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### Subjects of care: Living with overweight in the Netherlands

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## Chapter 1

# INTRODUCTION

## *Caring about weight*

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*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.*

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### 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

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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?**

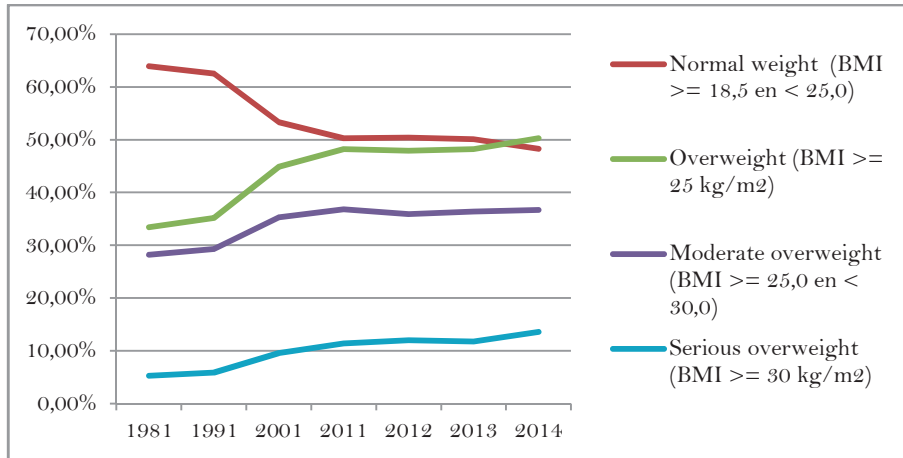
Exploring how people, with the help of health care professionals or their significant others, live with overweight requires a focus beyond individuals and their behavior. Discourses in politics and public health, and the ways in which body weight is known, problematized and handled, shape what modes 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'.<sup>1</sup> 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  $\text{Mass (kg)}/(\text{Height (m)})^2$ , 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

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<sup>1</sup> <http://www.voedingscentrum.nl/encyclopedie/overgewicht.aspx>. Last accessed May 16, 2016.

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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

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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

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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?<sup>2</sup>

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.<sup>2</sup> Although such abundance is the reason that in the Netherlands obesity is sometimes labeled a *welvaartsziekte* [‘prosperity disease’]<sup>3</sup>, 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

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<sup>2</sup> 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://voedselbanknederland.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).

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

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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.<sup>4</sup> 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

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<sup>4</sup> 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.



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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.<sup>5</sup>

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

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<sup>5</sup> Although such ideals are not universal (Davis, 2003; Popenoe, 2012).

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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.<sup>6</sup>

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 *recipie*, 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).<sup>7</sup>

In turn, calories, converting food and exercise into energy intake and expenditure, communicate that 'what must go in, must go out'.<sup>8</sup> The

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<sup>6</sup> See Trudy Dehue (2014) for an analysis of Dutch 'lifestyle politics' in which health is presented as a choice, obligation and product.

<sup>7</sup> Geographers Hayes-Conroy and Hayes-Conroy likewise criticize 'hegemonic nutrition' (2013) and its focus on metrics and standardization.

<sup>8</sup> 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).

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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'.<sup>9</sup> 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

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<sup>9</sup> 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).

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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.

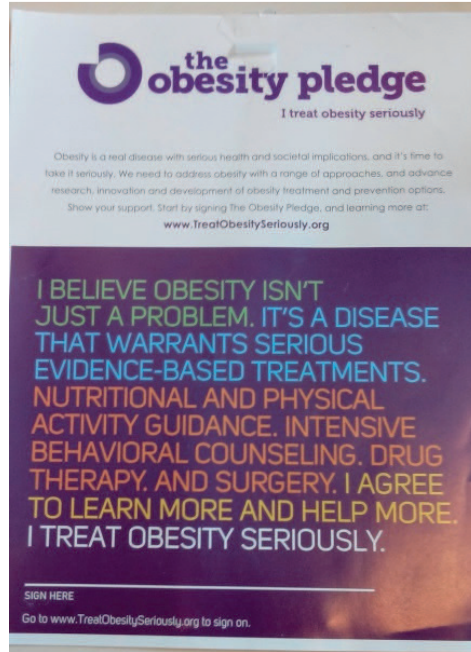
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Warin suggests the life sciences such as epigenetics may be an ally in the project of debunking common obesity myths of individual responsibility and the stigmatization that results from those myths (Warin, 2014). As she and her colleagues argue, far 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

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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

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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.<sup>10</sup> Thus, I take from the aforementioned literature the importance of social, political and material environments, but I do not give them causal

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<sup>10</sup> 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).

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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



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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.<sup>11</sup>

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 responsabilizing 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

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<sup>11</sup> 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](http://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).

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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.<sup>12</sup> 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'.

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<sup>12</sup> 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).

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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

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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-scripting (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 dietitians, 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 dietitians, 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).

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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.

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### The chapters

**Chapter 2** explores the diverse ways in which dietitians, 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.