

Deconstructing health and the un/healthy fat woman

Short title: Health and the un/healthy fat woman

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Abstract

Dominant discourses represent body weight as a consequence of lifestyle; equate 'fatness' with 'disease' and 'thinness' with 'health'. Consequently, 'fat' subjects become framed as lazy, and not willing to follow a 'healthy' lifestyle. In neo-liberal societies, where 'the autonomous, self-regulating individual' is highly valued, the above construction of 'fat' subjects appears particularly damning. The aim of this study is to explore how women who self-identify as 'large' or 'fat' negotiate their body-weight, health and neo-liberal credentials. To this end, interviews were conducted with 18 women and the transcripts were analysed using discourse analysis. We found that the constructions of health and well-being articulated by the women in our interviews were much broader and more complex than those re-produced in culturally dominant neo-liberalised discourses of health and body weight. While most participants positioned themselves as healthy, as well as knowledgeable about health, prevailing constructions of "fat is bad and unhealthy" were also re-produced such that participants often

struggled with the conflicting subject positions of the healthy and health-conscious ‘good neo-liberal citizen’ and the ‘fat’ ‘failed’ individual risking ill health. Drawing on our analysis, we assert that, regardless of who is right in debates about the putative health implication of ‘fat’, the current reductionist approach to health and the global ‘war on obesity’ are problematic and potentially harmful.

Despite the near ubiquity (LeBesco, 2009) of the notion that ‘obesity’ is caused by fat¹ individuals simply eating too much of the wrong types of food there is considerable academic and clinical debate over the causes of ‘obesity’. Theories range from the dualistic energy balance theory of “too much energy in – not enough out/used” to theories that posit obesogenic physiology and/or environment, depression or sleep deprivation as aetiological factors (e.g. Blaine, 2008; Egger & Swinburn, 1997; Hilbert et al., 2009; Sekine et al., 2002; Tataranni & Ravussin, 2002; Wells & Cruess, 2006). The discussion around the alleged health risks posed by ‘obesity’, however, seems to be less varied with the mainstream biomedical perspective, linking excess body weight to many adverse health conditions, being generally accepted as commonsensical truth both in clinical literature and day-to-day discourse (Campos, 2004; Cogan & Ernsberger, 1999; Gard, 2005; LeBesco, 2009). Put simply, culturally and clinically dominant discourses tend to represent body weight as a consequence of lifestyle and thus as an individual’s personal responsibility (e.g. Saguy & Riley, 2005; Throsby, 2007). They almost invariably equate ‘fatness’ with ‘disease’ and ‘thinness’ with ‘health’; and, despite considerable evidence to the contrary (e.g. Aphramor, 2008b; Berg, 1999; Campos, 2004; Ernsberger & Koletsky, 1999), promote weight loss as an efficient (if not the only) way to achieve or maintain health.

Whilst the importance of lifestyle for health is generally accepted, these relationships between weight and lifestyle (Gard, 2009) and weight and health (Lebesco, 2009; Kolata, 2006)) have been contested by a range of critical researchers and others who have argued that the view that excess weight is caused by inactivity and poor diet and that excess weight results *per se* in ill-health is poorly evidenced and often based on flawed research (Campos, 2004; Aphrapmor, 2005; 2008a). As part of the emerging field of fat studies, this article seeks to add to these critical

voices, by interrogating the current culturally dominant ‘collective knowingness’ about fat bodies which frames fat subjects as ‘lazy, not willing to commit to change or to the dictates of healthy living’ (Murray, 2005: 154-5).

In contemporary Western neo-liberal societies, where ‘the autonomous, self-regulating individual’ is highly valued, the above construction of fat subjects appears particularly damning and pernicious. The ‘ideal’ neo-liberal subject is “obliged to be free” (Rose, 1996, p. 17) but only to choose the *right* self-improving actions or in Foucault’s (1988) terms to apply appropriate “technologies of the self” “for understanding and improving ourselves in relation to that which is true, permitted, and desirable” (Rose, 1996, p. 153). The implication of this for health (and thereby body weight) are clearly set out in neo-liberalised health care policies around the globe (see e.g Lupton, 1996; Markula, Burns & Riley, S. 2008; Ogden, Clementi, & Aylwin, 2006) including the UK government’s policy statement ‘Choosing Health’ (DoH, 2004).

Small changes in the choices people make can make a big difference. Taken together, these changes can lead to huge improvements in health across society. But changes need to be based on choices, not direction. We are clear that Government cannot - and should not - pretend it can 'make' the population healthy. But it can - and should - support people in making better choices for their health and the health of their families. It is for people to make the healthy choice if they wish to. Choosing Health sets out what this Government will do to help them. (Tony Blair, foreword to 'Choosing Health', Department of Health, 2004, p. 3)

In this statement health and illness appear to be matters neither of nature nor luck. The role of a welfare state in creating and/or maintaining a population's health is rolled back and presented as a mere facilitator of individuals' health-determining lifestyle choices through means of education.

In the early twenty-first century dominant 'regimes of truth' (Foucault, 1989/1972; 1998/1978; see also Weedon, 1997) present health and ill-health as matters of individual lifestyle choice *and* as states that are determined and accurately indexed by body weight. Not only does fatness continue to be construed negatively as unattractive, particularly for girls and women (e.g. Bordo, 2009), and as a prominent signifier of ill-health, but the fat subject thus also appears as a failed neo-liberal citizen; framed as indifferent to, or ignorant of 'health truths' and/or as too lazy to engage in the technologies of self-improvement that are premised on those 'truths' and promoted by contemporary health promotion campaigns. Women seem to bear at least a 'double responsibility' here. Not only does the female body remain much more intensely targeted than male bodies (see however Monaghan, 2008) as an object of gendered aesthetic scrutiny whereby 'proper' femininity continues to be constituted in terms of bodily appearance, including crucially, the prescription of slenderness (e.g. Lupton, 1996; Malson, 1998; Markula et al., 2008; Orbach, 2006). But, in addition, women - as mothers - are also charged with a responsibility not only for their own health but also for the health of their children and spouses (Davies, 1998). As Foucault (1979: 104) argued, the production and regulation of the bourgeois family places

the feminine body in organic communication with the social body (whose regulated fecundity it was supposed to ensure), the family space (of which it had to be a substantial and functional element), and the life of children (which it produced and had to guarantee,

by virtue of a biological-moral responsibility lasting through the entire period of the children's education).

In contexts where health is so prominently construed in terms of body weight, this 'biological-moral responsibility' becomes a responsibility for all family members body weight. Indeed, as Kokkonen's (2009) analysis of talk about childhood 'obesity' clearly illustrates, the alleged 'failings' of mothers (much more than fathers) – including her 'excess' weight 'poor' eating habits, and 'unhealthy' lifestyle as well as her allegedly poor parenting - feature prominently in 'everyday' explanations of 'overweight' children. Analyses of men's talk about their own 'excess' weight (Tischner, 2009) illustrates a similar location of responsibility for health and weight with female partners. Thus, whilst men too are clearly targeted in the 'war against obesity' (Monaghan, 2008), women, we would argue, occupy a particularly exposed position in this discursive (battle) field both because the convergence of a moralised aesthetics of femininity with constructions of 'healthy' weight and because of the construction of woman as responsible for the well-being of all family members: their own 'excess weight cannot be so easily deemed the responsibility of another. Whilst the neo-liberalisation of health (Ogden, 2006) renders health (and therefore body weight) as the responsibility of the individual, ostensibly regardless of that individual's gender, the production and regulation of that 'responsibility' will nevertheless, we would argue, be read in articulation with these longer-standing constructions of women as IDAELLY SLIM AND AS responsible for family well-being AND THEREFORE FOR OTHERS' AS WELL AS THEIR OWN BODYWEIGHT.

The aim of this study is therefore to explore how, in such a seemingly hostile discursive environment, women who self-identify as ‘large’ or fat negotiate their body-weight AND health IN THE CONTEXT OF THE (GENDERED) NEO-LIBERALISATION OF HEALTH.

Research Method

The analysis presented in this paper is drawn from a broader critical psychological exploration of ‘being large’ (Tischner, 2009; 2010) involving a discourse analysis of semi-structured interviews conducted with 18 women in which participants were asked to discuss their views on and experiences of ‘being large’. The interviews lasted between 40 and 100 minutes and were carried out in participants’ homes or at the University of the West of England, Bristol. Each interview was digitally recorded, transcribed verbatim² and anonymised with pseudonyms given to participants. The interviews covered a range of issues including identity, relationships and lifestyle issues such as clothing, activities and socialising but the analysis presented here focuses specifically on the ways in which participants negotiated the seeming dilemma of ‘being large’ in the context of neo-liberalised healthism.

Participants

The participating women, aged between 23 and 48 years, were recruited via leaflets distributed through plus size clothes shops in the South West of England, and through a press release resulting in a newspaper article and a brief radio interview. The women came from a variety of backgrounds, with diverse levels of education, employment status, relationship status and sexual orientation. Nine self-identified as white British, two as British, one as white, and one each as ‘Church of England, English’, white other, Black Caribbean, white European and of mixed ethnic background. Nine participants were married, five were single, two were divorced, one was

engaged and one participant had two partners. Eight were full-time employed, four part-time employed, one unemployed; two were housewives, two full-time students and one a full-time carer. All participants self-identified as 'large'.

Analytic framework

The interview transcripts were analysed using a broadly Foucauldian approach to discourse analysis (e.g. Willig, 2008). For Foucault, discourses are historically and culturally located, dynamic webs of statements which are interrelated with other statements (Foucault, 1989/1972). Within these discursive fields knowledges and realities are viewed as discursively constructed, and the types of discourses available shape and delimit what can be said and by whom (Parker, 1992). Hence, for Foucault knowledge and power are joined in discourse. Knowledges, or 'regimes of truth', are constituted in discourse, which in turn creates fields of possibilities for acting, being and knowing.

The subject in post-structuralist theory is understood as constituted and regulated in discourse, and through dynamic and 'power-infused processes of embodied subjectification' (Papadopoulos, 2008, p. 143). This means that whilst the availability of certain discourses produce particular possibilities of 'doing' and 'being', subjectivities are not only imposed and either accepted or rejected but produced and reproduced through embodied experiences within these fields of possibilities (cf. Papadopoulos, 2008; Smith, 1990). In Foucauldian discourse analysis (FDA) we thus investigate not only what discourses are available to and deployed by individuals but also explore what Ian Parker (1997) calls the micro-level that is how these discourses are used and how subjectivities are produced within them.

The discourses FDA examines are constituted through the articulation of statements, and the relations between these statements (rather than, necessarily, through any direct interaction between speakers). As Foucault (1989/1972) puts it, the respective authors of the statements need not be aware of the relations between their own and others' statements, neither do the authors need to know each other, or even be aware of each others' existence. As such the instances of discourse we investigate will always only be fragments of the shifting and dynamic, discursive field to which they belong. Hence, the relations that form that discursive field are always only provisional, never fixed (Foucault, 1989/1972). The aim of FDA is therefore to locate statements within discursive fields and explore their relations with other statements, the knowledges, regimes of truth and power-relations that are constituted within these discursive fields and the subject positions and ways of being that are thereby constructed and made available (cf. Malson, 1998; Malson, Schmidt, & Humfress, 2006).

The procedural steps involved in FDA have been variously described elsewhere (Willig, 2008; Wetherell, 2001). Briefly, however, the process involves first, a close reading and re-reading of the transcripts; identification of dominant themes, issues, objects and subject positions, and a systematic coding of the transcripts followed by a more detailed analysis of the categories of coded data. In the following analysis we will concentrate on the discursive constructions of health, lifestyle and neo-liberal citizenship and on the ways in which 'large' women, negotiate the gendered tensions between these constructions and their always-already 'spoiled identities' (Goffman, 1968) as fat women.

Analysis

In the following analysis we will therefore, explore the constructions of health articulated by these women and at the ways in which these are deployed to position the women as sometimes both healthy and health-literate, but also at times, as unhealthy and hence as 'failing' in neo-liberal citizenship. In doing so we seek to explore the complex and dynamic 'regimes of truth' that function in the interstices between the (gendered) discourse of neo-liberalism and the (orthodox and alternative) discourses of health in the production of 'fat' women's subjectivities.

Re-constructing health

Health and being healthy were constructed in the interviews as important and as something the women we interviewed took seriously:

Jemima: I think there is a lot of perception that if you are bigger you can't be healthy while I know that's that's no I know some people who eahm are quite big and yet they'll run a couple of miles a day and eham do exercises I mean I walk a lot eehm I've got a little steppy type machine over there [. . .] I mean I can't remember the last time I added salt to anything, probably about 20 years ago because I don't like the taste of salt [. . .] I try and make sure I have my five plus portions a day fruit and veg like we are like we are told to.

Sue: I'm sort of *fully* aware of what I need to eat and I *do* on the whole eat a pretty good diet uhm you know I'm a lot healthier than some people who are *not* 'obese' that I know you know, I, you know, I have very good resistance to disease, I *don't* get bugs that everybody else gets.

In the above extracts, medical and, more particularly health promotion discourses are drawn on by Jemima and Sue to underline the seriousness with which they take health and healthy lifestyles. Borrowing from prevailing health promotion discourses, they construct health as something one can achieve by eating a healthy diet and by exercising. Sue also borrows from medical discourse in constructing health as a “good resistance to disease”, and thus further defends herself against commonly held assumptions that fat people cannot be healthy. The women in our study generally positioned themselves as ‘knowing’ about health and as healthy, indeed, as equally if not more healthy than “people who are *not* obese”. The reductionist equations of ‘slimness with health and of fatness with ill-health are thus, at least implicitly rejected both for the participants themselves and for other fat individuals.

This is further illustrated in the following extract taken from the interview with Samantha:

Samantha: To me the connection between weight and health isn't necessary straightforward, it's not necessarily the case that someone fat is unhealthy, and someone thin (is), I think it's more complex and I wish to God that (.) the discussion around 'obesity' would be a bit more complicated that we recognize that (.) you know, someone who is fat (.) or overweight, you know, who doesn't smoke, who doesn't drink that much, who eats a really healthy diet and takes regular exercise is probably far more healthier than someone who *looks* (.) slim but, you know, is a couch potato who never moves, who

smokes 25 a day, drinks loads of beer and eats everything deep fried but the discussion doesn't seem to acknowledge *that* complexity whatsoever.

Similarly to Sue and Jemima, Samantha employs the discourse of health promotion to construct health as lifestyle-related and thereby positions herself as 'health-literate'; as knowing about currently dominant health truths. At the same time, however she questions the relationship between health and bodyweight. By emphasising the multiple aspects of 'good' and 'bad' lifestyles, she construes the equation of fat with poor healthy as exasperatingly simplistic, 'wish[ing] to God that the discussion around 'obesity' would be a bit more complicated'. In all three extracts, as in interviews, health is constructed as multi-faceted and as considerably more complex than a simple weight-issue, whereby all fat women would be constituted as always-already unhealthy.

This construction of 'health' as more than a issue of weight/diet is taken further still in the following quote where Charlotte construes health as a matter of holistic well-being that exceeds biomedically informed constructions of health as a physical state:

Charlotte: Creating a lifestyle that is good for, for my health my mental health which also impacts on my physical health [. . .] I mean, even not necessarily to do with eating or you know, adopting exercise anything like that, because those (.) I mean I've exercised throughout my life, you know, I was a very active kid, and uhm (.) I uh (.) was a synchronised swimmer [laughs] when I was a little girl and you know, throughout my teens I was swimming and riding my bicycle and you know, I still do those things, that's been a

constant throughout my life and I love to go out dancing and you know, I'm pretty active so uhm (.) I don't think about health changes in (.) in those kinda terms but uhm (.) but, yeah, changes that I've made for my mental health are things like thinking about my future, going to do another masters degree to, you know, invest in my future, my future career (.) I I guess the, the lifestyle things that concern me the most are how to (.) have more of an income, how to, you know, develop my work those are the things rather than whether I'm eating the right food or exercising, cause I feel like (.) I eat o.k. and my exercise life is (.) is alright, too you know (.) yeah.

Rearticulating current common health advice to keep active (Department of Health, 2006; Shaw, Gennat, O'Rourke, & Del Mar, 2006; South Gloucestershire Council, 2006), Charlotte, above, employs health promotion discourses to position herself positively as healthy. and physically active. Like other participants, she thus resists the culturally prominent subject (im)position of the unhealthy fat person and, simultaneously, troubles the construction of physical health as *the* index of wellbeing. For Charlotte 'health' should encompass not only a healthy body but also her mental health, and thus involves lifestyle issues such as financial security as well as body-maintenance. In this context health (or well-being) appears as holistic rather than as a discrete (and narrowly defined) function of diet and exercise. At the same time, however, the neo-liberal discourses of individual accountability for— albeit holistic — health are reified: Charlotte clearly positions herself as a good neo-liberal citizen, taking responsibility not only for her physical health but for her general wellbeing — her mental health, financial security and career development.

'Healthy' fat embodiment and neo-liberal citizenship

While the above construction of health as complex and holistic was articulated by all our participants, the subject positions these women occupied varied considerably and shifted, often contradictorily, within each participant's account. While participants often took up a positively construed subject position of the physically active healthy eater, and the good neo-liberal citizen they also often portrayed their bodyweight as an index of current or future illness. In the two extracts below these contrasting constructions are articulated together.

Yvonne: I go to the gym, I swim, I can do twenty-odd lengths no problem, I get on the rowing machine I'll cycle a mile, so, and my heart recovery rate is good, so *yes*, I'm sort of eighteen-plus stone (.) but in that respect I feel that I'm physically quite healthy so when I look at sort of text books, research articles, the media and say right 'obesity's the main cause of this that and the other I think well actually, *yes* it maybe, but it's not the whole picture because I think it- you know, I'm not trying to fool myself that I'm not going to get cancer or diabetes or whatever down the line (.) but I think actually my general health, if you look at it holistically, *yes* 'obesity''s a factor but I *don't* smoke I *don't* drink and everything else is fallen in line but but I think it does need to be taken holistically

Jenny: Um (.) the 'obesity' epidemic kind of stories (.) I don't know I feel, I guess I feel a bit conflicted 'cause I, I you know I know how comfortable I am um but I'm not sure that (.) I'm not sure it's necessarily a good thing to be fat you know it's kind of like (.) [sighs] I don't know how um (.)

Similarly to those extracts discussed above, Yvonne draws on a discourse of health promotion to construct her own health as good, while Jenny construes herself as comfortable with her body size. However, in both extracts a conflict is evident between this image of the ‘healthy’ and comfortable fat subject and the culturally dominant construction, drawn from “textbooks, research articles, the media” and “obesity’ epidemic kind of stories” of ‘excess’ weight’ as both index and cause of disease and early mortality. Jenny reflects on this conflict directly and by expressing uncertainty – she is “not sure it’s necessarily a good thing to be fat” whilst for Yvonne the equation of fatness with ill health is articulated as a self-evident truth: to doubt it would amount to “fooling” herself.

These accounts can be interpreted as illustrating, in part, the imperialising power of medical discourse to colonising and pathologise bodies to the extent that we may no longer trust embodied feelings of well-being or ill-health 'but rely instead on medical knowledge' of the body (Illich, 1976; cf also Skolbekken, 2007). While participants drew on medical and health promotional discourses to position themselves as ‘healthy’, they were also interpellated by those same discourses as unhealthy fat individuals. This, we would argue, is a particularly hard trap to avoid because fat people are so frequently construed as stupid, ignorant and uneducated (e.g. Cordell & Ronai, 1999; Puhl & Brownell, 2003) – as health illiterate as well as unhealthy. TV ‘documentaries’ – for example, in the UK, “You Are What You Eat” (Channel 4), “Diet Doctors” (ITV) and “The Biggest Loser” (ITV) repeatedly portray fat people as ignorantly making the wrong choices about food and therefore as needing expert help to achieve weight-loss and improved health. But how are accusations of ignorance (about health truths) to be

countered without re-producing those very truths which produce the fat person – and, arguably, fat women in particular - as failing in both health and neoliberal citizenship?

The equation of fatness with ill health clearly constitutes a highly prominent aspect of contemporary western cultures' "general politics of truth" (Foucault, 1991, p. 73) which shapes and delimits the types of discourse which 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.

As the extract below illustrates, participants rejected constructions of themselves as stupid or ignorant in a variety of ways, for example by highlighting their higher education and well-paid jobs. But in the current climate of neo-liberal healthism this also seemed to entail participants demonstrating their knowledge of 'health truths', making it particularly difficult to avoid re-producing the 'truths' that fatness is unhealthy and a consequence of diet.

Sue: It's not as if we're (.) uneducated people either I mean this is a big problem that that people would stereotype, if you're fat, you're stupid and we, all the friends I've got who are overweight, (my friends and) myself all are all people who've got degrees and got or have had well-paid jobs uhm you know and we fully understand and could, can *read* the literature, and we fully understand what we should eat and what we shouldn't eat.

In the accounts above, (pp. –xx-xx) participants managed their spoiled fat identities (see Goffman, 1968) by constructing health as complex, multifaceted and not reducible to body weight. Similarly, here, Sue rejects a negatively construed fat subjectivity. She rejects the subject position of the uneducated and health-illiterate fat person by positioning herself and her friends as educated, informed and successful individuals who “can *read* the literature”, understand health issues and know what they should and should not be eating. Arguably Sue achieves a construction of herself and her friends as intelligent, educated, health literate and (implicitly) as eating healthily. But arguably, too, she opens the door to ‘knowing’ that fatness and ill-health are caused by poor diet. That is, to position herself as health literate whilst avoiding the construction of herself as unhealthy involves balancing a demonstration of knowledge of current health truths with an assertion of alternative counter-truths about health, body-weight and/or lifestyle.

Like Charlotte in the following extract most of the women in our study thus positioned themselves as active and *critically* knowing agents in regards to knowledge of health and healthy lifestyles.

Charlotte: I tend to question quite a lot of things that I’m told and try and make up my own mind about it I try and (.) really look at my body (.) and (.) acknowledge and notice what it’s capable of, how it, how I’m feeling, what *I need* so uhm (.) for example I know that for my mental health it’s really good for me if I go swimming once a week so (.) so I do that.

In Charlotte's account here health literacy is demonstrated through re-articulating current health truths about the health determining nature of lifestyle but, at the same time, 'health' is again (see also pp. -xx-xx) constituted in holistic rather than narrowly defined physical terms and Charlotte's emphasis on attending to how her body feels and 'what it's capable of' stands in contrast with Yvonne's and Jenny's more medically imperialised accounts above (pp. -xx-xx) of living healthy lifestyles and feeling healthy and comfortable but 'knowing' that fatness is unhealthy. Charlotte constitutes her own embodied experience (as well as popular and institutionally sanctioned health 'truths') as a valid source of knowledge about health. Rather than demonstrating knowledge of health truths by 'doing what you're told' (see p. x), Charlotte positions herself as 'question[ing] quite a lot of things that [she's] told and try[ing] and make up [her] own mind'. And in doing so, empowers and enables herself to challenge prevailing discourses on fat, related health risks and recommended health practices, construing herself as the (only) expert on herself and thus as knowing best what is good for her physical and mental health.

Discussion

The multiple, dynamic and contradictory subject positions that were variously taken up and rejected by our participants draws attention, we would argue, to some of the limitations and dangers of current 'anti-obesity' orthodoxies,. Regardless of who is right and wrong in debates about the putative health implication of fat (see e.g. Blair & LaMonte, 2006; Campos, 2004; Campos, Saguy, Ernsberger, Oliver, & Gaesser, 2006; Cogan & Ernsberger, 1999; Ernsberger, 2004; Gard, 2005; Kim & Popkin, 2006), the current reductionist approach to health in the global

‘war on ‘obesity’ is, we would argue, problematic in targeting an over-simplistically defined ‘problem’ group (see Campos, 2004; Gard 2005) with a hyper-individualised and rather narrowly defined concept of health (Ogden et al., 2006) that is problematically indexed to body-weight (Campos, 2004; Gard 2005).

The constructions of health and well-being articulated by the women in our study are much broader and more complex than those orthodoxies, re-produced in neo-liberalised and bio-medically oriented discourses of health where health is constituted as a physical state - reduced to the absence of medically diagnosable disease – and equated with thinness/slimness. . By constituting health in alternative terms – as an holistic state of well-being – and by questioning body weight as a simple index of health, our participants frequently positioned themselves as healthy and health-literate, Yet prevailing constructions of fat as bad and unhealthy were also re-produced such that participants often struggled with the conflicting subject positions of the healthy and health-conscious ‘good neo-liberal citizen’ and the fat ‘failed’ individual risking ill health.

The appearance of this latter negatively constructed ‘fat self’ clearly re-articulates culturally dominant views of fatness (Gard, 2009; Lebesco, 2009; Campos, 2004) and was, we have argued, made all the more likely by the neo-liberalisation of health where, first, health is constituted as a matter of individual responsibility for lifestyle choices (Ogden et al., 2006) and, second, good neo-liberal citizenship requires knowing and adhering to current ‘regimes of (health) truth’. For our participants, then, demonstrating good neo-liberal citizenship risked them articulating those ‘truths’ that would constitute them as unhealthy, and health-illiterate (and

thereby also as failing in neo-liberal citizenship as well as health terms). And, as noted above, this risk can be viewed as a gendered risk in that women - rather more than men – are charged with a responsibility for the (especially physical) well-being of the family (Davies, 1998; Foucault, 1979). As women, our participants arguably had less scope than ‘fat’ men might have had to shift responsibility for their ‘excess’ weight onto someone else such as a female partner ‘responsible’ for providing the family’s or couple’s meals.

The women in our study clearly resisted constructions of themselves and other fat people’ as unhealthy or health-illiterate but at the same time often struggled to reconcile their lived, embodied experience of health with dominant discourses that positioned them as fat and thus unhealthy individuals (see also Tischner & Malson, 2008). However, constructing the fat self as both healthy and health literate, was, we have suggested, more sustainable when dominant constructions of health were challenged and reconfigured as a socially located holistic state of well-being that could be known through embodied experience.

As Elspeth Probyn (2008; 2009) points out, bodies and experiences such as ‘being fat’ are embodied and are located in cultural, societal and economic contexts, and cannot be adequately considered in contextually isolated or static ways. Julianne Cheek (2008) further argues that the more we know about health, the more we are aware that there is something else to worry about, such that perfect health is unattainable. She calls on us to therefore question our largely unchallenged assumptions about health and health care practice. We would similarly argue a need to move away from an individualised body-weight-focused approach to health towards a more life-inclusive model focused on the well-being of the nation – whatever their size.

There are also clear parallels here between our study and the findings by Davies (1998) and Throsby (2007) in as much as both Davies and Throsby also highlighted the complexities of fat individuals' negotiations of their fat subjectivities in a healthist and anti-fat environment and of the gendered dimensions of this discursive field. Our study builds on these by highlighting the discursive struggle of fat women to resist dominant constructions of 'the fat woman' as a doubly 'spoiled identity' through the deployment of alternative constructions of health. Surprisingly, the women in our study rarely mentioned or even alluded to the gendering of body weight and weight management or to their roles as mothers or wives. Whilst women are clearly constituted as agentic neo-liberal subjects in western societies, and made responsible for their own, individual health choices in line with dominant expert knowledges, their neo-liberal citizenship, is cross-cut with heteronormative 'ideals' of (post-feminist) femininity in which beauty continues to be equated with thinness/slimness (Gill, 2008; Malson et al., 2011; Ringrose and Walkerdine, 2008). And, as noted above, it also entails responsibility for the care and well-being of children, husbands and other family members (e.g. Petersen & Lupton, 1996). Men, in recent years have experienced an increased scrutiny of their appearance, embodiment and health, (e.g. Petersen & Lupton, 1996); with a focus on a strong, muscular physique (Monaghan, 2008;) and a neo-liberalised responsibility for their own (but generally not others') health. The absence of talk about gender in our interviews is therefore perhaps rather surprising and may have been an artefact of the interviewer being a woman, perhaps creating a sense of shared – and therefore unspoken – knowing about gender but it nevertheless constitutes a limitation of this project.

At the same time, however, gender was arguably an unspoken presence in our participants' assertions of alternative constructions of health. Their talk about health and wellbeing entailed a discussion of life generally - housing, work, financial security, leisure time, self-expression, and so forth. Well-being was constituted as the achievement

encompassing life in general rather than of narrowly defined medical ‘health’ and choices had to be made in achieving or attempting to achieve that well-being. Body weight was frequently not the main priority. As Nicolson (2002) has argued, to be a ‘successful’ woman today – as clearly the majority of our participants were – often involves juggling career, housework, childcare, relationship maintenance and appearance-enhancement such that ‘having it all’ becomes ‘doing it all’, leaving no time for the less-than-absolutely necessary. Within this context, that our participants’ often did not prioritise weight-loss might be read as indicating an untenably pressured life and/or as a ‘feminine’ self-sacrificing of health and beauty (in favour of others’ priorities) but, we would argue, this might also be read rather more positively. Our participants barely mentioned gender and challenged neither neo-liberalism nor the prioritisation of health/well-being. But, as Foucault has argued:

We must make allowance for the complex and unstable process whereby discourse can be both an instrument and an effect of power, but also a hindrance and a stumbling-block, a point of resistance and a starting point for an opposing strategy. Discourse transmits and produces power; it reinforces it, but also undermines it and exposes it, renders it fragile and makes it possible to thwart it (Foucault, 1981: 101)

That is, our participants perhaps did not so much counter ‘head on’ but rather ‘work’ the stumbling-blocks of neo-liberalised healthism. Their de-prioritisation of their bodyweight in pursuit of their own – and others’ – more holistically defined wellbeing might illustrate a cheerily remarkable power to challenge the culturally-abjected subjectivity of ‘the fat woman’

produced by neo-liberal, healthist orthodoxy with an arguably preferable construction of health as a pragmatically constituted construction of socially located well-being.

Notes

1. The adjectives ‘fat’ and ‘large’ are used throughout this article instead of ‘obese’ or ‘overweight’ or any other descriptor, as the majority of the participants in our research seemed to deem these terms acceptable. Terms such as ‘obese’ or ‘overweight’ denote diseases and are used within the bio-medical and other mainstream academic literature. Our participants’ preference for ‘fat’ and ‘large’ mirrors the use of such words within the field of fat studies, but also reflects one way of rejecting the subject position of the ‘obese’ and thus pathological, individual.
2. Transcription conventions
[laughing/laughter] spoken while laughing
[...] omissions from the transcript
[name] passages (e.g. names) anonymised by researcher or additional explanations that are not part of the original interview
(.) pause
() inaudible or unclear passages, so the accuracy of the transcription is not guaranteed
do – Italics denote words/phrases that were emphasised/stressed by the interviewee
// - interjections

= denote beginning and end of overlapping speech or if there was no break between the two speaker's utterances

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