disengages it from ethics. Bodil Just Christensen, moreover, argues that although talk of aesthetics has been limited to gourmet food, it potentially matters in all eating practices, where 'connoisseurs articulate various aesthetic values through their eating practices in which many dimensions and concerns combine.' (2014: 61) Just Christensen invites us to consider that 'good food' is a non-elitist category that people variously shape in everyday life (see also Mann et al., 2011).

how one 'feeds one's life'. By doing so, this subject slowly inhabits the body and cares for itself. In the jar of conflicting positions and incoherent thoughts towards oneself and the world that comprise this subject, one must find and then live from the position that takes one's best interests at heart. Mindfulness exercises should divert attention from desires to lose weight, commitments to keep in busy lives or admonitions to what is good or bad to eat, to what is 'truly' nourishing and valuable. While one may experience personal growth through this search, examining what one hungers after is a pursuit without end. Old strategies of feeding oneself risk stagnating in the form of 'internal critics', obstructing nourishment. This subject thus engages in continuous *minding* – of tasting, feeling and observing what one hungers after, and of the nourishing qualities of such diverse things as food, the countryside and friends.

In closing

There is no 'natural' imperative for how to care for overweight, revealed to us by facts on food and the body. As I have shown, there are different modes of engaging with overweight in peoples' lives. All of these alternatives are situated, complex, normative negotiations, where not one problem, but various problems shaped by different terms and playing out on different scales, come to the fore. Calling upon people to be good citizens and to take control of their bodies will not equip them to grapple with these problems. The modes of care I presented enact subjects who care, learn, feel, experience pleasure, and share with others; these subjects are moreover enmeshed in collectives that do not ever render them independent. My intervention has been to present this diversity of subject positions and collectives. Through this research, we have gained insight into the supporting relations that bring out certain bodies and subjects. But we also learned about the many relations that make it difficult for them to flourish.

At the level of policy making, nutritional advice and public health, some of these subject positions and care practices tend to be overshadowed by the omnipresence of a narrative that privileges control. Time and again, the

overweight body is foregrounded as the problem, deemed the result of eating too much and exercising too little, and reflecting the poor choices of individuals. The mode of care that aims to control input and output is thus the one most supported by the broader socio-material structuring of food and eating. In contrast, the painstaking work required by care practices that aim to sensitize the body suggests that rather than an attentiveness to bodily needs and signals, what is consistently fed are our heads, not our hands, tongues, stomachs and hearts. How to make space, then, for the other practices and the worlds they enact? Where can they travel, and how? Where do they flourish or fail? In relation to what other problems, conditions and concerns might these modes of care be relevant?

The modes of care I identified do not fit in a commensurate whole in which one is universally better than the other; neither are they just options left to the preferences of professionals and their clients/patients. Rather, my analysis opens up a new evaluative field in which to engage with overweight. Crucially, the practices I studied are not beyond criticism. Now that these modes of care have been articulated, they may be amended, shaped and contrasted with others. More research is needed on how this may be done. Currently, care practices are often evaluated by comparing the effect of different interventions on pre-established criteria such as body weight or health behavior. But my research showed that care practices that address issues with bodily weight not only have different ways of working, adapting to local concerns and circumstances, but also differ in their goals. How to create institutional spaces for these different care practices, their creativity and their possibilities for improving themselves, is worthy of further exploration. We need research into the ways in which insurance companies, public health programs and health care institutions can evaluate and help strengthen these forms of care. Such evaluation practices would have to attend to, and keep asking, difficult questions: Which self-care practices should be supported? How could this be done? What should we value while doing so? These questions do not yield definitive answers. But this doctoral work offers new terms with which they may be approached.

BIBLIOGRAPHY

Abbots, E., & Lavis, A. (2013). *Why we eat, how we eat: Contemporary encounters between foods and bodies*. Farnham: Ashgate.

Abrahamsson, S. (2014). An actor network analysis of constipation and agency: Shit happens. *Subjectivity, 7*(2), 111-130.

Abrahamsson, S., Bertoni, F., Ibáñez Martín, R., & Mol, A. (2015). Living with omega-3: New materialism and enduring concerns. *Environment and Planning D: Society & Space, 33*(1), 4-19.

Ainsworth, B. E., Haskell, W. L., Herrmann, S. D., Meckes, N., Bassett, D. R., Jr, Tudor-Locke, C., . . . Leon, A. S. (2011). 2011 compendium of physical activities: A second update of codes and MET values. *Medicine and Science in Sports and Exercise, 43*(8), 1575-1581. doi:10.1249/MSS.0b013e31821ece12

Akrich, M., & Berg, M. (2004). Introduction - Bodies on trial: Performances and politics in medicine and biology. *Body & Society, 10*(2-3), 1-12.

Akrich, M., & Pasveer, B. (2000). Multiplying obstetrics: Techniques of surveillance and forms of coordination. *Theoretical Medicine and Bioethics, 21*(1), 63-83.

Akrich, M., & Pasveer, B. (2004). Embodiment and disembodiment in childbirth narratives. *Body & Society, 10*(2-3), 63-84.

Alaimo, S., & Hekman, S. (2008). *Material feminisms*. Bloomington: Indiana University Press.

Austin, S. B. (2011). The blind spot in the drive for childhood obesity prevention: Bringing eating disorders prevention into focus as a public health priority. *American Journal of Public Health, 101*(6), e1-4. doi:10.2105/AJPH.2011.300182

Bacon, L., & Aphramor, L. (2011). Weight science: Evaluating the evidence for a paradigm shift. *Nutrition Journal, 10*(9), 1-13.

Bennett, J. (2009). *Vibrant matter: A political ecology of things*. Durham, NC: Duke University Press.

Bertoni, F. (2013). Soil and worm: On eating as relating. *Science as Culture, 22*(1), 61-85.

Biltekoff, C. (2013). *Eating right in America: The cultural politics of food and health.* Durham: Duke University Press.

Bonelli, C. (2014). What Pehuenche blood does: Hemic feasting, intersubjective participation, and witchcraft in southern Chile. *HAU: Journal of Ethnographic Theory, 4*(1), 105-127.

Bordo, S. (1993). *Unbearable weight: Feminism, western culture, and the body.* Berkeley: University of California Press.

Brazier, D. (2013). Mindfulness reconsidered. *European Journal of Psychotherapy & Counselling, 15*(2), 116-126.

Brown, S. D., & Stenner, P. (2009). *Psychology without foundations: History, philosophy and psychosocial theory.* London: Sage.

Burgard, D. (2009). What is 'Health at every size"? In E. Rothblum, & S. Solovay (Eds.), *The Fat Studies reader* (pp. 41-53). New York: University Press New York.

Butler, J. (1990). *Gender trouble.* New York: Routledge.

Candea, M., & Da Col, G. (2012). The return to hospitality. *Journal of the Royal Anthropological Institute, 18*(Suppl. 1), S1-S19.

Cannon, G. (2005). Out of the box. *Public Health Nutrition, 8*(04), 344-347.

Centraal Bureau voor de Statistiek. (2016). Leefstijl, preventief onderzoek; persoonskenmerken; 2010-2013 [dataset]. Retrieved from http://statline.cbs.nl/Statweb/publication/?DM=SLNL&PA=81177ned&D1=39-43&D2=0-12,26-38&D3=0&D4=l&VW=T

Centraal Bureau voor de Statistiek. (April 5, 2016). Lengte en gewicht van personen, ondergewicht en overgewicht; vanaf 1981. Retrieved from http://statline.cbs.nl/Statweb/publication/?DM=SLNL&PA=81565NED&D1=0-4&D2=0&D3=5&D4=0&D5=0,10,20,30-33&HDR=T&STB=G1,G2,G3,G4&CHARTTYPE=3&VW=T

Chang, V. W., & Christakis, N. A. (2002). Medical modelling of obesity: A transition from action to experience in a 20th century American medical textbook. *Sociology of Health & Illness, 24*(2), 151-177. doi:10.1111/1467-9566.00289

Cooper, C. (2010). Fat studies: Mapping the field. *Sociology Compass*, *4*(12), 1020-1034. doi:10.1111/j.1751-9020.2010.00336.x

Cousins, T. (2015). A mediating capacity: Towards an anthropology of the gut. *Medicine Anthropology Theory*, *2*(2), 1-27.

Coveney, J. (2002). *Food, morals and meaning: The pleasure and anxiety of eating*. Abingdon: Routledge.

Coveney, J., & Bunton, R. (2003). In pursuit of the study of pleasure: Implications for health research and practice. *Health*, *7*(2), 161-179.

Csordas, T. J. (1993). Somatic modes of attention. *Cultural Anthropology*, *8*(2), 135-156. doi:10.1525/can.1993.8.2.02a00010

Cullather, N. (2007). The foreign policy of the calorie. *The American Historical Review*, *112*(2), 337-364. doi:10.1086/ahr.112.2.337

Cussins, C. (1998). Ontological choreography: Agency for women patients in an infertility clinic. In M. Berg, & A. Mol (Eds.), *Differences in medicine: Unraveling practices, techniques, and bodies* (pp. 166-201). Durham: Duke University Press.

Dalen, J., Smith, B. W., Shelley, B. M., Sloan, A. L., Leahigh, L., & Begay, D. (2010). Pilot study: Mindful eating and living (MEAL): Weight, eating behavior, and psychological outcomes associated with a mindfulness-based intervention for people with obesity. *Complementary Therapies in Medicine*, *18*(6), 260-264.

Danholt, P. (2013). Factish relations: Affective bodies in diabetes treatment. *Health*, *17*(4), 375-390.

Darmon, M. (2012). A people thinning institution: Changing bodies and souls in a commercial weight-loss group. *Ethnography*, *13*(3), 375-398. doi:10.1177/1466138111435871

David, M. (2005). *The slow down diet: Eating for pleasure, energy, and weight loss*. Rochester: Healing Arts Press.

Davis, D. (2003). Changing body aesthetics: Diet and exercise fads in a newfoundland outport community. In A. Bolin, & J. Granskog (Eds.), *Athletic intruders: Ethnographic research on women, culture, and exercise* (pp. 201-226). Albany: State University New York Press.

De Cocq, M. (2015, February, 21). 'Obesitas is de cholera van deze tijd'. *Het Parool*.

De Laet, M., & Dumit, J. (2014). Curved to bodies: The material life of graphs. In D. L. Kleinman, & K. Moore (Eds.), *Routledge handbook of science, technology and society* (pp. 71-89). New York: Routledge.

de Wilde, J. A., van Dommelen, P., Middelkoop, B. J., & Verkerk, P. H. (2009). Trends in overweight and obesity prevalence in Dutch, Turkish, Moroccan and Surinamese South Asian children in the Netherlands. *Archives of Disease in Childhood, 94*(10), 795-800. doi:10.1136/adc.2009.163709

Dehue, T. (2014). *Betere mensen: Over gezondheid als keuze en koopwaar*. Amsterdam: Atlas Contact.

Despret, V. (2004). The body we care for: Figures of anthropo-zoo-genesis. *Body & Society, 10*(2-3), 111-134.

Despret, V. (2008). The becomings of subjectivity in animal worlds. *Subjectivity, 23*(1), 123-139.

Dougherty, C. J. (1993). Bad faith and victimblaming: The limits of health promotion. *Health Care Analysis, 1*(2), 111-119.

Douketis, J., Macie, C., Thabane, L., & Williamson, D. (2005). Systematic review of long-term weight loss studies in obese adults: Clinical significance and applicability to clinical practice. *International Journal of Obesity, 29*(10), 1153-1167.

Duff, J. (2004). Setting the menu: Dietary guidelines, corporate interests, and nutrition policy. In J. Germov, & L. Williams (Eds.), *A sociology of food & nutrition: The social appetite* (pp. 148-169). South Melbourne: Oxford University Press.

Ertelt, T. W., Mitchell, J. E., Lancaster, K., Crosby, R. D., Steffen, K. J., & Marino, J. M. (2008). Alcohol abuse and dependence before and after bariatric surgery: A review of the literature and report of a new data set. *Surgery for Obesity and Related Diseases, 4*(5), 647-650.

Evans, B. (2006). 'Gluttony or sloth': Critical geographies of bodies and morality in (anti) obesity policy. *Area, 38*(3), 259-267.

Evans, B., & Colls, R. (2009). Measuring fatness, governing bodies: The spatialities of the body mass index (BMI) in anti-obesity politics. *Antipode, 41*(5), 1051-1083.

Evans, J., Davis, B., & Wright, J. (2004). *Body knowledge and control: Studies in the sociology of physical education and health.* London: Routledge.

Feiring, E. (2008). Lifestyle, responsibility and justice. *Journal of Medical Ethics, 34*(1), 33-36. doi:34/1/33

Felder, K., Felt, U., & Penkler, M. (2015). Caring for evidence: Research and care in an obesity outpatient clinic. *Medical Anthropology,* doi:10.1080/01459740.2015.1101100

Ferzacca, S. (2000). "Actually, I don't feel that bad": Managing diabetes and the clinical encounter. *Medical Anthropology Quarterly, 14*(1), 28-50.

Fletcher, I. (2014). Defining an epidemic: The body mass index in british and US obesity research 1960-2000. *Sociology of Health & Illness, 36*(3), 338-353. doi:10.1111/1467-9566.12050

Foucault, M. (1973). *The birth of the clinic: An archaeology of medical perception.* London: Tavistock Publications, Ltd.

Foucault, M. (1977). *Discipline and punish: The birth of the prison.* New York: Pantheon.

Foucault, M. (1998). *The will to knowledge: The history of sexuality, volume 1.* London: Penguin Books.

Foucault, M. (2000). Technologies of the self. In P. Rabinow (Ed.), *Ethics: Essential works of foucault 1954-1984, vol. 1* (pp. 223-252). Harmondsworth: Penguin.

Foucault, M. (2003). In Bertani M., Fontana A. (Eds.), *Society must be defended: Lectures at the College de France, 1975-1976* (D. Macey Trans.). (50th ed.). New York: Picador.

Foucault, M. (2012 (1984)). *The history of sexuality, vol. 2: The use of pleasure.* New York: Vintage.

Foucault, M. (2014 (1979)). The politics of health in the eighteenth century. *Foucault Studies, 0*(18), 113-127.

Fried, M., Yumuk, V., Oppert, J. M., Scopinaro, N., Torres, A., Weiner, R., & . . . Frühbeck, G. (2014). Interdisciplinary European guidelines on metabolic and bariatric surgery. *Obesity Surgery*, *24*(1), 42-55.

Gard, M., & Wright, J. (2005). *The obesity epidemic: Science, morality and ideology*. New York: Routledge.

Gibson, J. J. (1979). *The ecological approach to visual perception: Classic edition*. Boston: Houghton Mifflin.

Gingras, J. R., & Aphramor, L. (2010). Empowerment, compliance, and the ethical subject in dietetic work. In R. Harris, N. Wathen & S. Wyatt (Eds.), *Configuring health consumers: Health work and the imperative of personal responsibility* (pp. 82-93). Hampshire: Palgrave Macmillam.

Goffman, E. (1959). *The presentation of self in everyday life*. New York: Anchor House.

Gomart, E., & Hennion, A. (1999). A sociology of attachment: Music amateurs, drug users. *The Sociological Review*, *47*(S1), 220-247.

Goodwin, D. (2008). Refashioning bodies, reshaping agency. *Science, Technology & Human Values*, *33*(3), 345-363. doi:10.1177/0162243907306694

Government Office of Science. (2007). *Foresight: Tackling obesities, future choices*. London: Department of Innovations, Universities and Skills.

Govers, E., Seidell, J. C., Visser, M., & Brouwer, I. A. (2014). Weight related health status of patients treated by dietitians in primary care practice: First results of a cohort study. *BMC Family Practice*, *15*(161), 1-12.

Greenhalgh, S. (2015). Disordered eating/eating disorder: Hidden perils of the nation's fight against fat. *Medical Anthropology Quarterly*, *0*(0) doi:10.1111/maq.12257

Greenhalgh, S. (2012). Weighty subjects: The biopolitics of the U.S. war on fat. *American Ethnologist*, *39*(3), 471-487. doi:10.1111/j.1548-1425.2012.01375.x

Gremillion, H. (2003). *Feeding anorexia: Gender and power at a treatment center*. Durham/London: Duke University Press.

Gremillion, H. (2005). The cultural politics of body size. *Annual Review of Anthropology*, *34*, 13-32.

Grossman, P. (2011). Defining mindfulness by how poorly I think I pay attention during everyday awareness and other intractable problems for psychology's (re) invention of mindfulness: Comment on brown et al. (2011). *Psychological Assessment*, *23*(4), 1034-1040. doi:10.1037/a0022713

Groven, K. S., Råheim, M., Braithwaite, J., & Engelsrud, G. (2013). Weight loss surgery as a tool for changing lifestyle? *Medicine, Health Care and Philosophy*, *16*(4), 699-708.

Gudzune, K. A., Doshi, R. S., Mehta, A. K., Chaudhry, Z. W., Jacobs, D. K., Vakil, R. M., . . . Clark, J. M. (2015). Efficacy of commercial weight-loss programs: An updated systematic review. *Annals of Internal Medicine*, *162*(7), 501-512.

Guthman, J. (2011). *Weighing in: Obesity, food justice, and the limits of capitalism*. Berkeley: University of California Press.

Guthman, J. (2013). Too much food and too little sidewalk? Problematizing the obesogenic environment thesis. *Environment and Planning A*, *45*(1), 142-158.

Guthman, J. (2014). Introducing critical nutrition: A special issue on dietary advice and its discontents. *Gastronomica: The Journal of Food and Culture*, *14*(3), 1-4.

Guthman, J., Broad, G., Klein, K., & Landecker, H. (2014). Beyond the sovereign body. *Gastronomica: The Journal of Food and Culture*, *14*(3), 46-55.

Guthman, J., & DuPuis, M. (2006). Embodying neoliberalism: Economy, culture, and the politics of fat. *Environment and Planning D*, *24*(3), 427.

Hacking, I. (1983). *Representing and intervening: Introductory topics in the philosophy of natural science*. Cambridge: Cambridge University Press.

Hacking, I. (2006). Genetics, biosocial groups & the future of identity. *Daedalus*, *135*(4), 81-95.

Hacking, I. (2007). Where did the BMI come from? bodies of evidence: Fat across disciplines. *Bodies of Evidence: Fat Across Disciplines*, Cambridge, UK.

Haraway, D. (1991). *Simians, cyborgs, and women: The reinvention of nature*. New York: Routledge.

Haraway, D. J. (2013). SF: Science fiction, speculative fabulation, string figures, so far. *Ada: A Journal of Gender, New Media, and Technology*, (3) doi:10.7264/N3KH0K81

Harbers, H., Mol, A., & Stollmeyer, A. (2002). Food matters arguments for an ethnography of daily care. *Theory, Culture & Society, 19*(5-6), 207-226.

Hayes-Conroy, J., & Hayes-Conroy, A. (Eds.). (2013). *Doing nutrition differently: Critical approaches to diet and dietary intervention*. Surrey, UK: Ashgate Publishing, Ltd.

Hennion, A. (2004). Pragmatics of taste. In M. Jacobs, & N. Hanrahan (Eds.), *The blackwell companion to the sociology of culture* (pp. 131-144). Oxford: Blackwell.

Hennion, A. (2007). Those things that hold us together: Taste and sociology. *Cultural Sociology, 1*(1), 97-114.

Hennion, A. (2010). Open objects, open subjects?… bodies, things and attachments. *IKKM Annual Conference 'Open Objects', 28-30 April*, Weimar.

Henwood, F., Harris, R., & Spoel, P. (2011). Informing health? Negotiating the logics of choice and care in everyday practices of 'healthy living'. *Social Science & Medicine, 72*(12), 2026-2032.

Herrick, C. (2009). Shifting blame/selling health: Corporate social responsibility in the age of obesity. *Sociology of Health & Illness, 31*(1), 51-65.

Heyes, C. J. (2006). Foucault goes to weight watchers. *Hypatia, 21*(2), 126-149.

Hillersdal, L. (2013). *Situating hunger and fullness through the lived body - an anthropological analysis of eating*. (Unpublished PhD dissertation). Department of Food and Resource Economics, University of Copenhagen, Copenhagen.

Hillersdal, L., Just Christensen, B., & Holm, L. (forthcoming). Changing tastes: Learning hunger and fullness after gastric bypass surgery. *Sociology of Health & Illness*.

Hirschauer, S. (1991). The manufacture of bodies in surgery. *Social Studies of Science, 21*(2), 279-319.

Hoenderdos, K. (2014). *Eet meer! lekker in je vel met PuurGezond.* IJsselstein: Scriptum Communicatie over Voeding.

Howell, J., & Ingham, A. (2001). From social problem to personal issue: The language of lifestyle. *Cultural Studies, 15*(2), 326-351.

Ibáñez Martín, R. (2014). *Bad to eat? empirical explorations of fat as food.* (Unpublished Doctoral dissertation). University of Salamanca, Madrid.

Ibáñez Martín, R., & González García, M. (2010). Una alimentación de cuidado: La biomedicalización y la persistencia de la performatividad de género en la comercialización del os alimentos funcionales. *Cuadernos KORÉ, 1*(3), 71-82.

Ingold, T. (2000). *The perception of the environment: Essays on livelihood, dwelling and skill.* London/New York: Routledge.

Inthorn, S., & Boyce, T. (2010). 'It's disgusting how much salt you eat!' Television discourses of obesity, health and morality. *International Journal of Cultural Studies, 13*(1), 83-100.

Jallinoja, P., Pajari, P., & Absetz, P. (2010). Negotiated pleasures in health-seeking lifestyles of participants of a health promoting intervention. *Health, 14*(2), 115-130. doi:10.1177/1363459309353292

Jullien, F. (2007). *Vital nourishment: Departing from happiness.* New York: Zone Books.

Just Christensen, B. (2014). *Eating practices: Social and cultural aspects of hunger and fullness.* (Unpublished PhD Dissertation). University of Copenhagen, Department of Food and Resource Economics, Copenhagen.

Jutel, A. (2006). The emergence of overweight as a disease entity: Measuring up normality. *Social Science & Medicine, 63*(9), 2268-2276. doi:dx.doi.org/10.1016/j.socscimed.2006.05.028

Kalarchian, M. A., Marcus, M. D., & Courcoulas, A. P. (2008). Eating problems after bariatric surgery. *Eating Disorders Review, 19*(4).

Kendrick, R. (2013). Metabolism as strategy: Agency, evolution, and biological hinterlands. In E. Abbots, & A. Lavis (Eds.), *Why we eat, how we eat: Contemporary encounters between foods and bodies* (pp. 237-254). Farnham: Ashgate.

Kickbusch, I. (1989). Self-care in health promotion. *Social Science & Medicine*, *29*(2), 125-130.

Kirmayer, L. J. (1992). The body's insistence on meaning: Metaphor as presentation and representation in illness experience. *Medical Anthropology Quarterly*, *6*(4), 323-346.

Knutsen, I. R., & Foss, C. (2011). Caught between conduct and free choice: A field study of an empowering programme in lifestyle change for obese patients. *Scandinavian Journal of Caring Sciences*, *25*(1), 126-133.

Knutsen, I. R., Terragni, L., & Foss, C. (2013). Empowerment and bariatric surgery: Negotiations of credibility and control. *Qualitative Health Research*, *23*(1), 66-77.

Kortink, J. (2015). *Mindful afvallen: Een nieuwe oplossing met blijvend resultaat.* Utrecht: Kosmos Uitgevers.

Landecker, H. (2011). Food as exposure: Nutritional epigenetics and the new metabolism. *BioSocieties*, *6*(2), 167-194.

Landecker, H. (2013). Postindustrial metabolism: Fat knowledge. *Public Culture*, *25*(3 71), 495-522.

Latour, B. (1987). *Science in action: How to follow scientists and engineers through society.* Cambridge, MA: Harvard University Press.

Latour, B. (1993). *We have never been modern.* Cambridge, MA: Harvard University Press.

Latour, B. (1999). Factures/fractures: From the concept of network to the concept of attachment. *RES: Anthropology and Aesthetics*, *36*, 20-31.

Latour, B. (2004a). How to talk about the body? The normative dimension of science studies. *Body & Society*, *10*(2-3), 205-229.

Latour, B. (2004b). Why has critique run out of steam? From matters of fact to matters of concern. *Critical Inquiry*, *30*(2), 225-248.

Latour, B. (2005). *Reassembling the social - an introduction to actor-network-theory.* Oxford: Oxford University Press.

Latour, B., & Woolgar, S. (1979). *Laboratory life: The construction of scientific facts.* Beverly Hills: Sage.

Laurier, E., & Wiggins, S. (2011). Finishing the family meal. The interactional organisation of satiety. *Appetite*, *56*(1), 53-64.

Lave, J. (1988). *Cognition in practice: Mind, mathematics and culture in everyday life*. Cambridge: Cambridge University Press.

Law, J. (1994). *Organizing modernity*. Oxford: Blackwell.

Law, J. (2002). *Aircraft stories: Decentering the object in technoscience*. Durham, NC: Duke University Press Books.

Law, J. (2009). Actor network theory and material semiotics. In B. Turner (Ed.), *The new Blackwell companion to social theory* (pp. 141-158). Malden, MA: Wiley-Blackwell.

Law, J., & Mol, A. (2008). The actor-enacted: Cumbrian sheep in 2001. *Material agency: Towards a non-anthropocentric approach* (pp. 57-77). New York: Springer.

LeBesco, K. (2011). Neoliberalism, public health, and the moral perils of fatness. *Critical Public Health*, *21*(2), 153-164.

Lettinga, A., & Mol, A. (1999). Clinical specificity and the non-generalities of science. *Theoretical Medicine and Bioethics*, *20*(6), 517-535.

Levin, N. (2014). Multivariate statistics and the enactment of biological complexity in metabolic science. *Social Studies of Science*, *44*(4), 555-578. doi:10.1177/0306312714524845

Lin, W. (2013). Displacement of agency: The enactment of patients' agency in and beyond haemodialysis practices. *Science, Technology & Human Values*, *38*(3), 421-443.

Lindeman, M., & Stark, K. (2000). Loss of pleasure, ideological food choice reasons and eating pathology. *Appetite*, *35*(3), 263-268.

Lupton, D. (2012). *Fat*. New York: Routledge.

Mann, A. M., Mol, A. M., Satalkar, P., Savirani, A., Selim, N., Sur, M., & Yates-Doerr, E. (2011). Mixing methods, tasting fingers: Notes on an ethnographic experiment. *HAU: Journal of Ethnographic Theory*, *1*(1), 221-243.

Marcus, G. E. (2009). Multi-sited ethnography: Notes and queries. In M. Falzon (Ed.), *Multi-sited ethnography: Theory, praxis, and locality in contemporary research* (pp. 181-196). Ashgate Burlington, VA: Routledge.

Martin, E. (1987). *The woman in the body: A cultural analysis of reproduction*. Boston: Beacon Press.

Martin, E. (1994). *Flexible bodies: Tracking immunity in American culture from the days of polio to the age of AIDS*. Boston: Beacon Press.

Mattingly, C. (1994). The concept of therapeutic 'emplotment'. *Social Science & Medicine*, *38*(6), 811-822.

Mayes, C. (2014). Governing through choice: Food labels and the confluence of food industry and public health discourse to create 'healthy consumers'. *Social Theory & Health*, *12*(4), 376-395.

McIver, S., McGartland, M., & O'Halloran, P. (2009). "Overeating is not about the food": Women describe their experience of a yoga treatment program for binge eating. *Qualitative Health Research*, *19*(9), 1234-1245. doi:10.1177/1049732309343954

Miewald, C. E. (1997). Is awareness enough? the contradictions of self-care in a chronic disease clinic. *Human Organization*, *56*(3), 353-362.

Ministerie van Algemene Zaken. (2013). Troonrede 2013. Retrieved from https://www.rijksoverheid.nl/documenten/toespraken/2013/09/17/troonrede-2013

Moffat, T. (2010). The "Childhood obesity epidemic": Health crisis or social construction? *Medical Anthropology Quarterly*, *24*(1), 1-21.

Mol, A. (1999). Ontological politics. A word and some questions. *The Sociological Review*, *47*(S1), 74-89.

Mol, A. (2002). *The body multiple: Ontology in medical practice*. Durham: Duke University Press.

Mol, A. (2008a). I eat an apple. On theorizing subjectivities. *Subjectivity*, *22*(1), 28-37.

Mol, A. (2008b). *The logic of care: Health and the problem of patient choice*. New York: Routledge.

Mol, A. (2009). Good taste: The embodied normativity of the consumer-citizen. *Journal of Cultural Economy*, *2*(3), 269-283.

Mol, A. (2010a). Actor-network theory: Sensitive terms and enduring tensions. *Kölner Zeitschrift Für Soziologie Und Sozialpsychologie. Sonderheft*, *50*, 253-269.

Mol, A. (2010b). Care and its values. Good food in the nursing home. In A. Mol, I. Moser & J. Pols (Eds.), *Care in practice. On tinkering in clinics, homes and farms* (pp. 215-234). Bielefeld: Transcript Verlag.

Mol, A. (2013). Mind your plate! The ontonorms of Dutch dieting. *Social Studies of Science, 43*(3), 379-396.

Mol, A., & Law, J. (2004). Embodied action, enacted bodies: The example of hypoglycaemia. *Body & Society, 10*(2-3), 43-62.

Mol, A., Moser, I., & Pols, J. (Eds.). (2010). *Care in practice: On tinkering in clinics, homes and farms*. Bielefeld: Transcript Verlag.

Mol, A. (2006). Proving or improving: On health care research as a form of self-reflection. *Qualitative Health Research, 16*(3), 405-414. doi:16/3/405

Mol, A. (1998). Lived reality and the multiplicity of norms: A critical tribute to George Canguilhem. *Economy and Society, 27*(2-3), 274-284. doi:10.1080/03085149800000020

Monaghan, L. F. (2007). McDonaldizing men's bodies? Slimming, associated (ir)rationalities and resistances. *Body & Society, 13*(2), 67-93.

Monaghan, L. F., Colls, R., & Evans, B. (2013). Obesity discourse and fat politics: Research, critique and interventions. *Critical Public Health, 23*(3), 249-262.

Moreira, T. (2004). Self, agency and the surgical collective: Detachment. *Sociology of Health & Illness, 26*(1), 32-49.

Moreira, T. (2006). Heterogeneity and coordination of blood pressure in neurosurgery. *Social Studies of Science, 36*(1), 69-97.

Moser, I. (2005). On becoming disabled and articulating alternatives: The multiple modes of ordering disability and their interferences. *Cultural Studies, 19*(6), 667-700.

Moser, I. (2010). Perhaps tears should not be counted but wiped away. On quality and improvement in dementia care. In A. Mol, I. Moser & J. Pols (Eds.), *Care in practice: On tinkering in clinics, Homes and farms.* (pp. 277-300). Bielefeld: Transcript Verlag.

Mudry, J. (2009). *Measured meals: Nutrition in America.* Albany: State University of New York Press.

Mulder, A. (2011, April 29). Preventie van leefstijlziekten leidt tot hogere zorgkosten. *NRC Handelsblad*.

Muroff, J. A. (2011). Policing willpower: Obesity as a test case for state empowerment of integrated health care. *Houston Journal of Health Law & Policy*, *11*, 47-78.

Murray, S. (2010). Women under/in control? Embodying eating after gastric banding. *Radical Psychology*, *8*(1)

Murray, S. (2007). Corporeal knowledges and deviant bodies: Perceiving the fat body. *Social Semiotics*, *17*(3), 361-373.

Neter, J. E., Dijkstra, S. C., Visser, M., & Brouwer, I. A. (2014). Food insecurity among Dutch food bank recipients: A cross-sectional study. *BMJ Open*, *4*(5), e004657-2013-004657. doi:10.1136/bmjopen-2013-004657

Nhat Hanh, T., & Cheung, L. (2010). *Savor: Mindful eating, mindful life*. New York: HarperCollins.

Nicholls, S. G. (2013). Standards and classification: A perspective on the 'obesity epidemic'. *Social Science & Medicine*, *87*(0), 9-15. doi:dx.doi.org/10.1016/j.socscimed.2013.03.009

National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK); derivative work Fruitsmaak, S. (n.d.). Model of a Roux-en-Y Gastric Bypass [Illustration]. Retrieved June 19, 2016, from https://commons.wikimedia.org/wiki/File%3ARoux-en-Y_gastric_bypass.png.

Paxson, H. (2012). *The life of cheese: Crafting food and value in America*. Berkeley: University of California Press.

Paxson, H., & Helmreich, S. (2014). The perils and promises of microbial abundance: Novel natures and model ecosystems, from artisanal cheese to alien seas. *Social Studies of Science*, *44*(2), 165-193.

Pearce, S., & Pickard, H. (2010). Finding the will to recover: Philosophical perspectives on agency and the sick role. *Journal of Medical Ethics*, *36*(12), 831-833. doi:10.1136/jme.2010.035865

Persson, K. (2013). The right perspective on responsibility for ill health. *Medicine, Health Care and Philosophy*, *16*(3), 429-441.

Pols, J. (2005). Enacting appreciations: Beyond the patient perspective. *Health Care Analysis, 13*(3), 203-221.

Pols, J. (2013a). The patient 2. many. About diseases that remain and the different forms of knowledge to live with them. *Science & Technology Studies, 26*(2), 80-97.

Pols, J. (2013b). Through the looking glass: Good looks and dignity in care. *Medicine, Health Care and Philosophy, 16*(4), 953-966.

Pols, J. (2013c). Washing the patient: Dignity and aesthetic values in nursing care. *Nursing Philosophy, 14*(3), 186-200.

Popenoe, R. (2012). *Feeding desire: Fatness, beauty and sexuality among a Saharan people.* New York: Routledge.

Prior, L., Chun, P. L., & Huat, S. B. (2000). Beliefs and accounts of illness. views from two Cantonese-speaking communities in England. *Sociology of Health & Illness, 22*(6), 815-839.

Puig de la Bellacasa, M. (2011). Matters of care in technoscience: Assembling neglected things. *Social Studies of Science, 41*(1), 85-106.

Rabinbach, A. (1992). *The human motor: Energy, fatigue, and the origins of modernity.* Berkeley: University of California Press.

Rabinow, P. (1992). Artificiality and enlightenment: From sociobiology to biosociality. In J. Crary, & S. Kwinter (Eds.), *Incorporations* (pp. 234-253). New York: Zone books.

Rijlaarsdam, K. (2012, September 1). Het nieuwe diëten is mindful eten. *Trouw.* doi: http://www.trouw.nl/tr/nl/5009/Archief/archief/article/detail/3309551/2012/09/01/Het-nieuwe-dieten-is-mindful-eten.dhtml

Rose, N. (1990). *Governing the soul: The shaping of the private self.* London: Routledge.

Rose, N. (2007). *The politics of life itself: Biomedicine, power, and subjectivity in the twenty-first century.* Princeton: Princeton University Press.

Rothblum, E. D., Solovay, S., & Wann, M. (2009). *The fat studies reader.* New York: New York Unviersity Press.

Rozin, P. (1999). Food is fundamental, fun, frightening and far-reaching. *Social Research, 66*(1), 9-30.

Sanabria, E. (2015). Sensorial pedagogies, hungry fat cells and the limits of nutritional health education. *BioSocieties*, *10*(2), 125-142.

Sanabria, E. (2016). Circulating ignorance: Complexity and agnogenesis in the obesity "Epidemic". *Cultural Anthropology*, *31*(1), 131-158.

Schleifer, D. (2012). Categories count: Trans fat labeling as a technique of corporate governance. *Social Studies of Science*, doi:10.1177/0306312712461573

Schüll, N. D. (2016). Data for life: Wearable technology and the design of self-care. *BioSocieties*,

Schwartz, H. (1986). *Never satisfied: A cultural history of diets, fantasies, and fat*. New York: Free Press.

Scrinis, G. (2013). *Nutritionism: The science and politics of dietary advice*. New York: Columbia University Press.

Sharkey, K., & Gillam, L. (2010). Should patients with self-inflicted illness receive lower priority in access to healthcare resources? Mapping out the debate. *Journal of Medical Ethics*, *36*(11), 661-665. doi:10.1136/jme.2009.032102

Sjöström, L., Narbro, K., Sjöström, C. D., Karason, K., Larsson, B., Wedel, H., . . . Carlsson, L. M. S. (2007). Effects of bariatric surgery on mortality in Swedish obese subjects. *New England Journal of Medicine*, *357*(8), 741-752.

Smith, C. (2002). Punishment and pleasure: Women, food and the imprisoned body. *Sociological Review*, *50*(2), 197-214.

Solomon, H. (2014). Short cuts: Metabolic surgery and gut attachments in India. *Social Text*, *32*(3), 69-86.

Sontag, S. (1978). *Illness as metaphor*. New York: Farrar, Straus & Giroux.

Star, S. L. (1990). Power, technology and the phenomenology of conventions: On being allergic to onions. *The Sociological Review*, *38*(S1), 26-56.

Stinson, K. M. (2001). *Women and dieting culture: Inside a commercial weight loss group*. Piscataway, NJ: Rutgers University Press.

Strathern, M. (1992). *After nature: English kinship in the late twentieth century*. Cambridge: Cambridge University Press.

Strathern, M. (2004). *Partial connections*. Oxford: AltaMira Press.

Strathern, M. (2012). Eating (and feeding). *Cambridge Anthropology*, *30*(2), 1-14.

Struhkamp, R. (2004). Goals in their setting: A normative analysis of goal setting in physical rehabilitation. *Health Care Analysis*, *12*(2), 131-155.

Struhkamp, R. (2005). Wordless pain: Dealing with suffering in physical rehabilitation. *Cultural Studies*, *19*(6), 701-718.

Struhkamp, R., Mol, A., & Swierstra, T. (2009). Dealing with in/dependence doctoring in physical rehabilitation practice. *Science, Technology & Human Values*, *34*(1), 55-76.

Tapper, K., Shaw, C., Ilsley, J., Hill, A. J., Bond, F. W., & Moore, L. (2009). Exploratory randomised controlled trial of a mindfulness-based weight loss intervention for women. *Appetite*, *52*(2), 396-404.

Tengland, P. (2008). Empowerment: A conceptual discussion. *Health Care Analysis*, *16*(2), 77-96.

Thompson, C. (2005). *Making parents: The ontological choreography of reproductive technologies*. Cambridge: MIT press.

Throsby, K. (2008). Happy re-birthday: Weight loss surgery and the 'new me'. *Body & Society*, *14*(1), 117-133.

Throsby, K. (2012). Obesity surgery and the management of excess: Exploring the body multiple. *Sociology of Health & Illness*, *34*(1), 1-15.

Tribole, E., & Resch, E. (2003). *Intuitive eating: A revolutionary program that works*. New York: St. Martin's Griffin.

Turner, B. S. (1982). The government of the body: Medical regimens and the rationalization of diet. *The British Journal of Sociology*, *33*(2), 254-269.

Van Berkum, F. (2010). *Gezond slank met dr. Frank*. Amsterdam: Carrera.

Van de Port, M. & Mol, A. (2015). Chupar frutas in Salvador Da Bahia: A case of practice-specific alterities. *Journal of the Royal Anthropological Institute*, *21*(1), 165-180.

Van Herwijnen, M. (2012). *Weg met de weegschaal*. Houten: Spectrum.

Van Hoyweghen, I., Horstman, K., & Schepers, R. (2007). Genetic 'risk carriers' and lifestyle 'risk takers'. which risks deserve our legal protection in insurance? *Health Care Analysis*, *15*(3), 179-193.

Varela, F. J. (2001). Intimate distances: Fragments for a phenomenology of organ transplantation. In E. Thompson (Ed.), *Between ourselves: Second-person issues in the study of consciousness* (pp. 259-271). Thorverton: Imprint Academic.

Verburgh, K. (2015). *De voedselzandloper: Over afvallen en langer jong blijven.* Amsterdam: Bert Bakker.

Voedingscentrum. (n.d.). Energiebalans. Retrieved February 26, 2016, from http://www.voedingscentrum.nl/nl/mijn-gewicht/gezond-gewicht/energiebalans.aspx.

Vogel, E. (2014). Clinical specificities in obesity care: The transformations and dissolution of 'will' and 'drives'. *Health Care Analysis*, *0*(0), 1-17. doi:10.1007/s10728-014-0278-3

Vogel, E., & Mol, A. (2014). Enjoy Your Food: on Losing Weight and Taking Pleasure. In S. Cohn (Ed.), *From Health Behaviours to Health Practices: Critical Perspectives* (pp. 145-157). Oxford, UK: Wiley Blackwell.

Vogel, E., & Mol, A. (2014). Enjoy your food: On losing weight and taking pleasure. *Sociology of Health & Illness*, *36*(2), 305-317. doi:10.1111/1467-9566.12116

Warin, M. J., & Gunson, J. S. (2013). The weight of the word: Knowing silences in obesity research. *Qualitative Health Research*, *23*(12), 1686-1696. doi:10.1177/1049732313509894

Warin, M. (2011). Foucault's progeny: Jamie Oliver and the art of governing obesity. *Social Theory & Health*, *9*(1), 24-40.

Warin, M., Moore, V., Davies, M., & Ulijaszek, S. (2015). Epigenetics and obesity the reproduction of habitus through intracellular and social environments. *Body & Society*, *0*(0), 1-26. doi:10.1177/1357034X15590485

Warin, M. (2014). Material feminism, obesity science and the limits of discursive critique. *Body & Society*, doi:10.1177/1357034X14537320

Webb, H. (2009). 'I've put weight on cos i've bin inactive, cos i've'ad me knee done': Moral work in the obesity clinic. *Sociology of Health & Illness*, *31*(6), 854-871.

Westenhoefer, J., & Pudel, V. (1993). Pleasure from food: Importance for food choice and consequences of deliberate restriction. *Appetite, 20*(3), 246-249.

Williams, J. (1997). 'We never eat like this at home': Food on holiday . In P. Caplan (Ed.), *Food, health and identity* (pp. 151-171). London: Routledge.

Wilson, E. (2015). *Gut feminism.* Durham: Duke University Press.

Wilson, E. A. (1998). *Neural geographies: Feminism and the microstructure of cognition.* New York: Routledge.

Wilson, M. (2005). Indulgence. In D. Kulick, & A. Meneley (Eds.), *Fat: The anthropology of an obsession* (pp. 153-167). New York: Penguin.

Womack, C. A. (2012). Public health and obesity: When a pound of prevention really is worth an ounce of cure. *Public Health Ethics, 5*(3), 222-228.

World Health Organisation (WHO). (2013). Obesity and overweight, fact sheet N°311. Retrieved from http://www.who.int/mediacentre/factsheets/fs311/en/

Wright, J., & Harwood, V. (Eds.). (2009). *Biopolitics and the 'obesity epidemic': Governing bodies.* London: Routledge.

Yates-Doerr, E. (2012a). The opacity of reduction: Nutritional black-boxing and the meanings of nourishment. *Food, Culture and Society: An International Journal of Multidisciplinary Research, 15*(2), 293-313.

Yates-Doerr, E. (2012b). The weight of the self: Care and compassion in Guatemalan dietary choices. *Medical Anthropology Quarterly, 26*(1), 136-158.

Yates-Doerr, E. (2015). *The weight of obesity: Hunger and global health in postwar Guatemala.* Oakland: University of California Press.

Yates-Doerr, E., & Mol, A. (2012). Cuts of meat: Disentangling western natures-cultures. *Cambridge Anthropology, 30*(2), 48-64.

Zimmerman, D. H., & West, C. (1987). Doing gender. *Gender & Society, 1*(2), 125-151.

Zuiderent-Jerak, T. (2015). *Situated intervention: Sociological experiments in health care.* Cambridge, MA: MIT Press.

SUMMARY

Overweight people currently find themselves cast as part of an urgent societal problem. Statistics suggest that in the Netherlands and elsewhere being overweight is becoming a true 'epidemic'. But from the numbers offered in such statistics, we learn little about how people might live with overweight as both a concern and a bodily state in their daily lives. This dissertation analyses the practices and techniques through which people who classify as overweight or obese, or who feel they are fat or at a risk of becoming so, care for their bodily weight.

In chapter 1, I introduce my approach and research question and relate it to the existing social science literature concerned with overweight and obesity. In this body of work, most authors emphasize the disciplining, moralizing and calculating character of nutritional recommendations, diets and related bodily techniques. Their critical reading of these techniques is that they aim at making bodies docile, their desires tamed. Moreover, these techniques call upon people to take control of their health as individual subjects. Social scientists locate this normative injunction in a 'lifestyle politics'. That is, part of being a good citizen now entails regulating one's weight by making so-called healthy choices and engaging in good behavior.

But although in the arena of 'obesity epidemic' discourse the webs of normalizing biopower are becoming ever tighter, care practices are often messier. People care for their weight in ways that often elude the tropes of (self)disciplining that social scientists are so concerned with. It is such care that I have sought out. The aim was to study practices which neither responsibilize nor victimize individual subjects. I thus looked for alternatives to calls for bodily discipline in practices where weight care is being *done*.

A 'science-based' approach to healthy eating presents education and the supply of up-to-date information as the main tasks of professional care. In contrast to that I explore the creative strategies of both professionals and the people concerned to bring about meaningful changes in daily life. In 'the wild', people grapple with often contradictory messages embedded in cooking

traditions, printed on labels and spread through popular media. In addition, people are engaged in different practices of cooking, tasting and eating together. There are several ways in which care practices may relate to such complexities. I find that despite body weight's clear-cut measurements, care practices do not target a well-defined condition. Instead, informed by various therapeutic concerns, they work on altering a wide array of modes of doing, being and relating.

My concern is particularly with the subject engaging in (self-)care. I ask what it may mean to 'take up' the task of living with their overweight in practice. What do professionals encourage their clients to strive after when caring for their weight? How does this help to configure the bodies and environments people then come to live in? In what normative relations are the subjects of (self-)care bound up? In this dissertation I contrast different forms of care. In other words, I engage in an *articulation* of the messy socio-materially embedded relations and practices through which living and caring are done. The aim is to thus explore how people may variously craft themselves as persons when weight is a concern. These, then, are the research questions that animate this dissertation:

What forms of care emerge in practices that address issues with bodily weight and how do these configure the body and the environment? What may subjects become as they engage in these forms of (self-)care?

To answer these questions, I conducted ethnographic fieldwork on practices through which various practitioners and people care for bodily weight. The means they draw on are as diverse as dietary recommendations, exercise regimes, meditation, tasting, diet shakes and surgery. Such techniques, I stress, not only intervene *on* the body. They reconfigure the lives of the people involved. They change the practicalities and meanings of everyday life – of cooking and eating, of pain and pleasure, of shopping, of being a family. In this dissertation, I demonstrate that different forms of care do so in different ways.

Working from a material semiotics approach, a set of sensitivities emerging from Science and Technology Studies (STS), I analyze *modes of ordering* in care practices. That is, I explore how a certain form of care implies

a practical arranging of people and things – of subjects, bodies, environments, techniques, professionals and activities. In a particular ordering, certain problems are attended to and specific normative ideals are pursued, while others are left out. I study these different orderings as they enact different modes of living with overweight. By contrasting them, we gain new vocabularies with which to value the modes of living that emerge in care practices.

In **chapter 2,** I position my analysis of caring practices in relation to ethical debates in philosophy around responsibility for obesity, on the one hand, and poststructuralist criticisms of discursive constructions of the problem of obesity on the other. I do this by exploring the dominant terms in Dutch public debates around obesity. I show how targeting excess body weight is often presented here as a matter of controlling bodily *drives*. An individual or collective *will* is then called upon to restrict these drives. I then move on to analyze in what ways this 'logic of control' comes to matter in clinical care practices of dieticians, weight consultants and nutritionists. Here I find that control is not always foregrounded. Professionals may even state discipline is problematic as it leaves people to develop a 'disturbed relation' with their bodies. Professional ways of working, moreover, reveal a richness of practiced ideals, oriented towards feeling well, eating well and caring well. Such an attention to 'clinical specificities', I argue, opens up a space for productive normative engagements with obesity care that move beyond dominant logics in public debate and its critiques.

In **chapter 3** I explore how knowledge inflects consumption practices. This knowledge was initially shaped by the industrial preoccupation with efficiently maintaining a healthy, productive workforce; it is now formed by a post-industrial concern with the ailments associated with a misbalance between food intake and lack of exercise. I analyze how exercise practices in the Netherlands that are primarily concerned with weight tie eating to exercise and thus enact what I call 'metabolic logics'. My question is which modes of relating to their body people are thus offered in these practices. A first metabolic logic premises *calculating* as a strategy to ensure energy efficiency and weight loss. This strategy depends on the measuring and quantifying of bodies, food and exercise. A second logic puts its hopes in

activating people's metabolic rate in order to enhance the body's functionality. This second logic operates as a critique to the first. I stress these logics do not just present *ideas* on what is healthy and what is not, but are also and importantly a material and practical affair. That is, these logics structure *particular* ways of healthy living, rather than others. Their material character implies that as professionals working from the second logic encounter, for example, their clients' fears of eating more and gaining weight, they are not only confronted with different *ideas* about what is or is not healthy, but also with calorie lists, food packaging, weighing scales and commercial diets that convey the very norms they try to change. The analysis therefore highlights the limits of providing education about foods and bodies.

In **chapter 4**, written together with Annemarie Mol, we question the idea that healthy eating requires people to control themselves and abstain from pleasure. This idea is dominant, but in this chapter we bring out practices of professionals who work in alternative ways. By means of 'positive prevention', these professionals seek weight loss for their clients by cultivating their capacity for pleasure and their body's amenability to satisfaction. We stress the practical work required for enacting sensitive bodies felt from within. It appears that 'enjoying your food' depends on being attentive to tastes and feelings and that recognizing needs demands training. What is more, food may only be inviting if the right conditions are crafted. From the perspective of these practices, we argue, the notion of 'health behavior' prevalent in public health discussions is problematic because it concerns itself with actions observable and judged *from the outside.* The professionals presented in this chapter encourage people to no longer ask 'Am I being good?' but help them to wonder instead 'Is this good for me?' Both questions are normative and target individuals. Yet, in thinking about overweight they mark a difference worth making: that between externally controlling your behavior and self-caringly enjoying your food.

In **chapter 5,** I analyze a mindful eating course. The idea of the course is that people use eating to cope with troubles in their lives, while at the same time they are hindered by a preoccupation with the size and shape of their bodies. Mindfulness coaches aim to help people let go of this 'struggle with eating' by posing as the central question: '*what do I *really* hunger after?*

The self's hungers include 'belly hunger' but also stem from mouths, hearts, heads, noses and eyes. They cannot all be fed with food. This mode of care shifts from focusing on bodily norms to an orientation to *nourishment*. Techniques focus on the training of attention to recognize and disentangle hungers; developing self-knowledge of and a sensibility to what 'feeds' personal life; and the way a person positions herself in relation to herself and the world. Although examining what one hungers after is a pursuit without end, satisfaction and personal growth are part of the process. I argue that rather than introducing new norms to correct a body out of bounds, in mindfulness configures a different kind of normativity, oriented to living. It therefore changes the worlds people come to inhabit through engaging in self-care.

Chapter 6 describes the processes through which patients diagnosed with 'morbid obesity' become active subjects through undergoing bariatric surgery and a lifestyle program in a Dutch obesity clinic. I argue that surgery does not take the task of handling obesity away from patients. On the contrary: in the clinic's elaborate care assemblage - consisting of dieticians, exercise coaches and psychologists - the person is not only actively involved in his/her own treatment, but treatment is aimed at becoming, feeling, appreciating differently altogether. The empirical examples reveal that the self capable of self-care is not readily available, but can only come about due to costly and laborious conditioning through which patients will never be the same. The surgical procedure allows patients to anchor their will in the body's anatomy, permitting a mode of embodiment in which will and cravings are in synch. While the transformation harbors great potential, it can also disrupt. As patients depend on others to realize forceful changes in themselves, this is a mode of care that aligns support and submission with agency.

In **chapter 7** I come back to my main research question. I argue again that there is no 'natural' imperative for how to care for body weight, handed to us by facts on food and the body. Instead, there are different modes of engaging with overweight in people's lives. All these alternatives are situated, complex normative negotiations. In these negotiations, not one problem, but various problems, playing out on different scales and shaped by different terms, come to the fore. By way of conclusion, this chapter clusters

the differences I found in the chapters in four modes of care. The first is care through the control of input and output by a rational mind. The subject is here called upon as a cognitive center making decisions. The second mode of care works through changing the self by reconfiguring its anatomy; thus enacting an embodied and relational subject transforming itself. The third mode of care aims at cultivating the tasting body. Here, the subject becomes a sensitized self who lives her body from the inside. Finally, a fourth mode of care foregrounds a 'hungering' subject as this care is premised on nourishing hungers in fitting ways. In this chapter I articulate the bodies staged in these forms of care and the environments they engage with, in particular through eating and taking exercise. The modes of care do not fit on a commensurable whole in which one is universally better than the other; neither are they options left to the preferences of professionals and their clients/patients. Instead, my analysis opens up a new evaluative field that allows for new ways of deliberating about care for and life with overweight. It gives new handholds for differentiation between supporting relations and relations that make it difficult for certain modes of living to flourish. In that way, this dissertation opens up the question of how to create institutional space for creative care practices that invent and foster better ways of living in situations where overweight is a concern.

SAMENVATTING

Subjecten van zorg: leven met overgewicht in Nederland

Mensen met overgewicht worden tegenwoordig onderdeel gemaakt van een urgent maatschappelijk probleem. Statistieken laten zien dat in Nederland en daarbuiten overgewicht 'epidemische' vormen begint aan te nemen. Maar van de cijfers die deze statistieken ons bieden, leren we weinig over hoe mensen in hun dagelijks leven omgaan met overgewicht. Dit proefschrift analyseert de praktijken en technieken waarmee mensen die overgewicht of obesitas hebben – of die zichzelf te dik vinden, of het risico lopen dat te worden – zorgen voor hun gewicht.

In Hoofdstuk 1 introduceer ik mijn aanpak en plaats deze in de bredere sociaalwetenschappelijke literatuur over overgewicht. In deze literatuur wijzen veel auteurs op het disciplinerende, moraliserende en calculerende karakter van voedingsadviezen, diëten en gerelateerde lichaamstechnieken. Hun kritische lezing van deze technieken is dat ze gericht zijn op het tot gehoorzaamheid dwingen van het lichaam en het temmen van zijn verlangens. Bovendien spreken ze mensen als individueel subject aan op hun plicht controle te hebben over hun eigen gezondheid. Ze plaatsen deze normatieve opdracht binnen een 'leefstijlpolitiek'. Deze houdt in dat je pas een goede burger bent als je op je gewicht let en zogenoemde 'gezonde keuzes' maakt.

Maar hoewel door het vertoog rond de 'obesitasepidemie' de netten van normaliserende *biomacht* steeds strakker worden gespannen, gaat het er in zorgpraktijken vaak rommeliger aan toe. De manieren waarop mensen zorgen voor hun gewicht komen vaak niet overeen met de (zelf)disciplinering waar sociale wetenschappers zo bezorgd over zijn. Het is deze zorg waar ik naar op zoek ben gegaan. Het doel was vormen van zorg te onderzoeken die subjecten noch als verantwoordelijk individu noch als passief slachtoffer benaderen. Ik heb dus gekeken naar alternatieven voor een appèl op lichaamsbeheersing in de praktijken waarin deze zorg *gedaan* wordt.

SAMENVATTING

Bezien vanuit een wetenschappelijke benadering van gezond eten, vormen educatie en het leveren van up-to-date informatie de belangrijkste taken van professionele zorg. In tegenstelling tot deze benadering verken ik de creatieve strategieën van zowel professionals als de betrokken personen om betekenisvolle veranderingen in het dagelijks leven aan te brengen. In 'het wild' worstelen mensen met vaak tegenstrijdige boodschappen, ingebed in kooktradities, afgebeeld op labels of verspreid door populaire media. Daarnaast zijn mensen gewend aan bepaalde manieren van koken, proeven en eten met elkaar. Er zijn verscheidene manieren waarop zorgpraktijken zich verhouden tot zulke complexiteiten. Ik vond dan ook dat niettegenstaande de scherpomlijnde criteria waaraan lichaamsgewicht tegenwoordig afgemeten wordt, zorgpraktijken geen welomschreven aandoening behandelen. In plaats daarvan werken ze, ingegeven door allerhande therapeutische belangen/idealen, aan het veranderen van een grote diversiteit aan manieren van doen, zijn en verbinden.

Mijn interesse ligt voornamelijk bij het subject dat betrokken is bij (zelf-)zorg. Ik stel de vraag wat het nou eigenlijk betekent om het leven met overgewicht als taak 'op je te nemen'. Waartoe moedigen professionals hun cliënten aan in de zorg voor hun gewicht? Hoe draagt dit bij aan het configureren van de lichamen en omgevingen waar mensen dan in komen te leven? In welke normatieve relaties zijn de subjecten van (zelf-)zorg gevat? In dit proefschrift contrasteer ik verschillende vormen van zorg. Met andere woorden, mijn onderzoek levert een *articulatie* van de sociaal-materieel ingebedde relaties en praktijken waarin leven en zorgen gedaan worden. Mijn doel is om zo nieuwe manieren te verkennen waarop mensen zichzelf vormgeven als persoon wanneer hun gewicht een probleem is. Daarmee kom ik op de onderzoeksvraag die dit proefschrift inspireert:

Welke vormen van zorg ontstaan er in zorgpraktijken en hoe configureren deze het lichaam en de omgeving? Hoe geven deze praktijken vorm aan het subject van (zelf)zorg?

Om deze vraag te beantwoorden, put ik uit etnografisch veldwerk in zorgpraktijken waarin verschillende praktijkbeoefenaars, en mensen met

overgewicht zelf, overgewicht te lijf gaan. Dit doen ze door gebruik te maken van middelen zo divers als dieetadviezen, beweegprogramma's, meditatie, smaakoefeningen, afvalshakes en operaties. Deze technieken, zo benadruk ik, grijpen niet alleen in *op* het lichaam, maar wijzigen de levens van de betrokken personen. Ze veranderen de praktische invulling en betekenis van het dagelijks leven – van koken en eten, van pijn en plezier, van boodschappen doen, van het familieleven. In dit proefschrift laat ik zien dat verschillende vormen van zorg dat doen op verschillende manieren.

Werkende vanuit een materieel semiotische aanpak, een 'set van gevoeligheden' voortgekomen uit het wetenschapsonderzoek, analyseer ik *manieren van ordenen* in zorgpraktijken. Dat wil zeggen, ik verken hoe een bepaalde vorm van zorg samenhangt door het praktisch, materieel en talig rangschikken van en betekenis geven aan mensen en dingen– van subjecten, lichamen, omgevingen, technieken, professionals en handelingen. In een ordening krijgen bepaalde problemen aandacht en worden specifieke normatieve idealen nagestreefd, terwijl andere weggelaten worden. Ik onderzoek de aard van de samenhang van deze uiteenlopende ordeningen en hoe ze verschillende manieren van leven met overgewicht laten zien. Door deze te contrasteren, krijgen we een nieuw vocabulaire waarmee we de manieren van leven die verwezenlijkt worden in zorgpraktijken kunnen waarderen.

In **hoofdstuk 2** positioneer ik mijn analyse van zorgpraktijken in verhouding tot ethische debatten in de filosofie over verantwoordelijkheid voor obesitas enerzijds, en poststructuralistische kritieken op discursieve constructies van het probleem obesitas anderzijds. Hierbij verken ik de dominante termen van het publieke debat rond obesitas. Ik laat zien hoe het aanpakken van overgewicht hier vaak wordt gepresenteerd als een kwestie van het controleren van *lichaamsdriften.* Een individuele of collectieve *wil* wordt bovendien opgeroepen om deze beheersing op zich te nemen. Ik analyseer vervolgens op welke manier deze 'logica van controle' doorwerkt in de klinische zorgpraktijken van diëtisten, gewichtsconsulenten en voedingsdeskundigen. Hieruit blijkt dat controle van driften niet altijd belangrijk gevonden wordt en professionals discipline zelfs als zeer problematisch bestempelen omdat het mensen opzadelt met een 'verstoorde

relatie' met hun lijf. Professionele werkwijzen onthullen bovendien een groot scala aan andere praktische idealen, gericht op goed voeden, goed eten en goed zorgen. Een dergelijke aandacht voor 'klinische specificiteit', beargumenteer ik, geeft ruimte aan productieve normatieve betrokkenheid met obesitaszorg die niet vast zit in de dominante logica van het publieke debat en zijn kritieken.

In **hoofdstuk 3** onderzoek ik hoe kennis consumptiepraktijken vormt. Deze kennis is eerst gevormd door de industriële preoccupatie met het efficiënt onderhouden van een gezonde, productieve arbeidskracht en nu door een postindustriële bezorgdheid om volksziekten ten gevolge van een misbalans tussen voedselinname en hoeveelheid beweging. Ik analyseer hoe Nederlandse beweegpraktijken die zich richten op gewichtsverlies, eten en lichamelijke oefening aan elkaar koppelen en daardoor diverse 'metabolische logica's' tot stand brengen. Mijn vraag is welke relatie tot hun lichaam mensen zo geboden wordt in deze praktijken. Een eerste metabolische logica stelt *rekenen* voorop als strategie voor het bereiken van efficiënt energieverbruik en gewichtsverlies. Deze strategie komt tot stand in het meten en kwantificeren van lichamen, voedsel en beweging. Een tweede logica vestigt haar hoop op het *activeren* van het metabolisme van mensen om zo de functionaliteit van het lichaam te verhogen. Deze tweede logica vormt een kritiek op de eerste. Ik benadruk dat deze logica's niet alleen verschillende *ideeën* weergeven over wat gezond is of niet, maar ook vooral een praktische en materiële aangelegenheid zijn. Dat wil zeggen, deze logica's structureren bepaalde manieren van gezond leven en niet andere. Hun materiële karakter behelst dat de professionals die werken vanuit de tweede logica niet alleen geconfronteerd worden met bijvoorbeeld de angst van hun cliënten om meer te eten en aan te komen, maar ook met calorielijsten, voedselverpakkingen, weegschalen en commerciële diëten die de normen uitdragen die zij proberen te veranderen. In de analyse komen daarmee de beperkingen van educatie over voedsel en lichamen aan het licht.

In **hoofdstuk 4**, geschreven samen met Annemarie Mol, betwijfelen wij het idee dat gezond eten van mensen verlangt om zichzelf te beheersen en af te zien van genot. Dit idee is dominant, maar in dit hoofdstuk laten we de praktijken zien van professionals die op andere manieren werken. Door middel

van 'plezierige preventie' proberen deze professionals gewichtsverlies voor hun cliënten te bewerkstelligen door hun vermogen om van eten te genieten te cultiveren en daarmee de beleving van verzadiging te vergroten. We richten ons hierbij met name op het praktische werk dat nodig is voor het tot stand brengen van lichamen die gevoeld worden van binnenuit. Het wordt duidelijk dat het 'genieten van je eten' van de persoon vraagt om aandacht te hebben voor smaken en gevoelens; en dat het herkennen van behoeften training vereist. Daarnaast kan voedsel alleen uitnodigend zijn als de omstandigheden daartoe zijn uitgerust. Vanuit het perspectief van deze praktijken, zo stellen we, is het concept 'gezondheidsgedrag' dat veel voorkomt in discussies rond de publieke gezondheidszorg, problematisch omdat het zich richt op gedrag geobserveerd en beoordeeld *van buitenaf*. De professionals die aan bod komen in dit hoofdstuk moedigen mensen niet langer aan te vragen 'Doe ik het goed?' maar helpen hun cliënten te onderzoeken 'Is het goed voor mij?' Beide vragen zijn normatief en richten zich op het individu. Maar in ons denken over overgewicht signaleren ze een waardevol verschil: tussen het extern controleren van gedrag en het zorgend genieten van eten.

In **hoofdstuk *5*** analyseer ik een 'mindful eten' cursus. Het idee achter de cursus is dat mensen eten gebruiken om met moeilijkheden in hun leven om te gaan, terwijl ze tegelijkertijd last hebben van een preoccupatie met de vorm en grootte van hun lichaam. Mindfulness coaches proberen mensen te helpen in deze 'strijd met eten' door als centrale vraag te stellen: 'waar honger ik nu *echt* naar?' Dit zelf voelt 'buikhonger' maar ook hongers die ontstaan in monden, harten, hoofden, neuzen en ogen. Deze kunnen niet allemaal gevoed worden met voedsel. Deze vorm van zorg verschuift zo de focus van lichamelijke normen naar een oriëntatie op *voeding*. Technieken richten zich op het trainen van aandacht om hongers te herkennen en te onderscheiden; het ontwikkelen van zelfkennis van en een gevoeligheid voor wat het persoonlijk leven 'voedt'; en de manier waarop een persoon zich verhoudt tot zichzelf en de wereld. Hoewel het onderzoek waar men naar hongert geen einde kent, zijn bevrediging en persoonlijke groei onderdeel van het proces. Het hoofdstuk beargumenteert dat in plaats van het introduceren van een nieuwe set normen om een onbegrensd lichaam te corrigeren,

mindfulness een vorm van normativiteit uitdraagt die gericht is op het leven zelf. Zij geeft daarmee vorm aan een andere werkelijkheid rondom zelfzorg.

Hoofdstuk 6 beschrijft de processen waardoor mensen gediagnosticeerd met 'morbide obesitas' actieve subjecten worden door het ondergaan van een maagverkleinende operatie en een leefstijlprogramma in een obesitaskliniek. Ik stel dat de operatie de taak van het omgaan met obesitas niet wegneemt van patiënten. Integendeel: in de uitgebreide zorgopstelling van de kliniek – bestaande uit diëtisten, beweegcoaches en psychologen – is de persoon niet alleen actief betrokken in zijn/haar eigen behandeling; de behandeling zelf is gericht op helemaal anders worden, voelen en waarderen. De empirische voorbeelden laten zien dat 'het zelf in staat tot zelfzorg' niet zomaar beschikbaar is, maar alleen tot stand kan komen door een aantal kostbare en moeizame aanpassingen waarna patiënten nooit meer dezelfde zijn. De operatie stelt patiënten in staat hun wil te verankeren in de anatomie van hun lichaam, waardoor zij een belichaming kunnen bereiken waarin wil en trek met elkaar overeenstemmen. De transformatie heeft daarmee veel potentie voor mensen maar kan ook verstorend zijn. Omdat patiënten van anderen afhankelijk zijn voor het realiseren van krachtige veranderingen in henzelf, is dit een vorm van zorg waarin steun en onderwerping samenvallen met *agency*.

In **hoofdstuk 7**, tenslotte, kom ik terug bij mijn hoofdvraag. Ik stel nogmaals dat er geen 'natuurlijk gegeven' is, gelegen in de feiten over voedsel en het lichaam, hoe met overgewicht om te gaan. In plaats daarvan zijn er verschillende manieren waarop mensen in hun dagelijks leven met overgewicht om kunnen gaan. Al deze alternatieven omvatten gesitueerde, complexe normatieve overwegingen. Deze overwegingen laten niet één, maar meerdere problemen zien, die spelen op verschillende niveaus en in verschillende termen worden gevat. Bij wijze van conclusie, cluster ik in dit hoofdstuk de gevonden verschillen in vier vormen van zorg. De eerste is zorg door controle van input en output door een rationele geest. Het subject wordt hier aangesproken als een cognitief centrum dat beslissingen maakt. De tweede vorm van zorg werkt aan het veranderen van het zelf door in te grijpen op zijn/haar anatomie; een belichaamd en relationeel subject verschijnt dat zichzelf vormgeeft. De derde vorm van zorg richt zich op het

cultiveren van de goede smaak van het lichaam. Het subject wordt hier een sensitief zelf dat haar lijf beleeft van binnenuit. Tot slot gaat een vierde vorm van zorg uit van een 'hongerend' subject omdat deze zorg gericht is op het voeden van diverse hongers op de juiste manieren. In dit hoofdstuk articuleer ik de lichamen die ten tonele verschijnen in deze vormen van zorg en de omgevingen waarmee ze in relatie staan, met name door middel van eten en bewegen. De vormen van zorg passen niet in een allesomvattend geheel waarin één altijd beter is dan de ander; ook zijn het geen opties die we overlaten aan de voorkeuren van professionals en hun cliënten/patiënten. In plaats daarvan opent mijn analyse een nieuw evaluatief veld dat nieuwe deliberaties over zorg voor en leven met overgewicht mogelijk maakt. Zij geeft nieuwe aanknopingspunten voor het differentiëren tussen ondersteunende relaties en situaties die het moeilijk maken om bepaalde manieren van leven tot bloei te laten komen. Het proefschrift leidt zodoende tot de vraag hoe we institutionele ruimte kunnen creëren waarin creatieve zorgpraktijken passende manieren van leven kunnen ontwikkelen in situaties waarin overgewicht een zorg is.

LIST OF PUBLICATIONS

Vogel, E. (2014). Clinical specificities in obesity care: The transformations and dissolution of 'Will' and 'Drives'. *Health Care Analysis*, 1-17. doi:10.1007/s10728-014-0278-3

Vogel, E. (2016). Metabolism and Movement: Calculating food and exercise or activating bodies in weight management. Under review.

Vogel, E., & Mol, A. (2014). Enjoy your food: On losing weight and taking pleasure. *Sociology of Health & Illness*, *36*(2), 305-317. doi:10.1111/1467-9566.12116, simultaneously published as: Vogel, E., & Mol, A. (2014). Enjoy Your Food: on Losing Weight and Taking Pleasure. In S. Cohn (Ed.), *From Health Behaviours to Health Practices: Critical Perspectives* (pp. 145-157). Oxford, UK: Wiley Blackwell.

Co-authored, first author.

Vogel, E. (2016). Hungers that need feeding: On the normativity of mindful nourishment. Under review.

Vogel, E. (2016). Operating (on) the self: Transforming agency through obesity surgery and treatment. Under review.

ACKNOWLEDGEMENTS

Over the years, countless people have touched this project in one way or another. This means that even though I take full responsibility for all its faults and imperfections, this dissertation is truly a relational achievement. First of all, I am deeply grateful for the ways in which my informants invited me into their work spaces, homes and lives, willing to share their successes, troubles and vulnerabilities with me. This book would not have existed without their generosity and hospitality. Their insights into the problem of overweight and the practicalities of self-care gave this dissertation substance.

In Annemarie Mol I found the perfect supervisor with whom I could combine my philosophical training with my interest in social scientific methods and questions. Her intellectual curiosity and commitment to keep reinventing herself as a scholar are truly inspiring. Sometimes, when it meant going back to a chapter for the hundredth time, her demands for analytical rigor were hard to swallow. But of course she was always right, and I am very grateful for all her pushes. Annemarie not only invested in this dissertation but also in my development as a scholar, generously opening up her network and resources. Her insistence that we are part of an academic 'family' is a welcome antidote to today's neoliberal university.

Jeannette Pols joined this project halfway, but with twice the enthusiasm. I learned a lot from Jeannette's ability to let one's empathy fuel productive analysis. Completely at home in the intricacies of health care, but fresh to the topic of overweight, her comments and difficult questions helped sharpen my last chapters and gave me a lot to think with.

Doing a PhD can be a lonely endeavor. But not for me, since I was fortunate to conduct my research being a part of a larger research project. Who knew that serious scholarship can come with so much laughter! With their particular disciplinary training, national background and colorful character, each member of the 'Eating Bodies team' added something unique: Filippo Bertoni brought wits; Rebeca Ibáñez Martín, feminist sensitivity; Sebastian Abrahamsson, dry eloquence; Emily Yates-Doerr, a refusal to settle questions; Cristóbal Bonelli, poetry; Anna Mann, an insistence on the

empirical; Michalis Kontopodis, a curiosity for stories; and Tjitske Holtrop, generosity. Over the years, the team extended into a fluid network, adding Justine Laurent, Oliver Human, Carolina Dominguez, Annelieke Driessen, Hasan Ashraf, and Jeltsje Stobbe. I learned a lot, too, from the team's various permanent and returning visitors: Emil Holland, Wakana Suzuki, Bodil Just Christensen, Pierre du Plessis and Marianne de Laet.

This wonderful team was often enriched with visitors from around the world, giving rise to numerous inspiring encounters, among them with Hannah Landecker, Elspeth Probyn, John Law, Mette Svendsen, Matei Candea, Antonia Walford, Stefan Ecks, Joseph Dumit, Vibeke Phil, Michael Penkler, Line Hillersdal, Simon Cohn, Carlos Baum and Atsuro Morita. I was able to share my work and learn from the work of others through various meetings, seminars, reading groups, workshops and panels, among which the Walking Seminar, the STS reading club, the Writing Care group, Health, Care & the Body meetings, the AMC Philosophy of Care meetings, the Qualification in Practice series and the (Ir)relevance of Race seminars.

A special thanks goes to all my friends and colleagues in the AISSR who have made the University of Amsterdam feel like home: Stine Grinna, Swasti Mishra, Willemijn Krebbekx, Lex Kuiper, Megan Raschig, Ariane d'Hoop, Carola Tize, Lisette Jong, Ildikó Plajas, Dorothea Dechau, Daniel Guinness, Arsenii Alenichev, Mark Hann, Kristine Krause, Amade M'charek, Victor Toom, Henry Kalter, Retna Hanani, Willy Sier, Lieke Wissink, Anneke Beerkens, Thijs Schut, Marianna Fotiadou, Ryanne Bleumink, Davide Gnes, Basje Bender, Carolina Frossard, Tracian Meikle, Rowan Arundel, Thomas Franssen, Mandy de Wilde, Jesse Hoffman and many others. I am excited to continue working with Mutsumi Karasaki, Gerlieke Veltkamp, Christian Bröer and Gerben Moerman as part of Sarphati Amsterdam.

For administrative support and collegiality I could always count on Muriël Kiesel, Cristina Garofalo and Janus Oomen. For editing and improving the writing of various parts of this dissertation I thank Amal Chatterjee, Mercedes Duff, Carolyn Fisher, David Hymans and Yvonne Brink.

During this PhD project I was fortunate to be able to spend 5 months as a guest in the Anthropology department of MIT, allowing me to be in the midst of the intellectual jazz of the world's two best universities. My gratitude

goes to all the staff, but in particular to Heather Paxson, for intellectual support, and Stefan Helmreich, for letting me audit his wonderful Social Theory course. I learned a lot from the HASTS Program Seminar and the STS circle at Harvard, hosted by Sheila Jasanoff. In addition, for great discussions and lots of fun I thank Peter and Jamie Oviatt, Jia Hui Lee, Luisa Reis de Castro, Claire Webb, Beth Semel, Richard Fadok and others. I also thank Lotte Holm for hosting me for a few weeks in the Institute of Food and Resource Economics at the University of Copenhagen and Bodil Just Christensen for continuing conversations on obesity, and for her hospitality and friendship.

Without Maarten Derksen, Trudy Dehue and Hans Harbers I would have never ended up in Amsterdam doing this PhD. I am grateful to them for introducing me to the field of Science and Technology Studies and for enthusing me throughout my studies at the Rijksuniversiteit Groningen. Important, too, was Michiel van der Ree, with whom during our time in Groningen's philosophy department I eagerly devoured my first STS literature.

During this PhD I learned that sometimes, the best thing one can do for one's work and one's sanity is to leave it behind. I thank reading group Stolz for providing regular Dionysian escapes from the office. Michiel van der Ree, Sandrien van Ommen, Matthieu van de Borst, Peter van der Beek, Simone van der Beek-Bouma, Niek Steendam, Marjolein Gielstra and Henri van der Heiden: I am grateful for the delirious and fantastic worlds our books and meetings revealed to me, and for our continuing friendship. To Marloes Prins, Marloes van Putten and all the other volunteers from the PJ den Hartog Stichting: thanks for amazing summers full of cooking, sailing and craziness.

My thanks go to Roos Hagt and Stefan van Staveren, who are family to me. It is wonderful to see us go into different directions but remain as close as ever. Fulvio and Giulietta Colona taught me important lessons on food and care. Grazie mille per la vostra ospitalitá, per avermi accolto nella vostra casa e famiglia. Vera and Albert, my siblings, I thank for the joy of growing up together, and for their continuous reminder of how important it is to think outside the box.

For their dedication in organizing the practicalities around this important moment in my life, I thank my paranymphs. Stine Grinna, you have been my partner-in-crime since we started in Amsterdam. I love your self-deprecating sense of humor, and I am so grateful for your patience and kindness with the endless drafts I made you read. Rebeca Ibáñez Martín, thanks for your silly dances in the office and for accompanying me on the study of eating and health. You and Paula have instilled our neighborhoud with a sense of home.

I thank my parents, Henrie and Alice, for showing me that in facing fears, doors open; for teaching me to never stop learning; and for the trust that in their eyes, I always succeed. To you I dedicate this thesis. Finally, I thank Francesco Colona – my friend, partner, colleague, table-companion and diving buddy. Even though you were not always nearby, we were always close. I am deeply grateful to have you by my side.