Healthism and the Bodies of Women: Pleasure and Discipline in the War against Obesity

Talia L. Welsh
University of Tennessee at Chattanooga

Healthism and the Bodies of Women:
Pleasure and Discipline in the War against Obesity
Talia L. Welsh, University of Tennessee at Chattanooga

Abstract: This paper explores how the discipline required for good health influences female embodiment. It examines the justification in the United States for a war against obesity and the criticism of that war made by Health at Every Size (HAES) proponents.[1] It finds that a "good-health imperative" operates within both the fight against obesity and the size-acceptance movement. I question how such an imperative curtails the range of possibilities for pleasure. The self-monitoring required in eating and exercising for health demands a constant reading of one's behavior as good/healthy or bad/unhealthy. In addition, attention to health achieved through behavior modification draws focus away from underlying socioeconomic issues. I posit that a feminist position on the war against obesity clearly argues against a focus on weight, but that the larger issue of behavior modification for health remains much more difficult to solve.

Introduction

Fat women occupy a nebulous space in contemporary ethical discourse.[2] Equating the value of a woman with her appearance clearly violates contemporary standards of academic research. Even in everyday discussions, it would be rare to enter a college classroom in the United States and find a group of students who were unaware and unable to discuss how the contemporary obsession with a highly managed and typically quite thin body has been deleterious to women's psychological health. The exclusive and narrow model of beauty is the material for many a talk show and popular magazine article. Yet, one can simultaneously support the concept that Americans, and increasingly the rest of the world, are too fat, even if one remains critical of the assumption that thinness is required for attractiveness. Significant differences exist on what should be done about the growing girth of Americans. Should unhealthy foods be taxed? Should health insurance be more expensive for the overweight and obese? Should children be made to exercise more at school? In any case, the idea that something *should* be done remains.

The ability to reject the demonization of fat in one context and to accept fat's negative status in another is based in the idea that one view of fat (the bad one) arises from sexism and that the other (the good one) arises from a concern about health. It is wrong to equate a woman's value with her looks, but it is acceptable to encourage that same woman to lose weight if it would augment her health. Thus, while many feminists are sympathetic to canonical works where dieting for "looks" is seen as a practice that encourages demeaning and sexist views of women (Beauvoir 1989; Bordo 2004; Heyes 2007; Lintott 2003; Orbach 1986, 1998, 2009), the same feminists might agree that monitoring weight through behavior modification is positive for women.

For instance, such concerns have caused Rosemarie Tong (2004) to argue that despite risks to the

infringement of individual rights, concerns about body image, and a weight-obsessed population, the costs of an increasingly overweight society justify certain initiatives to help reduce the size of Americans. Tong supports "common-sense" approaches, such as legislation that bans soft drinks at schools, funds nutrition education, subsidizes walking and bike paths, and provides tax incentives to employers that allow for fitness breaks (53). Tong writes that the culture is unhealthy in its excessive overconsumption of all things, including food, and possesses a desire for quick and easy solutions to complex problems. While she makes a passing reference to the epidemic of eating disorders as tied to unrealistic beauty ideals in young women, she does not think that gender is the primary factor in the need for better public health.

In this paper, I consider the effects on female embodiment of theories that encourage behavior modification designed to improve health. I examine how attention toward health, instead of appearance, has shifted attention away from feminist concerns about the objectification of women toward seemingly gender-neutral concerns of proper nutrition and adequate exercise. First I examine two sides of the controversy over weight. One of them is the "good-health imperative" side, which I have divided into two camps. The first is the "anti-fat" camp, which is by far the largest and loudest. This camp encourages viewing fat as an enemy to be conquered in the populace. I will explore the research and public policy proposals surrounding the need to engage in weight monitoring and weight loss (CDC, "Strategies"; Park 2007; Satcher 2001). The other camp, the "health at every size" movement, is composed of researchers who are critical of the focus on weight as a barometer of health (Bacon 2008; Gibbs 2005; Kolata 2007; Mitchell and McTigue 2007; Oliver 2006). This camp investigates how the fear of fat may be unjustified and, moreover, dangerous. It suggests that public health policies designed to curtail weight are more likely to cause poorer health than to improve health.

However, both sides of the debate about weight are allied in their focus on the goal of policy to be better health. This "good-health imperative" argues that our modifiable behaviors should be directed toward improving our physical well-being for our own good, as well as that of others. I argue that close attention should be paid to the actual and possible products of such a seemingly innocent and valuable goal. The good-health imperative requires women to increasingly conform to standards that have obvious alternative economic and social motivations. It passes over structural socioeconomic reasons for weight and poor health disparities and identifies the individual and her poor health choices as its target. Such a move is particularly focused on poor women who are the primary caregivers of children and disproportionately suffer from obesity-related illnesses. Based on these concerns, I address another side, what I call the "critical" side. With attention to fat activists, I will explore the idea of subverting dominant models of appropriate aesthetics. I appeal to the work of Samantha Murray in her book *The 'Fat' Female Body* (2009). Murray notes that underlying both the traditional war against obesity and fat activism is a strong implicit theory of the subject. The subject is essentially a free, autonomous agent capable of either modifying herself to be "healthy" or modifying her self-evaluation to love her looks despite social norms. The second discussion will be to consider how modifying one's body for health entails a different kind of bodily monitoring that limits pleasure. Not only do modification rituals split the subject into a controlling mind over a wayward body, they also imply a far greater reduction on the pleasures of the poor than those of the rich. In conclusion, I call for feminists to follow the empirical and theoretical work that underlines how damaging a focus on weight is for the well-being of women. However, a clear feminist position on the larger issue of health as being produced by behavior modification remains elusive.

The Good-Health Imperative: Anti-Fat and the War against Obesity

A shift in the media campaigns of diet plans in the last several years has been to highlight diets as healthy lifestyles rather than diets as merely providing women with the ability to look better in their swimsuits. The testimonials of success stories usually highlight not only looking good, but being fitter, more active, and able to run around with the children. In the TV show *The Biggest Loser*, where contestants undergo extreme diet and exercise regimes to lose weight, there is much discussion of this challenge being one of "life or death." If these contestants don't succeed in conquering their poor health habits, they will "kill themselves."

But it isn't just a tactic of sensationalist reality shows and the diet industry to make us think that our fat is killing us; the government also engages in this rhetoric. The Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH) have commissioned numerous studies and distributed various public policy proposals for the war against obesity (CDC, "Strategies"). First Lady Michelle Obama has made conquering childhood obesity her cause. Private corporations and state and federal governments propose a variety of policies designed to slim down Americans, including banning junk food in schools, taxing soda, and providing wellness incentives (Mello and Rosenthal 2008; Singer 2010; Pear 2010; Zamosky 2010).

Heart disease, hypertension, diabetes, sleep apnea, asthma, fatty liver disease, osteoarthritis, and polycystic ovary disease are related to obesity, and individuals have shown improvement when they lost weight (Malnick and Knobler 2008). Given these concerns and the rising rate of overweight and obesity over the last several decades (CDC, "U.S. Obesity Trends"), there has been a strong push in governmental recommendations in the last ten years to consider obesity a public health crisis. Former US Surgeon General David Satcher (2001) summarizes the position of the government by saying that "overweight and obesity may soon cause as much preventable disease and death as cigarette smoking." The comparison to smoking provides the theoretical framework needed to justify a war against obesity. First, smoking is a set of behaviors that are modifiable. While difficult, it is possible for the overweight person to change her habits like a smoker can quit smoking. Second, to quit smoking is achievable. The campaigns against smoking in the United States and Europe are seen as victories for public health advocates (Khuder et al. 2007; Lemmens et al. 2008). A policy-directed war against obesity, the reasoning goes, would yield similar positive results.

In addition to health concerns, the economic cost of obesity-related illnesses strongly motivates the call for action. Many news reports have highlighted, with varying degrees of alarm, the costs of obesity for the US taxpayer (Finkelstein, Fiebelkorn, and Wang 2004; Herper 2006). A recent study (Finkelstein, Trogdon, Cohen, and Dietz 2009) puts the estimate at $147 billion for 2008. Indeed, the desire of the CDC to quantify the cost of being overweight even extends into reports on the amount of excess airline fuel larger bodies require (Associated Press 2004). An article by Philip J. Cafaro, Richard B. Primack, and Robert L. Zimdhal (2006) argues that obesity is contributing to the loss of biodiversity. The fat are not only unhealthy, they are too expensive and more responsible for global warming than others.

For women, this normalizing force to obey the good-health imperative is tightly connected to the care they provide for others and the primary role they play in feeding and raising children. Women are encouraged to lose weight to be healthier and thus capable of providing better care for their children, as well as to feed their children appropriately so that they do not become overweight. The rising rate of childhood overweight and obesity is worrisome to researchers, since early obesity greatly predicts a variety of negative health outcomes, from asthma, sleep apnea, and polycystic ovary syndrome to type 2

diabetes (Daniels 2006). One of the odder concerns about the rising weight of children is its connection to national security. In 2001, a former US Surgeon General, Dr. Richard Carmona, warned that "America's obesity epidemic is a national security problem as the more than 9 million overweight and obese children in the country threaten to shrink the pool of eligible servicemen and women in the future" (Gosik 2007).[3] Too many fat children will produce too few recruits for the military. Michelle Obama's campaign against childhood obesity is, in her own words, justified not just by a concern for children's health, for lowering health care costs, and for creating a healthy workforce, but also out of fear that the United States will run out of soldiers. Recently, the First Lady has echoed Carmona's words by saying that the "epidemic" of childhood obesity is dangerous for our national security. In her words, "This epidemic also impacts the nation's security, as obesity is now one of the most common disqualifiers for military service" (Keating 2010).

The attempt to attack childhood obesity can be seen as a more easily defensible public means to obtain more funding and support for wellness initiatives. It also acknowledges the ineffectiveness of "treating" obesity through dieting and hence attacks the problem at its root. But obesity is not primarily a problem for the rich. Obese people—adults and children—are, like military recruits, more likely than their non-obese counterparts to be poor (Enger 2009; Jeffery and French 1996). Poor children are much more likely to be raised by single parents (Dowd 1997) and single parents are overwhelmingly women. The war against obesity is very much a war fought on the bodies of poor women and their children.

The Good-Health Imperative: Health at Every Size

Research that documents the growing proportions of overweight and obese Americans, the cost associated with illnesses correlated with fat bodies, and the health concerns facing the fat underscores the view that better public health requires addressing the weight of the American citizenry. Without attention to weight, other public health goals will be difficult, if not impossible, to address. Even those not classified as overweight or obese are presented with a combination of warnings about the dangers of extra pounds. Everyone should engage in weight maintenance; anyone could slip over that boundary into poor health. If one falls outside of the appropriate weight limits for one's height, then diet and exercise activities should commence. If a regime of diet and exercise is not initiated, one runs the risk of having one's behaviors viewed as immoral and pathological (Heyes 2006). It is immoral to be fat because the guiding idea of the war against obesity is that obesity is preventable. It is possible to not become obese; if one does become obese, then one has failed to moderate one's behavior appropriately. The argument appears to be that obesity is pathological because it is inherently irrational not to do things that are good for your health and to do things that are bad for your health.

However, despite this rhetoric around the need for a war against overweight and obesity, critical discussion does surround the focus on weight as an important measure of health (Gibbs 2005; Kolata 2007; Mitchell and McTigue 2007; Oliver 2006). Recent data on women show that obesity has plateaued in the last decade, suggesting that there might not be an "epidemic" of obesity after all (Flegal et al. 2010, 239). Data on mortality and weight have varied, many having a U-shaped relation between BMI and mortality, where both the very thin and the very large are at risk (Flegal et al. 2010; Keys 1980; Menotti et al. 1993; Waaler 1984). As a nation, Americans are living longer during the same time we are getting fatter (although this is usually attributed to improvements in health care; NIH, "Americans Living Longer"). Indeed, in 2010 there were signs of America's overall health slightly improving ("America's Health Rankings" 2010). But despite these positive statistics, the studies note that the health of the poor

continues to deteriorate. The focus on weight obscures much deeper economic and social disparity issues.

Critical assessments of the war against obesity have also drawn attention to how damaging the prejudice against the overweight is. Weight discrimination in the workplace and lower wages for the obese and overweight have been repeatedly documented (Cawley 2004; Haskins and Ransford 2000; Roehling 2002). The idea that the overweight and obese are necessarily unhealthy helps reinforce prejudices that have their origins in less politically correct models of acceptable aesthetics. Non-smokers can loudly rail against smokers, not only with impunity but with moral self-praise, in a way they could not against people of a different skin color. The overweight fall into the category of what could be call "the discriminatable" (and don't even have the benefit of "coolness" that smokers enjoy in some movies and popular culture). Since the war against obesity is hoping to repeat the behavioral modification gains obtained in the war against smoking, little advocacy exists against the demonization of fat people.

The high failure rate of diets (Kolata 2007; Mann et al. 2007) and the increasing rates of eating disorders provide us with additional evidence of the harmful effects of obsessions over size. Diets are notoriously ineffective in promoting weight loss. One study found that

the potential benefits of dieting on long-term weight outcomes are minimal, the potential benefits of dieting on long-term health outcomes are not clearly or consistently demonstrated, and the potential harms of weight cycling, although not definitively demonstrated, are a clear source of concern. The benefits of dieting are simply too small and the potential harms of dieting are too large for it to be recommended as a safe and effective treatment for obesity. (Mann et al. 2007, 230)

If diets were merely ineffective, their potential harm would be less worrisome. The authors note that it isn't just that dieting often fails to succeed in taking pounds off; it also results in yo-yo weight gain and loss, which has serious health risks. Dieting takes up a tremendous amount of time and financial resources of the dieter. In addition, the psychological cost of not only being obese, but then "failing" to lose weight, is not insignificant. The comparison to smoking also obscures important differences in the relationship of the overweight person to food and the smoker to cigarettes. Obviously, eating is not possible to "quit" as smoking is. Eating disorders that arise from an original investment in a healthy diet plan provide evidence that modifying eating can have unintended outcomes.

The National Eating Disorders Association (NEDA) reports that around 10 million women live with eating disorders such as anorexia or bulimia. The highest rates are among girls and young women (Hoek and van Hoeken 2003; NEDA). Only a minority of people who meet "stringent diagnostic criteria" for eating disorders receive mental health care (Hoek and van Hoeken 2003, 394). What is alarming about the lack of treatment for persons with eating disorders is just how dangerous having an eating disorder is: anorexia nervosa has the highest mortality rate of any psychiatric condition, including schizophrenia and bipolar disorders (Park 2007). However, the funding to cure anorexia pales in comparison to less common but more widely publicized disorders such as Alzheimer's disease and schizophrenia. In 2005, approximately 2.2 million people lived with schizophrenia and NIH funded 250 million dollars for research. Approximately 10 million people have eating disorders, but only 12 million dollars was given to study anorexia nervosa (NEDA). The idea that obesity is a preventable disease would also suggest that anorexia is likewise under the control of the individual and hence, unlike those coping with a "real" disease like Alzheimer's, individuals experiencing eating disorders should simply start eating normally.

Such data have led to the celebration of the "health at every size" (HAES) movement, whose activists refer to it as "the new peace movement" (Bacon 2008). The thrust of HAES literature is to suggest that

health is possible for people of many different sizes and that a negative rather than positive focus on weight affects one's health. It underlines that dieting is rarely successful and often dangerous; thus, the best approach to greater health, both for the individual and the society, is to stop focusing on weight as a measure of health. If one embraces HAES, one quits dieting and pledges to find "the joy in moving one's body and becoming more physically vital" (HAES, "The Pledge"). As a movement, its very basis is the imperative toward good, or better, health.

The bible of HAES is the book *Health at Every Size* (2008) by Linda Bacon. Therein, Bacon outlines recommendations about nutrition that in many ways are strongly similar to the recommendations found in many health-centered diet plans. One is to eat slowly, increase whole foods, educate oneself about the dangers of packaged and unhealthy foods, such as high-fructose corn syrup (253-55). But the modification plan is based on the idea that instead of dieting per se one finds an intuitive, body-driven way of eating. Bacon argues for a "set-point" theory of weight that suggests one's body intuitively knows a good weight for itself, and if one "listens" to it, it will settle on a healthy weight (11-28). She writes that while education about nutrition is valuable—and indeed the book contains a fair amount of it—ultimately one should trust one's intuition about eating: "As valuable as academic research may be, your intuition is much more effective in guiding you to feed yourself well" (75).

The continuity between HAES and the war against obesity is the imperative to do what is healthy. On the side of the war against obesity, it is imperative to monitor weight and reduce the number of overweight and obese persons. On the side of HAES, it is imperative to stop monitoring weight as the marker of good health and to engage in a variety of healthy practices, including self-esteem building exercises.

Critical Assessments: Fat Activism

In *The History of Sexuality. Vol. 2: The Use of Pleasure* (1990), Michel Foucault explores how the growth of "priestly power" in early Christianity moved against the "arts of existence" and "techniques of the self" of the classical age (11). These early practices are more reflective of a connection with the real nature of embodiment. While Foucault is famously difficult to read as an advocate, one can read in his texts the preference for the counter-aesthetic to any particular dominant norm that has acquired the status of a stable, static truth. In *The Use of Pleasure*, one finds a celebration of these ancient techniques and a call to complete such projects: "Still, I thought that the long history of these aesthetics of existence and these technologies of the self remained to be done, or resumed" (11).

What might such a "completion" look like? One example of this kind of technique can be found in the case of the size-acceptance movement and fat activism providing a counter-aesthetics to the overwhelming media exposure of limited models of beauty (Wann 1998). Images of fat women as beautiful, sexy, confident, and, most of all, not hiding their fatness are disruptive to the consensus of what beauty requires. The "fat-o-sphere," the ever-developing online community of fat activists and size-acceptance bloggers, provides a place for women-of-size celebrations and a community that mobilizes against the prevailing norms and for advocacy and education ("Big Fat Deal" 2011; "Big Fat Facts" 2011; Harding and Kirby 2009). As with other largely online communities, it is difficult to suggest that there is a simple consensus about health, but many fat-activist bloggers do ally themselves with HAES insofar as it proclaims that the war against obesity is pointless and destructive for the psychological and physical well-being of fat people.

Samantha Murray's *The 'Fat' Female Body* (2008) provides one of the most extensive considerations

of how fatness is constructed both within the fat activist movement and within the larger anti-fat world. Murray writes that public health policies directed toward encouraging "proper" eating and exercise are not educational so much as *disciplinary* (29). But this discipline is not to be administered centrally by the government; rather, it is to be instituted at the individual level. People in the developed world are aware of the correlation of obesity and overweight with poor health, thus public health policies do not inform people of the problem; rather, they provide different methods, rules, and tools for how to master the wayward body. Murray notes that despite the seemingly population-wide focus of public health policies, they depend upon a certain idea of the individual controlling her behavior.

Take Michelle Obama's "Let's Move!" program. On the website of "Let's Move!" is a link to "5 simple steps to success" (www.letsmove.gov). Clicking on this link will take one to a variety of groups that each have their own "steps" to success: parents, health-care providers, children and older youth, community leaders, chefs, schools, and elected officials. Each subgroup then has five things an individual member of that community is supposed to do. The subgroup of children, those who one might think are least empowered to have self-directed health, are also targeted as capable of behavior modification. Children should: (1) Move everyday!, (2) Try new fruits and vegetables, (3) Drink lots of water, (4) Do jumping jacks to break up TV time, and (5) Help make dinner. This assumes that it is individuals who control the future of health. Even children must be encouraged to regard their bodies and behaviors as improvement projects directed toward better health.

Murray (2008) notes that this kind of "humanist/individualist logic" is so powerful that any data provided to contradict it are often rejected (71). The overwhelming evidence of the failure of diets, as cited above, is such an example. Medicine itself is filled with the blind insistence that the individual has the power to change her weight; thus, obeying the good-health imperative becomes a moral issue. "Given the oft-proclaimed 'objectivity' of medicine, it is telling that the very ways in which we separate 'pathological' bodies from 'normal' bodies is just as much about upholding morality as it is about 'health'" (71). The consequence of fatness being something one can overcome with proper action implies that those who have not overcome it are to blame. The fat itself is not the problem, it is the individual *within* the fat, the self who controls the fat. This creates a divided self, where the true self is some kind of disembodied will that exerts, or fails to exert, its influence over the mundane body.

But in her discussion of fat activism Murray draws a different face on the same problem. She provides an important examination of how the autonomous liberal subject haunts the seemingly emancipating politics of fat activism. Murray argues that a type of disembodied autonomy underlies fat activism, where one is replacing one set of negative stereotypes with positive, celebratory ones. In order for such a model to work, a type of Cartesian dualism must be implicit, where the mind is seen as free in relation to the body. The celebration of fleshliness and of fat is counter to the dominant norms. "The 'fat goddess,' standing firm against the world with her cottage-cheese thighs akimbo refuses normative ways of knowing: the knowledge others believe they have of her" (97). But to celebrate one's fatness against the dominant aesthetic norm requires the now-liberated fat person to be separated in a different fashion from her body. "One must be 'fat and proud,' with no grey areas, no contradictions, no questions, no ambivalence" (99). Such a project is based in the idea that the core self is the individual's will. I am what I judge myself to be; I am not what others judge me to be. Murray observes that the same humanist/individualist logic appears to be at play in much fat-positive literature, and the true nature of our embodied selves remains hidden. "As women, our bodies have been made strange to us: projects we are set apart from, and even the language we employ to talk about our bodies constantly moves from our flesh

to our selves" (166).

Thus I can either, in the case of the war against obesity, modify my eating and exercise to fit a certain model of health and beauty, or, in the case of fat activism, I can alter my mind to stop seeing my body as loathsome. If the public health outcry tells us to change our bodies, fat activists tell us to change our minds. As Murray justly points out, we are always embodied and intersubjective and thus have no ability to independently think our way into a world where fat equals fabulous. My beliefs about my own body are not separate from having a body, nor are they separate from the long history of discourse about bodies in my social world.

Certainly, in the online community that considers fat activism and fat acceptance, one finds both the kind of dualism Murray notes and a clear understanding that the kinds of changes called for require a social, not just an individual, revolution. Take, for instance, the web page about facts that is part of *Big Fat Blog* (www.bigfatfacts.com). The page summarizes much of the work of HAES and outlines how many "facts" about obesity are overblown, if not altogether false. The page ends with this call:

OUR COLLECTIVE TRUTH: What do you suppose would happen if size were no longer an issue?
What if there was no such thing as being too fat, obese, overweight, heavy, super-sized, or girthy?
Would we be liberated to create more art?
To write more books?
To be involved in more theater?
To participate more as global citizens of the world?
To see more of the world?
To see more of each other?
To revel in our meals?
To revel in our bodies?
To revel in one another?
To dance naked in the sunlight, pleasuring in bodies big enough to contain all our possibilities?
Here's to boldly living the questions.

A call to a world free from the confining stereotypes of fat hatred is appealing and common to other feminist calls for emancipation from norms that harm rather than help. But, as Murray notes, if I "revel in my body," who is "reveling"? Am I something separate from my body? While the identity politics of changing the valuation of fat to one that is, at minimum, inclusive or even celebratory does provide important counter-aesthetics, it repeats the sense that the self is in charge. The individual, through some kind of action, can obtain the proper body or the proper attitude toward the body.

Critical Assessment: Modifying Pleasure

For many, a healthy body image remains elusive in a culture inundated with the emphasis on how weight is related to health and beauty. For women, this struggle is particularly trenchant, and writers have long drawn connections between feminism, fat prejudice, and eating disorders (Bartky 1990; Bordo 2004; Braziel and LeBesco 2001; Orbach 1998; Wann 1998). In a society that embraces a more and more plastic and photoshopped model of beauty, women aren't just told to be thin, but to *manage* their appearance. The idea of managed bodies encourages the view that if you are willing to devote yourself to self-improvement, you can have an ideal body. Dieting, chemically treated and dyed hair, makeup, a skincare regimen, toning exercises, cosmetic surgery, clothes, and teeth-whitening have all made the female body a site of infinite improvement and modification. Admittedly, men's bodies are also increasingly a site of

such improvements, but women are by far the main target of the diet and beauty industry.

A diet-centered life requires a divided position toward one's embodiment, regardless of whether one undertakes dieting because of health concerns or aesthetic ones (or, as many people do, a combination of both). My body becomes the place where I engage in a project, like building a house. I have a blueprint (my diet plan), the raw materials (my body), and a move-in date (a certain weight, lower blood pressure, etc.). I think that it is difficult, if not impossible, for the individual being asked to limit her consumption in order to obtain a thinner body for health reasons to separate out this goal from that related to the overwhelming cultural aesthetics of thin bodies as beautiful ones. But, assuming one can at least focus on health as the goal, the body offers significant resistance. The goal of a healthy body, and the subsequent control that pursuing such a goal requires, can be equal in discipline to, if not more disciplinary than, dieting to obtain an aesthetic standard. Sandra Bartky (1990) highlights how much dieting impairs the lived reality of the dieter, since it causes the body to become the enemy. As she writes,

> Dieting disciplines the body's hungers: Appetite must be monitored at all times and governed by an iron will. Since the innocent need of the organism for food will not be denied, the body becomes one's enemy, an alien being bent on thwarting the disciplinary project. (66)

I will assume that the readers of this paper follow Bartky's assessment that there is something dangerous about our culture's obsession with modifying the bodies of women to fit cultural norms of beauty and acceptability. However, it would appear that a woman in pursuit of a health goal, who is changing her diet to a healthier one, would be just as engaged in a disciplinary project, and that her project would be lived without the input provided in large part by feminist work that critiques beauty norms. If Mary chooses not to diet due to a rejection of limiting beauty norms, she can find in this rejection a path of liberation. If Mary chooses, against well-researched medical advice, not to modify her diet, she will have a difficult time justifying this decision in standard discourse.

Hunger does not only appear as an indication that the body requires food. Hunger can appear after a good meal, as a demand for unhealthy foods in unhealthy quantities. Indeed, many persons in the Western world have never experienced the extreme hunger that arises from a survival instinct. Our hunger is deeply shaped by desires that far transcend health. The pleasure we receive from eating is as complex and multifaceted as the pleasure we receive from sexuality.

To eat healthily, I must spend a sufficient amount of time informing myself about nutrition. I must purchase and cook healthy food (something that is not always easy). I must make sure to assess options when I travel or go out to eat. I must guard against excess in my consumption. I must make sure to guard against my desires for fattening, artificial, and comfort foods. The latter requires, for many, breaking with familial and social settings where favorite foods and the mutual enjoyment of them are front and center. The benefit of such discipline is supposedly the increased pleasure that comes with better health—such as more energy and less need for medication.

Permissible pleasures are thus healthy pleasures. Forbidden pleasures are fatty comfort food, the satisfaction of eating too much, the double pleasure experienced when consuming good things that are forbidden, and the abatement of anxiety that comes with a rush of blood to the stomach. These pleasures are increasingly associated with dangerous behavior that must be curtailed. On the glossy website of *Obesity, Fitness & Wellness Week*, America's Health Rankings (a joint project with the United Health foundation, American Public Health Association, and Partnership for Prevention) proclaims: "Inaction is no longer an option where our nation's health is concerned."[4] It is vital for us to act to ensure better public health, and the populace is encouraged to take "steps" to personally modify their behavior to obtain this

necessary goal. Appropriate pleasures are physical activity, moderate levels of healthy food consumption, and the occasional treat of an unhealthy beloved food. Such modification plans acknowledge hunger as an important part of our embodiment, one that should not be denied in anorexia or ignored in an extreme diet. However, the individual is encouraged to respond only to "real" hunger—hunger that is related to the continuation of one's existence—and to reject and modify "false" hunger—hunger related to emotional needs, historical associations, and social situations.

Even the pleasures one might obtain in dieting are now curtailed under the ideal of health. You can modify your diet, but only because it is good for your health. The popular American morning news show, *The Today Show*, often features Dr. Nancy Snyderman and nutrionist Joy Bauer discussing the dangers of poor eating and the successes of men and women in "The Joy Fit Club" who have lost weight. However, Snyderman is also often presenting stories about the worrisome excesses of dieting—such as "Mommy-rexia" (where pregnant women diet in order to not gain too much weight)—and the rising rate of teen eating disorders. These people are either pitied or strongly shamed (in the case of "Mommy-rexia"). The imperative is clear—dieting must be part of a health project; it cannot be an aesthetic one alone.

Given the high failure rate of diets and the sheer impossibility for most women to achieve a culturally "ideal" body, it is surprising that so many women continue to reinvest in this likely doomed project. In the chapter "Foucault Goes to Weight Watchers (Redux)," Heyes (2007) explores how dieting produces self-transformative possibilities for dieters. While admittedly oppressive and restricting, dieting allows for an attentiveness to the self. Heyes notes how the very practices of monitoring food and tracking weight loss provide a place in which women can take pleasure in the power that comes with a care of the self, even if, ultimately, the very reasons for engaging in such practices are suspect. Heyes does not suggest that the power that results from dieting is a reason to continue such practices, largely concurring with the verdict that they are politically motivated and failed endeavors for women, but argues rather that feminists must recognize the positive experience women have in diet rituals and realize that their erasure would be missed if not replaced.

Lintott (2003) also discusses how dieting is not without its pleasures. Extreme dieting can be read as obedience to an aesthetic norm, but it also affords women the opportunity to experience the "sublime." In anorexia, for instance, the individual with an eating disorder feels a kind of triumph over nature, in particular over the insistent force of hunger. The body is now vanquished—"the eating-disordered individual believes she is a being with a body, but she cannot entirely identify herself with her body"—and the dieter is "stoked as it is by starvation and deprivation, the hunger of the eating-disordered individual is as immense and formless as the sky above" (75). Dieting thus becomes a pleasure in itself, devoid of any needed connection to health or beauty.

We find a similar path in Foucault's discussion of avoiding the normalization of pleasures into ones guided by moderation. He advocates pleasures that must not be "middle pleasures" (such as having a nice glass of wine or a good sandwich). Instead, Foucault wants a pleasure that is "so deep, so intense" that he "couldn't survive it" (1996, 378). Lintott suggests that the reason for the continuation of extreme dieting might indeed be the fact that women are presented with few options to enjoy a sublime experience, and the desire for this kind of pleasure might lead women into the risky business of excessive forms of self-monitoring. The pleasure of sating hunger with excess or of refusing hunger altogether might be two pleasures we increasingly are encouraged to erase in the march toward healthy bodies.

It is important to acknowledge the tremendous force, both social and individual, that one experiences when violating the good-health imperative. The continual association of certain behaviors with poor

health encourages spending one's time monitoring food intake, activity levels, and appropriate healthy psychological states. I am both to love my body and modify my body. I should change who I am, but not too much, not so much that my psychological or physical health suffers. An elusive and shifting model of the "self" and the "body" appears, and one is trying to negotiate now both attitudes and behaviors around an endless supply of health recommendations. One should want appropriate pleasures and restrict inappropriate ones to "healthy" sizes, like the small bags of cookies that have only 100 calories. Excessive, intense, sublime pleasures are forbidden if they are harmful to one's well-being.

The tightest noose around bodily pleasures today is the set of norms regarding health. I cannot engage in any behavior without processing it as healthy/good or unhealthy/bad. The spread of the knowledge about health now extends far beyond the endless prescriptions regarding diet and exercise. Everything from watching TV (Mistry, Minkovitz, Strobino, and Borzekowski 2007), getting an education (Ross and Wu 1995), and working late at night (Klitzman, House, Israel, and Mero 1990), to having friends (Marmot 2005) is codified. Each activity is studied for how it is correlated with one's health. No matter how apparently removed a behavior, thought, or feeling is from the physical operations of one's body, they are accompanied by a sometimes quiet, sometimes loud running commentary on their relative health risks and benefits. While HAES offers an important corrective to the zealousness of the war against obesity, it too is replete with a set of prescriptions about proper and improper attitudes and behaviors.

The public's relationship with food is increasingly monitored by those interested in the good-health imperative. As one of the most obvious sites of combating behavior-related disease and disability, getting the populace to change its eating habits is seen as an imperative in developed societies. Whether it is with attention to weight or without, proper diet is seen as a precursor to good health. Rejecting and transcending healthy food behaviors is a source of pleasure to some, but the argument goes that more pleasure is available to those who maintain good health, even if the price is the limitation of certain pleasures. I am healthier if I do not overindulge and limit my intake of poor-quality food choices. This economy of pleasure is very much an economy that is sensible to those who have access to other kinds of pleasure. To the poor in the United States, pleasures of food are likely to be available and affordable. The good-health imperative remains deeply embedded in the privilege of the middle class, not just in its economic assumptions but insofar as those assumptions include a modification of pleasure that more adversely affects the poor than the rich.

Conclusion: Feminist Approaches to Health

The fact that America, as a rich nation, provides its poor with such minimal health care should weigh heavily on our consciences. We lack fresh, local foods in low-income areas and have a paucity of safe spaces in which we can be active and explore the natural world. It is no laughing matter to see ever younger children suffer from obesity-related illnesses, such as type 2 diabetes. Many of Michelle Obama's proposals, like those of the CDC and the NIH, are reasonable. If all other things were equal, the following of these proposals by the populace would likely result in certain health markers—blood pressure, glucose levels, cholesterol—shifting to levels that are correlated with better health outcomes. It remains unclear, given how rarely dieting results in weight loss, whether Americans would become significantly smaller, but likely they would have better health.

But all things are not equal. Such health policies encourage and promote a set of practices designed to track and monitor the population's behavior. The monitoring would increasingly become the responsibility of the medical community and of the health insurance industry. The focus moves away

from poverty and toward "preventable" behaviors, thus taking attention away from the structural issue—socioeconomic disparity—toward the individual issue of one's weight. The amount of attention given to weight highlights the lack of attention given to poverty. As Nancy Tuana writes, "What we attend to and what we ignore are often complexly interwoven with values and politics" (2008, 785). Socioeconomic issues are acknowledged and studied in the war against obesity, but the rhetoric goes that since good health is good for everyone, the poor also need public health programs, rather than focusing on the causes and possible solutions for poverty. In addition, good health programs augment the idea that fat people need to be saved from themselves by the intervention of public service campaigns, wellness incentives, and diet and exercise regimes. As I wouldn't hesitate to pull a stranger back from stepping out in front of a car, I apparently should feel no hesitation to cajole and blame the overweight for any and all health problems they face. The promotion of diet and exercise programs under the guise of "it's good for you!" presents a message ridden with normative assumptions.

Where to now as a feminist interested in promoting the well-being of women? The "good-health imperative" party described above seems clearly biased in its first, anti-fat, formulation, but far more feminist-friendly in its health-at-every-size approach. HAES avoids the obvious pitfalls of conflating health policies with our deeply embedded aesthetic values, which themselves are often grounded upon highly restrictive objectifications of women. Feminists could advocate against using weight as a measure of health and encourage approaches that value healthy eating, active lifestyles, and a removal of attention to looks or weight. For instance, feminists could call for a modification to public health programs like Michelle Obama's "Let's Move!" Instead of focusing on weight as the standard of healthy children, feminists could argue for a straightforward focus on health without worrying about children's weight. Benchmarks of progress, such as blood sugar levels and blood pressure, would be free from prejudicial stereotyping and would likely be far more objective. At first glance, such an approach is attractive. It doesn't throw the baby out with the bathwater: it doesn't eschew focus on the betterment of the health of women and children in reaction to the sexist, objectifying, and classist attitudes that inform the rhetoric of the war against obesity. It appears clear to me that the use of public funds and attention toward monitoring weight is neither ethical nor functional. Instead, the kinds of practices that are clearly demonstrated to promote health can be encouraged without assuming that their effect on weight proves or disproves their success.

But upon closer examination, some of the critical points raised above remain. A rather monolithic view of the need to modify one's behavior for health persists. The notion of the good-health imperative says that reasonable, well-informed persons should be engaged in projects of self-improvement if they violate medical standards of health. As I have argued above, there are a couple of problems with such an approach. The kinds of food-related pleasure marked as excessive and unhealthy, such as overeating, are pleasures that are more affordable. Thus, while to wealthier persons the loss of these pleasures might be minimal, this is not necessarily the case for the poor.

In addition, self-improvement projects targeting better eating and increased activity, even if they are stripped of a focus on weight, assume a subject who is both capable of a distanced approach to her body and not fundamentally entwined with other persons. To engage in a bodily self-improvement project, I must be capable of taking a split view of myself, where my mind controls the wayward body. In addition, the self-improvement perspective assumes that health is an individual concern addressable by individual decisions and behaviors. Since we are beings dependent upon and caring for others, few of my decisions are made simply for myself, by myself. This is particularly the case for women who take on the lion's share

of caregiving for dependents.

The nuances of biopower playing out in public health discourse have only been cursorily explored here, and they deserve greater examination. How is the war against obesity funded in research institutions and within the government? What are the implications of having medical providers monitor the population? What are the expectations of good health behaviors for a community with limited resources? While important critical voices about the war against obesity, such as HAES, do exist, I believe they will only be listened to as long as they support the fundamental premise of the good-health imperative: all discussion must obey a directive toward health. Health becomes an argument-ending trump card.

Finally, I wish to ask: should the goal of good health take precedence over other feminist values? I am deeply concerned about the value of public projects—such as public health policies—that are directed at modifying our behavior. In particular, I find the increasing corporate, governmental, and social pressure to eliminate unhealthy habits from one's behavior disturbing. Such pressure assumes a simple type of agency behind behaviors that are far more complex than a series of "choices," ignoring one's intersubjective and embodied condition, and consequently passing over the fact that the war against obesity is not a gender-neutral battle. The exclusive focus on health turns our attention away from the economic and social situation of poor women toward the shape of their bodies and those of their children, and it reinforces the unquestionable authority of the medical field. Promoting good health appears to be a politically neutral and universally valued goal, and this claim alone should call for greater scrutiny from feminists.

Notes

1. In the interest of space limitations, this paper will consider the media attention and public health policy surrounding the war against obesity and overweight in the United States alone. It is important to note, however, that the empirical and experimental research that guides media reports and US public health policy often draws from studies conducted outside the United States.

2. The Centers for Disease Control and Prevention (CDC) qualifies someone as overweight if her Body Mass Index (BMI) is 25-29.9, obese if her BMI is 30-39.9, and extremely obese if her BMI is above 40. (To calculate BMI, divide weight in pounds by height in inches squared, then multiply the results by a conversion factor of 703.) Some discussion exists whether BMI is an accurate measurement of fatness (Burkhauser and Cawley 2008). One of the main problems with BMI is that it does not measure waist to hip ratio, which causes some very fit persons to be considered overweight or obese. Studies have shown that for adults waist-to-hip ratio is a better predictor of mortality than BMI (Srikanthan, Seeman, and Karlamangla 2009).

3. Richard Carmona is now the Health and Wellness Chairperson of the STOP Obesity Alliance. According to the organization's website, "The Strategies to Overcome and Prevent (STOP) Obesity Alliance is a collaboration of consumer, provider, government, labor, business, health insurer and quality-of-care organizations united to drive innovative and practical strategies that combat obesity" (STOP). The close connection between business, health insurance, government, and research institutions (STOP operates out of The George Washington University School of Public Health and Health Services), and the fact that many anti-obesity researchers receive substantial income from studies funded by the diet and health-care industry, are important to highlight. For more, see Oliver's *Fat Politics*.

4. This research-gathering institution is funded by United Healthcare, a private insurance company. As with much scientific research, it is difficult to find studies that have not been sponsored by corporate interests.

References

"America's Health Rankings Indicates Overall Healthiness Slightly Improved, but Obesity, Children in Poverty, and Diabetes Worrisome for States' Health." 2010. *Obesity, Fitness & Wellness Week*, December 25. 101.

Associated Press. 2004. "Feds: Obesity raising airline fuel costs." *USA Today.com*, November 7, http://www.usatoday.com/travel/news/2004-11-05-obese-fliers_x.htm.

Bacon, Linda. 2008. *Health at Every Size*. Dallas: BenBella.

Bartky, Sandra Lee. 1990. *Femininity and Domination: Studies in the Phenomenology of Oppression*. New York: Routledge.

Beauvoir, Simone de. 1989. *The Second Sex*. Translated by H.M. Parshley. New York: Vintage.

"Big Fat Facts." 2011. *Big Fat Deal* (blog), http://www.bigfatfacts.com. Last updated March 14, 2006.

Bordo, Susan. 2004. *Unbearable Weight*. Berkeley: University of California Press.

Braziel, Jana Evans, and Kathleen LeBesco, eds. 2001. *Bodies out of Bounds: Fatness and Transgression*. Berkeley: University of California Press.

Burkhauser, Richard V., and John Cawley. 2008. "Beyond BMI: The Value of More Accurate Measures of Fatness and Obesity in Social Science Research." *Journal of Health Economics* 27 (2): 519-29.

Cafaro, Philip J., Richard B. Primack, and Robert L. Zimdahl. 2006. "The Fat of the Land: Linking American Food Overconsumption, Obesity, and Biodiversity Loss." *Journal of Agricultural and Environmental Ethics* 19 (6): 541-61.

CDC (Centers for Disease Control and Prevention). "Strategies to Prevent Obesity in the United States." *CDC*, http://www.cdc.gov/Features/preventingobesity/. Last updated August 24, 2009.

_____. "U.S. Obesity Trends." *CDC*, http://www.cdc.gov/obesity/data/trends.html#State. Last updated July 21, 2011.

Cawley, John. 2004. "The Impact of Obesity on Wages." *The Journal of Human Resources* 39 (2): 451-74.

Daniels, Stephen R. 2006. "The Consequences of Childhood Overweight and Obesity." *The Future of Children* 16 (1): 47-67.

Dowd, Nancy E. 1997. *In Defense of Single-Parent Families*. New York: New York University Press.

Enger, Daniel. 2009. "Give Me Your Tired, Your Poor, Your Big Fat Asses…: Does Poverty Make People Obese, or Is It the Other Way Around?" *Slate.com*, Sept. 28, http://www.slate.com/id/2229523/pagenum/all/.

Finkelstein, Eric, Ian Fiebelkorn, and Guijing Wang. 2004. "State-Level Estimates of Annual Medical Expenditure Attributable to Obesity." *Obesity Research* 12 (1): 18-24.

Finkelstein, Eric, Justin G. Trogdon, Joel W. Cohen, and William Dietz. 2009. "Annual Medical Spending Attributable to Obesity: Payer- and Service-Specific Estimates." *Health Affair*, July 27, 2009: w 822-w 831. doi: 10.1377/hlthaff.28.5.w822.

Flegal, Katherine M., Margaret D. Carroll, Cynthia L. Ogden, and Lester R. Curtain. 2010. "Prevalence and Trends in Obesity Among US Adults, 1999-2008." *Journal of the American Medical Association* 303 (3): 235-41.

Foucault, Michel. 1996. *Foucault Live: Collected Interviews, 1961-1984*. Edited by Sylvère Lotringer. Translated by Lysa Hochroth and John Johnston. New York: Semiotext(e).

_____. 1990. *The History of Sexuality.* Vol. 2, *The Use of Pleasure.* Translated by Robert Hurley. New York: Random House.

Gibbs, Wayt. 2005. "Obesity: An Overblown Epidemic?" *Scientific American* 292 (6): 70-77.

Gosik, A. 2007. "Obesity Undercuts National Security, Surgeon General Says." *Chattanooga Times Free Press*, November 4: A3.

HAES (Health at Every Size). "The Pledge." *HAES*, http://haescommunity.org/pledge.php. Accessed March 8, 2010.

Harding, Kate, and Marianne Kirby. 2009. *Lessons from the Fat-o-sphere: Quit Dieting and Declare a Truce with Your Body.* New York: Perigee.

Haskins, Katherine M., and H. Edward Ransford. 1999. "The Relationship between Weight and Career Payoffs among Women." *Sociological Forum* 14 (2): 295-318.

Herper, Matthew. 2006. "The Hidden Cost of Obesity." *Forbes.com*, November 24, http://www.forbes.com/2006/07/19/obesity-fat-costs_cx_mh_0720obesity.html.

Heyes, Cressida J. 2007. *Self-Transformations: Foucault, Ethics, and Normalized Bodies.* Oxford: Oxford University Press.

Hoek, H.W., and D. van Hoeken. 2003. "Review of the Prevalence and Incidence of Eating Disorders." *International Journal of Eating Disorders* 34 (4): 383-96.

Jeffery, Robert W., and Simone A. French. 1996. "Socioeconomic Status and Weight Control Practices among 20- to 45-Year-Old Women." *American Journal of Public Health* 86 (7): 1005-10.

Keating, Joshua. 2010. "Michelle Obama: Americans Getting Too Fat to Fight." *Foreign Policy* (blog), February 10, http://blog.foreignpolicy.com/category/topic/health.

Keys, Ancel. 1980. *Seven Countries: A Multivariate Analysis of Death and Coronary Heart Disease.* Cambridge, MA: Harvard University Press.

Khuder, Sadik, Sheryl Milz, Timothy Jordan, James Price, Kathi Silvestri, and Pam Butler. 2007. "The Impact of a Smoking Ban on Hospital Admissions for Coronary Heart Disease." *Preventive Medicine* 45 (1): 3-8.

Klitzman, Susan, James S. House, Barbara A. Israel, and Richard P. Mero. 1990. "Work Stress, Nonwork Stress, and Health." *Journal of Behavioral Medicine* 1 (3): 221-43.

Kolata, Gina. 2007. *Rethinking Thin: The New Science of Weight Loss—and the Myths and Realities of Dieting.* New York: Farrar, Straus and Giroux.

Lemmens, Valery, Anke Oenema, Inge Knut, Klepp Knut, and Johannes Brug. 2008. "Effectiveness of Smoking Cessation Interventions among Adults: A Systematic Review of Reviews." *European Journal of Cancer Prevention* 17 (6): 535-44.

Lintott, Sheila. 2003. "Sublime Hunger: A Consideration of Eating Disorders Beyond Beauty." *Hypatia* 18 (4): 65-86.

Malnick, S.D.H., and H. Knobler. 2006. "The Medical Complications of Obesity." *QJM: An International Journal of Medicine* 99 (9): 565-79.

Mann, Traci, A. Janet Tomiyama, Erika Westling, Ann-Marie Lew, Barbra Samuels, and Jason Chatman. 2007. "Medicare's Search for Effective Obesity Treatments: Diets Are Not the Answer." *American Psychologist* 62 (3): 220-33.

Marmot, Michael. 2005. *The Status Syndrome: How Social Standing Affects Our Health and Longevity.* New York: Holt.

Mello, Michelle M., and Meredith B. Rosenthal. 2008. "Wellness Programs and Lifestyle Discrimination—The Legal Limits." *The New England Journal of Medicine* 359 (2): 192-99.

Menotti, A. G. C. Descovich, M. Lanti, A. Spagnolo, A. Dormi, and F. Seccareccia. 1993. "Indexes of Obesity and All-Causes Mortality in Italian Epidemiology Data." *Preventive Medicine* 22 (3): 293-303.

Mistry, Kamila B., Cynthia S. Minkovitz, Donna M. Strobino, and Dina L.G. Borzekowski. 2007. "Children's Television

Exposure and Behavioral and Social Outcomes at 5.5 Years: Does Timing of Exposure Matter?" *Pediatrics* 120 (4): 762-69.

Mitchell, Gordon R., and Kathleen M. McTigue. 2007. "The U. S. Obesity 'Epidemic': Metaphor, Method, or Madness?" *Social Epistemology* 21 (4): 391-423.

Murray, Samantha. 2008. *The 'Fat' Female Body*. London: Palgrave Macmillan.

NEDA (National Eating Disorders Association). 2011. "Eating Disorders Information Index." *NEDA*, http://www. nationaleatingdisorders.org/.

NIH (National Institutes of Health). 2008. "Americans Living Longer, Enjoying Greater Health and Prosperity, but Important Disparities Remain." March 27, http://www.nia.nih.gov/NewsAndEvents/PressReleases/ PR20080327OlderAmericans.htm.

Oliver, J. Eric. 2006. *Fat Politics*. Oxford: Oxford University Press.

Orbach, Susie. 1998. *Fat Is a Feminist Issue*. London: Arrow Books.

_____. 1986. *Hunger Strike*. New York: Norton.

_____. 2009. *Bodies*. New York: Picador.

Park, Denise. 2007. "Eating Disorders: A Call to Arms." *American Psychologist* 62 (3): 158.

Pear, Robert. 2010. "Congress Sends Child Nutrition Bill Championed by Mrs. Obama to President to Sign." *The New York Times*, December 3. http://www.nytimes.com/2010/12/03/us/politics/03child.html.

Roehling, Mark. 2002. "Weight Discrimination in the American Workplace: Ethical Issues and Analysis." *Journal of Business Ethics* 40 (2): 177-89.

Ross, Catherine E., and Chia-ling Wu. 1995. "The Links Between Education and Health." *American Sociological Review* 60 (5): 719-45.

Satcher, David. 2001. "The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity." *U. S. Department of Health & Human Services: Office of the Surgeon General*, December 13. http://www. surgeongeneral.gov/news/pressreleases/pr_obesity.htm.

Singer, Natasha. 2010. "Fixing a World that Fosters Fat." *The New York Times*, August 22. http://www.nytimes. com/2010/08/22/business/22stream.html.

Srikanthan, Preethi, Teresa E. Seeman, and Arun S. Karlamangla. 2009. "Waist-Hip Ratio as a Predictor of All-Cause Mortality in High-Functioning Older Adults." *Annals of Epidemiology* 19 (10): 724-31.

STOP (Strategies to Overcome and Prevent Obesity Alliance). "About the Alliance." *STOP*, http://www. stopobesityalliance.org/about/. Accessed March 10, 2010.

Tong, Rosemarie. 2005. "Taking on 'Big Fat': The Relative Risks and Benefits of the War against Obesity." *Public Health Policy and Ethics* 19: 39-58.

Tuana, Nancy. 2008. "Coming to Understand: Orgasm and the Epistemology of Ignorance." In *The Feminist Philosophy Reader*, edited by Alison Bailey and Chris Cuomo, 765-91. New York: McGraw-Hill.

Waaler, H.T. 1984. "Height, Weight and Mortality: The Norwegian Experience." A*cta Medica Scandinavica. Supplementum* 679: 1-56.

Wann, Marilyn. 1998. *Fat!So?* New York: Ten Speed Press.

Zamosky, Lisa. 2010. "Employers Ready to Raise the Stakes for Health Incentives." *Los Angeles Times*, November 15. http://www.latimes.com/health/la-he-insurance-rewards-20101115,0,4410483.story.