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THE BIOMEDICAL AND HOLISTIC PRACTICES OF THE CONTINUUM OF
HEALTHISM

by

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Sociology Honours with Distinction, Wilfrid Laurier University, 2013

Major Research Paper

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Abstract:

This MRP critically interrogates the concepts of biomedical healthism and holistic healthism. The existing literature posits that holistic healthism is conceived as the positive solution to the restraints of biomedical healthism. Grounded in an analysis of obesity, the main assertion of the MRP concerns the way in which both forms of healthism are not oppositional, but rather, create a continuum. As such, the MRP argues that both forms of healthism are differing processes which work to foster the same end goal of achieving optimum health. Consequently, the MRP will also argue that healthism is a metaphysical ideal/ethos in which biomedical and holistic paradigms are subsumed under. Situated in neither Health Studies nor Fat Studies, the MRP will consider the implications for a life expressed and finally provide suggestions for an alternative conception to the restrictive lens of healthism.

Reconceptualizing Healthism as a Metaphysical Ideal/Ethos: Operationalized Through Biomedicine and Holistic Practices on a Continuum

OVERVIEW OF THE MRP

Originally, “healthism”, as purported by Robert Crawford (1980) was conceived of as a medicalized “health consciousness” which elevated health to a “super-value” (365). Highlighting the defects of biomedical healthism, critics deemed its practice as coercive. Consequently, as a reaction to these limitations of biomedical healthism, holistic healthism developed as a positive solution. Thus, the literature posits that biomedical healthism and holistic healthism are oppositional. In addition, the existing literature also argues that healthism is subsumed under the polarities of biomedical and holistic regimes.

This MRP will add to the literature in two ways. Firstly, by demonstrating that the polarities of healthism are not reactionary or oppositional, but rather, are on a continuum. This is not to say that one regime is more important than the other, in fact often both biomedical and holistic healthism co-exist. Secondly, this MRP will postulate that the notion that healthism is subsumed under the polarities of biomedical and holistic health may be misguided. In fact, this MRP will demonstrate that healthism permeates and thus restricts every aspect of life and therefore, is a metaphysical ideal/ethos that can never be reached, but must be strived for¹. Subsequently, biomedical (coercive) and holistic regimes are subsumed under the metaphysical ideal/ethos of healthism. Moreover, either

¹ This MRP uses both the concepts of ideal and ethos. The concept of ideal is used because healthism is something that individuals strive for, but can never completely accomplish as articulated by Faith Fitzgerald’s (1994) notion of “potential perfection” (196). Ethos is used in order to demonstrate how healthism becomes a metaphysical characteristic that is manifested in a material sense, in the everyday lives of groups and individuals.

biomedical and holistic healthism are processes through which healthism is accomplished. The above assertions lead to a paradigm shift in the study of healthism.

The overall thesis of this MRP seems to be counterintuitive in that healthism restricts life; because how could any researcher critique the notion of health? This is precisely the point. This MRP is not discussing health, or making any value judgments on what is considered to be 'healthy'; rather, this MRP is focused primarily on how the concept of healthism restricts people's life expressed. Moreover, the polarities of healthism including the biomedical and holistic models are critiqued; as the existing literature posits that holistic medicine is a reaction to coercive medicine and thus, is oppositional.

This MRP does not come from a Health Studies perspective, or an identity politics perspective including Fat Studies; nor is it making a judgment of what might be a preferred life. Rather, this MRP highlights the problems associated with a politics of recognition within the context of healthism. The author feels that this MRP needs to be grounded in the materiality of life. Consequently, the MRP looks at the question of obesity without judgment but as an illustration of how healthism as a continuum, ideal and ethos works.

The first chapter of the MRP will begin with an examination of the theoretical concept of biomedical healthism, and will end with applying the theoretical insights to the 'problem' of obesity. The second chapter will theoretically examine the development of holistic healthism as an alternative to biomedical healthism, while also applying these theoretical insights to the 'problem' of obesity. In the third chapter, the MRP will compare and contrast the insights of both biomedical healthism and holistic healthism

within the context of obesity. The fourth chapter will highlight the theoretical shortcomings of the continuum of healthism as predicated by the twin concepts of representation and identity while also considering an alternative to the continuum of healthism through the lens of a politics of imperceptibility.

CHAPTER 1: OVERVIEW AND CRITIQUE OF BIOMEDICINE

An Overview of Biomedicine

Adding to previous debates concerning medicine, health and illness, in their article *Technoscientific transformations of health, illness and U.S. biomedicine* Clarke et al. (2003) present the notion of biomedicine. Drawing attention to the historical shifts in medicine (Conrad, 1992, 2005; Armstrong, 1995; Zola, 1972; Illich, 1976), biomedicalization concerns the increasingly complex processes of medicalization that have been extended and reconstituted through technoscientific means of understanding the body (Clarke et. al, 2003, 2010; Clarke, Mosleh and Janketic, 2014; Foucault, 1963; Metzl and Kirkland, 2010; Illich, 1976, Clarke, 2010, 2011a, 2011b; Conrad, 2005). Defined more broadly, technoscience points to the integration of scientific knowledge with the use of technological mechanisms to achieve precise measurements within social contexts (Clarke et al., 2003, 2010). Along with others (Beck, 1992; Conrad, 2005; Armstrong, 1995; Zola, 1972; Illich, 1976) Clarke et al. (2003, 2010) contend that the expansion of technical organization coupled with the institutional changes to medicine have drastically altered the diverse processes of medicalization.

Consequently, the authors draw attention to the myriad of ways in which medical technology constructs and articulates the ways in which groups and individuals live (Beck, 1992; Conrad, 2005; Armstrong, 1995; Zola, 1972; Illich, 1976; Foucault, 1963; Metzl and Kirkland, 2010; Illich, 1976, Clarke, 2010, 2011a, 2011b; Conrad, 2005; Clarke et. al, 2003, 2010). Clarke et al., (2003) argue, “Standards of embodiment, long influenced by fashion and celebrity, are now transformed by new corporeal possibilities made available through the applications of technoscience” (162). While some scholars

focus on how “technoscience is producing knowledge through experimentation with the structure and organization of bodies, matter, and life” (Clough 2004: 3), others draw attention to the specific way in which “New individual and collective identities are also produced through technoscience” (Clarke et al. 2003: 162).

Each society has its own ‘regime of truth’, often presupposed by the notion of ideology. Michel Foucault (1980) describes the way in which

Each society has its regime of truth, its general politics of truth: that is the types of discourse which it accepts and makes function as true; the mechanisms and instances which enable one to distinguish true and false statements, the means by which each is sanctioned, the techniques and procedures accorded value in the acquisition of truth, the status of those who are charged with saying what counts as true. (207)

Likening biomedicine to Foucault’s notion of ‘regime of truth’ (Lupton 1995, 2003; Foucault 1963; Clarke et al. 2003, 2010), biomedicine has the authority to pass judgment on what constitutes as ‘being healthy’ and how to achieve ‘health’ through technological and scientific advancement. However, scientific and technological truth regimes have become a cultural phenomenon in a prescriptive way, to inform citizens about resources to alleviate or prevent ‘health’ problems. Thus, for many years, medical practitioners were considered to have the last word on notions of ‘health’ (Armstrong 1995; Conrad 1992, 2005; Crawford 1980, 2006; Clarke et al. 2000, 2010; Peterson and Lupton 1996; Lupton 2003; Rose 1998, 2001, 2007). In this sense, many authors argue that biomedicine can be understood as a culture due to the way in which it interacts with technoscience, medicine, and society (Clarke et al. 2003, 2010; Conrad 1990, 2005; Armstrong 1995; Crawford 1990, 2006; Peterson and Lupton 1996; Rose 1998, 2001, 2007). In summation, this pervasive form of technological change and the implications of biomedicalization affect

the way in which medical knowledge is created and distributed (Armstrong 1995; Conrad 1990, 2005; Crawford 1980, 2006; Clarke et al. 2003, 2010; Peterson and Lupton 1996; Rose 1998, 2001, 2007). As such, it is argued (Clarke et al. 2003, 2010; Lupton 1995, 2003; Rose 1998, 2001, 2007) that biomedicine functions as a ‘regime of truth’, providing an overarching framework in which to situate the highly complex and newly emergent forms of technoscientific medicine in contemporary Western society.

Biomedicine and Productivity

As a mechanism of governmentality, or more specifically, a “technology of the self” whereby individuals learn to manage themselves by adhering to the dominant circulating discourses, (Foucault 1980, 1991; Samerski 2009; Clarke Mosleh and Janketic 2014), biomedical regimes focus on health and well-being “as a matter of ongoing moral self-transformation [...] something to work towards [...] as apart of an] ongoing project composed of public and private performances” (Clarke et al. 2003:172). In *Security, territory, population...* Foucault (2007) argues,

‘to govern’ may mean to ‘impose a regimen,’ on a patient for example: the doctor governs the patient, or the patient, who imposes treatment on himself, governs himself. Thus a text says: ‘A patient who, after having left Hotel-Dieu, passed away as a result of his bad government.’ He had followed a bad regimen. ‘To govern,’ or ‘government,’ may refer to conduct in the specifically moral sense of the term. (121)

In turn, various biomedical procedures (e.g., genetic testing, epidemiology, prevention, DNA profiles, identification of “high risk” populations, etc.) are deployed as apart of the larger process to achieve the end goal of optimum health (Clarke et al. 2003, 2010; Fitzgerald 1994; Cheek 2008; Ball 2003). More specifically, the increasing tendency to transform the human and non-human through technoscientific innovations

(Clarke et al. 2003, 2010) requires the expertise of trained professionals including physicians, specialists, technicians etc. (O’Byrne and Holmes 2007; Lupton, 1995, 2003; Peterson and Lupton 1996; Clarke 2010; Metzl and Kirkland 2010; Clarke 2011b; Clarke Mosleh and Janketic 2014). In turn, these experts hold the authority to invoke various biomedical practices in order to enhance the greater goal to achieve optimum health (Ball 2008; Cheek 2003), or as others have called it “potential perfection” (Fitzgerald 1994:196). This desire for “potential perfection” is related to the parallel desire for people to maintain optimum functionality that allows them to be productive citizens (Lupton 1995, 2003; Clarke et al. 2003, 2010; Bercovitz 2000; Shephard 1986; Ball 2003; Cheek 2008) even to the extent of the consumption of cold medicines.

Lauren Berlant (2010) provides a compelling example of the relation between biomedical attempts to achieve optimum health (Ball 2003; Cheek 2008; Fitzgerald 1994; Bercovitz 2000) through the maximization of productivity in her discussion of the anti-cold drug ‘Sudafed’. She points out that the commercials advertising this drug “are about managing symptoms so that cold sufferers can go to work while ill, while infectious and infected [...] they’re about having more energy to be more productive” (28). Similarly, other cold medication commercials such as Benylin, and Dayquil have also focused on increasing the sufferers productivity by allowing them to either return to work, or in the case of parenting, return to the demands of their daily lives. In short, while biomedical regimes enhance well-being through the expansion of technoscientific understandings of the body and mind (Clarke et al. 2003, 2010; Armstrong 1987; Rose 1998, 2001, 2007; Clarke 2011b; Clarke Mosleh and Janketic 2014; Berlant 2010; Peterson and Lupton 1996; Lupton 1995, 2003; Shephard 1986), the end goal of optimum health is largely

defined by the enhancement of individual productivity (Cheek 2008; Ball 2003; Fitzgerald 1994; Bercovitz 2000).

Introducing Coercive Healthism

In the previous section, the MRP outlined the myriad of ways biomedicine is a truth regime, how it is operationalized, and how citizens internalize its authority and its unquestioned efficacy. In his later analysis of healthism entitled *Health as a meaningful social practice*, Robert Crawford (2006) argues, “In modern societies, the meaningful practice of health is inextricably linked to the science, practice and layered meanings of biomedicine” (403). Clarke et al. (2003, 2010) argue that biomedicalization is an expansion of medicine due to the way in which it utilizes technology and technoscientific understandings of well being. Given Clarke et al.’s (2003, 2010) assertion, and Crawford’s (2006) statement, one could infer, that “healthism” as purported by Crawford (1980, 2006) is subsumed under the biomedical model due to the way in which it utilizes the technoscientific regimes of biomedicine.

Nevertheless, Crawford (1980, 2006) through the concept of “healthism” moves beyond the biomedical understanding of ‘health’ to a “health consciousness”. Highlighting the everyday value of the concept of ‘health’, Crawford’s (1980, 2006) analyses provide a description of the ways in which health has expanded into other arenas of contemporary life. Thus, Crawford (1980, 2006) introduces the term “healthism” in order to emphasize a new “health consciousness”, which he and many others (Fitzgerald 1994; Lavrence and Lozanski 2014; Greenhalgh and Wessely 2004; Askeegard and Eckhardt 2012, Kirk and Colquhoun 1989; Rysst 2010) argue constitutes an extremely pervasive medicalized ideology within Western culture.

While Clarke et al. (2003, 2010) draw attention to the technological developments to medicine, Crawford (1980, 2006) emphasizes the way in which notions of health, illness and medicalized meanings are imposed on everyday life. For example, due to healthism, implanted in people's thought processes, is the idea that headaches may be an underlying symptom of a greater illness, (for example migraines or blood clots) whereas prior to healthism, people considered headaches as related to daily stresses. So pervasive is healthism that individuals experiencing headaches consider their manifestation as indicative of a larger medical issue.

As apart of the biomedical notion of expanding productivity (Lupton 1995, 2003; Clarke et al. 2003, 2010; Bercovitz 2000; Shephard 1986; Ball 2003; Cheek 2008), the ideology of "healthism" purports that one must lead a healthy lifestyle, requiring "intensive work on the self or self-governance" (Petersen et al. 2010) in order to achieve full citizenship (Rich Holroyd and Evans 2004; Cheek 2008; Peterson et al. 2010; Metzl and Kirkland 2010). Conversely, "Individuals who are seen to be 'at risk' and who do not take what is deemed to be appropriate preventative action [such as dieting and exercising] can potentially be charged as culpable in failing to fulfill their duties of citizenship" (Peterson 1996:56).

Moreover, Crawford (1980, 2006) contends that healthism repositions healthy behavior as a standard for good living, and thus, involves a sort of reductionism whereby groups and individuals come to see more of their experiences as health experiences, and by extension, more of their values as health values (1980:380 see also Peterson et al. 2010; Metzl and Kirkland 2010; Lupton, 1995, 2003; Peterson and Lupton 1997). In this sense, health "has become not only a preoccupation; it has also become a pan-value

standard by which an expanding number of behaviours and social phenomena are judged” (Crawford 1980:381). In short, the discourse of healthism reduces good living to a health problem, and consequently, health is expanded to all that is ‘good’ in life (Crawford 1980:382; see also Peterson et al. 2010; Metzl and Kirkland 2010; Lupton 1995; Peterson and Lupton 1997; Lee and Macdonald 2010; Cheek 2008). In summation, Crawford (1980, 2006) introduced the term healthism as a way to highlight the expansion of health as an ideological metaphor, which encompasses an array of human conditions.

Further articulating Crawford’s (1980, 2006) arguments, other scholars have drawn attention to the ways in which healthism places blame on the individual for both their acts and omissions, (Lupton 1995, 2003; Peterson and Lupton 1997; Cheek 2008; Yoder 2002) emphasizing a larger shift from the notion of ‘good’ health as a right to the idea of ‘good’ health a duty (Metzl and Kirkland 2010; Galvin 2002; Lupton 1995, 2003; Peterson and Lupton 1997) As such, Crawford’s (1980, 2000) concept of healthism not only describes the expansion of health, but also points to the newly emergent fixation on “personal health as the primary focus for the definition and achievement of well-being” (1980:368) primarily through medicalization as a regulatory device (Lupton 1995, 2003; Peterson and Lupton 1997; Lee and Macdonald 2010; Cheek 2008; Metzl and Kirkland 2010).

While operative in neoliberal societies, healthism as an ideology adheres to the neoliberal emphasis on individualism, which postulates that individuals are free to make their own decisions in their own terms (Blaxter 1997; Yoder 2002; Lavrence and Lozanski 2014; Ayo 2012; Leichter 2003; Mendes 2003). Drawing attention to this principle, many have articulated that such an emphasis on individualism often obscures

the underlying imperative that individuals are obliged to make a 'correct' choice (Petersen 2003; Overboe 2007; Samerski 2009).

Building on Jeremy Bentham's (1791) conception of the panopticon, Foucault (1979) articulates the way in which individualizing citizens as well as placing them within a state of constant visibility increases both surveillance and responsibility. He argues,

He who is subjected to a field of visibility, and who knows it, assumes responsibility for the constraints of power; he makes them play spontaneously upon himself; he inscribes in himself the power relation in which he simultaneously plays both roles; he becomes the principle of his own subjection (Foucault 1979:202-203)

Applying the insights of Foucault (1979) within the context of healthism, each citizen simultaneously plays both roles: they are subjected to the "field of visibility" whereby their health is judged and simultaneously, they assume the responsibility for their own health. While Foucault's (1979) expansion of the disciplinary mechanism of the 'panopticon' speaks to the interrelated surveillance between the self and other, healthism operates in the same manner as a mechanism of social policing whereby the individual is engaged in a constant process of monitoring themselves and being monitored by their peers (Shephard 1987; Lupton 1995; Bercovitz 2010; Yoder 2002). More importantly, this process engages the self and the other as citizens held responsible for conducting their behaviour in an appropriate manner (Peterson 2003).

Relatedly, Crawford (1980, 2006) and others have highlighted the ways in which healthism supports the idea that it is up to the individual to pursue and adopt 'healthy' practices which in turn, leads to the preoccupation of healthy as a fundamental condition of a 'good' or 'moral' life (LeBesco 2011; Lupton 1995, 2003; Peterson and Lupton 1997; Berlant, 2007, 2010; Yoder 2002; Forde 1998; Perhamus 2010). In this sense, the

ideology of healthism perpetuates the notion of calibrating whether the individual or society achieves good citizenship (Rich Holroyd and Evans 2004; LeBesco 2011; Yoder 2002; Galvin 2002; Lupton 1995, 2003; Peterson and Lupton 1996; Ayo 2012; Perhamus, 2010; Petersen et al. 2010; Lee and Macdonald 2010; Burrows et al. 2002). As such, Crawford (1980, 2006) and others argue that healthism becomes self-perpetuating by extending deviance to new arenas of life, and providing solutions to such problems (Armstrong 1995; Rose 1998, 2001, 2007; Peterson and Lupton, 1997; Lupton 1995, 2014, 2003; Cheek 2008; Fitzgerald 1994; Kwan 2009). In turn, risk is further perpetuated, and healthism becomes a form of social control (Petersen et al. 2010; Rose 1998; 2001, 2007; LeBesco 2010; Forde 1998).

By extension, there has been much attention given to the limitations of biomedical healthism as a coercive and regulating discourse (Yoder 2002; Galvin 2003; Lupton 1995, 2003, 2014; Peterson and Lupton 1997; Ayo 2012; Perhamus 2010; Petersen et al. 2010; Lee and Macdonald 2010; Burrows et al. 2002; Shephard 1987; Bercovitz 2010; O’Byrne and Holmes 2007; Petersen 2003; Metzl and Kirkland 2010; Clarke et al. 2003, 2010). While some emphasize the ways in which biomedical healthism has proliferated the use of technologies in the management of human misery (Lupton 1995; Petersen and Lupton 1997; Metzl and Kirkland 2010; Clarke et al. 2003, 2010), others argue that it perpetuates an individualistic approach to treatment, (Lee and Macdonald 2010; Kirk and Colquhoun 1989; Crawford 1980, 2006; Clarke et al. 2003; Johnson, Gray and Horrel 2013). While also arguing the way in which coercive healthism comes to be constitutive of an array of human conditions (Crawford, 1980, 2006), such critiques have thus, indirectly emphasized the “Utopian nature” (Skrabenek 1980:11; see also Fitzgerald

1994; Edgley and Brissett 1990; Cheek 2008; Ball 2003) of coercive healthism more generally.

In accordance with these critiques, many scholars have focused on the ways in which coercive healthism and its related approaches to individualistic understandings of health and wellbeing are operationalized in many different aspects of daily life (Kirk and Colquhoun 2006; Lee and Macdonald 2010; Rich 2011; Wright and Burrows 2004; Burrows and Wright 2002, 2004, 2007; Burrows Wright and McCormak 2009; Johnson Gray and Horrel 2013). For example, much of this attention has concentrated on the ways in which dominant health promotion messages are adopted by young people and perpetuated through school practices in ways that emphasize individualistic and corporeal approaches to wellbeing (Lee and Macdonald 2010; Ball 2003; Jennings 2014; Rich Holryod and Evans 2004; Perhamus 2010; Johnson Gray and Horrel, 2013; Kirk and Colquhoun 1989). More specifically, others have highlighted the degree to which such notions of wellbeing are often linked particularly with fitness and specific ideas of what constitutes ‘healthy’ practices (Lee and Macdonald 2010; Wright and Burrows 2004).

Drawing upon the critique of the ‘Utopian’ nature of coercive healthism (Skrabeneck, 1980; Edgley and Brissett 1990), it is important to reiterate that these approaches to wellbeing as intrinsically linked to specific ‘healthy’ daily practices promote an ideal/ethos end goal that is ultimately unobtainable (Fitzgerald 1994; Cheek 2008; Ball 2003). More importantly, such a narrow understanding of what constitutes being ‘healthy’ contains consequences for everyday life (Cheek 2008; Edgley and Brissett 1990). The coercive and ‘Utopian nature’ (Edgley and Brissett 1990; Fitzgerald 1994) of healthism resides in the way in which it promotes specific practices which, work to foster

an idealistic end goal that we are continuously striving to achieve, yet remains fundamentally non-existent. Comparable to Foucault's (1993) concept of the 'panopticon' as mentioned earlier, and the continuous, invisible and interrelated surveillance of the self and other, the coercive practices of healthism engage both the individual and their peers to participate in the social surveillance of one another in obtaining this optimal end goal of being 'healthy'.

Obesity Examined Through the Lens of Coercive Healthism

Thus far this MRP has introduced the notion of coercive healthism in a rather abstract way; however, this next section will ground coercive healthism using the concept of obesity. Within recent years there has been an increased anxiety and concern over the "problem" of obesity (Kwan 2009; Phillipson 2013; Lupton 2014; Guthman 2013; Jennings 2014, Berlant 2007, 2010; Schorb 2013; Moffat 2010). This MRP challenges the assumption that there is an "obesity epidemic", and argues that this ideological construct exemplifies the coercive nature of healthism. In order to analyze and rebut this notion of the "obesity epidemic", the previous literature on biomedicine as well as coercive healthism must be considered.

The recent Western obsession with obese youth has used a variety of technoscientific methods and research such as genomic association studies (Grarup et al. 2014), as well as cellular physiological extraction combined with chemical testing (Fernández-Trasancos et al. 2014) as mechanisms to identify the "risks" associated with childhood obesity. In effect, these apparatus and technologies restrict the notion of childhood to a goal of 'non-obesity', and by its nature, healthism is coercive in that it perpetuates a feeling of 'shame and blame' within children (Lee and Macdonald 2010). In

adherence to such technoscientific methods of knowledge creation and distribution, the Centre for Disease and Control (CDC) “Childhood obesity fact sheet” contains numerous statistics stating both the “immediate and long term effects on [childhood] health and well-being” including the increased “high risk for development of diabetes” as well as a “greater risk for bone and joint problems, sleep apnea, and social and psychological problems such as stigmatization and poor self esteem” [Appendix A]

While seemingly neutral these statements not only socially construct the identities and experiences of obese youth, but they also infer an association between certain problems with particular types of bodies (Kwan 2009; Lee and MacDonald 2010; Jennings 2014). The obese body type projects to the general public that these individuals are predisposed to various health problems. Furthermore, these individuals who are considered obese, often internalize these narratives (Kwan 2009; Lupton 2014, Lee and Macdonald 2010; Burrows and Wright 2002, 2004, 2007). The external pressures along with the internalization results in people living lives that are restricted by coercive healthism.

Within the context of this MRP, the problem may not be with whatever causes obesity and its link to disease, but rather, the restrictive notion of health as it pertains to life. An example of people internalizing ‘blame and shame’ (as mentioned above), for their obese condition would be in the daily ritual of eating. Social constructivist perspectives have pointed out that

the experience of being diagnosed as ‘at risk’ is highly personal [... and] the ‘fact’ that dietary fat leads to obesity and heart disease has meant that many people have almost a horror of fat[...] Should they decide to eat a food or meal that they consider particularly ‘fatty’ [...] people find themselves feeling guilty and anxious about the effect the fat will have upon their bodies in terms of both health and physical appearance (Peterson and Lupton 1997:50).

As a graduate student attending small class sizes, there is an unspoken rule and moral imperative as to what constitutes an acceptable snack to eat amongst your peers (Kwan 2009; Herndon 2002; Lupton 1995). While eating ‘healthy’ foods such as cut up vegetables, fruits, grain bars, etc., constitutes an appropriate snack, chocolate bars, candy, chips, etc. are regarded as inappropriate snacks. By bringing a ‘healthy’ snack, the student is making the ‘correct’ and ‘responsible’ choice, while bringing an ‘unhealthy’ snack is regarded as an ‘incorrect’ and ‘irresponsible’ choice. As a mechanism of surveillance the imperative to bring the ‘proper’, ‘healthy’ snack operates as an invisible practice of social and self-surveillance as previously mentioned in this chapter, and is an example of coercive healthism. In this sense, not only do we bring healthy snacks in order to meet the optimum goal of ‘health’, but we also want to be *seen* eating ‘healthy’ foods, in order to be known as a ‘healthy’ and ‘responsible’ citizen who makes the ‘right’ choices (Kwan 2009; O’Byrne and Holmes 2007; Petersen 2003; Petersen et al. 2010; Lupton, 1995; Metzl and Kirkland 2010; LeBesco 2010).

In addition, the perpetrator of the sin of eating ‘unhealthily’ must develop a narrative that explains why this is an exceptional case, while also explaining that they are aware that they are acting inappropriately. Statements such as “I was rushed for time”, or “these are leftover ‘treats’ from the holiday”, are an illustration of the earlier discussion on the Foucauldian panopticon and internalized governmentality, to make ourselves known as the citizen with optimum health. Thus, there are ‘correct’ and ‘incorrect’ choices to be made (Burrows et al. 2002; McGannon and Mauws 2002; Petersen 2003; Lupton 1995, 2014; Metzl and Kirkland 2010; O’Byrne and Holmes 2007; Kwan 2009). Even as an MA student studying coercive healthism, I am still susceptible to the coercive

nature of partaking in meals, snacks, etc. and feeling the anxiety of not making the right choices. While such a formulation holds grave implications for contemporary understandings of what constitutes a ‘healthy’ and ‘correct’ choice, this will be explored more intensely in chapter three.

Drawing attention to the newly emergent obsession between weight and food consumption (Schorb 2013; Peterson and Lupton 1996; Berlant 2007, 2010) some researchers have highlighted the ways in which technoscientific identification between obesity and various health ‘risks’ as outlined above, largely ignore differences of personal lived experiences (Kwan 2009; Berlant 2007, 2010; Peterson and Lupton 1996; Lupton 1995). For example, in *Risky Bigness...* Lauren Berlant (2010) articulates that the stressors of Western society affect how individuals make negative food choices in regards to consumption. More importantly, she argues that eating “provides a kind of rest for the exhausted self, an interruption of being good, conscious, and intentional that feels like a relief” (26). However, this MRP asks, with the proliferation of coercive healthism, should people—like the student in the grad class—have to provide a narrative explaining their ill-advised eating to lessen the moral responsibility for such food choices? In and of itself, is Berlant (2010) not providing a moral rationale based on emotions for ill-advised eating? Such a position illustrates how pervasive and constraining biomedical healthism is; that an author who is arguing against coercive healthism, in fact, has a rationale concerning food consumption that excuses ill-advised eating. From her perspective, ill-advised eating is a way to alleviate the pressures of stress. However, from the perspective of this MRP, Berlant (2010) is still caught within the web of coercive healthism because one cannot eat ill-advised food, just for the pleasure of eating. In other words, Berlant

(2010) provides a rationale or a reason as to why it is acceptable to eat ill advised, when no rationale is required.

Furthermore, others have articulated the structural barriers faced by low-income families whom cannot afford to purchase 'healthy' foods (Drewnowski and Specter 2004; Drewnowski 2007; Brudette Wadden and Whitaker 2006; Lumeng et al. 2006; Gordon-Larsen et al. 2003, 2006). These arguments articulate that food prices as well as socio-economic issues around urban planning prohibit specific types of families from gaining access to 'healthy' foods or delivery systems (grocery stores) that allow for 'healthy' consumption (Drewnowski and Specter 2004; Drewnowski 2007; Lumeng et al. 2006; Gordon-Larsen et al. 2003, 2006). As such, in addressing the technoscientific 'facts' concerning the alleged associations between obesity and 'risk', many point to the problematic ways in which these statements construct and articulate new and individual identities which are posited as 'factual' and uncontested (Berlant 2007, 2010; Peterson and Lupton 1996; Lupton 1995; Kwan 2009; Lee and MacDonald 2010; Guthman 2013; Moffat 2010; Gard and Wright 2001).

Commonly described in Western culture as the 'obesity epidemic' (Schorb 2013; Rysst 2010; Peterson and Lupton 1996; Boero 2007; Berlant 2010), the growing perception concerning food consumption contends that it is the individuals' responsibility to maintain a 'healthy' diet combined with the proper amount of physical activity (Schorb 2013; Lupton 1995; Peterson and Lupton 1996; Metzl and Kirkland 2010; Berlant 2007). As such, over-eating, consumption of 'unhealthy' foods as well as a lack of exercise are regarded as an individual weakness, and an ultimately undesirable trait (Rich 2011; Berlant 2007; Metzl and Kirkland 2010; Gard and Wright 2001; Schorb 2013; Jennings

2014; Cheek 2008). Therefore, it is not a matter of people making choices in regards to food consumption, but rather that they make the ‘right’ choices.

In addition, technoscience as a practice of coercive healthism also fails to consider diversity among ethnic racialized groups in food consumption. For example, in her article entitled *The geneticization of Aboriginal diabetes and obesity...* Jennifer Poudrier (2007) writes, “[...] the thrifty gene [among Aboriginal peoples] reifies racial categories of biological risk by matching neo-colonial ideologies of ‘problematic races’ with disease ‘epidemics’” (237). Poudrier (2007) concludes,

by suggesting that the full story of the thrifty gene thus far has only begun to include Aboriginal perspectives from decolonizing perspectives. Decolonizing projects are about revealing knowledges that sometimes come from colonizing perspectives (258).

While space and time limitations do not allow the MRP to address coercive healthism within the context of colonialism in regards to food consumption, these examples are illustrative of the way in which coercive healthism may be considered as a colonizing ideology that requires further research.

In summation, this chapter has outlined generally the concept of biomedical coercive healthism and more specifically, applied it to the notion of the obesity epidemic. Other researchers have realized the coercive nature of healthism and have opted for alternative ways of considering health including but not restricted to holistic healthism. The following chapter will consider the concept of holistic healthism.

CHAPTER 2: HOLISTIC HEALTHISM

An Overview of Holistic Healthism

As concern grew around the limitations of coercive biomedical healthism (Smuts 1926; Lupton 1995, 2003; Peterson and Lupton 1996; Edgley and Brissett 1990; Crawford 2006), there was a search for a solution, a more humanist approach to medicine, health and illness (Shrobb 2013; LeBesco 2011). Thus, at the beginning of the twenty-first century, holistic healthism began to slowly emerge as a response to the limitations inherent within coercive healthism (Lowenburg and Davis 1994; Borins 1984; Patel 1987; Guttmacher 1979; Scott 1999; Muir 1999). For the sake of the breadth of the MRP, the discussion of holistic healthism will begin with its deployment beginning in the 1990's.

As a response to coercive healthism, holistic—a generic term that encompasses alternative, complementary and to some degree, depending on the circumstances, biomedical regimes—healthism specifically addressed two main concerns: (1) the reductionist focus of treating ‘parts’ of the individual (Scott 1999; Gordon 1990; Patel 1987; McKee 1988; Muir 1999; Borins 1984; Pietroni 1984) and (2) the inability of the individual consumer to resist the authority of “physician promoted medicalization” (Clarke, et al 2003:152; see also Scott 1999; Gordon 1990; Guttmacher 1979). Drawing attention to the ways in which coercive healthism utilized technology and specialized knowledge in a way that made patients feel “alienated, inhumanely treated, and chopped up into parts” (Borins 1984:101), holistic healthism became a movement towards countering the trend of dehumanization and “bioreductionism” as inherent within biomedical healthism (Scott 1999; McKee 1988).

As a way to controvert the “bioreductionist” (Scott 1999; McKee 1988) practices of biomedical healthism, holistic healthism’s most fundamental principle implies both an approach to the entirety of the individual in relation to their environment, as well as a “variety of therapeutic and health promoting strategies” (Gordon 1990:358). While regarding the whole as “greater than the sum of its parts” (Pietroni 1984:463) holistic healthism encompasses a wide range of medical interventions as mentioned earlier, including the use of biomedical approaches (Gordon 1990; Lappe 1979) and alternative or complementary methods of healing (Pietroni 1984; Borins 1984).

Due to the way in which holistic healthism considers the entirety of the individual as comprised of mind, body and spirit (Guttmacher 1979; Pietroni 1984) it is argued that “Holistic views of the concepts of health and disease differ in a number of important respects from the biomedical or allopathic model” (Guttmacher 1979:16). For example, holistic healthism initiatives give credence to the environmental, political, and social factors that inform a person’s well being (Guttmacher 1979). As such, holistic healing and notions of treatment often use methods that focus on the interrelation of the individual and the various components within their life in order to acknowledge the “uniqueness of each patient” (Gordon 1982:546) (Guttmacher 1979; Pietroni 1984; Bendelow 2009; Sultanoff 1997). In his article entitled *Whole Person...* Steven Sultanoff (1997) provides an analysis comparing and contrasting the biomedical and holistic practices to health and wellbeing. Drawing attention to their differences, Sultanoff (1997) asserts that holistic healthism is “multi-dimensional [... because it] explore[s] human ecology to generate change that can become integrated, lifestyle changes for health and wellness” (127-128) Similarly, other authors advocating for the use of holistic healthism

argue that it provides for a more rewarding approach to healing and wellbeing (Bendelow 2009; Pietroni 1984; Scott 1999; Sultanoff 1997; McKee 1988). These authors argue that holistic healthism with its approach to treating the entirety of the person provide an oppositional form of treatment in comparison to the reductionist and “one-dimensional” (Sultanoff 1997:127) perspective of biomedical healthism (Guttmacher 1979; Pietroni 1984; Bendelow 2009; McKee 1988; Scott 1999).

Specifically countering the expert-driven practices of biomedical healthism (Clarke et al. 2003, 2010; Scott 1999; Gordon 1990; Guttmacher 1979) holistic healthism focuses on allowing the patient to select from a wide variety of conventional and alternative approaches, the most suitable treatment for themselves (Gordon 1990; Lappe 1979; Crawford 1980, 2006). Such a shift from the expert-driven provision of medical treatment to the allowance of the patient to make such choices in healing and treatment has modified the role of the patient to become a consumer (Crawford 2006; Lowenburg and Davis 1994; Greenhalgh and Wessley 2004). Consequently, this affects the role of the physician. Under the biomedical model, the physician as ‘expert’ holds the authority to define and provide the most effective method of treatment; however, within the holistic model, this authority and responsibility shifts to the consumer. As such, the previously known ‘expert’ now becomes the ‘specialist’ or the “treatment-coordinator” (Sultanoff 1997:128) whose primary responsibility focuses on relaying the various options in treatments from which the consumer has the ability to choose from (Sultanoff 1997; Gordon 1982).

As mentioned previously, rather than the ‘expert’ selecting and detailing the type of treatment required, holistic healthism allows the patient, as a consumer to hold the

authority to choose from a variety of healing and treatment methods (Lowenburg and Davis 1994; Patel 1987; Lappe 1979; Willis and Rayner 2013). For example, the front page of the Toronto-based Holistic Health Care Clinic website [See Appendix B] presents to the visitor a detailed list of over fifteen various treatment methods to choose from. More interestingly, the consumer also has the choice to click on each healing practice to “find out more” about what this specific method entails. Furthermore, as the visitor scrolls down the page, there are sixteen specialist profiles to click on, which list the doctor’s name and area(s) of specialization(s). If the visitor clicks on the specialist’s profile, it opens up a new page detailing their personal understanding of their area(s) of knowledge, as well as an elaborate description of what the consumer might expect upon their first visit. Such an extensive focus on the differing types of healing methods, the specialists themselves, as well as what the consumer might *experience* or *expect* upon their visit to the health care center points to the way in which holistic healthism specifically focuses on countering the biomedical trend of ‘expert’ dominated healthcare provision. In this sense, holistic healthism and the way in which it offers the consumer the choice among a myriad of differing specialists and practices operates in a dualistic and oppositional manner to the practices of biomedical healthism.

Holistic Healthism as Oppositional to Biomedical Healthism

Scholars addressing the limitations of coercive biomedicine often advocate for the use of holistic approaches to health and medicine as a way to militate against the reductionist and de-humanizing approaches of biomedical healthism (Bendelow 2009; Lee and Macdonald 2010; Burrows and Wright 2004, 2007; Burrows Wright and McCormack

2009; Sultanoff 1997). In her book entitled *Health, emotion and the body*, Gillian Bendelow (2009) states,

Integrated models of health and illness are increasingly permeating contemporary healthcare, and are gaining popularity and credibility within mainstream medical literature and research, as the limits of biomedicine become increasingly evident in contemporary times (140-141).

Reiterating the oppositional argument, biomedical healthism is understood as coercive, while holistic healthism is conceived as positive due to the way its methods actively work to discourage the reductionist and expertise-driven constraints of biomedical healthism (Lowenburg and Davis 1994; Scott 1999; Willis and Rayner 2013; Sultanoff 1997; Patel 1987; Muir-Gray 1999). While biomedical healthism methods entail “tunnel-vision” (Borins 1984:101) or “one-dimensional” (Sultanoff 1997:128) approaches which leave patients feeling “alienated and inhumanely treated” (Borins 1984:101), it has been argued that holistic healthism understands the idea of well-being as “multi-dimensional” (Sultanoff, 1997:128) in that it takes into account “the whole person and the whole situation, deal[s] with both symptoms and the root cause, and consider[s] both conventional and alternative therapies” (128). In contrast to biomedical healthism, holistic healthism shows an

appreciation of patients as mental, emotional, social and spiritual, as well as biological and physiological beings. It respects their uniqueness and regards them as active and responsible partners in, rather than recipients of, their healthcare (Gordon 1990:358).

Thus, while the literature posits biomedical healthism as coercive (as demonstrated in chapter 1) and undesirable, holistic healthism is posited as the positive, reactionary solution. Drawing attention to this dualism, Bendelow (2009) points out that while

biomedical healthism “based almost exclusively on individual behaviours and practices considered to be risk factors for disease are inadequate” (134), “holistic concepts of health enable radical change in what is meant by health, illness and disease” (144).

Crawford’s Critique of Holistic Healthism

Responding to the critique of his original theory of healthism, Crawford (1980) provides a criticism of the alternative of holistic healthism that is substantially based upon the notion of individual responsibility. First, he argues that the notion of individual responsibility is a political language due to the way it involves a reclaiming of power from the physicians. Specifically addressing the shift from patient to consumer, Crawford’s (1980) concern focuses on the way in which such an emphasis on the notion of choice may overlook a more important “language of control” (378) in a way which delegitimizes existing authority and makes us as individuals responsible for the conditions around us (Lowenburg and Davis 1994). In reference to the example of the Toronto Holistic Health care clinic, although the clinic provides a myriad of choices with explanations, etc., and this seems to be empowering the consumer; the onus is on the consumer to not only make a choice, but to make the ‘right’ choice (Samerski 2009; Overboe 2007).

Consequently, Crawford (1980) argues that such an emphasis on individual choice may overlook the social constraints against choosing (Patel 1987; Rothman 1987; Gupta 2000). In respect to the treatment of chronic illnesses such as cancer, diagnosed individuals have two choices: they may choose to undergo treatment, or they may choose to not. While the former is constructed as a ‘responsible’ and desirable choice for both the individual and their family and friends, the latter is understood as a selfish or

irresponsible decision and thus places blame upon the individual for choosing to reject treatment. Thus in actual fact, the diagnosed individual has only one choice, which is to undergo treatment in order to live longer, be seen as responsible, as well as satisfy their family and friends. In this scenario, the social constraints as imposed by relationships control the diagnosed individual's ability to make a free choice.

Thirdly, Crawford (1980) argues that individual responsibility,

may also exacerbate an already prevalent sense of powerlessness about controlling the forces which impinge on individuals by promoting a concept of control which may be viewed as an alternative to political efficacy (378).

Statements such as "I can't change the world around me but I can change myself" iterate this notion of 'self-cultivation' as a mechanism of political engagement. For example, the growth in the trend of cleansing juices points to the increased desire to 'purge' the internal system of environmental toxins which the individual may have no control over.

Articulating the holistic perspective that argues "illness is beyond our control" (Borins 1984:104), Christina Sarich (2013) states,

From the chemtrails being sprayed over our neighborhoods to the poisons killing our bees and making our food toxic 'medicine' we need a way to purge the deadly elixirs of a greedy government, owned and run by corporate interests. For the sake of keeping your attention, I won't go on ad nauseum about fluoridated water, oil spills, and contaminated air and water due to fracking and mining (see Sarich 2013).

In addition, Crawford (1980) and others (McKee 1988; Labonte and Penfold 1981; Scott 1999; Gordon 1982; Todd 1979) also argue that such an emphasis on individual choice may translate into an idea of individual blame or "victim-blame" (Gordon 1982:548), and thus, would ultimately responsabilize the individual for any misfortune.

Pointing to the ways in which “Holistic medicine emphasizes the responsibility each person should assume for his or her health” (Gordon, 1982:548), Janet McKee in her article *Holistic health and the critique of Western medicine* (1988) argues,

The victim-blaming ideology promoted by the holistic health movement tends to shift the burden of blame for health problems from the social system to the individual. It tends to assign responsibility to the individual for maintaining a healthy lifestyle (775).

Relatedly, in her article *Tyranny of health*, Faith Fitzgerald (1994) articulates the shift from the notion of a good ‘life’ to the modern idea of leading a healthy ‘lifestyle’ and argues, “The emphasis on healthy lifestyles, although salutary in many ways, has a very dark side to it and has led to the increasing peril of a tyranny of health” (196). Others (Cheek 2008; Edgley and Brissett 1990) have also drawn attention to this emphasis in lifestyle, such as Deborah Lupton (1995) who adds,

Lifestyle [...] is conceived of as an aesthetic project of the self, a central means of constructing subjectivity. From this perspective, engaging in sporting activities or exercise is strongly associated with the construction of subjectivity (143).

In summation, Crawford (1980) and others (Gordon 1982; McKee 1988; Labonte and Penfold 1981; Scott 1999; Todd 1979; Borins 1984) provide a critique of holistic healthism based upon the notion of individual responsibility. These authors argue that such an emphasis on the individual can provide for problematic implications in terms of perpetuating a “language of control” (Crawford 1980:378), promoting a façade of ‘free’ choice (Samerski 2009), fostering a greater trend of ‘self cultivation’ (Crawford 1980) as well as shifting the emphasis from having a ‘good’ life to leading a ‘healthy lifestyle’ (Lupton 1995; Gordon 1982; McKee 1998) which restricts the lives of individuals.

Thus far, this chapter has repeatedly demonstrated the ways in which biomedical healthism and holistic healthism differ in their practices, and as such, are regarded by the existing literature as dualistic and oppositional. Despite its shortcomings as mentioned above, many authors still advocate holistic healthism as the positive solution to the limitations of biomedical healthism (Bendelow 2009; Borins 1984; Sultanoff 1997; Lowenburg and Davis 1994; Scott 1999; Willis and Rayner 2013; Patel 1987; Muir-Gray 1999). In the first chapter, the MRP examined obesity as a means to ground the concept of coercive healthism. Similarly, in this next section, the MRP will use the concept of obesity in order to ground the analysis of holistic healthism.

Obesity Examined Through Holistic Healthism

Holistic approaches to the growing ‘problem’ of obesity differ from biomedical regimes as they take into consideration the whole person including the mind, body and spirit. While pointing to the way in which “Holistic interventions aimed at mind, body and spirit are necessary for weight management to be successful and lasting” (Popkess-Vawter et al. 2005:162), many argue that holistic regimes provide for a more useful method of treatment when it comes to the ‘problem’ of obesity (Kopelman 2007; Cinar and Murtomaa 2009; Brown and Wimpeny 2011; Popkess-Vawter et al. 2005). For example, in the article *Getting the balance right: qualitative evaluation of a holistic weight management intervention to address childhood obesity*, Visram et al. (2012) argue,

Because of the complex nature of obesity, a holistic approach is often identified as best practice. [...] [Whole systems complementary medicine] WSCAM, including Traditional Chinese Medicine, Ayurveda, Naturopathy and classical homeopathy[...] share a perspective that imbalances in the patient’s overall constitution are at the root of disease and dysfunction, including obesity (693).

Statements such as these, which accentuate an association between obesity as a “disease and dysfunction” socially construct the identities of ‘obese’ individuals. In turn, it is emphasized that obesity is undesirable, and as such, must be avoided or eliminated. By extension, such positions perpetuate a feeling of ‘shame and blame’ in obese individuals (Puhl and Brownell 2003), which will be discussed later.

Consequently, born are “holistic nutrition and healthy lifestyle management programs” (Hollar et al. 2010:93), such as the Healthier Option for Schoolchildren Programme (HOSP) which is specifically “designed to keep children at a normal, healthy weight, and improve health status and academic achievement” (93). Relatedly, such approaches have also helped to foster other holistic programs aimed at ridding childhood obesity, such as the ‘Balance It! Getting it Right Balance’ programme which,

refer[s] overweight and obese children (4-17 years) into appropriate lifestyle interventions. These interventions include dietary advice from a school nurse or dietician (depending on the level of overweight), free access to leisure facilities run by local authority staff, incentive ‘fun days’ and specialist support from consultant paediatricians and clinical psychologists (Visram et al. 2012:247).

While seemingly well intended, initiatives such as these not only reduce childhood to the notion of ‘non-obesity’, but they also perpetuate shame and blame by insinuating that obese children lead a lifestyle which requires intervention. While the ‘HOSP’ program specifically implies that obese children have issues performing academically, the ‘Balance It! Getting it Right Balance’ program places shame and blame on obese children for living inappropriate lifestyles (Phillipson 2013). These programs project to the general public that the obese child experiences unsatisfactory academic achievement while leading ‘inappropriate’ lifestyles that include poor dietary choices as well as a lack of proper physical activity. As such, both programs construct childhood

obesity as an ultimately undesirable identity that is directly related to various health issues. In turn, these external pressures along with the internalization of these narratives results in people living lives that are restricted by holistic healthism.

Included in holistic approaches to the treatment of obesity and weight management are initiatives that focus on food consumption. For example, the 'Health-Friendly Logo' program "promote[s] the foods that are friendly to health of the whole body [...] Labeling healthy food as 'health friendly' based on an international consensus will provide a clear and uniform picture of what is healthy to eat" (Cinar and Murtooma 2009:357). Advocates of this program argue that, "Such a programme can prove an effective holistic tool in tackling the global pandemic of obesity" (359). Exemplifying the critique of holistic health as placing 'blame' upon the individual, this attempt to label foods as 'healthy' directly implies that obesity and poor food consumption choices are interrelated (Phillipson 2013). While those who consume 'health-friendly' foods make the 'correct' choice, those who do not consume such foods make the 'incorrect' choice. Thus, the attempt to label 'healthy' food not only implies that obese individuals are to blame for ill-advised eating, but it also socially constructs what is considered to be a 'good' or 'correct' choice when it comes to food consumption. In turn, the consumption of 'health-friendly' foods projects to others that one is making the 'responsible' choice of consuming the 'proper' foods. Such an approach to the 'problem' of obesity directly exemplifies the way in which obese individuals are shamed for ill-advised eating.

In addition to initiatives that focus on individual choices concerning the different types of foods we consume and their effects on our bodies, authors such as Lauren Outland (2013) emphasize the way in which different methods of eating are also related

to the notion of obesity [see Appendix C]. In her article *Intuitive eating for a healthy weight*, Outland (2013) argues that obesity occurs due to certain consumption behaviours such as eating when full, ‘binge-eating’, as well as ‘yo-yo’ dieting whereby the individual repeatedly alters dieting patterns (Outland 2013; Vandyke and Drinkwater 2013). Thus, as a holistic approach to the treatment of obesity, Outland (2013) coins the term “intuitive eating” to connote a ‘healthy’ approach to food consumption (Outland 2013; Vandyke and Drinkwater 2013). Using internal cues to determine the ‘appropriate’ time to eat, “intuitive eating” involves three fundamental principles “(i) eating when hungry; (ii) stopping eating when no longer full/hungry; (iii) no restrictions on types of food eaten unless for medical reasons” (Vandyke and Drinkwater 2013:3).

Consequently, such an emphasis on the association between food consumption patterns and obesity implies that obese individuals make ill-advised decisions concerning consumption. While identifying these individuals as making ‘poor’ choices, such a holistic approach to obesity also socially constructs the experiences of obese individuals by suggesting that they do not listen to their bodies. In turn, obese individuals are deemed as ‘irresponsible’ due to their inability to make the ‘correct’ choice when it comes to consuming food. More importantly, such an emphasis perpetuates individual ‘shame and blame’ by insinuating that the obese body is directly related to making ‘poor’ and ‘irresponsible’ choices concerning food consumption (Puhl and Brownell 2003).

While attempting to provide a well-rounded approach to the treatment of obesity, programmes such as ‘HOSP’ and ‘Balance It! Getting it Right Balance’ as well as methods such as “intuitive eating” are part of a greater mechanism of governmentality and thereby function as methods of surveillance. Earlier, in Crawford’s (1980) criticism

of holistic healthism, he spoke about the “language of control”; however, this MRP extends that argument to include the concepts of governmentality and the panopticon, which will be discussed later.

While consuming ‘health-friendly’ foods constitutes a ‘correct’ choice, eating when full/hungry is regarded as a ‘poor’ choice. In turn, the obese individual along with the choices they make regarding the types of foods they consume as well as the way in which they consume foods, are policed and constructed as ‘responsible’ or ‘irresponsible’ behaviours and choices. For example, in *The role of spirituality in weight management* Popkess-Vawter et al. (2005) argue

Holistic interventions aimed at mind, body, and spirit are necessary for the weight management to be successful and lasting [...] To make lasting changes in eating and exercise habits, patients learn to identify and conquer triggers within themselves and in relationships that often result in weight management failures. (162).

Statements such as these are exemplary of the ways in which holistic methods emphasize preferred behaviours. In addition, statements such as “triggers within themselves” directly places blame upon the individual for behaving in particular ways (Puhl and Brownell, 2003). These assertions socially construct the obese body in ways which suggests to the general public that obese individuals have no self-control and are therefore ‘irresponsible’. Directly linked to the imperative to be rid of the obese body, constructed ‘responsible’ and ‘irresponsible’ choices in terms of food consumption function as mechanisms of surveillance.

In attempt to address the ways in which approaches to obesity as a ‘problem’ socially constructs the lived experiences of obese individuals, the ‘Health at Every Size’ (HAES) model is

described as “the new peace movement” (Bacon, 2008, p. 157), a paradigm shift, and “an alternative public health model for people of all sizes” (Burgard, 2009, p. 42). HAES is guided by the following principles: accepting and respecting the diversity of body shapes and sizes; recognizing health and well-being are multi-dimensional; and promoting all aspects of health and well-being for people of all sizes including balanced eating and individually appropriate, life-enhancing physical activity rather than exercise solely focused on weight loss (National Association to Advance Fat Acceptance, 2010) (Lindly et al. 2014:182).

Although seemingly well intended, this model falls back into the constraining nature of healthism by still maintaining the imperative to be ‘healthy’ at any weight. Furthermore, within this need to be perceived as being ‘healthy’, the ‘HAES’ provides a counter-narrative to the prevailing hegemonic discourse of the ‘obesity epidemic’. Instead of challenging the construction of ‘healthy’ as an ideal, the ‘HAES’ model attempts to include fat people within healthism by advocating ‘health at any size’. Furthermore, the model still uses normative concepts such as ‘balanced eating’ and ‘appropriate life-enhancing physical activity’ which are notions directly related to the nature of holistic healthism practices. In turn, there still exists the notion of individual responsibility for the maintenance of an ‘acceptable’ lifestyle which involves making the ‘correct’ and ‘responsible’ choices. As such, the ‘HAES’ model falls back into the constraining regimes of healthism.

Adhering to the holistic focus on the importance of treating the entirety of the individual as including body, mind, spirit, as well as environmental, social, economic and political conditions (Guttmacher 1979), Jodi Sawyer (2012) as published on Dr. Oz’s website, states

In most cases, childhood obesity doesn’t start with the child. It’s more the environment that the child has grown up in, and the way their parents shaped the child’s environment. A child is less likely to be obese if their parents model good, healthy habits for the child at an early age. Tests have shown that if one parent is

obese, there is a 50% chance that the child will also be obese. If both parents are obese, then the child has an 80% chance of being obese as well, [...] By making changes to diet and exercise routines, parents can stop the cycle of obesity moving through a family's generations [...] By encouraging more physical activity and the consumption of fruits and vegetables as a first choice, today's youth will soon be able to make better and healthier decisions as they grow older (see Sawyer 2012).

Sawyer's (2012) holistic approach to the 'problem' of childhood obesity socially constructs the experiences of obese children in three different ways. First, by articulating that the environment may play a causal factor in 'childhood' obesity, she creates an association between problematic bodies with specific environments. By stating that the environment in which the child was raised is the reason why childhood obesity "starts", she problematizes specific types of environments and associates them with the 'issue' of childhood obesity. Thus, this holistic approach constructs the obese child as a product of specific 'problematic' environments.

Secondly, Sawyer's (2012) emphasis on the weight of the parent as associated to childhood obesity also implies that the parents of obese children are 'irresponsible'. This emphasis is problematic for two reasons. Firstly, her assertion insinuates that whether aware of it or not, the obese parents model behaviour that children emulate, which causes childhood obesity; and secondly, that obese parents use flawed parenting skills such as meal preparation and family activities that are 'insufficient' or 'irresponsible' parental choices. Following Sawyer's (2012) reasoning, she informs the public that obese children are more likely predisposed to the 'problem' of childhood obesity, and that the parents of obese children have 'insufficient' parenting skills. Thus, she ultimately places 'blame and shame' upon the parents for the failure to give their child a 'healthy' childhood (Parker 2014; Boero 2010).

In addressing these types of positions on the *cause* of obesity, scholars situated in Fat Studies such as George Parker (2014) and N. Boero (2010) argue that this type of emphasis on parenting often results in the blaming and shaming of mothers for the ‘failure’ to raise a ‘healthy’ non-obese child. As such, they point to the problematic way in which the social construction of ‘bad parenting’ often places mothers in a precarious position whereby they are socially stigmatized as ‘bad’ mothers (Parker 2014; Boero 2010).

Relatedly, by drawing attention to the importance of ‘healthy’ eating habits, Sawyer’s (2012) assertions also imply that childhood obesity is a result of ill-advised eating, whether on behalf of the choices of the child or the ‘irresponsible’ parent, (obese or not). Although this analysis of Sawyer (2012) may seem like an overemphasis of the same point, that being the social construction of obese children and their parents, the importance lies in the way in which her assertions contain subtle differences which play a direct role in restricting lives.

Throughout this section of the MRP, blaming the victim has been illustrated through blaming the individual, the child, and the parent. In sum, each of these illustrations refers back to the notion of the freedom of choice, which ends up being an obligation to make the ‘right’ choice (Samerski 2009; Overboe 2007).

While this chapter has focused on holistic healthism and the ways in which the existing literature contends that it is the oppositional form of coercive healthism, the MRP hypothesizes that the relationship is along a continuum rather than dualistic. In turn, the following chapter will provide an analysis comparing the example of the biomedical approach to obesity and the holistic approach to obesity in order to argue that both

biomedical and holistic healthism are along a continuum and thus, differ in processes yet share the same end goal. In the next chapter, the continuum of healthism will be prevalent as the MRP compares and contrasts both forms of healthism through an analysis grounded in the example of obesity.

CHAPTER 3: COMPARING AND CONTRASTING COERCIVE AND HOLISTIC HEALTHISM THROUGH THE LENS OF OBESITY

The Continuum of Healthism

In the previous chapters the MRP outlined what constitutes coercive healthism and holistic healthism. While the existing literature posits that the biomedical and holistic paradigms are oppositional, advocates of holistic healthism argue that its approaches are a corrective to biomedical healthism. Although each paradigm critiques the other on their limitations concerning health as a procedural matter, the concern of this MRP lies with the problematic restrictions inherent within the end goal of healthism itself. Cognizant of the existing literature, the MRP hypothesizes rather than oppositional and dualistic, both holistic and biomedical healthism occupy a continuum in that the end goal remains the same: achieving optimum health. In other words, a person experiencing some health ‘problems’—such as obesity—has the opportunity to choose between various health regimes along the continuum. The continuum does not mean that one polarity is inferior to the other. In fact under certain conditions, practices of both biomedical healthism and holistic healthism may be combined in treatment regimes (see Gordon 1990; Pietroni 1984; Lappe 1979; Borins 1984). As a recent example of the continuum, the HAPIfork (www.HAPI.com) is device that combines aspects of both biomedical healthism and holistic healthism. The electronic fork uses technology to measure food consumption in an effort to promote ‘intuitive eating’ or ‘mindful eating’.

This fluctuating relationship is not just about the combination of holistic and biomedical healthism, but also points to the multitude of health practices that are available under each type of healthism, whether holistic or biomedical. For example,

within biomedical healthism, there is the concept of a second opinion from a physician, and within holistic healthism, there are various types of therapies that one can choose from. In the previous chapters the MRP has grounded the theoretical positioning in an analysis of obesity. Similarly, in this chapter, the MRP will compare and contrast biomedical healthism and holistic healthism as it applies to the ‘issue’ of obesity.

Obesity Examined Through Biomedical and Holistic Healthism:

Social constructions

In order to address the growing ‘problem’ of obesity, both biomedical and holistic healthism use differing approaches. Biomedical healthism heavily relies on the use of technoscientific methods to identify “risks” as associated to various health ‘problems’. Criticized for its “bioreductionist” approach (Scott 1999; McKee 1988), this process compartmentalizes the body. In the context of obesity, the major concern is that the patient loses weight because of the associated “risks” as identified by technoscience [Appendix A]. Holistic healthism, by contrast, focuses on the way in which obesity constitutes an imbalance within the individual (and their environment), like a “disease and dysfunction” (Visram et al. 2012; Sawyer 2012).

A good illustration of the differences between biomedical and holistic healthism is the ‘issue’ of childhood obesity. The biomedical CDC fact sheet [Appendix A] articulates the varying health ‘problems’ facing the obese child while the holistic ‘HOSP’ program (Hollar et al. 2010) similarly posits that the obese child experiences unsatisfactory academic achievement. Additionally, within the holistic healthism paradigm, obesity constitutes an imbalance in the individual’s overall well being (Visram et al. 2012). While the biomedical identification of risk projects to the public that the

obese child is destined to face numerous health issues [Appendix A], the holistic program insinuates that obesity is an “imbalance” and that the obese child will suffer academically (Hollar et al. 2010). Despite the way in which the existing literature posits the biomedical and holistic regimes as oppositional, both of these approaches restrict the notion of the life of a successful childhood to a goal of ‘non-obesity’. As a result, both regimes socially construct obesity as undesirable and something to be eradicated. More specifically, both biomedical and holistic techniques project to the general public that the obese child is undesirable. Although the holistic approach is posited as the solution to the reductionist understandings of biomedical healthism, both methods of treating the ‘issue’ of obesity ultimately imply the same message: the obese body is diseased and must be voided.

Similarly, both biomedical and holistic approaches to the ‘problem’ of obesity socially construct the obese child as predisposed to various health ‘issues’. Holistic approaches that claim to improve the “health status and academic achievement” (Hollar et al. 2010) of obese children as well as referring overweight and obese children (4-17 years) into lifestyle interventions (Visram et al. 2012) function in the same manner as technoscientific identification of risk as they both insinuate that the obese child will experience certain ‘issues’ regarding their health. While the biomedical CDC fact sheet [Appendix A] argues that the obese child holds a greater risk for diabetes, bone, joint and sleep issues, as well as social and psychological problems, the holistic ‘HOSP’ (Hollar et al. 2010) and ‘Balance It! Getting It Right Balance’ (Viseram et al. 2013) programmes both emphasize lifestyle interventions designed “to lower or modify weight and its associated health risks” (Hollar, et al. 2010:103). They differ in their approaches, as the biomedical focuses on the medical, and the holistic mainly focuses on lifestyle, which

may be impacted by some healing regimes. While the biomedical approach focuses on the individual body and mind, the holistic approach focuses on the interrelation between the individual and the environment.

Despite the differences between the biomedical technoscientific identification of risk and the encompassing technique of the holistic programs, both approaches to obesity infer an association between the obese body type and related health ‘issues’.

Correspondingly, both forms of healthism construct the obese body as problematic because it is predisposed to certain health ‘problems’, whether they are scientifically defined (i.e., diabetes, see Appendix A) or lifestyle-related (i.e., academic achievement, see Hollar et al. 2010).

Shame and blame and healthism

Another similarity between both biomedical and holistic healthism is that they perpetuate feelings of shame and blame. While both regimes approach obesity as a ‘problem’ to be rid of in ways that socially construct the obese body type as predisposed to both biological and lifestyle ‘issues’, such positions directly place shame on the obese individual. By emphasizing the extent to which the obese body type is undesirable and thus, must be eliminated, both coercive and holistic healthism reduce good living to a goal of ‘non-obesity’. In turn, the obese body signifies the ‘objectionable’ body type and consequently, shames the obese individual (Lee and Macdonald 2010; Peterson and Lupton 1996; Puhl and Brownell 2003; Phillipson 2013; Ickes 2011). Furthermore, while both forms of healthism also emphasize the related health ‘issues’ of obesity, these assertions place blame on the obese individual for failing to lead a ‘non-obese’ life (Lupton 1995, 2003, 2014). In this sense, both biomedical and holistic healthism place

the obese individual in a precarious position whereby their bodies signify the antimony of the ‘healthy’, ‘acceptable’, or ‘proper’ life.

To illustrate the blaming and shaming through an emphasis on individualism, (as discussed in chapter 1), Louise Townend (2009) in her article entitled *The Moralizing of obesity...* articulates the way in which the increase in the income gap has separated the poor from rich in ways that have reduced human worth to market values. In turn, she argues that such a reduction “can provide a pathway- beyond arguments around health- for marginalizing people who are obese on the basis of their apparent economic liability” (172). Quoting a health specialist from Northern Sydney Area Health Service, she points to the moralizing tone of biomedical experts whom directly shames obese individuals.

It is going to be a society decision as to where people put their tax dollars, but I would always hope the system would treat people who need it. However, we would be reluctant to transplant a kidney to an obese person because chances of failure are higher . . . (Crouch, 2007:26 as sited in Townsend, 2009:172)

This expert’s moralizing statement points to the degree to which obesity is seen as a risk. In turn, such a position reads that obese people cannot expect the same level of health care as others due to their imposed risk on society. As a result, the expert shames the obese individual for their body-type.

Militating against biomedical expert approaches that use such moralizing discourses that shame the obese individual for their failure to lead a ‘healthy’ life, holistic approaches to the ‘issue’ of obesity emphasize the need to shift the focus from “obesity prevention” to “health promotion” (Ickes 2011). As Melinda Ickes (2011) argues in her article *Stigmatization of overweight and obese individuals...* in order to reduce stigmatization, this shift addresses the need to “Focus only on modifiable behaviors

where there is evidence that such modification will improve health” (49). However, while such approaches seem to provide a more encompassing view on the ‘issue’ of obesity, the obese body type remains stigmatized as ‘morally inadequate’, signifying the individual’s inability to maintain an ‘acceptable’ lifestyle. For example, in interviewing obese adolescents and their experience of ‘health promotion’ strategies within school, many of the respondents reported that they felt ashamed to participate in various physical activities because their peers would often bully them (Lindelof et al. 2010; see also Puhl and Luedicke 2011; Faith et al. 2002; Haines et al. 2006; Hayden-Wade et al. 2005; Storch et al. 2007).

In elementary school, I remember my obese peers chose not to participate in various health activities such as nutrition lessons and organized recess activities including tug-of-war, red-rover, or the number game, thereby rejecting interventions of holistic healthism. This is consistent with the literature focusing on “weight victimization” (Schorb 2013; Puhl and Luedicke 2012; Puhl and Brownell 2003) in schools.

In this sense, both biomedical and holistic approaches to obesity perpetuate the stigmatization of the obese body by blaming the victim. While biomedical healthism uses experts and technoscience to construct the obese body type as problematic, holistic approaches focus on lifestyle intervention in ways that exacerbate the already prevalent moralizing tone concerning the ‘failure’ of obese individuals to lead a ‘proper’ and ‘healthy’ lifestyle.

Healthism and the imperative to eat ‘right’:

In addition to the ways in which biomedical and holistic healthism socially construct the ‘problem’ of obesity and the lives of obese individuals, both regimes regard ‘obesity’ as a problem that affects the individual. From the biomedical approach, the identification of ‘risks’ as associated to obesity largely ignores socio-economic differences (Kwan 2009; Berlant 2010; Peterson and Lupton 2000; Lupton 1995). Drawing attention to the structural barriers faced by low-income families (Drewnowski and Specter 2004; Drewnowski and Darmon 2005; Drewnowski 2007; Brudette et al. 2006; Lumeng et al. 2006; Gordon-Larsen et al. 2003, 2006; Townend 2009) these authors point to the problematic ways in which the technoscientific identification of risk dismisses the socio-economic problems in accessing ‘healthy foods’. Food prices and urban-planning are among the many socio-economic issues that prohibit specific types of families from gaining access to the ‘proper’ foods that would allow for ‘healthy’ consumption (Drewnowski and Specter 2004; Drewnowski and Darmon 2005; Drewnowski 2007; Brudette et al. 2006; Lumeng et al. 2006; Gordon-Larsen et al. 2003, 2006).

Among these authors, L. Kaufman and A. Karpati (2007) in their article *Understanding the sociocultural roots of childhood obesity* highlight the problematic way in which the distribution of food stamps structure familial consumption patterns. They argue that when food stamps become available at the beginning of the month, the family overeats. As a result, when food stamps become scarce towards the end of the month, food supplies lessen, and starvation results. Consequently, it is not a matter of the ‘moral failings’ of obese people in terms of food consumption, but rather, this analysis

implicates a failure in the provision of food stamps and urban planning which results in discrimination against people of a lower socio-economic status.

As a means to counter the “one-dimensional” (Sultanoff, 1997:127) approaches of coercive healthism as it applies to the reductive micro-focus of healthism, holistic healthism considers the entirety of the individual in relation to their environment (Gordon 1990). As mentioned in chapter 2 (page 24), highlighting the interrelation between the individual and their environment, Lauren Outland (2013) introduces the term “intuitive eating” which refers to a ‘healthy’ approach to food consumption (Outland 2013; Vandyke and Drinkwater 2013). As a method which specifically militates against overeating and/or ‘binge eating’, Outland’s (2013) approach argues that individuals should only eat when hungry, stop eating when full, and refrain from dieting unless for medical reasons (Vandyke and Drinkwater 2013). Seemingly well intended, such an approach directly insinuates an association between consumption and obesity. As a result, it is directly implied that obese individuals make ill-advised decisions concerning eating. In turn, this holistic approach socially constructs the experiences of obese individuals by suggesting that they do not listen to their bodies. Thus, like biomedical healthism, holistic healthism fails to consider the social practice of the provision of food stamps and the designs of urban planning which discriminates against people of a lower socio-economic status and continues to blame the victim.

Other holistic approaches to the ‘problem’ of obesity also infer an association between consumption and weight. As discussed earlier in chapter 2 (page 30) the holistic ‘Health-Friendly’ Logo program, which labels ‘healthy’ foods in order to aid the consumer in purchasing the ‘right’ foods (Cinar and Murtomaa 2009), makes the same

assumption concerning the relationship between ill-advised eating and obesity. By positing the idea that the labeling of ‘healthy’ foods addresses the ‘issue’ of obesity it is insinuated that obesity is directly related to ill-advised eating. As apart of the problem with simplifying the ‘issue’ of obesity to poor food consumption, such a holistic perspective regarding the cause of obesity also assumes that obese individuals can afford to purchase or access healthy foods. This approach directly insinuates that the ‘healthy’ citizen is one who will purchase the ‘correct’ foods without having to consider the availability of said foods. By contrast, the ‘unhealthy’ individual is blamed for ill-advised eating, when access to ‘healthy’ foods may be restricted by income or lack of availability. Such a position fails to consider the financial ability along with the accessibility in purchasing ‘healthy’ foods. So insidious is the divide between those who can afford to participate in the prescriptive discourses of healthism and those who cannot, that both biomedical and holistic approaches to the ‘issue’ of obesity disregard socio-economic differences.

In addition to the socio-economic barriers facing low-income families, there are also issues concerning the availability of ‘healthy’ foods. As an illustration, the area in which I reside has two types of grocery stores: ‘Wal-Mart’, and ‘Healthy-Foods & More’. While the Wal-Mart provides the consumer with an assortment of ‘unhealthy’ foods, the Healthy-Foods store contains a wide variety of foods associated with leading a ‘healthy’ lifestyle. While I would prefer to purchase my groceries from the Healthy-Foods store, the prices are extremely high and as a result, I cannot afford to shop there. As a result, I am forced to do my grocery shopping at Wal-Mart because of the lack of other affordable stores in my location. In turn, I am faced with an overwhelming anxiety that I am not

living up to the standard of leading a ‘healthy’ lifestyle. In addition to my personal experiences, many others in my apartment-complex share the same frustration. While they would prefer to shop at the ‘healthy’ store, they are unable to afford its high prices and thus, are forced to purchase their family’s food from Wal-Mart. A single, immigrant mother of three, my neighbor, Abida [pseudonym] repeatedly expresses her frustration with the types of foods she is forced to purchase due to the issues related to affordability and location, which limit her choices in grocery shopping for her children. On several different occasions, Abida has told me that she is concerned about the weight and overall health of her children.

Healthism, cultural denial and the appropriation of different cultural practices

Theoretically advancing the implications for the way in which coercive and holistic approaches to ‘health’ and well being actively ignore socio-economic differences, many authors have pointed to the ways in which the Western obsession with the enhancement of health through healthism has involved the denial of some cultural practices while also appropriating other cultural differences (Askegaard and Eckhardt 2012; Gilbert 2004; Lavrence and Lozanski 2014; Watters 2010). With the spread of neoliberalism, biomedical understandings of health and well-being have suppressed indigenous cultural practices. As mentioned in chapter 1, Poudrier’s (2007) assertions concern the way in which Western medicine has argued that the cause of diabetes is genetic. In her view, the obesity ‘problem’ within the context of aboriginal communities is closely associated with the genetic imposition of the ‘thrifty gene’, which has no scientific validity, but is a form of biomedical healthism that is taken for granted and uncontested.

As an example of holistic healthism, in the article *Re-appropriation in the Indian consumptionscape*, S. Askegaard and G. Eckhardt (2012) draw attention to the transformation of Indian yoga practice in Western society. Initially an Indian practice, which originated from the Sanskritic cultural mold as well as the Buddhism, Jainism, and Hinduism religious traditions, yoga was a practice previously used to initiate spiritual enlightenment (Askegaard and Eckhardt 2012). Previously regarded as a method to “transcend ignorance and train the embodied mind to experience Truth”, yogic practice has been a deeply entrenched aspect of Hindu spiritualism (47). However, since the 1960’s, yoga practice has been steadily increasing across the West as apart of “modern society’s quest for liberatory practices” (47). With the expansion of yoga into Western society, the principles and uses of yoga have drastically changed. Today, yoga is used in the Western world as “a way to reconnect with the spiritual world, reduce stress, and regain health and freedom” (47). For example, Waterloo Moksha Yoga advertises its studio with the motto “Calm Mind, Fit Body, Inspired Life” (http://waterloo.mokshayoga.ca/about/hot_yoga/).

Emphasizing the interrelation between the ‘spiritual’ and ‘health and freedom’, Askegaard and Eckhardt (2012) argue that the Western use of yoga practice functions as source of “spiritual capital” (47). Pointing out the ways in which “spiritual capital” operates as both religious and non-religious, Askegaard and Eckhardt (2012) highlight three major issues associated with the transformation to yoga practice. First, they argue that yoga practice, as a means to gain “spiritual capital” is paradoxically both religious and secularized and operates as “a religion that requires neither faith nor belief, but instead [as a] rigorous (bodily and mental practice) and also a high degree of self-

discipline” (47). While practicing yoga, the individual is forced to partake in extremely diligent bodily movements, which involves meticulous concentration on balance, (involving the body and the mind). Demonstrating this relation between bodily and mental practices and self-discipline, the images portrayed in the background of the Moksha Studio’s motto of “Calm Mind, Fit Body, Inspired Life” contain three yoga teachers holding extremely rigorous poses [Appendix D]. Furthermore, each image takes place in a different ‘calming’ environmental setting, such as a field of tall grass, a calm river, or amongst trees.

Second, Askegaard and Eckhardt (2012) argue that emphasis on the body as a means to access “spiritual capital”, which requires neither faith nor belief, indicates the degree to which modern yoga involves bodily technologies more so than religious belief. They argue

Modern yoga as it is currently practiced in the West, then, tends to have a focus on health and fitness [... and] is fundamentally based on scientific claims and as such highly rational and instrumental in its approach to explanatory frameworks for ‘how it works’. (47)

As a sort of embodied religion, the Moksha Waterloo website provides its visitor with twelve different posture videos which detail the mechanics of each posture and the related bodily movements which help to achieve the precise yoga positions. Furthermore, demonstrating the scientific basis as mentioned above, the website also lists several “benefits” to yoga practice, including the ailment of “Depression, Stress, Back/Knee Pain, Insomnia, Arthritis, Poor Digestion and Constipation, Headaches, Pregnancy, Poor Posture, and Scoliosis” (<http://waterloo.mokshayoga.ca/about/benefits/>). While yoga practice was initially regarded as a means to achieve spiritual enlightenment, the Western

use has fundamentally re-defined what constitutes spiritual enlightenment to include notions of the body, health and well being.

Finally, Askegaard and Eckhardt (2012) also point to the way in which the West, transforms the practice of yoga in and by itself and inscribes it in a contemporary mindscape of healthism [...] that institutes self, body and lifestyle practices as a moral system. Furthermore, this contemporary body culture relates to an equally contemporary cult of performance (Heilbrunn, 2004), which in our case (and numerous others) is specifically oriented towards the optimization of bodily performance (48)

As an illustration, the first of the seven fundamental pillars of the Moksha Waterloo Studio states,

Be Healthy. We work to support lifelong health for the body and mind. We start our pillars with Be Healthy, because without our health, well...we've got a whole lotta nothing, right? By bringing a healthy awareness to what we eat, a ripple effect happens where we feel better and stronger in every aspect of our life. Ailments disappear, our yoga practice deepens and kale chips actually start tasting pretty good! If we commit to making small, significant changes to our diet like cutting out processed foods, increasing our organic veggie intake, and telling the pizza delivery dude it's time to start seeing other people, we will be amazed with the changes we see on our yoga mat, and in everything else we do on a daily basis (http://waterloo.mokshayoga.ca/about/the_7_pillars/).

Proceeding from the notion of maximizing bodily productivity, this statement exemplifies the degree to which modern, Western yoga practice focuses heavily upon the body as a means to achieve a 'healthy' life as defined within healthism.

Pointing to the way in which the body is constructed as the site of primary achievement in the article *'This is not your practice life': Lululemon and the neoliberal governance of self*, Christine Lavrence and Kristin Lozanski (2014) use the corporation Lululemon as an example of the way in which Western appropriation of yoga practice emphasizes a moralized approach to civic participation and well-being through bodily-

optimization. Associated to the transformation of yoga practice, these authors argue that corporations such as Lululemon (the world's leading yoga apparel brand name) are linked to "hegemonic ideologies of health and consumer culture" in ways that are related to the ideology of healthism (84).

The governmentality and surveillance of healthism in the everyday life of a student

As apart of the biomedical model, exercise—as primarily focused on the body—is regarded as an important aspect in leading a 'healthy' lifestyle. Using technoscientific means to understand the body, trained physicians such as biologists, cardiologists, as well as physiotherapists argue that physical exercise plays a major role in our overall health and well-being. Relatedly, the Laurier gym has also undergone recent expansive changes. The two-story building contains an array of new machines as well as a brand new layout. Similarly to Foucault's (1979) theoretical discussion of disciplinary society, the layout of the gym is an exact replication of the 'panopticon'. Duplicating the 'watchtower', the service desks on each floor are located directly in the centre of the open room, where the employees sit and monitor individuals in the gym. With no walls or partitions to separate the various workout machines, the floor layout resembles a giant open square. Additionally, located randomly around the room are different sized mirrors that allow individuals to observe other areas of the gym-floor. While this particular layout allows the employees to monitor the individuals, the mirrors also allow the individuals to monitor themselves as well as their peers. Furthermore, the entire gym is made of glass, so that cars, buses, and other individuals walking past can observe those inside the gym from any angle. Cognizant of this transparency, the individual becomes aware of the degree to which un-known others are monitoring them. In turn, the individual is engaged

in a process of self-surveillance whereby they must perform up to a certain standard due to the way in which others are so easily able to watch them.

Within the context of holistic healthism, the layout of the Waterloo Moksha Yoga studio can also be viewed from the perspective of the panopticon. The studio is a large square lined with mirrors that allow the individuals to monitor themselves and others in the room (similar to the Laurier gym). Additionally, the instructor's mat is centrally located giving it the same privileged position as the watchtower. Across from the entrance to the studio is the front desk where other employees are able to sit and watch individuals practicing. Similarly to the Laurier Gym, the building itself is made of glass, so that others passing by are able to see inside. As such, whether others are watching or not, the yoga practitioner internalizes the feeling of being under constant surveillance.

The difference between both examples of panopticon surveillance, is that the Laurier gym members are more aware of others monitoring them, whereas at the yoga studio, monitoring is cloaked in the auspice of helping each other reach optimum yogic practice. However, from the perspective of this MRP, both examples illustrate the surveillance of the panopticon. Within holistic healthism, the illusion of optimum practice is meant to lessen the effects of internalized surveillance upon the individuals. In both contexts, surveillance is the technique and the panopticon is the apparatus that allows for the concept of governmentality to be achieved. In his chapter *Governmentality* Michel Foucault (1991) argues,

One governs things. But what does this mean? I do not think this is a matter of opposing things to men [sic], but rather of showing that what government has to do with is not territory but rather a sort of complex composed of men [sic] and things. The things with which in this sense government is to be concerned are in fact men [sic], but men [sic] in their relations, their links, their imbrication with those other things which are wealth, resources, means of subsistence, the territory

with its specific qualities climate, irrigation, fertility, etc.; men [sic] in their relation to that other kind of things, customs, habits, ways of acting and thinking etc.; lastly, men in their relation to that other kind of things, accidents and misfortunes such as famine, epidemics, death, etc. (93)

Referring to the quote above, both biomedical and holistic processes of healthism allow for the concept of governmentality to be achieved. Applying the insights of governmentality, all facets of life are linked to, connected to and imbricated with healthism. While the techniques for healthism in the gym and yoga studio may differ, the outcomes are similar in that there is a desire for optimum citizenship through healthism.

As a student, I have experienced the pressures of surveillance in the context healthism. With the increasing attention paid to the growing ‘issue’ of obesity, many individuals feel the pressure to make the ‘correct’ or ‘responsible’ choices concerning food consumption. In chapter 1, the MRP outlined how the concern of biomedical healthism focused on *what* individuals consumed, for example junk foods as compared to healthy foods. In chapter 2, within the context of holistic healthism, while *what* individuals ate was a concern, an additional element was added: *how* individuals consumed food. In this chapter, the MRP will discuss the interplay of what individuals consume and how they consume it.

Related to Lauren Outland’s (2012) concept of ‘intuitive eating’ (as referred to on page 30), the imperative to bring ‘healthy’ snacks to class as well as consuming foods in ‘proper’ ways, also functions as a form of internalized surveillance. As a result, many of us as graduate students are compelled to bring ‘healthy’ snacks to class in order to be seen as a ‘responsible’ citizen and to consume them in socially appropriate time intervals.

So no matter how hungry we are, it would be inappropriate of us to eat junk food and/or 'scarf it down'.

Commonly referred to as "shame eating" (Narby and Phelps 2013; Gailey 2012), the growing emphasis on 'proper' or 'healthy' consumption habits (i.e., what and how individuals consume) is extremely paralyzing, and thus, indirectly forces individuals to eat 'unhealthy' foods in 'unhealthy' ways (i.e. 'scarfing it down', 'wolfing it down' and/or 'inhaling it') in secluded places where they are not being watched, monitored, and judged by others for making such 'irresponsible decisions'. In other words, the increased surveillance surrounding 'healthy' eating has led to the desire to retreat to private places where one is free to indulge and make 'irresponsible' choices unaffected by the surveillance of others. Therefore in treating the 'issue' of obesity, both biomedical healthism- what people consume- and holistic healthism- how people consume- combine to create a prescriptive notion of how to eat properly. From both perspectives, by emphasizing the association between the 'problem' of obesity and ill-advised eating, the obese individual is held accountable for their own misfortune. In turn, the obese individual's consumption patterns are monitored by others and themselves.

Within the context of the discussions on obesity (including the assertions concerning social constructions and shame and blame), both biomedical and holistic regimes foster and perpetuate the same restrictive notions of what constitutes a 'desirable' and 'healthy' life. While operative within neoliberal society, both biomedical and holistic healthism reduce a 'healthy' or 'desirable' life to a goal of 'non-obesity', infer associations between the obese body and various health 'issues' as well as morally perpetuate feelings of shame and blame.

Furthermore, so pervasive is healthism that we end up appropriating other cultures in the name of reaching optimum health. While the initial use of yoga practice originated from various Indian traditions, it was a sacred physically grounded set of practices which has increasingly been modified to suit our Western pursuit for ideal well-being. In summation, healthism is so pervasive, that we savagely appropriate other ways of living, such as yoga, into our selfish pursuit for health and well-being. Thus, through an emphasis on lifestyle intervention, corporations such as Lululemon and Moksha Yoga perpetuate both biomedical and holistic healthism by focusing on scientifically founded notions of bodily performance as a means to display social responsibility through the achievement of a fit body and disciplined mind (Lavrence and Lozanski 2014). Simultaneously, there is a cultural denial of indigenous health practices such as the above-mentioned example the 'thrifty gene'.

Additionally, the imperative to eat right (including *what* we eat as well as *how* we eat) functions as a mechanism of surveillance; but also as a prescriptive means of how we can achieve optimum health through the combination of biomedical healthism and holistic healthism.

Consequently, there are problems with the way in which biomedical and holistic healthism are seen as oppositional, or one as reactionary to the other. Thus, as previously suggested at the beginning of this chapter, this MRP contributes to the literature first, by asserting that biomedical healthism and holistic healthism are not oppositional, but rather, they occupy a continuum of healthism. Through an analysis of obesity, the MRP has illustrated that the end goal of optimum health provides the basis for the continuum,

while the processes of each type of healthism may be different but often supportive of each other.

The metaphysical ideal/ethos of healthism

Throughout this chapter theoretically, and grounded in autoethnography, this MRP argues that the original hypothesis that healthism is subsumed under biomedicine and holistic health is flawed. Instead, healthism as a continuum ranging from coercive healthism to holistic healthism has become a metaphysical ideal/ethos that permeates all aspects of daily life. From the time you awake and examine your bodily stool to determine whether it is appropriately curved (Chutken 2011) to the time that you go to sleep, there are health regimes that one must either follow or provide narratives for why one cannot adhere to them. Whether we verbalize the influence of the continuum of healthism upon our lives or not, it impacts our thinking and decision making on a daily basis. Thus, this MRP demonstrates the shift in healthism to a metaphysical status that subsumes biomedicine and holistic health as differing processes to achieve the same end goal—optimum health.

From a disability studies perspective, James Overboe (2007) introduces the concept of “normative shadows” (229).

Like most shadows, normative shadows cannot be grasped in a material way. They remain a feeling, a sense that one is constantly being judged according to differing criteria of normality. Like all shadows, normative shadows are elusive yet always present, simultaneously everywhere and nowhere. Yet, for those of us deemed as possible ‘states of exception,’ adhering to ‘normative shadows’ is a necessary pre-condition to maintaining a ‘political life.’ A similar feeling is expressed by Neil Marcus who states, ‘People are always watching me... (ellipses in original) they’re watching to see how well I do this thing...(ellipses in original) this thing called ‘human’”(Brueggemann, 2002:322, as cited Overboe 2007:229)

Applying the insights of the ‘normative shadows’ to healthism, the normative shadows of healthism cannot be grasped in a material way. They remain a feeling, a sense that one is constantly being judged according to the criteria of what constitutes ‘being healthy’ as defined within the continuum of healthism. Like all shadows, the normative shadows of healthism are elusive yet always present, thus exemplifying why the MRP employs the twin concepts of ideal/ethos. Yet for those of us deemed as possible “states of exceptions” such as disease, disability, or fatness, adhering to the normative shadows of healthism is a necessary precondition to be considered a productive citizen leading a ‘healthy life’. While Neil Marcus (as cited in Brueggemann 2002) articulates how, as according to Overboe (2007) the normative shadows create an ideal/ethos that pressures him to become human, the normative shadows of healthism similarly create the environment and the metaphysical end goal of striving for optimum health or “potential perfection” (Fitzgerald 1994:196).

CHAPTER 4: BEING HEALTHY THROUGH HEALTHISM

If healthism is so pervasive, what is the alternative for the individual's life? Perhaps we have to shift the focus from examining the individual to considering how healthism restricts an expression of life. Moreover, perhaps we have to critique the notion of 'being' that is associated with the restrictive notion of optimum health and instead, consider the concept of becoming/unbecoming. To achieve this goal, the MRP must first begin with unpacking and then critiquing the twin concepts of identity and representation.

Identity and Representation

With reference to a politics of recognition, the following section of the MRP will critically interrogate the limitations inherent within the approach to a 'healthy' life, or in other words, the limitations associated to the imposition of value and meaning of healthism upon the subject. In what ways does 'being healthy' as defined through the lens of healthism restrict the vitality of life? Furthermore, how do the concepts of identity and representation restrict the fluidity of a life expressed?

Differentiating between a 'politics of recognition' and a 'politics of imperceptibility', Elizabeth Grosz (2011) argues that a 'politics of recognition' regards subjectivity through the twin concepts of representation and categorization. Consequently, a 'politics of recognition' corresponds with the notion of 'being', which delineates a rigid approach to the idea of life and life expressed. Within a 'politics of recognition' a subject's identity is conceived through representation and thus, reduces the subject to the notion of 'being', as comprised of rigid social categories and their associated social and cultural meanings. While individuals may have multiple identities such as 'female', 'student', 'healthy', 'unhealthy' etc., these are exclusive categories

which the ‘other’ may invoke at any time, given the appropriate social or cultural context, thus reducing the subject to different identities. Addressing this reductionism as inherent within a ‘politics of recognition’, Gilles Deleuze and Felix Guattari (1987) use the term “social grid” to refer to the way in which the social body attempts to establish itself as a monolithic entity comprised of subjects with such multiple exclusive identities.

Speaking in the context of health, Nick Fox and Katie Ward (2008) present the notion of ‘healthy identity’ to convey how ‘healthy’ and ‘identity’ are mutually constitutive. They argue “health identities are features of the clustering of relations around specific aspects of embodiment, such as sport and exercise, body modification, disability or growing old” (1010). In this sense, Fox and Ward (2008) use the term ‘healthy identity’ to point to the way in which a subject’s identity as ‘healthy’ is largely defined by the embodiment of certain behaviours which others in turn codify and categorize as a ‘healthy identity’. Thus, their framework for the multiply constituted ‘healthy identity’ relies on preconceived social categories of embodiment and representation. Consequently, the ‘healthy identity’ reduces the subject to a master status and thereby functions as the primary identity marker on the “social grid”. Therefore the presence/absence of health identities can either constitute ‘being healthy’ or being ‘unhealthy’. Thus a master status of disability more often than not imposes an ‘unhealthy’ identity upon individuals (Overboe 1999).

Critique of identity

From a Deleuzian and Nietzschean perspective, the following section will provide a critique of the notion of identity in the context of healthism. As an illustration, Fox and Ward’s (2008) concept of ‘healthy identity’ highlights how the subject’s identity is

largely defined by representation and embodiment. In this sense, the notion of identity is reliant upon representation and categorization as is produced by readings of the *body*.

Addressing the interrelation between the identity and the body, Brian Massumi (1991) says

each person has a limited range of characteristics that he or she broadcasts through his or her body which then is either visually or aurally received by others. These aural or visual images are filtered through the receiver's preconceived categories of identity. Thus the body is a medium that helps define each other's identity (17).

In considering the implications for a disabled identity, in *Difference in Itself...* James Overboe (1999) argues that such approaches to identity and the body “devalue[s] both a disabled embodiment and sensibility” (17).

While speaking from the perspective of Disability Studies, Overboe's (1999) argument also pertains to the more general implications related to those identities considered to be deficient. In the context of healthism, the appearance of the body is largely related to the notion of being ‘healthy’ or ‘unhealthy’. Those identified as ‘healthy’ have bodies which *appear* ‘healthy’, while those identified as ‘unhealthy’ have bodies that appear ‘unhealthy’. While the obese body type is regarded as ‘unhealthy’ due to ill-advised eating and/or poor lifestyle choices (see chapter 1 and 2 discussion on obesity), these individuals are regarded as deficits. As such, the reliance upon the representation of the body prohibits ‘unhealthy’ obese individuals from being considered to be a ‘worthy’ or ‘proper’ citizen unless they can prove or have a narrative that gives them a legitimate excuse for their obesity. Applying Massumi's (1987) insights, the designation of being ‘unhealthy’ is an imposition on part of the ‘other’ onto the obese body and thus restricts the vitality of the obese individual's life expressed.

As an illustration of the degree to which the obese body type is regarded as deficient, Rodrigo Alves has spent over \$170,000 in plastic surgery fees in order to create a body image which mirrors the 'healthy' body type of the 'Ken' doll (Taylor 2014). Alves' actions signify his desire to resemble the ideal body type. Aside from leaving unchallenged the assumption that 'being healthy' is normal, Alves' surgeries were not an attempt to meet the criteria of what is considered to be healthy. His main concern was the way in which his body *resembled* 'being healthy'. As an example, Alves' demonstrates the degree to which resemblance, representation and the body are all important aspects of identity.

Alves' desire to undergo multiple surgeries—which nearly ended his life (Taylor 2014)—points to the extreme measures that subjects are willing to undergo in order to resemble a 'healthy' body type. This further illustrates how people internalize healthism, even to their detriment. Similarly, Fox and Ward's (2008) concept of 'healthy identity' attempts to find different ways to allow for multiply constituted subjects to also resemble being 'healthy. However, like Alves' multiple surgeries, Fox and Ward's (2008) position is dependent upon the normative idea that being perceived as 'healthy' is in fact a component of an 'good' life. Under Fox and Ward's (2008) paradigm of 'health identity', the body is read through a lens of health: a fat person can no longer be seen as 'fat' but is seen as 'healthy fat'. Such a position dismisses the way in which the very concept of 'health' is constructed and defined in particular ways that ignore differences in the vitalities of life expressed. While seemingly well intended, this attempt to redefine what constitutes 'healthy' is predicated by the normative idea that 'being healthy' is the ideal way to live. Consequently, life expressed is reduced to the normative conception of what

constitutes a 'good' life: being 'healthy'. Thus, any bodily, mental or spiritual difference is subsumed under the resemblance of 'health' which becomes the predominant discourse by which people are judged.

As apart of the 'politics of recognition', the desire to resemble the normative 'healthy' ideal is so pervasive that some scholars critiquing healthism paradoxically disavow difference in order to achieve sameness which leads to normality. For example, as previously discussed in chapter 1, Lauren Berlant (2010) argues that the conditions of Western society are extremely stressful and thus lead individuals to over-eat as a way to generate feelings of relief. Consequently, her argument attempts to provide an alternative narrative detailing the extenuating circumstances for why being obese is acceptable. As such, her position disavows fatness as a "difference in itself" (Overboe, 1999), and instead, attempts to provide a reasoning for why obesity, as the antithesis of being 'healthy', should be tolerated.

Similarly, the Health At Every Size (HAES) model as discussed in chapter 2 also attempts to disavow difference in order to achieve normality. While arguing that "good health can best be realized independent from consideration of size" (<http://www.haescommunity.org/>), the HAES model attempts to point to the way in which the obese individual meets the normative criteria for being 'healthy'. As such, this approach disavows the embodiment and vitality of being fat as constituted in their previous lives as being 'blimps', in order to demonstrate how these individuals are indeed normal in the context of healthism.

Speaking from the context of Disability Studies, Overboe (1999) argues that the attempts of disabled individuals to achieve 'person first' status functions in their desire to be seen as normative.

But our negation or inequality is equalized and extended because other disabled people fail to meet normative expectations that are deemed 'damaged goods' (Bauman, 1988). For those disabled people who fail to achieve this status there is a legitimization of their position because of the fairness of distribution. One has failed because one does not meet the legitimized basic standards required for acceptance into the 'people first' circle. The decision is not based on a discrimination against this particular person but a matter of 'objective fact'. The 'nautralness' of the notion of the able-bodied [or in the context of health, the non fat] liberal individual coupled with the negation of a disabled [fat] sensibility makes many disabled [fat] people queue for the chance to be anointed as 'people first' [healthy fat], while simultaneously disavowing their previous embodied position as 'gimps' and 'cripples' ['fat', 'blimp' and 'large']. Ironically, disabled [fat] people who achieve 'people first' status [a healthy at every size identity] are not achieving full normative status but are only legitimizing an able-bodied [healthy non-fat] resemblance through their desire for normality. Moreover, they reinforce an extension of the legitimacy of this resemblance by validating a continuum of disabled [healthy] persons ranging from the successful 'people first' [healthy at any size] to the pitiful 'gimps' and 'cripples' ['fat', 'blimp' and 'large'] who are deemed worthless failures (24).

Thus the HAES model and its attempt to include obesity as a 'healthy identity' may also be understood as an ironic move to reinforce and legitimize the normative ideal of 'being healthy'. Instead of challenging the notion that 'healthy' is normal and desirable, the HAES model attempts to change the discourse around obesity in order to prove that fatness meets the normative ideal of 'being healthy'. Such a position disavows their previous existence as 'fat', 'blimp' or 'larger' in order to be seen as normative. Similarly, Berlant's (2010) alternative narrative concerning obesity and stress eating as well as Fox and Ward's (2008) concept of 'healthy identities' all attempt to do the same thing: provide reasons as to why fatness should be considered normal and 'healthy'. As such, by disavowing the embodied position of fatness, all three approaches (HAES, stressful

eating and 'healthy identity') legitimize the healthy body resemblance through their desire for normality. Moreover, as articulated by Overboe (1999) by leaving unchallenged the normative ideal/ethos of 'being healthy' such attempts also validate a continuum or range of what is considered to be 'worthwhile'.

In one of his later papers entitled *Theory, Impairment, and Impersonal Singularities: Deleuze, Guattari, and Agamben*, Overboe (2012) discusses the way in which identity and representation disavow difference and also function as a method to manage such differences that remain. Citing Melissa McMahon (2005) he argues,

'The function of the concept of identity, as Deleuze presents it in *Difference and Repetition*, is that of "managing" difference'. Consequently, the notion of identity developed from the need to differentiate the disabled from the able people. Consequently, there are subcategories of disability, cerebral palsy, autism, psychiatric disabilities are representations and categorizations that fail to see the vitality of assorted impairments. The vitality of assorted impairment [or being obese] is discarded as it is deemed as detrimental to achieving the full status of personhood (116-117).

Applying his assertions to the context of healthism, the attempts to understand fatness as an extension of 'healthy' as normality, 'HAES' functions as a way to manage the difference inherent within fatness itself. As an illustration, Fox and Ward's (2008) 'healthy identity' can be regarded as extending the 'healthy' identity category to include fatness as a 'healthy' representation and categorization in such a way that fails to see the vitality of fatness. In direct accordance with Overboe's (2012) assertions concerning disability, 'healthy identities' discard the vitality of fatness that does not fit within the 'HAES' paradigm. Subsequently this negates a vitality of fatness.

In addressing the specific feminist attempts to refute the gender binary, Stephen Linstead and Alison Pullen (2006) write,

For both Judith Butler (1990) and Robert Cooper (1998), it is the performativity of the sexual labour of division that constitutes the gender binary, not the transparent recognition of the natural truths of physical bodies. The first means of deconstructing the gender binary is to cross it, as it reveals the auspices and tactics of its construction in the process of recognizing and responding to the transgression. Such crossing can be coupled with a physical transformation, assuming the body features of the other sex, but this, as we have noted, may have the effect of reinforcing the binary divide by simply effecting a changing of places which leaves the lines of demarcation relatively uncontested (1297).

In reference to Fox and Ward's (2008) 'healthy identities' and the HAES model as an extension of the conception of what constitutes 'healthy', Linstead and Pullen's (2006) argument points to the way in which these attempts to be seen as 'different yet equal' also paradoxically share the resemblance of sameness underneath. While the HAES and 'healthy identities' approaches attempt to argue that the fat subject is considered to be among the multiples of 'healthy identities', the concept of 'different yet equal' leaves unchallenged 'healthy' as an ideal normative, and instead fosters the sameness as inherent within the notion of 'healthy' itself. While HAES and 'healthy identities' are both attempts to legitimize fatness as 'healthy' and thus normative, they are predicated with the notion of sameness: the notion of 'being healthy' as defined within healthism. As such, the normative concept of 'being healthy' as defined within healthism is left unchallenged and continues to function as the ideal normative way of life.

Becoming/Unbecoming Beyond Restrictive Healthism

In addressing the claims put forth by Drucilla Cornell and Sara Murphy (2002) in *Anti-racism, multiculturalism and the ethics of identification*, Elizabeth Grosz (2002) distinguishes between a politics of recognition, and a politics of imperceptibility. While Cornell and Murphy (2002) seek a specific type of identity—one that is not some pre-given, fixed entity, but rather, one that allows the subject to imaginatively reform and

reconceive their own identity, Grosz (2002) argues that such a position fails to challenge the connection between ‘authentic identity’ and the demand for recognition (464). In turn, she highlights two constraints within Cornell and Murphy’s (2002) position, one of which emerges from within while the other reaches from without. From within, Grosz (2002) argues our internal structures of identification constrain our ability to have “imaginative take[s] on new images as part of [... our] self-representation”; and from without, she points to the limitations associated to the social order and its structure of recognition, which “requires the acknowledgment of value and worth—even dignity—from the other” (465). In turn, Grosz (2002) argues that this formulation can be understood within a politics of recognition, a Hegelian framework of desire whereby, “the subject can only become a subject as such through being recognized by another as a subject” (Grosz, 2010:465). From the perspective of ‘being’ healthy, the politics of recognition maintains that the hegemonic ‘Other’ in many ways, has the authority to set the parameters for what constitutes as ‘healthy’. For example, the biomedical expert uses technoscientific understandings of the body as a means to establish ‘objective’ parameters concerning health and well-being (see chapter 1). Consequently, within the context of healthism, the need to be ‘healthy’ is an internalized constraint, while the ‘objective’ parameters of what constitutes ‘being healthy’ are external constraints. As an illustration of the inner constraints, the growth in gym-use and mind-body-spirit yoga points to the degree to which healthism constrains the individual from within. Conversely, from without, objective parameters such as identification of risk or the interrelation between eating and ‘health’ is indicative of the outer constraints of healthism that are imposed upon the individual.

As an intrinsic feature of 'being', the politics of recognition not only problematically relies upon the concept of representation, but it also perpetuates a social aspiration to be read as authentic. For example, while searching to be recognized as authentic, the fat subject is confronted with resistance on part of others who do not see their representation of 'healthy' as legitimate. In turn, the legitimacy of the HAES fat subject as a 'responsible' and 'healthy' citizen is repeatedly called into question, and their only option for redemption is to turn to others to mimic their representation in order to be seen as legitimate. As such, working within a politics of recognition is extremely restrictive, and does not allow for individuals to create themselves anew. This will be further explored later.

In reference to this problematic positioning of identity within the framework of recognition, Butler (1997) asserts,

The link between survival and speakability is delineated in the speech that constitutes the inauguration of the self-denying and repentant homosexual into military ranks: I am not what you suspect me to be, but my not being that is precisely what I have become, thus, determined by my denial, my new self-definition (136).

In specific reference to the U.S. Congress policy that sanctions the use of the term homosexual within the military, Butler (1997) articulates the way in which the subject is caught in a literary trap: to respond to the value imposed by the 'Other' is to affirm what they have said, even if you are explicitly denying the claim, however, no response constitutes an act of complicity or tacit agreement, insinuating that you do not *dis*-agree with the value imposed by the 'Other'. In either case, the legitimacy of the subject's identity is dependent on the way in which the 'Other' conceives of their performance or representation. Applying Butler's (1997) insight to the notion of Fat politics, when an

individual is called fat with the underlying assumptions of ‘laziness’, ‘slothness’, or ‘being out of control’, they are caught in a similar literary trap. If they respond and say that they are in control or that they are a ‘healthy’ worthwhile citizen, in spite of their fatness (for example HAES), they are legitimizing the interrogator’s assertion by responding to them, because the conversation is restricted to the matter of being ‘fat’, and is not about being a legitimate citizen. And if they refuse to respond, they are implicitly legitimizing the assertion through tacit agreement. Consequently, the literary trap is set by the interpellation and assertion of fatness.

Speaking from the perspective of Disability Studies, Overboe (2012) cites Michael Hardt (2002) who argues

Exposed flesh is not transgression but scandal. In other words, exposure does indeed oppose and negate the norms of propriety, but its effect does not depend on that opposition as a support. Violation of the norm is not primary to exposure; the negation is secondary, an afterthought, an accident. It turns its back on the norm - that is its great offence. Exposure operates in ignorance of the norm, and thus conducts, in the only way possible, its real destruction (121).

Overboe (2012) continues, he argues that disabled people’s attempts to prove that they are ‘just like everyone else’ rest on the normative notion that being ‘able’ is the preferred and ideal way of living. He argues that this type of transgression in Disability Studies ironically supports the norm and dismisses the vitality of assorted impairments. Similarly, while arguments such as Berlant’s (2010) stressful eating as well as the HAES model attempt to transgress the norm and help liberate the persecuted identity of fatness, both of their arguments rest upon the normative conception that ‘being healthy’ is normal and ideal.

In order to render the ‘problem’ of obesity into a normative and ‘healthy’ identity, there are two responses: first, the transformation of fat individuals into thin individuals, and second, the promotion of a culture of fat acceptance. While initiatives such as Outland’s (2012) ‘intuitive eating’ and the HOSP and ‘Balance It! Getting It Right Balance!’ programmes are attempts to transform fatness into thinness, Berlant’s (2010) ‘stressful eating’ and the HAES model both attempt to promote an attitude of fat acceptance as ‘healthy’. While losing weight and fat acceptance aim to encourage an acceptance of obesity (including the narrative of extenuating circumstances such as ‘stressful eating’), such an acceptance is predicated by the underlying normative notion that ‘being healthy’ is itself desirable, and thus, attempts to situate fatness into this normative conception of life. As argued by Overboe (2012), Hardt (2002) as well as Linstead and Pullen (2008), these attempts to transgress the norm fail and instead, re-affirm the notion that being fat is unacceptable.

As previously mentioned, while attempting to transgress the norm, these attempts actually foster the norm due to the way in which they are continuously responding to the notion of ‘health’ as ideal. Consequently, the discipline of Fat Studies itself is theoretically situated in a position whereby fatness as is defined from their perspective, must always respond to the ideal/ethos of being ‘healthy’ as defined through healthism. In *Difference in Itself...* Overboe (1999) argues

According to Deleuze (1994:266) difference has been represented as opposition and limitation, which has led to hierarchical levels that have been counterproductive for people. For example, in his discussion about opposition and revolution, Deleuze (1994:268) writes, ‘Contradiction is not the weapon of the proletariat but, rather, the manner in which the bourgeoisie defends and preserves itself, the shadow behind which it maintains its claim to decide what the problems are’ (25).

In the context of healthism, fatness as articulated within the field of Fat Studies, is a state of being that responds to the ideal of being 'healthy'. By responding to the paradigm of healthism, Fat Studies maintains that it is oppositional (to the medicalized 'obesity epidemic' which is a derivative of healthism as demonstrated in chapters 1 and 2), but according to Deleuze, in reality, it is, upholding healthism. As such, Fat Studies positions fatness as the contradiction, or the opposition to 'being healthy'. Consequently, as articulated by Overboe's (1999) use of Deleuzian theory, such attempts to respond to the norm ironically promote and defend the norm itself. In the case of healthism, Fat Studies and its theoretical positioning indeed cultivates and preserves the ideal/ethos of 'health' as defined within healthism.

Earlier the MRP argued that the relation between representation and identity provided for violent conditions. Subsequently, the MRP agrees with Jean Baudrillard in *Symbolic exchange and death* (1993) that, "underscoring the celebration of difference is potential violence if individuals cannot prove that they are able to achieve the common currency of normality" (128), and authenticity. Therefore, while Fat Studies believes it is liberating the fat identity by responding to the ideal/ethos of 'healthy' as defined by healthism, in actual fact it is imposing normative meaning and judgment upon the expression of a fat life. Consequently, such attempts constitute a form of violence, which strips fat individuals of their agency.

From an identity perspective, obese individuals have only two options: either lose weight or use the alternative narratives such as HAES or 'stress-eating'. While seemingly progressive, this technique as advanced by Fat Studies is inherently violent. Drawing on Slavoj Zizek's (2008) book *Violence*, this tendency to impose identity is a form of

systemic cultural violence, and more specifically, a form of cultural violence dependent upon a politics of recognition which awards people who perceive themselves gatekeepers of various identity politics the right to impose identity (or lack of) upon fatness. In this sense, I do not blame Fat Studies for their approach; I blame the culture of the politics of identity which includes the politics of recognition. Consequently, the problem resides not on an individual level, but is a problem of the culture of 'being' authentically 'healthy' as defined within healthism.

In their article entitled *Violence of disablism*, Dan Goodley and Katherine Runswick-Cole (2011) argue that the culture of ableism is to blame for the violence inflicted upon and experienced by disabled people. Speaking from a Disability Studies perspective, they argue

violence against disabled people reflects a trenchant dimension of culture; in this case disablist culture [...] Violence experienced by disabled children and their families says more about the dominant culture of disablism and its effects upon the subjectivities of people, than it does of the acts of a few seemingly irrational, mad, bad or mean violent individuals (604).

Similarly, the desire of Fat Studies to render the fat identity as normative within the definition of 'healthy' as advanced by healthism also points to the precariousness of the way in which our culture is dependent upon a politics of recognition. Consequently, such attempts to impose identity upon fatness constitute systemic violence due to the way in which our culture as entrenched within a politics of recognition dismisses the vitality of fatness as a difference for itself and only recognizes as a legitimate 'fat' embodiment that which is accepted within the parameters of healthism.

Brief Considerations for Future Research

While it may seem that we are trapped by our cultural reliance upon rigid identities as advanced by a politics of recognition, there is another way of looking at the 'issue' of obesity and fatness. In opposition to the notion of 'being' and its related notions of identity and the politics of recognition, the process of becoming/unbecoming as initially advanced by Henri Bergson (1971) may provide for a more useful perspective from which to consider this troubling matter. Thus, in order to allow the conditions suppressed to flourish, the MRP will make a theoretical shift from 'being healthy' to becoming/unbecoming 'healthy', which, is argued to be constitutive to the affirmation of the expression of 'a life'. Thus the MRP will shift the focus of the argument to the notion of becoming/unbecoming and the politics of imperceptibility. Due to limitations of time and space, only theorists such as Gilles Deleuze and Felix Guattari and Elizabeth Grosz, and Michael Hardt will be considered for the following portion of this chapter.

Politics of Imperceptibility

While the last section of the MRP has critically discussed the limitations inherent within a politics of 'being healthy', the rest of the MRP will now focus on the notion of becoming/unbecoming 'healthy'. Instead of focusing on the ways in which people impose identity upon fatness through a politics of recognition, the MRP will now explore a politics of imperceptibility to articulate the ways in which 'a life' is expressed through the continuous process of becoming/unbecoming.

In opposition to the politics of recognition and the notion of 'being', Grosz (2002) draws on philosophers such as Friedrich Nietzsche and Gilles Deleuze, to highlight a politics of imperceptibility. For Grosz (2002) the politics of representation and

recognition are falsely considered to be products of discourses created by conscious beings with agency. Rather, Grosz (2002) points to and privileges prior assemblages whereby politics, subjectivity, and the social are understood as products of an interplay of the multiplicity of “active and reactive forces” (467) that often get reduced to the politics of recognition and identity. Grosz (2002) argues that while these active and reactive forces constitute the materiality of identity and recognition, such a reading limits the vitality of these forces. Grosz (2002) focuses on the notion of imperceptibility to articulate the need to shift our working assumptions in ways that do not resort to “the language and assumptions governing recognition” (468). In turn, she argues that we need to conceive of subjects as “modes of action and passion, a surface of catalytic events, events which subjects do not control but participate in, which produce what history and thus what identity subjects may have” (468). This approach to ‘life’ would break free from a politics of recognition, of the ways in which one represents themselves in authentic or non-authentic ways, and instead, focuses on privileging the processes, interactions, assemblages, behaviours, and situations in which the subject partakes (Grosz, 2002).

Given the differentiation between a politics of recognition and a politics of imperceptibility, Grosz’s (2002) analysis requires a theoretical choice to be made:

either we ascribe to a theory of the subject that strives to have its identity affirmed through relations, especially relations of desire, but also relations of identification, with other subjects, a subject that seeks the recognition of others and a place as a subject within culture [...] or we ascribe to a theory of the impersonal [...] in which inhuman forces, forces that are both living and non-living, macroscopic and microscopic, above and below the human, are acknowledged and allowed to displace the centrality of will and consciousness (470).


A politics of imperceptibility may allow for a life expressed to not be limited by the metaphysical ideal/ethos of healthism. By extension, and most importantly, a politics of imperceptibility inverts the emphasis on representation which a politics of identity and recognition imposes upon the subject. Instead of privileging notions such as identity, representation, and performance as constitutive of the subject, a politics of imperceptibility privileges the undetectable conditions of life itself as constitutive of the subject in a non-judgmental manner. This process can be considered the movement towards becoming/unbecoming.

Earlier this MRP suggested that the metaphysical concept of healthism not only subsumed biomedical healthism and holistic healthism, but with its emphasis on 'being' restricted life to a prescriptive notion of optimum health. The concept of becoming/unbecoming restores the materiality of a life expressed and frees it from the metaphysical imperative of healthism. Thus, healthism is restored as just one form of life among many expressed.

Further research might allow the author to look at healthism within particular populations with children, university students, aboriginal populations, etc. This research would be grounded through a focus on lives expressed, much the same as the research of the MRP has been grounded in an analysis of the vitality of fatness. This MRP has been a critique of healthism, but which answers the question how does healthism restricts the concept of life. However, the author wants to take it farther in order to consider what might be the alternative to a restrictive healthism. In future research, the author will delve into the works of Roberto Esposito, Giorgio Agamben and Friedrich Nietzsche, Michel

Foucault, along with Gilles Deleuze and Felix Guattari, Elizabeth Grosz and other theorists to further this examination of biopolitics, life and healthism.

Appendix A:



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Healthy Youth
All CDC Topics

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Childhood Obesity Facts

- Childhood obesity has more than doubled in children and quadrupled in adolescents in the past 30 years.^{1, 2}
- The percentage of children aged 6–11 years in the United States who were obese increased from 7% in 1980 to nearly 18% in 2012. Similarly, the percentage of adolescents aged 12–19 years who were obese increased from 5% to nearly 21% over the same period.^{1, 2}
- In 2012, more than one third of children and adolescents were overweight or obese.¹
- *Overweight* is defined as having excess body weight for a particular height from fat, muscle, bone, water, or a combination of these factors.³ *Obesity* is defined as having excess body fat.⁴
- Overweight and obesity are the result of “caloric imbalance”—too few calories expended for the amount of calories consumed—and are affected by various genetic, behavioral, and environmental factors.^{5,6}

Health Effects of Childhood Obesity

Childhood obesity has both immediate and long-term effects on health and well-being.

Immediate health effects:

- Obese youth are more likely to have risk factors for cardiovascular disease, such as high cholesterol or high blood pressure. In a population-based sample of 5- to 17-year-olds, 70% of obese youth had at least one risk factor for cardiovascular disease.⁷
- Obese adolescents are more likely to have prediabetes, a condition in which blood glucose levels indicate a high risk for development of diabetes.^{8,9}
- Children and adolescents who are obese are at greater risk for bone and joint problems, sleep apnea, and social and psychological problems such as stigmatization and poor self-esteem.^{5,6,10}

Obese Youth Over Time: Selected U.S. States

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Long-term health effects:

- Children and adolescents who are obese are likely to be obese as adults¹¹⁻¹⁴ and are therefore more at risk for adult health problems such as heart disease, type 2 diabetes, stroke, several types of cancer, and osteoarthritis.⁶ One study showed that children who became obese as early as age 2 were more likely to be obese as adults.¹²
- Overweight and obesity are associated with increased risk for many types of cancer, including cancer of the breast, colon, endometrium, esophagus, kidney, pancreas, gall bladder, thyroid, ovary, cervix, and prostate, as well as multiple myeloma and Hodgkin's lymphoma.¹⁵

Prevention

- Healthy lifestyle habits, including healthy eating and physical activity, can lower the risk of becoming obese and developing related diseases.⁶
- The dietary and physical activity behaviors of children and adolescents are influenced by many sectors of society, including families, communities, schools, child care settings, medical care providers, faith-based institutions, government agencies, the media, and the food and beverage industries and entertainment industries.
- Schools play a particularly critical role by establishing a safe and supportive environment with policies and practices that support healthy behaviors. Schools also provide opportunities for students to learn about and practice healthy eating and physical activity behaviors.


Key Resources


- [School Health Guidelines to Promote Healthy Eating and Physical Activity](#)
- [Child and Teen Body Mass Index Calculator](#)
- [Body Mass Index Measurement in Schools: Executive Summary](#)  [pdf 2.2M]
- [Children's BMI Tool for Schools](#)
- [Let's Move!](#)
- [More Publications & Resources](#)


Obesity

[Community Transformation Grants](#)

Contact Us:

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4770 Buford Hwy, NE
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Appendix B



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2174 Major Mackenzie Drive
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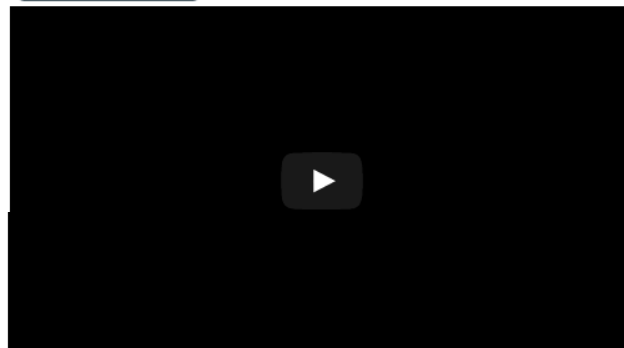
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Meditation Classes

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What is

alternative medicine? Also referred to as holistic health care, it is the practice of taking a person's physical, mental, and social conditions into account in the treatment of illness. Alternative health care focuses on achieving optimal health and vitality by determining and addressing the *root causes* of an illness versus simply treating the symptoms. Holistic therapies aim to strengthen the immune system, restore the balance of the various systems of the body, and help prevent disease. Holistic medicine treats all forms of health concerns and illnesses -- from pediatric to geriatric, from acute to chronic, and from physical to psychological. It is the approach, philosophy and training of alternative medicine practitioners that sets holistic healthcare apart from other forms of healthcare. Our team of Toronto alternative health and wellness practitioners is committed to providing integrated healthcare to all our clients, helping them on their healing journey while addressing all three aspects of our collective human existence: Mind, Body and Spirit. For more facts and statistics on Drug Free Health Care click the FAQ Page.

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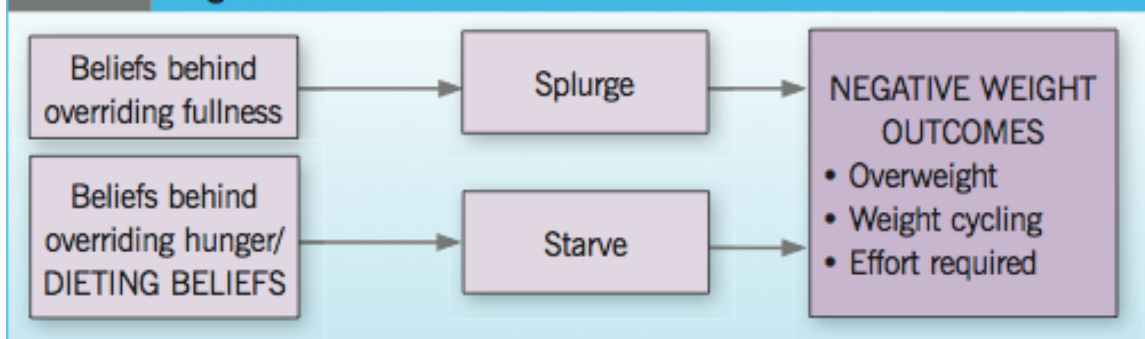


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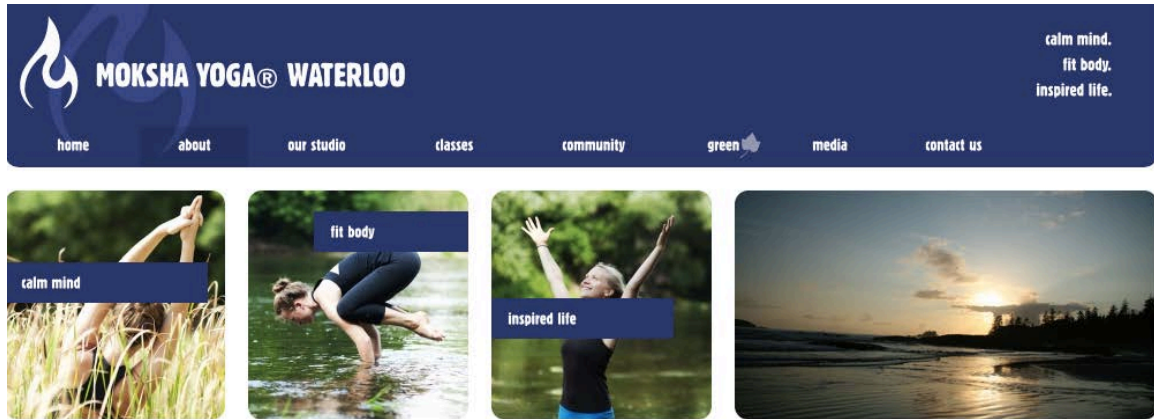
Appendix C:

Table 1 Relationships between beliefs and weight outcomes			
Beliefs	Behaviour	Outcome	
Any 'emotional' reasons	Overrode fullness	Weight cycling	RR = 1.82 (1.17, 2.83)
Any 'emotional' reasons	Overrode fullness	Expend effort	RR = 1.42 (1.12, 1.82)
'Eat like it was my last supper'	Overrode fullness	Overweight/obese	$\chi^2 (1, n = 188) = 5.20, p = .023$
'It was time'	Overrode fullness	Overweight/obese	$\chi^2 (1, n = 188) = 11.64, p = .001$
'Everyone else was eating'	Overrode fullness	Overweight/obese	$\chi^2 (1, n = 188) = 5.72, p = .017$
Any dieting reasons/hunger helpful	Overrode hunger	Weight cycling	RR = 2.00, 95% CI (1.26, 3.18)
Any dieting reasons/hunger helpful	Overrode hunger	Purging	$\chi^2 (1, n = 175) = 16.56, p < .0001$

Figure 1 Theoretical model showing role of beliefs and behaviours to negative weight outcomes



Appendix D:



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