Subjects of care: Living with overweight in the Netherlands

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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.

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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.

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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.