

Health As Embodied Authenticity

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HEALTH AS EMBODIED AUTHENTICITY

by

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ABSTRACT

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This dissertation offers a phenomenological and existential account of health. It considers the model of health that is dominant in the contemporary USA. Using the example of fatness, this dissertation argues that the dominant model of health is deeply flawed, because of its largely unexamined commitment to naturalism and positivism (in the Husserlian senses of these terms). It concludes that purported alternatives to the dominant model, such as the Foucault-influenced constructivist approach to health, fail to respond adequately to the problems posed by naturalism and positivism. Instead, this dissertation proposes a model of health as *embodied authenticity*. This model is developed on the basis of Edmund Husserl's account of embodiment and Simone de Beauvoir's account of action.

The central tenet of this model is that health is the embodied aspect of authentic action. That is, health is a feature not of bodies but of actions. A person is acting healthily -- and thus, can be said to 'be healthy' -- to the extent that she or he is engaged in physical action in pursuit of goals which are themselves conducive to the freedom of the agent her or himself and to the freedom of other persons. The goals themselves and the likelihood of the actions to be conducive to these goals must be capable of standing up to intersubjective critique in order for the person's action to be authentic and thus healthy. This model of health is then applied to the case of fatness, in order to show that it squares better with lived experience than the previously available models of health. This dissertation concludes with a discussion of freedom as central to health.

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INTRODUCTION

In this dissertation, I offer a critique of, and an alternative to, what I refer to as the dominant model of health. I argue that this model of health is founded on what Edmund Husserl would refer to as “naturalism,” that is, the belief that only nature (as opposed to any concept of a separate ‘mind’ or ‘spirit’) exists, and thus the natural sciences provide the best or only means to obtain knowledge. I use the example of fatness to demonstrate how the dominant model of health fails to make sense of lived experience. However, in examining the case of fatness, I find that critique of the dominant model has itself tended to fall into error in two main ways. First, there are critics who dispute some particular conclusions drawn by proponents of the dominant model, but do not challenge the model of health as a whole. This is exemplified in the work of those obesity researchers who use naturalistic methodology to challenge dominant model claims about fatness and fat people. This is an inadequate response because the model itself, not just its application to fatness, demands much more radical critique. Second, there are critics who take what I refer to as a constructivist line, arguing that the dominant model ought not to be accepted because health and fatness are not objective realities but socially constructed concepts. This is also an inadequate response because it fails to take seriously the embodied, lived experiences of those people for whom fatness itself is experienced as a problem.

In this dissertation, I undertake a radical critique of the dominant model of health, assuming neither that the naturalist thesis is true nor that it is false. I develop a model of health centered on action. On this model, which I refer to as the embodied authenticity model, one is healthy to the extent that one is acting in and through one’s body in a way that is conducive to the pursuit of one’s authentically chosen goals and projects. Health is not merely the potential to act; rather it is the action itself which is healthy. However, this

does not mean that one must be successful in accomplishing one's goals in order to be healthy. Drawing on the existential ethics of Simone de Beauvoir, I argue that the best we can do is to strive to realize our values, knowing that the world is not fully under our control, and we will never be able to bring about exact outcomes that we have chosen. Health is neither about the potential nor the outcome, but about the action itself. I am healthy to the extent that my body is facilitating my authentic, ethical life.

Since I am studying the topic of health by phenomenological and existentialist means, my example of fatness occupies perhaps more space than it might do in a study of health conducted by other methods. Nonetheless, my focus on isolating the essence of health means that I am often forced to give short shrift to the important philosophical, political and ethical aspects of fatness. My goal in the main body of the thesis is to isolate the health claims that are being made about fatness, in order to show that the dominant model of health is inadequate. Here, however, I would like to give a brief outline of some of the important ways in which fatness intersects with other identity categories. If these intersections are not central to this dissertation, that is only because each of them warrants a dissertation unto itself, not because I see them as less than crucial.

Fatness: An Overview

There are a number of examples I could have chosen on which to center my discussion of health in this dissertation. There are many phenomena that are understood essentially and invariably as health problems. One might choose cancer, AIDS or even, if one wanted to be especially timely, Ebola. No doubt important philosophical work has been done and might still be done in analysing the dominant understandings of such diseases. However, I choose fatness as my central example precisely because its status remains so contested even in the face of the dominant model. Almost nobody, at least in what one might term mainstream discourse, seriously contests the notion that cancer, or

AIDS, or Ebola is a disease, is a health problem and ought, ideally, to be eliminated. (The question of what and, especially, who is responsible for these diseases remains more controversial, of course.) There is, however, significant resistance to the notion that fatness ought always to be understood as a health problem, much less a disease, and there is, in some quarters, massive resistance to the idea that fatness can or ought to be eliminated. Because of this contested status, those who discuss fatness are often more explicit in making claims about how fatness ought to be understood (though, as I argue in Chapter Two, they are not as explicit as one might expect when it comes to discussing what they take fatness to be in an ontological sense). This contested status means that fatness is the ideal example for my purposes in this dissertation. However, using fatness in this way, focusing on its impact on health, I am obliged to brush over broader issues involving gender, race, sexuality and social class. I here outline some of these issues.

Many commentators have long considered fat to be, in Susie Orbach's terms, a feminist issue. There is no doubt that the burden of 'the tyranny of slenderness' (in Kim Chernin's phrase) falls heavier on women than on men. Women are more likely to be regarded as fat, and they are more likely to suffer as a result of such regard. In the essay, "Part-Time Fatso", transgendered person S. Bear Bergman describes how, "...whether the world thinks of me as fat depends entirely on how it interprets my gender." (139) Bergman (who also identifies as "...a butch, which is its own gender" (*ibid.*)) writes that, when perceived as a man, 'he' is not perceived as fat, but when perceived as a woman 'she' is. Bergman also points to concrete manifestations of this perception. When buying man's clothes, Bergman can sometimes find 'his' size in mainstream clothing stores, or made by mainstream labels like Levi Strauss, but when shopping for women's clothes, 'she' must always shop in specialist plus-size stores. One and the same body is invariably defined as 'plus sized', that is, excessive, when it is seen as a site of femininity but not

necessarily so when it is perceived as a site of masculinity. (*ibid.* 141) Bergman writes that, “As a man, I’m a big dude, but not outside the norm for such things. ... As a woman, I am revolting.” (*ibid.*) Such anecdotal evidence reflects the findings of studies showing that fat women are, as J. Eric Oliver puts it, “...more socially isolated, less likely to find dating partners or marry, and more likely to be harassed and abused for their weight.” (*Fat Politics* 81) Fatness is never truly acceptable, but it is more acceptable in men than in women. Oliver quotes the following from a blog post:

It’s a free country. If you wanna be a big, obese blob of human go right ahead. However, what I will ask is that you fat chicks stop deluding yourselves and realize that you are very fat and cumbersome and greasy and smelly and that no amount of primping or make-up can help you. Am I picking on fat women? I sure am. Fat men don’t try and lie about their size. Do you know what I think fat women should do? They should become the nicest, funniest people in the world. They need a redeeming quality. Fat women should dance around and laugh and fall down and amuse us. (Quoted in *Fat Politics* 79)

As Oliver notes, this may be an extreme expression, but what it expresses, the notion that fat women are worthless (because they are, by definition, not sexually attractive to straight men) and must be made to feel so, is actually quite typical of a cultural perspective that is by no means marginal in twenty-first century America. The hatred, scorn and disdain aimed at fat women in the contemporary USA is all but inexpressible. It is no coincidence that feminists, and, in particular, feminist lesbians, have been to the fore in fighting for the rights of fat people. Fat is, without doubt, still a feminist issue, and, speaking more broadly, a gender issue. Even women who are not fat are socially controlled and disciplined by the belief that they are fat, by the fear that they might get fat, or by the notion that they may be seen as fat. Fat is an issue for women in general and not just for fat women.

I cannot wholly agree, however, with Oliver's claim that white women suffer more under this tyranny of slenderness than non-white women. (*ibid.*) As I discuss later in this dissertation, the claim that it is more acceptable to be fat in some non-white – particularly black and Latina/o communities – does not hold up to scrutiny all that well. Feminist commentators of color have made this quite clear. The body ideal against which many black American women are measured within their own communities, for example, may indeed be 'curvier' than that against which white women feel measured, but this curvier ideal is no less an ideal, no more common, and certainly no more attainable for those not genetically endowed with it. The figures of Nicki Minaj and Beyoncé are indeed markedly different to those of Taylor Swift or Miley Cyrus, but they could hardly be called more attainable. Moreover, even if an American woman is part of, say, a black or Latina/o community with different aesthetic preferences, that woman still must function within the wider community where the aesthetic, cultural and social values of whiteness are dominant. In this wider community, which is culturally white (not to say white supremacist), it may in a certain sense be more acceptable for black and Latina women to be fat, but I suspect that this is only because, in those contexts, they are *already expected* to be 'greedy', 'lazy' and 'ugly' (traits which are seen as defining features of the fat) by virtue of their perceived race. That is, I suspect – though further research would be required to validate the suggestion – that it is not less shocking or less disgusting for black and Latina women to be fat, it is just less surprising.

In fact, I would suggest that it is precisely when fatness is understood as a manifestation of moral decay that it intersects most strongly with race. In a Harper's magazine cover story from 2000, Greg Critser muses:

What do the fat, darker, exploited poor, with their unbridled primal appetites, have to offer us, but a chance for we diet-and-shape-conscious folks to live

vicariously? ... Mami buys another apple fritter. Papi slams his second sugar and cream. Another young Carl supersizes, double supersizes, and then supersizes again. Waistlines surge. Any minute now, the belt will run out of holes. (Quoted in *The Diet Myth*, 66)

This is an unabashedly racialized, and indeed racist, way of characterizing the ‘obesity epidemic’. The writer calls the problem an epidemic, a term which suggests the problem is medical, but he then describes the problem in largely moral terms. The ‘obesity epidemic’, as described by Critser, is a problem centered on ‘darker’ people – Carls, Mamis and Papis – making poor choices because they don’t know better or they don’t care about the impact of their actions on themselves or others. Indeed, the fatness of black and Latina/o people has become a proxy for older racist beliefs that they are lazy and greedy. There are many situations in which it would be deemed unacceptable to claim that a certain race of people has greed or laziness as a moral flaw. You can, however, claim that fat people have such flaws. Their fatness itself is the proof. In “A Jury Of Your Skinny Peers”, Maggie Elise O’Grady gives the example of *Galbert v. Merkle*, a case in which a prosecutor (himself black) objected to all three black prospective jurors. When he was challenged on constitutional grounds, O’Grady says:

The prosecutor defended the strike by noting the clothing, age, and hairstyles of the women, culminating in the observation that all were overweight. As such, he regarded them as fitting a pro-defense, “self-indulgent” profile. (*ibid.* 55)

In this case, it seems quite likely that fatness (together with gender, clothing, age and hairstyles) is functioning as a proxy for race (and, indeed, for gender and social class). The prosecutor was barred, under the Constitution, from striking the prospective jurors on the basis of their race, but could use other features, including their fatness, as a basis for doing so. This emphasizes the moralizing that pervades the dominant understanding of

fatness. Unlike, say, cancer, fatness is understood as a choice or at least as the direct result of choice.

In this sense, fatness has common ground with AIDS, which has at times been understood as a consequence of the supposed immorality of gay men. Fatness, like AIDS, has thus been seen both as an illness and as a result of moral failure on the part of the individual. Indeed, there are a number of ways in which fatness has intersected with queerness, historically, theoretically and culturally. In 1973, when the National Association to Aid Fat Americans (NAAFA; now the National Association to Advance Fat Acceptance) split, many of those who left to form the more radical Fat Underground, "...had strong ties to the radical therapy, lesbian and feminist movements." (Gilman 2010 128) More recently, Kathleen LeBesco (for example) argues that fat bodies can meaningfully be understood as 'queer'. ("Queering Fat Bodies/Politics") Some fat acceptance activists, such as Marilyn Wann (*Fat?So!* 11), have adopted the language of "coming out" in reference to taking up their fat identity. (For an overview of fat activists' use of the language of 'coming out', see Saguy and Ward (2011).)

It may seem odd to talk about 'coming out' as fat, when fatness is so clearly visible. However, as Linda Martín Alcoff points out in *Visible Identities*, "When truth is defined as that which can be seen, there develops an uncanny interdependence between that which is true and that which is hidden. ... The 'truth' of what we are is sometimes 'as plain as the nose on my face' but sometimes it is hidden and must be brought into the light." (7) Alcoff notes that the difficulty of identifying truth with what can be seen is that what can be seen is effectively endless in that one can never see all of it. By committing ourselves to believe only what we can see, we commit ourselves to an endless uncertainty. Given the naturalism of the dominant model, it is fair to say that the current

context is indeed one in which ‘truth is defined as that which can be seen’. The current obsession with defining fat, and with identifying and eliminating every last ounce of it, can be seen as an attempt to cope with this endlessness. There is always another nook or cranny in which fat may be hiding. Those who are now thin must be ever-vigilant for the early signs of oncoming fatness. Women, in particular, must work endlessly to get or stay thin. Even apparently thin people may be secretly fat, as in the case of the so-called ‘normal weight obese’ or ‘skinny-fat’. Fat people may be ‘passing’ as thin before our very eyes, just as non-white people may pass as white, or queer people as straight and so on. In this context, one may well experience fatness as simultaneously one’s defining feature and one’s darkest secret, and thus as something with respect to which one may ‘come out’.

Of course, for those who are clearly and recognizably fat, there is no question of ‘passing’ as thin. Rather, for these people, as Samantha Murray argues, the fat body functions as a ‘virtual confessor’, attesting to the moral decay of the person inside. (“Marked As Pathological”, 82-87) There is, however, a sense in which even these people may ‘come out’, if they choose to respond to their fatness in a particular way. Consider again for a moment the quote above from *Fat Politics*, in which fat women (unlike fat men) are accused of lying about their size and deluding themselves. (*Fat Politics*, 79) The writer quoted by Oliver demands that fat women publicly acknowledge their fatness as something for which they must apologize and seek to compensate. As Oliver argues, this attitude is not as limited to the lunatic fringe as one might like to think; rather this quote is just an unusually explicit expression of what are actually pretty mainstream attitudes to fatness and, particularly, to women’s fatness. In this context, to ‘come out’ as fat is not so much to reveal the hitherto hidden truth that one is fat but rather to reveal the hitherto hidden truth that one accepts, likes, and embraces one’s fatness. Thus, to come out as fat

is, primarily, to reveal the secret that one does not hate oneself for being fat. In the USA today, that is perhaps as shocking and revolutionary a revelation as that of a hitherto hidden sexual orientation or gender. It is, for many, quite literally inconceivable. One need only look at the comments under any internet article or blog post whatsoever about fat acceptance to see that, for vast swathes of people, fatness is *essentially* unacceptable. Not only do these people themselves refuse to accept fatness, they regard it as utterly unconscionable and immoral for others to do so. “It’s just not healthy” functions in these debates about fatness much as “it’s just not natural” functions in debates about sexual orientation. In each case, what is really being communicated is, “it’s just not right.”

Thus, fatness intersects with queerness in the sense that each has been cast as a moral failing, as a manifestation of unnatural and perverted greed or lust. This same moral reading of fatness also ties in with class. For much of human history, fatness was the preserve of the wealthy. It was thus sometimes associated with greed and perhaps exploitation of others, but also with wealth and power. (See, for example, Oliver, *Fat Politics*, 65; Kolata, *Rethinking Thin*, 73) But, as Hillel Schwartz points out in *Never Satisfied*, when poor people started getting fat, their fatness was seen as a manifestation of their “profligacy”. (86) Thinness is now a hallmark of the wealthy and privileged elite. Those who have the resources to ‘be whatever they want to be’ invariably choose to be thin, whatever else they may also choose to be. In *Unbearable Weight*, Susan Bordo describes anorexia nervosa as, “the crystallization of [late twentieth century American] culture.” (139-164) Her account still resonates well into the twenty-first century. Bordo claims that certain kinds of anorexic ideation are normalized and even glamorized in contemporary culture, to the point where almost any amount of fat seems like too much, and almost everyone seems – and, indeed, feels – too fat. Returning to the intersection with race, one might almost say that in wealthy, white, upper class circles there is now a

‘one-ounce rule’ in place. Just as one drop of non-white blood was once taken to define one as non-white, any fat at all is now enough to put one in the category of ‘too fat’ and therefore inferior. But unlike non-white genetic heritage, we believe we can work off our fat. The solution is thus to devote oneself endlessly to the elimination of every last ounce of fat. In short, there is much that rings true in Bordo’s account even today, over ten years after the second edition of her book was published.

However, I would suggest that, as a society, the contemporary USA is more bulimic than anorexic. Anorexia nervosa is characterized by adherence to extremely strict rules about the quantity and quality of food one consumes and how one consumes that food. The obsession is with the control of appetite and the elimination of consumption. But in many ways contemporary US culture seems strongly to endorse *unfettered* consumption (though, as Bordo points out, this is less true for women, who are expected to eat less than men). In twenty-first century America, it is not consumption that is derided, but rather certain manifestations of consumption, including, above all, body fat. Thus, culturally speaking, the ideal citizen of twenty-first century America is someone who consumes insatiably but somehow never has too much. In support of this suggestion, consider the recent rash of reality TV shows about hoarders.¹ Both scripted and unscripted TV shows have frequently presented images of unimaginably wealthy people with massive amounts of material possessions², yet these people have typically not been presented in the pathological and/or moral terms in which the ‘hoarders’ are presented. The hoarders, on the other hand, are typically poor, and their material possessions are not

¹ A&E’s *Hoarders* ran from 2009 to 2013, while TLC’s *Hoarding: Buried Alive* premiered in 2010 and is still running at the time of writing. Both shows have been widely syndicated, and their formats have been copied in other countries.

² MTV’s long-running *Cribs*, together with its spin-offs, is perhaps the perfect example.

enviable. They are always presented as sick, and sometimes as immoral. This suggests that what disgusts us, what pushes our cultural buttons, is not voracious consumption, but the notion of being saddled with the detritus of that consumption. The wealthy person has masses of material possessions, but these possessions are beautiful, desirable and artfully arranged in a space which can accommodate them. In absolute terms, they have vast amounts of possessions, but yet they do not have 'too much', because what they have fits. The hoarder on the other hand has massive amounts of possessions that other people do not desire, that other people find unappealing, even dirty and disgusting, and all these possessions are crammed into a space in which they do not fit.

In my view, the fat person is the hoarder *par excellence* in the contemporary American psyche. Even the hoarder can, at least for a time, physically distance herself from her possessions. The fat person is both hoarder and hoard. Fat bodies represent, in the American imagination, an insane, insatiable drive to get and keep, a desire which is shameful and disgusting, and manifestations of which inspire, quite literally, abject horror. Like the hoarder's hoard, taking over his or her humble home, the fat body does not fit -- and thus will not stay -- within what ought to be its confines. Thus, as Lupton (2013 58-9) has pointed out, fat is the perfect example and embodiment of Julia Kristeva's (1982) concept of the 'abject'. Lupton writes that:

For Kristeva, the abject is that which is difficult to contain, which is liminal and crosses bodily boundaries. Its lack of definition and its liminal status inspire feelings of revulsion and fear of contamination. [...] The uncontained nature of the fat body, its looseness and liquidity, its lack of defined boundaries and tendency to ooze, inspires abjection. (58)

It is no surprise that fat people are often held to be dirty, smelly and repulsive. Indeed, I would suggest that fat people have come to be not only a symbol of all that Americans

collectively find disgusting and shameful in themselves but also a scapegoat for all the greed and excess of which Americans collectively feel culpable. Fat people have even been held responsible for climate change. (“Scientists: Fat People Make Global Warming A Lot Worse”; “Fat People Causing Climate Change”) But, again, fat people are by no means alone here; the greed and laziness of the poor, and most especially the black and Latina/o poor, is often cited as both the cause of and the evidence for the downfall of the once-great USA. Of course, it is no coincidence that those who are poor, and/or black, and/or Latina/o are also more likely to be fat.

In this context, fatness is certainly a political problem, whether or not it is a health one. At times, in the body of this dissertation, it may seem that I gloss over these political aspects of fatness, or its intersections with other identities. I argue, however, that the solution to the political problem lies partly in how we understand and respond to the health problem. The objectivist assumption that there can be some neutral, fact-based standard to which all bodies can be held is central to the moralized claims that fatness is “just not healthy”, just as it is central to the claim that homosexuality is “just not natural”. To critique the theory behind the supposedly neutral, objectivist and naturalist model of health is thus to shed light on many of the unexamined assumptions behind the moral and aesthetic claims that are used as sticks with which to beat fat people and, by extension, to beat those whose gender, race, ethnic or sexual identities are deemed unacceptable.

Moreover, I believe that the model of health I propose addresses many of the very legitimate and important political concerns raised by fat acceptance activists, but without insisting, in the teeth of the evidence, that fatness is never a health problem. In my view, it is a mistake to insist that fatness must be either a health problem or a political problem. On my model, which defines health with reference to action, all health problems are

political, and all political problems are health problems, in the sense that they concern and condition the fundamental scope of individuals for action and, thus, they inevitably concern and condition the workings of groups of people and societies. Fatness is not necessarily always a health problem for every individual but it can be one for many people, and is often so for women, for poor people, for people of color and for queer people. Offering a model of health that works better for fat people thus means offering a model of health that works better for all these intersecting communities. My model of health is one which places freedom at its center. Thus, on my model, the projects of being healthy and of advocating health are essentially political projects. The hope is that, since the political burden of the dominant model of fatness has fallen disproportionately on women, black and Latina/o people, queer people and other marginalized groups, then conversely a better model of fatness can be especially beneficial for these same groups.

Summary of the Dissertation

In this dissertation, I first argue for the need for a radically different model of health, and then I argue for the embodied authenticity model in particular. In Chapter One, entitled *How We Talk About Fatness*, I describe the different strands of the contemporary debate around fatness. I identify what I take to be the three central assumptions of the dominant model of fatness. These are: (1) that fatness is caused by, and therefore represents, excessive consumption and insufficient exertion; (2) that fatness either is or causes illness and therefore must be addressed in order to increase health; and (3) that the best way to address the problem of fatness is for fat/overweight/obese people to lose weight. By and large, these claims are taken to be ‘common sense’. The assumption is that to dispute any one of them one must be, as it were, either a fool or a knave. In contrast to this dominant model, there exists a competing model of fatness, emerging from the Fat Acceptance (FA) and Health at Every Size (HAES) communities.

This latter model may also be expressed in terms of three central assumptions, namely: (1) that some people are naturally fat; (2) that fatness in itself is not unhealthy; and (3) that it is all but impossible to make a naturally fat person thin over the long-term.

I characterize the first set of assumptions as ‘objectivist’, by which I mean that their proponents take these assumptions to be factual claims about the world, based on subject-neutral observation. More specifically, they are naturalist, in that they assume that the best kind of subject-neutral observation is that undertaken by the natural sciences. This objectivist approach gives rise to a narrative whereby fatness is invariably and essentially a health problem. Millions of Americans are now being encouraged by government health agencies, by media outlets, by medical experts, and by other powerful voices, to measure themselves and, should they find themselves in the overweight or obese categories, they are being told that they are, by definition, unhealthy, and that – again by definition – causing themselves to weigh less will make them healthier. This set of claims is repeated over and over in various ways, and almost never includes any acknowledgement that there may exist some diversity in the causes and consequences of fatness.

The most prominent alternative to this model is what one might term, broadly, the FA and HAES model. There are two different theoretical platforms on which this model has been based. First, there is what I term the objectivist platform. Critics operating on this platform do not dispute the fundamental naturalist thesis of the dominant model, but simply dispute the conclusions that its proponents have drawn about fatness. That is, they are satisfied with the standard methods of naturalism but merely feel these methods have been misapplied when it comes to studying fatness and fat people. Other critics of the dominant model base their critique on what I call a constructivist platform. These critics

dispute the naturalist dominant model because, as they see it, subject-neutral observation is impossible. For these critics, all concepts of health and, indeed, of fatness, are entirely socially constructed. On this model, neither health nor fatness is, so to speak, a thing that exists in the world, rather each of these ought to be understood as a concept by which things in the world may be categorized.

In Chapter Two, entitled *The Dominant Model of Health and Its Alternatives*, I argue that neither the objectivist nor the constructivist critique of health provides the theoretical basis on which to construct an adequate model of health, or even to mount an adequate theoretical challenge to the dominant model. Rather than following either of these lines of critique, then, I draw on Husserl's critique of naturalism to highlight the philosophical problems of the dominant model. Specifically, proponents of the dominant model display an over-reliance on, and at times almost an obsession with, measurement. They express health, fatness and the relationship between the two in numerical terms, allowing no room for qualitative analysis. This reliance on measurement is a manifestation of naturalism. It exemplifies the methodological approach whereby empirical investigation is taken to be the best and only means of knowledge of the world. Individual lived experience is taken to be fundamentally untrustworthy, at best a failed attempt at scientific investigation. However, it is precisely the return to lived experience that shows how problematic the dominant model of fatness is. In many ways, the strongest argument against the dominant model is the existence of fat people who display no manifestation of ill health other than their supposedly excessive fatness. Objectivist FA and HAES critics of the dominant model frequently use the existence of such people to argue that there is no causal link between fatness and health at all. However, I argue that this is mistaken as well.

I refrain from assuming either the presence or the absence of a causal link between health and fatness. Rather, I take a phenomenological approach and describe some of the patterns that recur in the experience of fat people and of fatness. To this end, I introduce Sarah, an imaginary fat woman. I show how the dominant model fails to make sense of Sarah's lived experience. However, I show that the FA and HAES alternatives also fail to do so. Sarah's experience of her own fatness as a problem is dismissed by some critics of the dominant model, who argue that fatness is never a health problem in and of itself. Some of these critics point to the fact that not all fat people experience their fatness as limiting. On this basis, they argue that fatness cannot be a health problem, since some fat people are healthy. Rather, they argue, some people are just naturally fat, and it is the social understanding of fatness that conditions us to assume that fatness is to blame for all the health problems of those who happen to be fat. Just like the dominant model approach, this ignores the possibility that different people may be fat for different reasons and that different people's fatness may affect them differently. In short, I find that neither the dominant model nor the most prominent alternative makes sense of the lived experience of fatness. Thus, I find that neither is based on a strong model of health.

In Chapter Three, entitled *An Alternative Model of Health*, I introduce my own phenomenological and existentialist model of health, again taking fatness as my example. Drawing on phenomenological methodology in the Husserlian tradition, I describe the experience of health both in oneself and in others. I argue throughout that action is central to health. Husserl's account of embodiment in *Ideas II* makes clear that to experience oneself as embodied is to experience oneself as capable of action, and as acting. The everyday sense of the term 'health' is clearly related to the body. Health, historically, culturally and linguistically, has always had to do with the body, though it may be used more broadly to refer to overall well-being. Thus, if health is about the body, and if the

body is essentially a site of action, then health is about action. Mine is far from the first account of health to be centered on action. However, in my view, other models have made the mistake of focusing on the potential for action rather than action itself.

On this point, and by way of contrast with my own model, I consider the phenomenological account of health offered by Fredrik Svenaeus. Svenaeus argues, in Heideggerian terms, that health is a homelike being in the world. In my view, however, to be healthy is not just to feel well or to be capable of acting in a particular way, but actually to be acting in that way. I agree with Svenaeus that the experience of well-being and capability in oneself is a manifestation of health. However, I argue that this feeling is not itself health. I turn to Husserl's account of embodiment because it is focused on action, and thus can account for the centrality of action to health. The structure of experience characterized by Svenaeus as 'homelike being in the world' I instead describe in Husserlian terms as an 'attitude' [*Einstellung*], because attitude, in Husserl's sense, is not merely a passive experience but is a predisposition to act in a particular way. In my view, what links the experience of 'homelike being in the world' to health is that it is the attitude in which one is most likely to act healthily, which in turn makes one more predisposed to be in this attitude, and thus to continue to act healthily, and so on in, as it were, a virtuous circle.

However, if one is to characterize health as a certain kind of action, then clearly, one needs a criterion by which to distinguish action that is healthy from action that is not. The ethics of Simone de Beauvoir provides this criterion in the form of authenticity. The criterion which Beauvoir applies to action in general is that it is authentic, and therefore justifiable, to the extent that it is undertaken with the genuine aim of realising the freedom of all people. In my view, health is the bodily manifestation of such action. Thus, I refer

to my model as the ‘embodied authenticity’ model of health. This model centers on the claim that health is manifested, first and foremost, in action. I show that this model fits best with the phenomenological description of the lived experience of health. I argue that health is not merely the potential to act in particular ways but rather health is the actualizing of such potential. One is healthy to the extent that one is acting in and through one’s body to pursue meaningful, authentically chosen goals.

I find Beauvoir’s account particularly compelling because, like Husserl’s account of embodiment, it acknowledges both the malleable and the immutable aspects of the human situation. To act authentically is to choose the best action possible, accepting that there are no absolute moral rules to which one can adhere unthinkingly, and that one’s actions may not lead to one’s preferred outcome. To act authentically is to do what one takes to be the best one can in the situation in which one finds oneself. As such, this embodied authenticity model of health accounts for the fact that individuals and communities are responsible for their own health, while also making sense of the social and systemic factors that condition health.

In Chapter Four, entitled *The Embodied Authenticity Model of Health Applied to Fatness*, I return to my example of fatness to show that my model of health makes more sense of lived experience. I argue that, crucially, the model I propose allows one to view health both as it is manifested in an individual body and also as it is conditioned by (and conditions) the broader groups, societies and cultures in which it is situated. In the current discourse, there is a tendency to insist that, if fatness is a problem, it must be either a health problem or a political problem, but it cannot be both. For proponents of the dominant model, fatness is a health problem. This means that the problem is best expressed in terms of objective, neutral, scientific fact. For these commentators, political,

social or cultural debate around the issue is really just distraction. The main point is that people are eating too much and exercising too little and it's killing them and affecting all of us. There are objectivist critics of the dominant model, who argue that a more careful analysis of the data show that fatness is not really such a health problem, and it is just bias that causes people to be so concerned about fatness. In other words, fatness is not really a health problem but a political problem. Constructivist critics, for their part, argue that there can be no neutral or objective knowledge about health, so there really is no such thing as a health problem. From this point of view, fatness is entirely a political problem, because it is just a conceptual category that some people use to exercise power over others. In my view, fatness may be and, in fact, is both a health problem and a political problem.

I base my understanding of healthy action on Simone de Beauvoir's *The Ethics of Ambiguity*. In this text, Beauvoir argues that actions are justified to the extent that the agent is willing him- or herself and others free in the acting. Thus, the notion of freedom, as Beauvoir presents it here, is central to my model of health. In Chapter Five, the conclusion, I give a fuller account of what Beauvoir means by freedom, and again using the example of fatness to show how freedom works as a criterion for healthy action. I argue that accepting the embodied authenticity model of health does not entail wholesale rejection of either the dominant model or the FA and HAES alternatives. Instead, I show how my model incorporates the strongest aspects of those models. Briefly, the scientific expertise of the dominant model, when deployed in the right way, empowers people to act healthily by helping them to understand the impact their short-term actions can have on their long-term potential for future action. Meanwhile, the FA and HAES models offer genuine sites of resistance to the undoubted anti-fat bias of the contemporary culture, thus empowering fat people and others to take responsibility for their health without having to

suffer blame and stigma for their fatness. Indeed, my model of health, based as it is on Beauvoir's freedom-centered ethics, actually addresses many of the concerns of FA and HAES critics of the dominant model, and in fact provides a firmer theoretical basis on which to rebuild stronger versions of these accounts. I argue that FA and HAES is the result of a grassroots movement (or, more accurately, a range of different grassroots movements), driven by admirable political and social motives, many of which are fundamentally compatible with the Beauvoirian model I propose. The potential impact of this goes beyond the health of fat people, or even health in general. In fact, since fatness overlaps with other political and social identities and problems, a better approach to health has the potential to benefit not only fat people but also people of color, especially black and Latina/o people, as well as women, queer people and poor people.

CHAPTER ONE: HOW WE TALK ABOUT FATNESS

Introduction

In this dissertation, I offer a critique of, and an alternative to, the dominant model³ of health in the contemporary United States of America. I use the phrase ‘dominant model’ to refer to the contemporary understanding of fatness⁴. Later, I also refer to the contemporary understanding of health as a ‘dominant model’ of health. I focus on the example of fatness in order to show what the dominant model of health is, and why a critique of and an alternative to the latter are necessary. As I noted in the introduction, the example of fatness gives a particularly rich insight into the dominant model of health, and into the philosophical assumptions on which that model rests, precisely because fatness and its relationship to health are hotly contested.

In this chapter, I explain the key claims of the dominant model of fatness. On the dominant model, fatness is first and foremost a health problem. Thus, examining the dominant model of fatness necessarily invokes the dominant model of health. Specifically, I will argue that the dominant model of health centers on a simplistic, mechanical understanding of the human body, and that it tends to conflate its methods of measurement with the purported objects of its measurement. (In Chapter 2, I will argue

³ I have borrowed the phrase ‘dominant model’ from the work of Charlotte Cooper (“What’s Fat Activism?”), though I use it somewhat differently than Cooper does.

⁴ In contemporary discourse, both expert and general, ‘obesity’ and ‘overweight’ are often used to refer to particular body sizes and compositions which are held to have more adipose tissue than is optimal for health. However, some Fat Acceptance and Health at Every Size commentators claim that no particular body size, shape or composition is, in and of itself, unhealthy, and, thus, they reject the terms ‘overweight’ and ‘obesity’ on the grounds that they are pathologizing and stigmatizing. I do not intend to defend either that claim or its contrary. My thesis is not, ultimately, about whether or how fatness impacts health; rather it is about health itself, how it is understood and how it ought to be understood. When I am recounting fact claims about the medical categories of obesity and overweight, I will use the words ‘obesity’ and ‘overweight’. When I am referring more generally to persons/bodies who are fat, overweight or obese, I will just use ‘fat’ or ‘fatness’.

further that these are manifestations of the essential naturalism of the dominant model of health.) As well as outlining the dominant model, I also consider the critique of the dominant model offered by proponents of Fat Acceptance (FA) and Health At Every Size (HAES). I argue that FA and HAES proponents by and large fail to challenge the theoretical weaknesses in the dominant model of fatness because they fail to identify naturalism as the central theoretical problem in the dominant models both of fatness and of health. Given these aims, my goal is not to defend or disprove the factual claims of either proponents or opponents of the dominant models of fatness and health. Rather, I want to report the factual claims made by proponents of the dominant model and the counterclaims made by opponents of the dominant model, to show the theoretical assumptions that are common to the great majority of commentators on both sides of this debate. In Chapter 2, I go on to argue that these assumptions are manifestations of naturalism, and that naturalism is itself deeply problematic.

The Dominant Model: How fatness, overweight and obesity are understood in the contemporary USA

In this section, I look at what I deem to be the most basic and important tenets of the dominant model of fatness. These beliefs are common not only to a great many medical and scientific experts across many disciplines, but also to (arguably) the majority of people in the contemporary USA. In my view, these basic tenets can be expressed as follows:

- (1) Fatness is caused by – and therefore represents – excessive consumption and insufficient exertion.
- (2) Fatness either is or causes illness, and therefore must be addressed in order to improve health.

(3) The best way to address the problem of fatness is for fat people to lose weight.

I am not primarily concerned with establishing the truth or falsity of these claims. Rather, I am using them as a starting point from which to trace back to what I am calling the dominant model of health.

(1) Fatness is caused by – and, therefore represents – excessive consumption and insufficient exertion.

From the point of view of the dominant model, the primary cause of fatness, overweight or obesity is excessive consumption and insufficient exertion. The word ‘obesity’ is descended from the Latin *obesitas*, which means “fatness” or “corpulence” and which is itself derived from *obesus*, meaning “that has eaten itself fat”. (“Obesity”, *Shorter Oxford English Dictionary*) Thus, there has long been a strong conceptual link between obesity and over-consumption of food. Much more recently, obesity has been referred to as “fork-to-mouth disease”. (“If Obesity is a Disease”) Overweight is now often defined as a precursor to obesity, different from obesity more in quantity than in quality, so the same association with over-consumption exists with overweight. In fact, from the point of view of the dominant model, claim (1) is tautologous; from this point of view, fatness just *is* what happens when one takes in too much food and/or engages in too little physical activity. As one medical textbook on obesity puts it, “Weight gain occurs when energy intake exceeds energy expenditure.” (Moore and Pi-Sunyer 25) Thus, eating and exercise are referred to in biomedical obesity research as the “Big Two” factors in weight control. (*ibid.*)

Within the dominant model, however, different accounts are given for why people over-consume and under-exert. Contemporary life, particularly in industrialised places, is

held to encourage over-consumption and insufficient exertion. As Moore and Pi-Sunyer put it:

... as peoples all over the world become more urbanized and make the transition from hard physical labor to intensive use of labor-saving technology, the incidence of obesity increases. Also, as food production and distribution systems modernize and as people's discretionary income increases, a wide variety of rich and highly palatable food is available to everyone. As a result, more people are overeating at a time when their energy expenditure is decreasing. (5)

That is, populations all over the world are getting fatter because they live in circumstances in which over-consumption is easier than before, while exertion is more difficult (perhaps in terms of time and other resources) than before.

This view is perhaps gaining more currency in recent times. For example, in the Pixar animated movie "Wall-E" (2008), we see a dystopian future in which a mega-corporation has taken over the world and has caused people to consume more and more of its products. (This idea of a future in which everyone will be fat is by no means unique to "Wall-E"; for a list of others examples in fiction, see "Big Fat Future" on TVTropes.org.) In this frightening vision of the future, all humans are obese and these obese humans are presented as extremely lazy. They spend all their time in mobile, reclining chairs, and, when they fall out of these chairs, they are unable to get up of their own accord but must be helped to do so by robots. "Wall-E", of course, is fictional, but the concept of fatness as (at least partly) the result of broader social, economic and political factors is discussed in, for example, the 2004 documentary "Super Size Me" and, in more scholarly terms, in Robert Lustig's *Fat Chance* (2012).

While some commentators thus emphasise the social nature of the problem of fatness, others emphasise the responsibility – even culpability – of individual fat people. Saguy and Gruys (2010) conducted a comparative case study of American news reporting on anorexia, bulimia, binge eating disorder (BED) and obesity between 1995 and 2005. They found that anorexia and bulimia were mostly presented as being illnesses that *happen to* people (242-244), while obesity was presented as being primarily the result of *individual choices* to over-consume and under-exert (244-246), and BED was either dismissed as a laughable ‘excuse’ to engage in such behavior or else it was treated as somewhat like an illness, but one whose cure was essentially ‘more self-control’. (246-247). Saguy and Gruys highlight especially the moralistic terms in which obesity and BED were discussed, in contrast to the morally-neutral, medical framing of anorexia and bulimia.

However, while there may be disagreement about why people over-consume and under-exercise, there is certainly broad consensus that these factors are causing an alarming rise in overweight and obesity, and that this, in turn, is causing all kinds of health problems.

(2) Fatness either is or causes illness, and therefore must be addressed in order to improve health.

As we have seen, fatness has not always and everywhere been considered unhealthy – in fact, at times certain kinds and degrees of fatness have enjoyed a strong association with healthful abundance. In the contemporary USA, some commentators argue that fatness ought to be regarded as neither healthy nor unhealthy, but as a health-neutral physical feature, like (they claim) height or being left-handed. (See, for example, *Lessons from the Fat-o-Sphere*, xi; *Fat?So!*, 47.) It is worth noting, however, that fatness

does not seem to have been widely regarded that way at any time in Western history. To various extents, different kinds and degrees of fatness have been regarded as either conducive to or representative of good health, while others have been identified as symptoms and causes of illness. This has been the case in the Ancient world, in the Middle Ages, throughout Modern times and right up to today. (See Gilman (2008 and 2010) and Schwartz (1986) for comprehensive histories of the understanding of fatness throughout Western history.) At different times in history, European and, later, American experts have had different ways of framing the relationship between fatness and health, but such a relationship has almost always been held to exist; that is, for the vast majority of Western history, fatness – or at least some particular kind or degree of fatness – has been seen as linked in some way to health, whether positive or negative, and whether as a cause, an effect or a manifestation. This does not bear out the suggestion that health concerns around fatness are largely new.

What does appear to be new – perhaps even historically unique – to the contemporary dominant model, is the simplicity and the lack of nuance in its understanding of fatness. As Gilman’s historical analysis (2008, 2010) shows, Western medicine has more or less always regarded certain *types* of fatness to be unhealthy. However, throughout the Ancient, Medieval and even much of the Modern eras, it mattered, for example, how one had become fat and how one’s fat was distributed on the body. Gilman writes that “... the boundaries between the obese and, therefore, unhealthy body and the stout, plump, heavy, well-fleshed, stately but healthy body are constantly shifting. What is a corpulent but healthy body in one system can and does easily become an obese and ill one in the next.” (2010 *x*) But, *pace* Gilman, in the contemporary USA, there are only a very few commentators – and even fewer who are widely regarded as experts – who are willing to defend the concept of a “stout, plump, heavy, well-fleshed,

stately but healthy body”. In reality, terms like ‘stout’ and ‘plump’ are now treated as euphemistic ways of referring to overweight and obesity, which are always necessarily health problems. Indeed the perceived need for such euphemistic usage is itself indicative of the near-universally negative understanding of fatness. Thus, in the contemporary USA (as elsewhere, especially in western Europe), there is markedly less room in public discourse for the concept of different kinds of fatness (with correspondingly different relationships to health and illness) than there was at other times and places. Granted, in recent literature, a distinction is made between ‘central adiposity’ which refers to an accumulation of fat in the abdominal area (Moore and Pi-Sunyer 7), and more general adiposity in which fat might be distributed in many different ways. The former is particularly linked with greater risk for diabetes and cardiovascular disease. (*ibid.*) It is for this reason that waist-to-hip ratio (WHR) is now considered a useful measure of the likely impact of an individual’s adiposity on his or her health. (*ibid.*) The society as a whole has been slow to take up this distinction, however. Significantly, BMI (which takes no account of body composition or fat distribution) is still widely used in clinical and other settings “as an index of adiposity or fatness”. (Gallagher and Yim “Measurement of Human Body Composition” 225) Government-sponsored websites, including www.CDC.gov and www.nhlbi.nih.gov, still encourage the public to check their BMI as a way of checking whether they are healthy or not. BMI is about as reductive a method of measuring fatness as it is possible to get, short of simply using weight (or, more accurately, mass). The widespread use of BMI (and sometimes even just mass) in both clinical and non-clinical settings thus points clearly to an understanding of fat that is much simpler and less nuanced than the great majority of those that have preceded it. In short, in the contemporary USA, most commentators assume that to be fat is to be in the

overweight or obese category (as defined by BMI), and that anyone in the overweight or obese category would be healthier if he or she were less fat.

Certainly most commentators, both expert and non-expert, also agree that there are more people in the overweight and obese categories – that is, there are more fat people – than ever before. Currently, we are said to be living through an “obesity epidemic” (see, for example, “10 Facts About Obesity”). The concept of obesity as an epidemic emerged in the late 1990s and spread rapidly. (See Gilman 2008 16-17) The number of news stories describing obesity as an ‘epidemic’ grew exponentially between 2000 and 2004. (*ibid.*; Oliver 36) The ‘epidemic’ spread of obesity is said to be affecting the population’s health in serious ways. This is because, to quote the National Institutes of Health patient booklet, “Aim for a Healthy Weight”, “We know that an increase in weight also increases a person’s risk for heart disease, high blood cholesterol, high blood pressure, diabetes, gallbladder disease, gynecologic disorders, arthritis, some types of cancer, and even some lung problems.” Similarly, the CDC reports that, as weight increases, so does the risk of coronary heart disease, type 2 diabetes, cancer, hypertension and stroke, amongst others. (“Overweight and Obesity: Causes and Consequences.”) Thus, more fat people quite simply means more sick people. In fact, in 2000, then Surgeon General Dr. C. Everett Koop warned that obesity was second only to smoking as a cause of preventable deaths in the USA. (“The Global Spread of Obesity.”) In 2001, Koop’s successor Dr. David Satcher went one better, warning that obesity was about to *overtake* tobacco as the chief cause of preventable deaths in the United States. (“U.S. Warning of Death Toll From Obesity.”) In 2003, on the eve of the Iraq war, then Surgeon General Dr. Richard Carmona told a reporter that obesity was a bigger threat to US citizens’ health than weapons of mass destruction. (Carmona; Campos *The Diet Myth* 3)

According to the Centers for Disease Control and Prevention (CDC), 37.5% of adults in the US were obese in 2010. (“Prevalence of Obesity in the United States.”) In 2004, the CDC claimed that obesity was causing as many as 400,000 deaths a year in the USA (“US Warning of Death Toll from Obesity”). (Indeed, it was largely on foot of this data that obesity was said to be overtaking tobacco as the leading cause of preventable deaths in the United States (*ibid.*)) The CDC later rowed back considerably on this claim (“Data on Deaths From Obesity is Inflated”), after a later study, widely held to be much more accurate, put the figure closer to 112,000. (Flegal *et al.* 2005) Nonetheless, it is still said that the current generation of children will be the first to die before their parents, and this will happen because of obesity (“Children’s Life Expectancy Being Cut Short By Obesity”). As one expert puts it, “... if we don’t take steps to reverse course, the children of each successive generation seem destined to be fatter and sicker than their parents.” (Ludwig 2325) Thus, there is broad – though, as we shall see, not universal – consensus that more people in the US are becoming overweight and obese, and that this is going to result in illness and death.

Obesity is, in fact, so strongly identified with ill health that it has come to be classified, at least by some people and for some purposes, as a disease in itself. In the 1980s and 1990s, two separate groups of US researchers claimed that obesity could be caused in part by an infectious agent – in other words, they suggested obesity was an infectious disease that could, at least in principle, be simply ‘cured’ by the use of anti-viral agents. (Gilman 2010 124-126) Others have argue that obesity fulfils the standard criteria for disease, which are “... (1) recognized etiological agents, (2) identifiable signs and symptoms, and (3) consistent anatomical alterations.” (Stern and Kazaks 41) These latter proponents argue that, despite its behavioral aspect, obesity should still be considered a disease, just as lung cancer is still considered a disease even when it is partly

caused by smoking. (*ibid.* 42) Aronne, Nelinson and Lillo follow the same line of argument, claiming that “Obesity meets all accepted criteria of a medical disease, including a known etiology, recognized signs and symptoms, and a range of structural and functional changes that culminate in pathologic consequences.” (“Obesity as a Disease State”)

Some powerful institutions have also chosen to treat obesity as a disease. In 1999, the Food and Drug Administration (FDA) announced that it agreed that obesity is a disease. (“Regulations on Statements Made for Dietary Supplements.”) In a report published in 2000, a group of experts convened by the World Health Organisation describes obesity as “a serious disease” and “a chronic disease”. (“Obesity” 4) In 2002, the Internal Revenue Service (IRS) ruled that treatment for obesity was tax deductible on the grounds that “Obesity is medically accepted to be a disease in its own right.” (IRS Revenue Ruling 2002-19) In 2004, the US Department of Health and Human Services removed from its official policy language that defined obesity as a result of behavior and therefore not a disease. (“Medicare Changes Policy On Obesity.”) In June 2008, the Obesity Society (TOS), which calls itself “the leading scientific society dedicated to the study of obesity” (“About Us”), declared that it regards obesity as a disease and encourages others to do the same. (“Obesity as a Disease.”) In June 2013, the American Medical Association (AMA) followed suit. (“AMA Adopts New Policies”)

There is by no means a universal consensus that obesity should be regarded as a disease, however. As we have seen, news reports on obesity and binge eating disorder tend to stress individual responsibility to a far greater degree than do similar reports on anorexia and bulimia. (Saguy and Gruys) The notion of obesity as a disease has even been mocked, for example by calling it “fork-to-mouth” disease (“If Obesity Is a Disease”), or

in the article “Scientists still seeking cure for obesity” on satirical humor website The Onion. Such humor is based on the idea that overweight and obesity are so clearly matters of individual behavior that it is ludicrous to suggest either should be regarded as a disease. But even amongst those who take seriously the possibility that obesity itself is a disease, there is dissent. For example, when it decided to regard obesity as a disease, the AMA went against the findings of its own Council on Science and Public Health (CSPH), which reported that obesity could *not* properly be called a disease, since there is no sufficiently broad consensus on the definition of disease and there is no reliable way of diagnosing obesity. (“Report: Is Obesity a Disease?”) The AMA CSPH report is notable in that it engages with ontological questions about the natures and definitions of both disease and obesity. Many other contributors to this and related debates do not engage with these questions, but rather focus on the practical, social, medical or financial effects of considering obesity to be a disease. The same is true of debates over whether obesity ought to be considered a disability, to which I now turn.⁵

There has been considerable discussion as to whether obesity is or should be protected as a disability under anti-discrimination employment law. Increasingly, it seems that “severe” obesity is so protected. Under the Americans with Disabilities Act Amendments Act of 2008 (ADAAA):

The term “disability” means, with respect to an individual— (A) a physical or mental impairment that substantially limits one or more major life activities of

⁵ I include a brief discussion of the relationship between fatness and disability here, in the section dealing with fatness as illness or cause of illness, notwithstanding the important ways in which disability studies scholars have problematised the relationships between disability, impairment, disease and illness. (Michael Oliver offers a good overview of these interventions. See “Theories in Health Care Research”.) My goal here is to list the basic tenets of the dominant model, and, from the dominant model point of view, disability constitutes a lack of or loss of health, even if it is not entirely or uncomplicatedly the same thing as illness or disease.

such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment. (ADAAA Sec. 4 (a) (1).)

In recent years, “severe” obesity has come to be seen as such an impairment, and one that can be a disability in certain cases. (“When Weight is Disabling”; “New Developments in the Law”) The attempt to protect obese employees under the ADAAA has met with some success. For example, in April 2012, Resources for Human Development, Inc. agreed to pay \$125,000 to settle a disability discrimination suit filed in September 2010 by the EEOC. In this case, the disability was “severe obesity”. (“Resources for Human Development Settles”.)

As well as legal debate, there has been medical discussion over whether obesity should be considered a disability. In June 2009, the American Medical Association (AMA), voted to endorse the following resolution:

If obesity is designated as a disability, physicians could be sued or reprimanded for discrimination under the Americans with Disability Act if a patient takes offense at the physician discussing obesity. Therefore be it resolved that our American Medical Association not support the effort to make obesity a disability. (Cox, “Doctors Fight Labeling Obesity a Disability”)

Note, again, how this resolution makes no claims about whether obesity is, in and of itself, a disability, but only claims that obesity or obese patients might be less treatable if obesity were designated as a disability. This implies that, even within medical circles, to some extent the discussion of obesity as disability is dominated by the practical issues involved.

As well as being understood as a physical disease or disability, fatness is sometimes regarded as a manifestation or effect of mental illness. One older but still highly influential expression of this conception is Susie Orbach’s *Fat is a Feminist Issue*,

in which Orbach gives a psychoanalytic account of fatness in women in the late twentieth century USA. On Orbach's account, fat women over-consume and/or under-exert as a response to psychic trauma or difficulty, specifically that brought about by living in a patriarchal society. Thus fatness is the result of disordered eating, which is itself a response to psychic trauma or difficulty. Orbach writes:

Feminism argues that being fat represents an attempt to break free of society's sex stereotypes. Getting fat can thus be understood as a definite and purposeful act; it is a directed, conscious or unconscious, challenge to sex-role stereotyping and culturally defined experience of womanhood. Fat is a social disease, and fat is a feminist issue. (15)

In this conception, the fatness of women is seen as an active choice, a deliberate (albeit perhaps subconscious or unconscious) rejection of gender stereotypes and expectations. Notably, Orbach almost entirely conflates fatness with disordered eating and, particularly, with compulsive over-eating. It is a cornerstone of her theory that fat women have chosen their fatness by choosing to overeat. While Orbach's feminist perspective could hardly be called 'dominant' in contemporary America, her understanding of fatness does fit in with the dominant model in significant ways. First, she treats fatness as essentially abnormal, as a temporary or artificial state, which is not a natural part of the ordinary run of things. Second, though she does not express it in dominant-model or medical scientific terminology, she treats fatness as a symptom of pathology. To be fat is, in some way, to be unhealthy, whether physically or mentally. On Orbach's account it is a kind of psychic, even political, malaise that explains the physical symptom of fatness. This psychological conception of fatness is still present in the contemporary USA. Gina Kolata relates how one obese woman's doctor told her, in 2005, that "... she had a mental problem because she weighed 400 pounds. She was trying to commit suicide by getting so fat, the doctor informed her." (*Rethinking Thin* 68) Meanwhile, Binge Eating Disorder

(BED), which often – though not always – results in weight gain and fatness, has been included in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). (“Feeding and Eating Disorders”)

Thus, there are a number of different conceptions about how exactly fatness affects health, though there is very broad agreement that the effect is negative. There is, however, an all but overwhelming consensus between all proponents of the dominant model about the solution to the problem of fatness: Individual fat people need to lose weight by eating less and exercising more.

(3) The best way to address the problem of fatness is for fat people to lose weight

As we have seen, according to the dominant model, most fat, overweight or obese people are so because they consume too much and exert themselves too little. There is also broad agreement that it would be better for their health if fat people were to lose weight. These points of agreement are based on the findings of successive studies in various scientific disciplines, and are disseminated to the public by various means, including through various government agencies. As one NIH pamphlet puts it, “Reaching and maintaining a healthy weight is important for overall health and can help you prevent and control many diseases and conditions.” (“Aim for a Healthy Weight”) It is widely accepted that, “To lose weight, you must use up more calories than you take in. Since one pound [of fat] equals 3,500 calories, you need to reduce your caloric intake by 500—1000 calories per day to lose about 1 to 2 pounds per week.” (“Losing Weight”; see also “Balance Food and Activity”, “Balancing Calories”.) There is also broad agreement amongst advocates of the dominant model that small weight reductions can have big benefits. We are often told that, “... even a modest weight loss, such as 5 to 10 percent of

your total body weight, is likely to produce health benefits, such as improvements in blood pressure, blood cholesterol, and blood sugars.” (“Losing Weight”) The overall message is that you should check your BMI and, if you are above the ‘healthy weight’ category, losing some weight will improve your health. As an article on the popular health website WebMD.com puts it, “Lowering body weight can reverse or prevent diabetes; lower blood pressure, cholesterol, and triglyceride levels; and improve sleep apnea and other sleep problems – along with helping you feel better about yourself.” (Zelman, “Lose Weight, Gain Tons of Benefits.”)

The most common method of weight loss is dieting, sometimes teamed with an exercise program. The goal is to redress the calorie imbalance that has led to fatness by consuming fewer calories (and, sometimes, by expending more calories in exercise). Moore and Pi-Sunyer write that, “From a practical standpoint, there are only two avenues to weight control that an individual can influence – how much is consumed (i.e., food and drink) and how much physical activity is engaged in.” (25) Accordingly, the advice given to those who would lose weight is almost always to consume fewer calories (while maintaining a good nutritional balance) and to exercise more. In the vast majority of dominant model discourse, the basic assumption is that it is possible for the vast majority of overweight and obese people to lose enough weight to put them in the normal weight category, or at least enough to improve their health significantly, by simply eating healthily and exercising. The general consensus is that “... combining dietary restriction with increased physical activity facilitates weight loss and helps prevent weight regain.” (Butryn, Clark and Coletta, “Behavioral Approaches to the Treatment of Obesity” 262) At certain times, especially in the twentieth century, the emphasis has been on diet, however, today, neither diet nor exercise alone is considered to be nearly as effective as the combination of the two. (*ibid.*)

Those who struggle to lose weight in the standard way may be offered help in the form of drugs or surgery. At the time of writing, there is only one anti-obesity drug approved by the FDA for long-term treatment of obesity, namely orlistat. (Bray, “Pharmacological Approaches to the Treatment of Obesity” 313-314) The FDA has approved other drugs for short-term use in the treatment of obesity, while there is also a number of drugs approved by the FDA for treatment of other conditions but which have a side effect of weight loss. (*ibid.* 314-318) Four weight loss drugs are currently in phase III clinical trials. (*ibid.* 318) Some weight loss drugs that were available in the past have been withdrawn from the market because they were found to have very dangerous side effects. Perhaps the most notorious example is phentermine-fenfluramine (‘phen-fen’), which was widely prescribed in the 1990s, but then pulled from the market when serious doubts arose as to its safety. (Kolata, *Rethinking Thin*, 22-26)

In the contemporary USA, many people are even willing to undergo major, life-changing surgery if it means they can shed (what they consider to be) their excess weight. Weight loss surgery (WLS) or ‘bariatric surgery’ is a growth area in contemporary medicine. There are surgical procedures which aim to limit food intake (these are known as ‘restrictive’ procedures), procedures which aim to limit nutrient absorption (‘malabsorptive’), and procedures which combine some aspects of the two. (Bessler et al., “Surgical Treatment of Severe Obesity” 323) There has been a huge increase in the number of people undergoing such surgeries, from about 16,200 in 1994 (Robinson, “Surgical Treatment of Obesity”, 520) to about 177,600 in 2006 (“Benefits of Bariatric Surgery”). These surgeries are expensive, potentially dangerous and require extreme changes of lifestyle even in cases with few to no complications. Thus, the fact that so many people are willing to undergo them shows how highly both they and their doctors value weight loss. This is certainly because, on the dominant model, fatness is considered

to be extremely dangerous to one's health. However, a very significant part of the desirability of weight loss is likely also attributable to the other aspects of the dominant model that I discussed in the introduction, such as the aesthetic preference for thinness, and the notion that fat people are greedy and lazy. Despite these factors, there is a growing minority of commentators, both within the scientific community and beyond, questioning whether significant, long-term weight loss is ever possible without severe side effects, and whether it is even a very important goal at all. There are a number of dissenting voices, some of whose critiques have begun to cohere in recent years into an alternative understanding of fatness. In the next section, I outline this alternative understanding.

Challenges and alternatives to the dominant model

Challenges to the dominant model come from a number of sources. Across various academic disciplines and professions, a growing (though still minority) number of commentators is challenging the dominant model of obesity. In this section, I focus in particular on the Fat Acceptance (FA) and Health At Every Size (HAES) approach to fatness, because it is FA and, in particular, HAES, that has, thus far, offered the strongest attempt at a genuine alternative to the dominant model of fatness and health. Below, I outline what I take to be the central tenets of this alternative model. Each of these tenets is (by no means coincidentally) a direct contradiction of one of the central tenets of the dominant model outlined above. Before I discuss these, however, I want to mention some of the researchers who, though in many cases they are not themselves directly aligned with the FA or HAES movements, have produced research or critique which has become central to arguments for the FA and HAES approaches.

A notable example is Albert J. Stunkard, emeritus director of the Center for Weight and Eating Disorders at the University of Pennsylvania, who published widely on

obesity in psychiatry and medicine journals. Stunkard tells Kolata, “Most obese people are no different than non-obese people.” (Kolata, *Rethinking Thin*, 93) Based on his decades of research, Stunkard has concluded that (in Kolata’s words):

There is no psychiatric pathology that spells obesity. And there is no response to food that is not shared by people who are not fat. [...] You can’t say you got fat because there is a lot of stress in your life. Thin people are just as likely to eat under stress. You can’t say it was because you used food as a reward. If that is the reason, then why do thin people, who also use food as a reward, stay thin? (*ibid.* 93-94)

The notion that fat people’s behavior around food is not different from that of thin people is clearly a challenge to the calorie balance concept of overweight and obesity. From the mainstream dominant-model scientific point of view, eating and exercise are the ‘big two’ controllable factors in overweight and obesity. If Stunkard’s claims are true, one of the ‘big two’ is practically eliminated as a controllable factor. While this would still leave intact the possibility that fat people are fat because they expend less energy in exercise and activity (and thus that they could lose weight by exercising more and being more active), it still flies in the face of majority expert – and, indeed, non-expert – opinion on the causes and meaning of fatness.

Stunkard’s work has been very widely published in peer-reviewed journals over his long career. Often, however, challenges to the biomedical obesity science of the dominant model come in the form of more popular books, rather than in peer-reviewed journal articles. For example, in *Big Fat Lies*, Glenn Gaesser argues that close analysis of the available data show that the dangers of being overweight and obese have been greatly overstated, and that, in fact, overweight and obesity may confer modest health benefits. (Gaesser 2002) In *The Diet Myth*, law professor Paul Campos “cross-examines” (as he puts it) the evidence for the idea that obesity can cause disease and even death, and he

claims that there is actually very little strong evidence that being overweight or obese increases the risk of disease or death. (Campos *The Diet Myth*; see especially 8-28.) Meanwhile, physical education expert Bruce Ross argues that, “There is little to no evidence to support the assumption that obesity causes non-communicable diseases such as non-insulin dependent diabetes mellitus and ischaemic heart disease rather than being a symptom of those diseases.” (Ross, “Fat or Fiction”, 106) Sports science and education researcher Michael Gard claims that the dominant model is based on inadequate scientific data, that we simply do not know enough about obesity to draw any conclusions like those drawn by the dominant model, and that (regardless of the possible dangers of excess adiposity) the present ‘obesity epidemic’ has been driven primarily by moral panic rather than medical concern. (Gard and Wright 2005; Gard 2011) Similarly, political scientist J. Eric Oliver argues that much of that panic around the obesity epidemic is based on hatred of fatness, which is in turn rooted in racism, classism and other biases. (Oliver, *Fat Politics*, 2005)

As I have said, these authors are not all themselves advocates of Fat Acceptance, nor do they all endorse the Health at Every Size approach. However, their work has been used extensively by FA and HAES commentators and activists to make the case for an alternative model of fatness. The development, discovery and dissemination of their ideas has been part of the work of the FA and HAES movement, many of whose members would see themselves as uncovering the scientific truth that has been obscured by fat hatred and moral panic around obesity.

FA itself is a broad movement.⁶ It encompasses activists, bloggers (the online FA community is referred to as “the fat-o-sphere” (see for example Harding and Kirby)), as well as organizations such as the National Association to Advance Fat Acceptance (NAAFA) and the International Size Acceptance Association (ISAA). There is significant overlap between the FA and HAES movements, though in public discourse the latter is represented more prominently by nutritionists and other health professionals. Like proponents of the dominant model, proponents of FA and HAES are diverse in their beliefs, practices and aims. However, like proponents of the dominant model, they by and large agree on a set of basic, central claims. Below, I list and discuss these claims. Again, my goal here is not to argue for the truth or falsity of these claims. Rather, I want to show that FA/HAES does not currently provide a radical alternative to the dominant model of health. This is the case, I will argue, because much FA/HAES commentary either accepts or simply ignores the problematic naturalist assumptions at the heart of the dominant models of both fatness and health.

(1) Some people are naturally fat.

⁶ In fact, not all those in the movement even refer to it as Fat Acceptance – some use the term Fat Liberation (Vesta44; Freespirit and Aldebaran), others Fat Activism (Cooper; “Three Dangerous Fat Activism Myths”), others Size Acceptance (“ISAA Mission Statement”). However, I deem the term Fat Acceptance especially apt. The first reason is that it is *fat* specifically, not size generally, that is the target of the prejudice the movement is trying to highlight and challenge. But this could also legitimate the use of Fat Liberation or Fat Activism as the umbrella term. So the second reason I deem Fat Acceptance most appropriate is that the terms Fat Liberation and Fat Activism suggest, and, indeed, refer to, movements united by particular political and activist principles. However, the political perspectives of FA writers and critics vary widely. Everyone in this movement (by definition) advocates fat acceptance, but not everyone in the movement argues for fat acceptance on explicitly political grounds, and, even amongst those who do, the political grounds vary. For example, in *Lessons From the Fat-o-sphere* (2009) Harding’s and Kirby’s arguments tend to align with traditional liberal principles, while in *Revolting Bodies* (2004), Kathleen LeBesco draws on identity politics to consider fatness as an “othered” identity. For these reasons, I think Fat Acceptance is the best umbrella term to use.

FA/HAES activists and writers claim that some people simply have more adipose tissue than others, and that someone's body size, shape or composition, on its own, tells us very little about his or her health. For most in the FA movement, the word "fat" is a purely physical description of a person who has more than the usual amount of adipose tissue. It should not imply any medical, let alone moral, judgement of the person. Marilyn Wann claims that, "Weight, like height, is a human characteristic that varies across any population in a bell curve." ("Foreword" ix) FA commentators often use the word 'fat' deliberately in an attempt to normalise it and reclaim it as a descriptive word with (as they see it) no more evaluative or normative content than terms like 'tall' or 'young'. Harding and Kirby write:

We can't stand the word 'overweight' because of the implication that there is a single, objectively correct weight for every human body. There ain't. ... We are fat, just as we are both fairly short, both have curly hair ... and both wear glasses some of the time. As far as we're concerned, the word 'fat' has no more moral value than those other descriptions; it just is what it is. (*Lessons from the Fatosphere* xi)

Marilyn Wann says, "...it's just as polite to say 'fat' as it is to say 'young' or 'tall' or 'human'." (*Fat? So!* 20) As Charlotte Cooper says, summing it up, "...fat rights activists believe that fat is something that is normal, part of a continuum of body sizes..." (*Fat and Proud* 13) Deb Burgard writes that encouraging fat people to lose weight for their health is comparable to, "...starving a St. Bernard because a study of dogs shows that greyhounds live longer." ("What is 'Health at Every Size'?" 44) Clearly, this way of understanding fat is a direct contradiction of the dominant model view, on which fatness is taken to be an abnormal state, and not part of the natural variation of healthy bodies.

Indeed, not all FA commentators even agree that fatness itself exists in the way that it is assumed to exist under the dominant model. Some regard fatness as a social construction. Charlotte Cooper points out:

Many of us [FA advocates] would argue that slenderness is real and quantifiable, while others would say that the distinctions between fat and thin are blurred and that slenderness only exists in opposition to fatness because it has been positioned as a primary desire in Anglo-American culture – that without such distinctions there would be no such thing as fat or thin. (*Fat and Proud* 6)

Cooper herself goes on to argue against the notion of fatness as social construct, concluding that fatness is “a very real and tangible physical difference” (*ibid.* 10). However, she cites Nicky Diamond’s 1985 critique of *Fat is a Feminist Issue* as an example of the argument that fatness ought to be understood as social construction. That conception of fatness as social construction persists into more recent debates. In their editors’ introduction to *Bodies Out of Bounds*, published in 2004, Kathleen LeBesco and Jana Evans Braziel refer to “the restrictive constructions of corpulence within discourses – medical, psychological, and capitalistic – that have accumulated around the site of the ‘fat body’ ...” (1). In her essay in the *Fat Studies Reader* (published in 2009), Elena Levy-Navarro refers to both obesity and health as ‘constructs’ that have been ‘invented’. Obesity, in particular, she describes as an ‘oppressive construct’. (“Fattening Queer History” 16) If one takes fatness to be a social construct, then it becomes meaningless to ask whether some people are just ‘naturally’ fat. Those who start from the assumption that fatness is a social construct tend to focus more on critiquing representations of fatness in the social, political and cultural realm rather than on questioning the explicit empirical claims of proponents of the dominant model.

(2) Fatness in itself is not unhealthy.

Those critics (only some of whom identify explicitly as FA or HAES advocates) who consider fatness in terms of social construction generally cast the so-called ‘obesity epidemic’ as a moral panic rather than a health crisis. (Gard and Wright *The Obesity Epidemic*; LeBesco and Evans Brazier *Bodies Out of Bounds*; Oliver *Fat Politics*; Wright and Harwood (eds.) *Biopolitics and the ‘Obesity Epidemic’*) For these commentators, the focus is on the social, cultural and political context in which the ‘obesity epidemic’ is occurring. It is notable that, like dominant model commentators I mentioned above, these commentators are often more concerned with the social and political implications of how we label fatness than they are with the ontological status of fatness itself. For example, discussing the issue of whether obesity ought to be thought of as a disability, Aphramor (2009) argues that fatness itself is not necessarily an impairment of the kind that typically characterises disability (899), however, she does argue that fatness has become the locus of “a specific form of disablist oppression” (901-903). Aphramor is herself responding to an earlier paper by Cooper (1997), who also discusses the question of fatness as disability in political rather than ontological terms, and rejects the notion that fatness or disability are in themselves necessarily problematic. Brandon and Pritchard (“Being Fat”) seem to move closer to the ontological issue. They apply three different models of disability to fatness, namely, the medical model, the social model and the affirmation model. They find that, when considered in terms of each of these three models, fatness does overlap with disability to a considerable extent. Again, however, their conclusions center on the advantages and disadvantages of fat advocates and disability advocates joining forces (“Being Fat” 87-88).

Even those FA and HAES commentators who accept the empirical assumptions of the dominant model still claim that being fat, in itself, is not harmful to one's health. This is not to say that every FA or HAES commentator claims that the link between obesity and mortality or morbidity is negligible. But, even so, they tend to argue that if there is a proven link between obesity and disease, that does not prove that obesity *causes* disease. In *Lessons From the Fat-o-sphere*, Harding and Kirby write:

So, yeah, there's an established correlation between obesity and excess mortality, but that doesn't tell us that being fat leads to early death. What it tells us is that something common to many obese people sometimes does lead to early death – and fat ain't the only thing a lot of fatties have in common. (*Lessons from the Fatosphere* 175)

On the HAES side, Bacon and Aphramor claim that, “Except at statistical extremes, body mass index (BMI) – or amount of body fat – only weakly predicts longevity.” (“Weight Science” 2) On the HAES blog, Marsha Hudnall defines healthy weight as, “...an outcome of living according to HAES principles.” (“Exploring Healthy Weight”) So, for HAES advocates, there is no particular weight range within which all healthy people are to be found; rather, the weight of any person who lives healthily is, by definition, a healthy weight. Deb Burgard argues that the concepts of ‘healthy weight’ and ‘unhealthy weight’ are the results of faulty reasoning. She writes, “The ‘risk factor’ of higher BMI comes from a comparison of always-been-thinner people to fatter people, and we do not know whether “reduced” fat people would have the same risk profile as always-been-thinner people ...”. (“What is ‘Health at Every Size?’” 43) HAES commentators regard the idea that fatness is unhealthy as more of a prejudice than a fact, thus, one of the aims of the HAES movement is to “... untangle the effects of weight stereotyping.” (*ibid.* 48)

Indeed, some FA and HAES commentators suggest that what Burgard calls ‘weight stereotyping’ may be more harmful to the health of fat people than their fatness itself. Bacon claims, “The real enemy ... is not weight, but weight stigma. Fear of fat is much more harmful than actual adiposity, distracting us from true threats to our health and well-being.” (“Fat Stigma – Not Fat.”) Harding and Kirby claim that fat people may suffer negative health outcomes because the anti-fat prejudice of medical practitioners makes medical settings ‘emotionally and physically treacherous’ for fat patients. (*Lessons from the Fat-o-sphere* 51) Cooper writes that, “The real risk to fat people’s health is in our attempts to lose weight.” (*Fat and Proud* 74) And, from the FA and HAES points of view, any harm caused by weight loss attempts is particularly tragic, since FA and HAES advocates do not regard long term, healthy weight loss as a real possibility for most of people.

(3) It is all but impossible to make a naturally fat person thin over the long term.

FA and HAES advocates argue strongly that most weight loss attempts fail, and, on the rare occasions that they succeed, they often do so at great cost to the health of the person. HAES, in fact, has its roots in a rejection of dieting and other weight loss attempts. The notion that weight loss is neither a valuable nor an achievable health goal is to all intents and purposes the defining belief of HAES. According to Linda Bacon:

The vast majority of people who try to lose weight regain it, regardless of whether they maintain their diet or exercise program. This occurs in all studies, no matter how many calories or what proportions of fat, protein or carbohydrates are used in the diet, or what types of exercise programs are pursued. Many studies also show that dieting is a strong predictor of future weight gain. (“HAES Manifesto”)

Indeed, HAES commentators often express anger and frustration at the refusal of dominant model proponents to abandon weight loss as a goal. HAES advocate Joanne P. Ikeda laments that:

... the results of the Look Ahead study were published in 2012 with no fanfare because after all the years of treatment and support, the average weight loss was around 7 pounds. “Why? Why?” I ask myself, “Why does the scientific community refuse to admit this approach has failed?” (“A Dietitian’s Road to HAES”)

The broader FA community is strongly allied with HAES on this point. Dieting in particular comes in for criticism from FA commentators. Harding and Kirby devote an entire chapter of their book to arguing that diets don’t work. (*Lessons from the Fat-o-Sphere* 3-12) Marilyn Wann says that, “...the more we diet, the more weight we gain. In fact you’re more likely to survive cancer than you are to lose weight and keep it off.” (*Fat? So!* 92) However, FA and HAES commentators also reject other weight loss options such as medical and surgical intervention. Reminding readers of the “phen-fen” scandal (see Kolata *Rethinking Thin* 22-26) and highlighting the case of similarly under-researched drug sibutramine, Paul Ernsberger claims that there is an “... absence of any safe and effective treatment for obesity...”. (*The Diet Myth* xiv) Weight loss surgery (WLS) is also rejected by FA and HAES commentators because they see it as ineffective at best and dangerous at worst. (See for example “Why We Oppose Weight-Loss Surgery”; “Mandatory Weight Loss Surgery?”)

Some commentators (Campos; Gaesser “Is ‘Permanent Weight Loss’ an Oxymoron?”; Harding and Kirby) simply say that there is *currently* no safe, long term way to make fat people thin, while leaving open the possibility that weight loss might be a good thing for some people if it could be safely accomplished. Others, however, seem to

be opposed to weight loss even in principle. In her introduction to the *Fat Studies Reader*, Marilyn Wann warns academics, “If you believe that fat people could (and should) lose weight, then you are not doing fat studies – you are part of the \$58.6 billion-per-year weight-loss industry or its vast customer base.” (“Foreword” ix) Such stark terms set up a very strong dichotomy: Either you refuse outright to consider that weight loss is ever possible (‘could’) or valuable (‘should’) for fat people, or you are just another lackey or dupe of what one might call the diet industrial complex.

Each of the three numbered claims above is a direct contradiction of one the basic tenets of the dominant model, thus, they are direct contradictions of claims that are widely accepted in the contemporary USA. Moreover, they are direct contradictions of claims that are understood as scientific, and therefore reliable and factual. To challenge the dominant model understanding of fat, FA activists have long believed that they must meet that model on its own turf, that is, in the field of science. It is for this reason that FA commentators draw extensively on the work of HAES researchers and practitioners as well as the work of those like Stunkard and Gaesser who have scientific credentials and yet dispute the dominant model conclusions on obesity. In fact, whether they themselves are scientists or not, FA activists often discuss scientific issues and evidence at length and in detail. Saguy and Riley quote FA activist Lynn McAfee:

I’m not actually particularly that interested in [health] and God I hate science ... but I recognized very early on that if we are ever to succeed, we have to get a foothold in the medical world and make them understand. And that’s what I’ve tried to do because, when it comes down to it, the last argument is, ‘oh but it’s so unhealthy for you. ...’ People get to discriminate against us because they’re just trying to help us with our health. (Saguy and Riley 878)

Thus, whether for theoretical or practical reasons or both, many FA commentators are reluctant to take on the dominant model of health or, indeed, that of knowledge. That is,

they don't object to the methodology of science in general, only to what they see as its misapplication in the case of obesity. Those who do reject scientific methodology (that is, those who see health, fatness and even science itself as social constructions) reject it so thoroughly that, by and large, they simply do not engage at all in the scientific and quasi-scientific debates that make up so much of the discourse on fatness in the contemporary USA. The upshot is that, while there are many commentators who reject the dominant model of fatness, and some who reject the dominant model of health more generally, we still lack the kind of detailed critique of these models themselves, and of their theoretical assumptions, that I will argue is needed if we are to develop a genuine alternative to these dominant models.

Granted, on the face of it, HAES advocates may seem to be offering a genuine alternative to the dominant model of health. Certainly the notion that weight or BMI is not a useful measurement of health is a radical one in the context of the contemporary USA. However, by and large, HAES advocates, like FA advocates, do not dispute the dominant model conception of health, they only dispute its relationship to fatness. In most cases, they present their claims not as alternatives to the data offered by dominant model researchers but as more accurate interpretations of those data. In one respect, however, HAES does offer a path to a genuinely radical way of understanding health. This is its emphasis on behavior. Since I ultimately argue that health is a characteristic of actions rather than of bodies, I regard this emphasis on behavior as a firm and significant step in the right direction. I will discuss this aspect of HAES in greater detail in Chapter 2. In the next section of the present chapter, however, I discuss the dominant model of health in more detail and show that, in their present states, FA and HAES fail to critique that model and thus are not in a position to provide a genuine alternative to it.

The dominant model of health

My goal in this section is to identify the claims that are being made about health itself, implicitly or explicitly, in expressions of the dominant model of fatness. In short, what does ‘health’ mean in the dominant model? When we examine the case of fatness, some key aspects of the answer to this question emerge.

As we have seen, the dominant model of health is almost always expressed in the language and concepts of contemporary scientific method and discourse. This is because, as we have seen, fatness is understood primarily and fundamentally as a health problem, and because, as we will see, health is understood primarily and fundamentally as a matter for science and scientists. For example, consider again the concept of the calorie balance, a concept which is treated almost as an article of faith by proponents of the dominant model of fatness. According to the conventional wisdom, in order to lose weight, one must ‘take in’ fewer calories than one ‘uses up’, thus creating an energy deficit for which the body will compensate by using up fat stores. David Berreby quotes then New York Mayor Michael Bloomberg: “If you want to lose weight, don’t eat. This is not medicine, it’s thermodynamics. If you take in more than you use, you store it.” (“The Obesity Era”) Berreby adds: “Got that? It’s not complicated *medicine*, it’s simple *physics*, the most sciencey science of all.” (*ibid.*, emphasis in the original.) As Berreby points out, the positions of actual obesity scientists are much more nuanced than Bloomberg’s statement would suggest. (*ibid.*) Nonetheless, Gard and Wright (*The Obesity Epidemic*; see especially the chapter entitled “The Ghost of a Machine”) argue that almost the entire field of obesity studies is indeed underpinned by the assumption that body weight operates in strict and predictable accordance with a law whereby “ $a - b = c$, where a is energy consumed, b is energy expended and c is the resulting change in body weight.” (*ibid.* 40) Bloomberg is emphasising the simplicity, the certainty and the truth of the

concept of the calorie balance by saying it's thermodynamics. In other words, he's saying it's pure, it's true, it's definite – it's real, hard *science*. This expectation, manifested in the dominant understanding of fatness, is a key part of the dominant model understanding of health.

As Gard and Wright argue, the 'thermodynamics' model of obesity rests on a wholly mechanical understanding of the human body. Language like that used by Bloomberg makes the fat body sound somewhat like a steam train that is weighed down and unbalanced by excess fuel. In order to get rid of the excess, those in charge of the train must make every effort to burn the fuel on board as quickly as they can, while taking on as little extra as possible. This conception of the human body as a machine – and a fairly straightforward, old-fashioned one at that – is common in the dominant model of health. The comparison is not necessarily entirely wrong, but it is limited for a number of reasons. As Gard and Wright point out, the 'body as machine' model:

...appears to fail on two fronts. First, it has not produced a robust and empirically verifiable account of why people become overweight or obese. Second, and perhaps more importantly, it has generated precious few insights for solving the problem it claims to study. (*ibid.* 69)

The problem is that, unlike the inner workings of actual machines, those of the human body remain obscure in many ways, even to our greatest experts. We know a great deal about how fuel gets into machines like steam trains, and what happens to it when it gets there. At least at the level of atoms and molecules, if not at subatomic level, we have a pretty good working account of that system. But we don't fully understand the systems by which human beings come to eat food (i.e. to take in fuel) or what happens to the food once it is eaten. If the body is a machine, it is a uniquely mysterious one; the manner in which 'fuel' is 'stored' and 'used up' in this machine is only partly understood.

Another point, not raised by Gard and Wright, but in my view just as crucial, is that the ‘body as machine’ model gives rise to a somewhat odd conception of personhood. It suggests that the person and the body are somehow separate, that the person is running the body (like one would a machine), but is not the body. The idea that I, as an individual person, can stand over and above my ‘fuel intake’ assumes that ‘I’ am somehow over and above the systems that regulate that intake, that I am independent of and in control of the ‘machine’ of my body. FA and HAES advocates do not critique this mistaken line of thinking. In fact, by and large, they fall into the same kind of error. Samantha Murray (2008) points out that FA and HAES advocates tend to argue that fat people can choose to love and accept their fat bodies no matter what the contents of their particular experiences of their fatness. This, as Murray argues, represents a complete failure to take seriously the embodied nature of lived experience. One cannot simply choose to experience one’s body in a particular way, no more than one can simply choose to stand outside one’s own internal systems of appetite and consumption.

Of course, this claim that the mind and the body are in some way radically separate could possibly be true, but it is a huge metaphysical assumption, and one that is at odds with experience of being embodied. By and large, I believe such metaphysical conundrums are the outcome of the kind of thinking according to which the body (and therefore health) is best understood in the manner and in the terms we use for other physical things. This kind of thinking I will refer to as physicalism. Physicalism goes hand in hand with naturalism, which, as I discuss further in Chapter 2, is a major theoretical weakness in the dominant model, leading in turn to significant practical problems.

As well as physicalism, Bloomberg's comment also exemplifies another, related aspect of the dominant models of fatness and health. This is the way in which, in the contemporary USA, one often uses the word 'weight' – the name of the measurement – as shorthand for all the interrelated phenomena of body size, shape and composition. (Strictly speaking, pounds and kilograms are measurements of mass, not weight, but in everyday usage, we generally refer to the measurement as 'weight'.) When we think about fatness, we immediately think not just of particular body sizes, shapes or compositions, but also of particular body weights (or masses). It makes some sense, in American culture today, to say of someone, "He looks like he weighs about two hundred pounds", even though bodies of quite widely varying sizes, shapes and compositions could have a mass of two hundred pounds. We have, to a considerable degree, conflated the object of the measurement and the tool with which we measure that object such that the one word 'weight' can mean both the measurement (that is, the number on the scale) and what it is intended to measure (that is, one's actual body size, shape or composition). This reflects a broader tendency of the dominant model to conflate health itself with its methods of measuring health. As we have seen, many FA and HAES commentators do not challenge this conflation of health itself with measurements of health, but simply reject the idea that weight or BMI is a good measurement of health.

One of the problems with this conflation is that it starts to seem as though changing the measurements is the same thing as changing the object that is being measured. This can be clearly seen in the case of fatness. The complex phenomena of body size, shape and composition are reduced to a number, often weight or BMI. This number is then treated as though it were a strong representation of the person's body size, shape and composition. As a result, rather than being told that his or her body size, shape and/or composition is associated with health risks, often the person is just told that he or

she will be healthier if he or she loses *weight*. In other words, the advice given, quite literally, is to change *the measurement*. Of course, the majority of doctors or other medical experts is highly unlikely to advocate weight loss by any means necessary, or to argue that lowering the number on the scale will *automatically* make the overweight or obese person healthier. But, the frequency with which the advice to ‘lose weight’ is given does contribute to a general acceptance that changing one’s weight (regardless of how or why) has an impact on one’s health.

In marked contrast to the perspective of the dominant model, it is practically an axiom of the Fat Acceptance movement that one cannot tell how healthy a person is merely by looking at him or her. For example, on the Dances With Fat blog, Ragen Chastain says, “There are exactly two things that you can tell by looking at someone’s size: (1) What size they are [and] (2) What your personal preconceived notions and prejudices about that particular body size are.” (“Things You Can Tell By Looking At Us”) This claim is at odds not only with the dominant model of fatness, but with the dominant model of health as a whole. Of course, it directly contradicts the factual claims of the majority of mainstream obesity researchers. However, it also contradicts the dominant model at a more theoretical level, because, on the dominant model, ‘looking at’ the body is *exactly* what one does to find out how healthy that body is. Granted, measurement of the body such as is used in medicine is not limited to mere ‘looking’, but uses other senses too, and, granted, the kind of observation that medical practitioners make use of in diagnosis is much more careful and more detailed than the kind of glance or once-over one might give a stranger on the street or even a friend. Nonetheless, it still boils down to the essential principle that looking at someone, or, more accurately, empirical observation, is actually a pretty good way of knowing how healthy he or she is.

Effectively, when someone who accepts the dominant model looks at a fat person, he or she makes an eyeball estimate of what that fat person's measurements (including and perhaps especially his or her weight) are likely to be, and, on this basis, he or she deduces that the fat person is unhealthy. This is not to say that every such judgement rests on a conscious thought to the effect of "This person must weigh such-and-such pounds. I'll bet her BMI is over 30!" Rather, it is that we are so strongly conditioned to conflate weight and size that, when we perceive body sizes, shapes and compositions, the possibility of expressing them as measurements is already part of our experience of them.

In fact, we are to some degree conditioned to look at physical objects in (what we take to be) a scientific way. The dominance of the natural sciences already conditions our experiences in many ways. We see physical things as measurable and analysable. And we see human bodies, at least partly and sometimes, as physical things. Thus, looking at someone is understood as a quick-and-dirty version of the kind of empirical observation undertaken by doctors and scientists. We accept that just looking at somebody is a very limited kind of empirical observation. But we also assume that it is on the same spectrum with more accurate kinds of observation, such as clinical measurements of mass, blood pressure, body fat percentage or blood glucose level. We tend to assume that simply looking at someone gives us the same *kind* of information, just not as much of it, as that used by doctors or scientists to assess a person's health. On this account, the idea that one cannot tell how healthy someone is by looking at him or her just doesn't make sense. On the dominant model, to appear healthy under observation *is* to be healthy.

On the face of it, it seems that many FA commentators reject this belief because they reject the notion that one can tell how healthy a person is by looking at him or her. But a closer examination of FA writing shows that, very often, this is not really the case

at all. In fact, as I indicated above, many FA commentators do not dispute the value of empirical observation at all, they only dispute the notion that just looking at a person constitutes an accurate method of observation. In fact, when defending the notion that fat people can be healthy too, they very often appeal to other empirical measurements. For example, Marilyn Wann says, “My blood pressure, blood sugars, and cholesterol levels are all normal. I feel great, and I weigh 270 pounds. I’m living proof that you don’t have to be thin to be healthy.” (*Fat?So!* 32) Harding and Kirby similarly suggest that, “The number on the scale is actually pretty irrelevant as a measure of health. [...] Instead of checking your weight, check out your numbers for blood pressure and cholesterol and triglycerides.” (*Lessons from the Fat-o-Sphere* 72) Clearly, these writers are assuming that, while weighing someone is not a good way of measuring health empirically, health nonetheless *can* be measured empirically – for example, by measuring blood pressure, blood sugars and cholesterol. This point becomes even clearer when we consider the following extract from a post on Ragen Chastain’s Dances With Fat blog:

When we use weight as a stand-in for health, we are putting a middle man where we don’t need one. We can test a patient’s blood pressure, give evidence-based interventions to lower it if it is too high, and then test the blood pressure again to see if the interventions are working. (“For Fat Patients”)

The implication here is that weight is a ‘middle man’ or ‘stand-in’ for health, whereas blood pressure (for example) *is not*. So, Chastain effectively says that it *is* possible to measure a person’s health directly by means of empirical observation of her body, it’s just that measuring her weight (or, strictly speaking, her mass) is not a reliable means of carrying out such observation. In other words, Chastain and others who take up similar lines of argument are assuming that health itself is something that is directly measurable

by means of empirical observation. If health can be directly measured by empirical observation of the body, then health must be a characteristic or a feature of the body.

Conclusion: Objectivist and Constructivist Conceptions of Health

Of course, there are, as we have seen, FA commentators who regard fatness itself as a social construction, and who are thus sceptical about measuring fatness itself – let alone its impact on health – by empirical means. If fatness is not ‘a real physical difference’ (to borrow Cooper’s phrase), then it cannot be measured by empirical means, and thus it is nonsense to argue that measuring it can somehow also measure one’s health. This ‘social construction’ model of fatness is a particular manifestation of a broader understanding of health in general as constructed, an understanding which stands in opposition to the physicalist and naturalist dominant model of health. Dominic Murphy (“Concepts of Disease and Health”) distinguishes between what he calls (following Kitcher (1997)) ‘objectivist’ and ‘constructivist’ understandings of health. Objectivism centers on the belief that claims about health and disease ought to be grounded on facts about the human body. The dominant model of health is, both in its theoretical assumptions and its practical methods, objectivist. The dominant model of fatness outlined above also fits neatly into the objectivist approach to understanding health. Those who reject the usefulness of weight as a measure of health, while yet upholding the value of other empirical measurements of health, also remain committed to an objectivist conception of health. On the other hand, the notion of fatness as social construction fits in with the broader constructivist notion of health which rejects the idea of biomedical knowledge as ‘grounded’ in facts.

As Murphy notes, other authors have referred to objectivism as ‘naturalism’ and to constructivism as ‘normativism’. Murphy shies away from this terminology because of the widespread usage and varied meanings of ‘naturalism’ in philosophy. I will, however,

use the term ‘naturalism’ to refer to the particular kind of objectivism that characterises the dominant model of health and the dominant model of fatness. I use the term ‘naturalism’ specifically in the sense in which it is used by Edmund Husserl. Thus, by ‘naturalism’, I mean the belief that the natural world constitutes the entirety of what exists and, thus, that the methodology of the natural sciences provides the best and only means of seeking knowledge of the world. In the next chapter, I will draw on Husserl’s critique of naturalism to show that the problems inherent in the dominant model of health are problems of naturalism and that, in various ways, HAES and FA alternatives fail to challenge this naturalism. Rather, I believe, it is necessary to apply a radical critique of naturalism itself to health (as I do in the next chapter), and, ultimately, to provide a non-naturalist model of health (as I do in Chapter Three).

CHAPTER TWO: THE DOMINANT MODEL OF HEALTH AND THE CURRENT ALTERNATIVES

Introduction

In the previous chapter, I argued that the debate over how fatness ought to be understood is situated within a wider debate about how health itself ought to be understood. Broadly speaking, this wider debate can be cast as one between objectivist and constructivist approaches, the former treating health as primarily a matter for empirical investigation and the latter treating it as primarily a matter for critical socio-political analysis. I outlined the basic tenets of what I called the dominant model of fatness, and from this I extracted some key points about the dominant understanding of health in the contemporary USA. I showed that the dominant model is strongly objectivist, resting as it does on the assumption that there is a fact of the matter about health and about how fatness relates to health, and that this fact can be discovered by means of empirical investigation. I also outlined the key tenets of Fat Acceptance (FA) and Health at Every Size (HAES), which purport to offer an alternative to the dominant model of fatness and a different approach to health. HAES is, by and large, objectivist in its framework. Many of its proponents are themselves trained in largely objectivist disciplines such as nutrition or exercise science. Very often, HAES practitioners dispute the dominant model view of the relationship between fatness and health, and they may even offer quite a different emphasis in their account of health; however, their conception of health is still, for the most part, objectivist. FA, being a broader movement, is more diverse. Some FA advocates take much the same line as HAES proponents, thus also assuming an objectivist framework. As we saw in Chapter One, however, other FA advocates take a strongly constructivist line, arguing that both fatness and health are socially constructed issues rather than mind-independent realities.

In this chapter, I argue that attempts to understand health (or fatness) in *either* objectivist *or* constructivist terms will always fail to capture some aspect of the lived experience of health, because health itself (like fatness) has both ‘objective’ and ‘constructed’ aspects. In other words, both objectivists and constructivists can offer valuable insights into health and fatness, but neither perspective offers unique and complete access, and indeed each tends to conceal important aspects. Further, I argue that, despite their apparent differences, virtually all the proponents of these competing models of health and fatness begin with an assumption of positivism and many commit, more specifically, to the form of positivism that I call naturalism. I conclude that a more serviceable model of health will require us to escape the objectivist-constructivist dichotomy by critiquing positivism in general and naturalism in particular.

Objectivism and Constructivism: A false dichotomy

Implicitly, proponents of the dominant model as well as advocates of FA and HAES all assume that fatness, like health, *either* must be understood as a fact in or about the physical world, something that can be empirically observed and the truth of which is not changed in any way by human action or understanding, *or else* it must be understood as a way of categorising the phenomena of the world, a way of thinking about things, but not itself, so to speak, a ‘real thing’. On the dominant model, fatness is the physical result of individual behavior, it is ‘thermodynamics’. For critics of the dominant model, it is either ‘something you’re born with’ just like ‘being left-handed’ (*Fat?So!* 47), or it is ‘not natural or “real”’ (“Fattening Queer History” 15). These are the only possibilities that receive any significant attention in debates on fatness or health. The majority of commentators describe fatness in objectivist terms, as a physical feature, whether it is seen as a symptom or manifestation of poor health caused by bad behavior, or as neutral human variant which ‘does not mean anything’ (*Lessons from the Fat-o-sphere* xi) and

‘just is what it is’ (*ibid.* xiii). A significant minority counters, in constructivist terms, that fatness is not meaningless, that it is, in fact, nothing *but* meaning. This latter group claims that, as Hillel Schwartz puts it, “Weight is a cultural condition. ... Fatness too is a cultural condition.” (*Never Satisfied* 4)

It is important to stress that these beliefs manifest themselves primarily in the way commentators discuss fatness as a problem rather than in how they discuss fatness as an entity. Few proponents of the dominant model of fatness deny that there are social and cultural aspects to the problem of fatness. For example, many respected, mainstream obesity experts lament what they see as the unfair treatment of fat people at the hands of others who (mistakenly, in the view of these experts) see fatness as an aesthetic or moral issue rather than a medical one. (For an overview of recent research on ‘weight bias’, see Latner, Puhl and Stunkard, “Cultural Attitudes and Biases Towards Obese Persons”.) This demonstrates a willingness to engage with questions of the framing of obesity, and to take seriously the social, cultural and political context of the medical problem of obesity. Nor does one typically find constructivists, for their part, arguing that the bodies of fat people are *not* physically different to those of thin people, that the physical feature of fatness is itself somehow imaginary or invented out of whole cloth. For example, Charlotte Cooper insists that fatness is “... a very real and tangible physical difference” (*Fat and Proud* 10), even though she also argues that, “...being fat is an identity more complex than the facts of my biological functioning. ... Being fat is more to do with being socially marginalised... .” (*ibid.* 77) In short, the objectivists consider the social aspects of fatness and health, while the constructivists also consider the physical aspects of fatness and health. This indicates how difficult it is for anyone with any lived experience of fatness (whether his or her own or that of others) to disentangle the supposedly ‘objective’ from the supposedly ‘constructed’. All but the most rabidly zealous anti-fat dominant model

campaigners concede that fatness and health have social, cultural and political causes and consequences, and recognize, at least to some degree, that there are, even now, in the scientific age, contingent and historical aspects to the ways we understand fatness and health. Meanwhile, even the most thoroughgoing constructivists allow that fatness and health are, at least partly, experienced in and through bodies, and have, therefore, an element of 'objective' existence, at least in the very loose sense that they may be said to be objects of direct experience. It is, in short, difficult to find anybody willing to make trenchant ontological or metaphysical claims on behalf of either objectivism or constructivism.

In fact, the 'objectivist versus constructivist' debate, whether around fatness or around health more generally, is not, generally speaking, located on the ontological or metaphysical level at all. In the case of fatness, the controversy is not primarily centered on the question of who is fat or what fatness is, rather the question is for whom fatness is a problem and why. Whether as a cause or as a result (or both) of this, all too many participants in these debates at best take for granted the ontological and/or metaphysical assumptions implicit in their account of fatness, and at worst fail even to recognize that they are making such assumptions in the first place. The objectivist discusses fatness first and foremost not as a physical *thing* but as a physical *problem*, which, for the objectivist, means it will only be solved by recourse to the medical and the scientific. The emphasis on the physical – the body as a material thing, the weighing scale, the laboratory – appears to be a natural consequence given this framing of the problem. The constructivist, on the other hand, sees fat people as subject to problematic social and cultural forms of control and dominance; thus, for the constructivist, the problem of fatness is essentially a *political* problem, which requires a political solution. When one views fatness in this latter frame, analysis of discourse, critique of cultural texts and political activism seem

like the clear way to respond to the problem of fat people. Each side, as a rule, seems to start with a solution and then seems to diagnose the problem in the way that indicates the solution. Neither side, as a rule, gives, or pushes the other to give, a full account of what it takes fatness to be, or, indeed, of what it takes health to be. When one does examine the metaphysical or ontological assumptions implicit in these debates, it emerges that almost all participants share a commitment to positivism and, in very many cases, to naturalism.

Underlying assumptions: Positivism and naturalism

I have claimed that competing models of fatness and of health in the contemporary USA are, despite their apparent differences, all ultimately founded on positivism and, in many cases, more specifically on the form of positivism known as naturalism. In identifying these models as naturalist and positivist, I am drawing on the work of Edmund Husserl in the first half of the twentieth century. Briefly, for Husserl, positivism is the belief that, “Science, objective truth is exclusively a matter of establishing what the world, the physical as well as the spiritual world, is in fact.” (*Crisis* 6) Positivism is thus the assumption that all knowledge claims must be claims about facts, that is, about what is the case in the world, independent of any particular mind or any particular subject’s experience. Naturalism is the belief that legitimate or coherent knowledge claims are not only limited to claims about mind-independent fact, but actually are limited to claims that can be verified by the methods of the natural sciences.

It is relatively uncontroversial to claim that the dominant model rests on positivism and naturalism (though, clearly, it is much more controversial to argue, as I do later in this chapter, that these positions lead to a problematic understanding of health). As we saw in Chapter 1, the dominant models, both of fatness and of health, are centered on the empirical and, more specifically, on physical measurement. Their claims are always positivist in that their claims always, explicitly, and unapologetically purport to be

statements about how the world is, about facts, about mind-independent reality. Their claims are also typically naturalist, in that they are typically justified with reference to the methods of the natural sciences. The weighing scale, the callipers and the height meter are the kinds of tools by which fatness is defined on the dominant model, because, on this model, these are the kinds of tools one uses to learn about the world as it is in itself. On this model, for example, to measure (and then compare) a person's hip and waist circumferences, is, very literally and directly, to measure his or her fatness and, it is understood, this, in turn, is a direct measurement of his or her health. When a proponent of the dominant model makes the claim that a person is overweight or obese, he or she believes him- or herself to be making a claim about the state of the person's body in and of itself, as a thing in the material world. This claim is understood to be objectively verifiable by means of empirical measurement, and its truth or falsity is understood to be independent of any particular mind or subject.

As I also noted in Chapter One, there are some who oppose the dominant model of fatness, but who generally do so on positivist and naturalist grounds, and who generally accept the dominant model of health, despite their concerns about the ways in which it has been applied to fatness. These commentators typically accept the notion that health is directly and simply measurable, however they argue that fatphobia has caused a widespread failure to apply the methods of measurement properly to fat people. This approach is summed up neatly in Marilyn Wann's statement that it makes no sense to say she is unhealthy based on her weight because, "My blood pressure, cholesterol, and blood sugars – the three best health indicators – are all normal." (*Fat? So!* 10) Wann does not dispute the notion that it is possible to measure one's health empirically, she simply rejects the notion that measuring one's fatness is a good way of measuring one's health. In other words, she does not dispute the positivist assumption that it is possible to make

mind-independent, objective fact claims about health, or the naturalist assumption that empirical measurement of the body is the best way to justify such claims. Rather, she simply disputes the particular fact claims that are typically made about fatness and health by proponents of the dominant model of fatness. This is a common position amongst objectivist critics of the dominant model.

It is perhaps less obvious that constructivist critics of the dominant model are also implicitly committed to positivism, however, careful examination of their claims reveals that they are. Unlike objectivist critics, constructivists often explicitly reject the notion of health as a mind-independent reality. However, they justify this rejection on the notion that empirical measurement is *not* objective and does *not* provide neutral or objective access to the world outside of particular, subjective, culturally mediated experiences. This is to imply that, in order to make knowledge claims, one ought to be able to access the world in such a way. This, in turn, is to commit, albeit implicitly, to the positivistic standard of knowledge. The objectivist claims to know what the world is like because he or she can access it as it is in itself independent of any particular mind. The constructivist counters that there can be no such knowledge, because there can be no such access. As such, the constructivist cannot be said to assume naturalism, since they do not assume that the methods of the natural sciences are the best and only means of learning about the world. Nonetheless, like objectivist critics, they are committed at bottom to a positivist conception of what it means to know about health, whether the health of an individual or health as a concept. Neither disputes that, in order to make defensible claims about health, one would need to have mind-independent access to health 'in itself'. In other words, they do not disagree over the desirability of meeting the positivist standard of knowledge, only over the possibility of meeting this standard.

In *The Creolizing Subject*, Michael Monahan criticizes this shared assumption of positivism as it manifests itself in debates on race. In debates over the reality or otherwise of race, Monahan uncovers the deeply held and widely shared assumption that, “The concept of race could only be real in [the] deepest sense, if it were biologically grounded.” (82) In the case of fatness and health, the battle lines have been drawn between medical orthodoxy and the objectivist and constructivist strands of FA and HAES in such a way as to parallel those drawn in philosophical debates about race, and in such a way that Monahan’s claim can be adapted to apply accurately to fatness and to health. The tacit, shared assumption is that, if the link between fatness and health is real, it must mind-independent, and ‘objectively’ verifiable. Thus, commentators in these debates share an assumption that fatness and health are only real to the extent that they are grounded in biology. Racial realists take race to be a feature of bodies, a biological and material reality, much as proponents of the dominant model take the link between fatness and health to be a matter of empirically verifiable reality. (However, it is interesting to note that racial realists are much rarer in contemporary academic debates than are proponents of the dominant models of health and fatness.) In opposition to racial realists, there stand (amongst other groups) racial eliminativists and abolitionists, who take a constructivist stance, arguing that there is no ‘natural’ biological criterion or feature by which people can be categorised into races. That is, there is no feature that all and only white people have in common, no feature that all and only black people have in common, and so on for any given racial category. On this basis, they argue that to categorise people into races at all, to think of them or to treat them as though they belonged to different races, can only ever be an exercise in power and subjugation. This mirrors the approach of constructivist critics of the dominant models of health and

fatness, who argue that health and fatness are not ‘real’ phenomena in the world, but rather sites of political, social and cultural struggle for dominance.

I believe that the widespread assumption of positivism and, very often, of naturalism, not only weakens the philosophical arguments of participants in debates on fatness and health, but actually impacts negatively on the lived reality of fat people and others. In the following sections of this chapter, I will argue for these claims on phenomenological grounds, by introducing an imaginary fat person I call Sarah. Through Sarah, I examine the lived experience of fatness, and I show that all the currently available frames through which one may view fatness are limited by their commitment to positivism and naturalism.

Introducing Sarah

Sarah weighs three hundred pounds and is five feet and four inches tall, giving her a BMI of 51.5. (“Calculate Your Body Mass Index”) Sarah is fat. In dominant model terms, she is in the obese category. Thus, for proponents of the dominant model, she has a health problem. Her body size, shape and composition are strongly correlated with poor health outcomes, and she is likely to face these in the future even if she does not already do so. Given her body size, shape and composition, FA and HAES advocates would also readily accept Sarah as a fat person, though, as we saw in Chapter 1, most would reject the label of ‘obese’. FA and HAES proponents would certainly agree that she has a problem, however, for them, Sarah’s primary problem is not that she is fat, but that she lives in a ‘fatphobic’ (see, e.g., the chapter “Identifying Fatphobia”, pages 17-34 in *Fat and Proud*) society in which fatness is valued so negatively that she is likely to face marginalisation, mistreatment and discrimination, whether in medical settings (the primary concern of many HAES advocates, in particular) or more generally.

Sarah very rarely has to miss work or go to a doctor due to illness. She has never been admitted to hospital. However, there are aspects of Sarah's situation that she herself considers problematic, some of which she considers to be related to her fatness or her health. Sarah finds that she gets out of breath any time she has to walk quickly, or if she has to run even a short distance. She always gets out of breath walking up stairs or hills. She experiences pain in her lower back, hips, knees and feet if she has to stand for a long time. She has to kneel down or sit on the ground in order to tie her shoelaces, because she can't easily reach her feet from a standing position or while sitting in a chair. In some stores, she has to get help reaching items on the higher shelves because she is unable to reach them. She often has trouble getting comfortable in a restaurant booth and she deliberately avoids some restaurants because she knows she can't fit in the booths at all. Similarly, she generally does not go to the old-fashioned, independent movie theater in her neighborhood, because though she can just about fit into the seats there, she finds it too painful and distracting to be able to enjoy a movie while squeezed in. She has to use an extension seatbelt when travelling on an airplane because the standard seatbelt is too small to tie around her hips. Sometimes a crew member offers her the belt, but usually she has to ask. She prefers when they offer, because she finds it embarrassing to have to ask and thus draw attention to herself. Sarah finds that very few stores carry clothing in her size, so she has to shop online. Even online, she often finds it difficult to find clothes that fit her well or that she really likes. Both the dominant model and the FA/HAES alternative offer Sarah ways to frame her situation, and to explain the nature and causes of these problems. However, as I show in the next two sections, each of these ways of framing the problem puts the focus on some aspects of Sarah's situation while drawing it away from others, and thus neither frame discloses the full picture.

Sarah and the dominant model: Get thin or die trying

According to the dominant model of health as applied to fatness, Sarah's big problem is that she is, pretty much by definition, unhealthy. Her BMI is in the obese range, meaning that she is too fat and she needs to lose weight. Sarah's difficulties with seating, with clothing and with travelling could all be eliminated if she lost enough weight. From this point of view, the seats and clothes are not too small, rather Sarah is too large. The problem is primarily with Sarah's body. The seats and clothes accommodate people in the 'normal' range of sizes, and if Sarah were a healthy weight, she would be a 'normal' size, and she would fit. By losing weight, Sarah will improve not only her health but also her life in general. In fact, from the dominant model point of view, it is difficult to imagine any other solution making a real difference to Sarah unless she also loses weight. Fatness and weight loss go hand in hand in the dominant model. In Chapter 1, I noted that, for proponents of the dominant model, fatness just is what happens when you consume too much and exercise too little, and, similarly, the problem of fatness is *ipso facto* the problem of how to lose weight. As Schwartz observes, "A history of the American experience of weight and of fatness must willy-nilly be a history of dieting. Slimming. Reducing." (*Never Satisfied* 3) From this point of view, even if Sarah's social conditions were to change such that she could easily fit in seats and clothes, her most serious problem would still remain – she would still be unhealthy and in danger of heart disease, stroke, diabetes and many other diseases associated with obesity. Her body, in and of itself, would still be too big, too heavy, too fat. In Chapter One, I mentioned the film "Wall-E", which portrays a dystopian future in which every human is hugely fat. In the world depicted in "Wall-E", every effort is made to ensure the comfort of these fat humans. Seats, clothes and transport are all provided to meet their needs. But they are still depicted as living miserable and meaningless lives, at least partly because they are so fat.

Perhaps driven in part by fear of a “Wall-E”-style future, some dominant-model commentators have actually resisted what they present as efforts to ‘normalise’ fatness, on the grounds that such efforts will cause more people to become obese. In 2011, for example, a number of media outlets reported on a study in which researchers at the University of Bologna explored the relationship between the size of catwalk and other fashion models, on one hand, and the fatness, thinness or otherwise of the wider population, on the other. (Dragone and Savorelli, “Thinness and Obesity”) The conclusion that made headlines was that, as a *Huffington Post* article put it, “Plus-Size Models Make Women Fat”, because seeing fat⁷ bodies being presented as acceptable or desirable reduces a person’s motivation to lose weight or to maintain their weight in the normal range. (Moss, “Plus-Size Models Make Women Fat”) Following this line of argument, one might conclude that it is in fact bad for Sarah for those around her to facilitate her fatness in any way, because it is to her benefit for her to experience her fat body as uncomfortable and unacceptable. To facilitate her comfort is, in effect, to shield her from the objective reality that her body is not of an acceptable size, shape or composition, and that she needs to change it.

Even for those proponents of the dominant model who do *not* favor making fat people as uncomfortable as possible, it is fair to say that fatness is seen as a problem with one clear and simple solution, and that solution is weight loss. For all proponents of the dominant model, the discomforts, difficulties and indignities faced by fat people are primarily consequences of their fatness itself. Their fatness is the problem, and therefore, it is their fatness that must change. Naturally, most fat people themselves buy into the

⁷ Or at least fat-ish; Most ‘plus size’ models are actually pretty close to the size of the average woman. Indeed, many are even thinner than the average woman and certainly would not be perceived as fat outside of a high fashion setting.

dominant model, just as most thin people do. If Sarah is statistically typical, she will want to lose weight herself. In a National Center for Health Statistics surveys, 71 per cent of women responded “yes” when asked “Would you like to weigh less?” (*Rethinking Thin* 65) (Notably, this is significantly more than the percentage of women that is actually overweight or obese.)

Thus, Sarah almost certainly would like to be thin if she could. For proponents of the dominant model, the good news is that it is entirely possible for Sarah to get thin, or at least to get less fat. As we saw in Chapter One, proponents of the dominant model typically advocate behavioral modification to bring about this weight change. Sarah would most likely be encouraged, perhaps by her physician, by family members and friends, or by media commentators of varying kinds, to consume fewer calories in food and expend more calories in exercise. However, Sarah’s BMI is also high enough to qualify her for more drastic interventions, such as prescription medications and weight loss surgery, even in the absence of any other current health complications attributable to her weight. Thus, from proponents of the dominant model, Sarah most likely will get the message that she can and should lose weight.

In reality, however, most weight loss attempts fail, so there is a really good chance that Sarah will not manage to maintain a significant weight loss. It is difficult to put a number on the rate of failure, not least because definitions of success vary. However, in an overview article in the recent *Textbook of Obesity*, Wing and Hill state that the most reliable study is that conducted by McGuire *et al.* (Wing and Hill 354) This study isolated participants whose top weight had been in the ‘overweight’ or ‘obese’ range, and found that, of those in this group who had attempted to lose weight, 21% were currently maintaining a weight loss. (*ibid.* 355) For the purposes of the study, this ‘maintenance’

meant that, for at least one year, they had been at least ten per cent below what their top weight had been. In my example, Sarah weighs 300 pounds. If Sarah lost ten per cent of her weight, *i.e.*, thirty pounds, and maintained that loss for over a year, she would count as a success for the purposes of the McGuire *et al.* study. However, at 270 lbs and 5 feet 4 inches in height, Sarah would have a BMI of 46.3 (“Calculate Your BMI”), which is still well into the obese range, and she would thus still (according to proponents of the dominant model) be at much the same (very high) medical risk as she was before. She would still be fat enough to qualify for weight loss surgery even in the absence of weight-related health problems such as diabetes. In other words, from the point of view of the medical establishment, she wouldn’t be much, if at all, healthier than she was to start with. Nor would she likely find it much easier to buy clothes or to fit in airplane seats. She might, however, find it easier to stand for long times, to walk up hills or to reach her toes. Nonetheless, even allowing for the fact that people as fat as Sarah are rare (and that, thus, for most people a ten per cent weight loss would represent a more significant change in body size, shape and composition), this is not, by any stretch of the imagination, a terribly demanding definition of weight loss success. Yet, even given this generous definition of success, a significant majority of people was found to have failed.

Having managed to maintain a thirty-pound weight loss for a year, Sarah would also qualify for inclusion in the National Weight Control Registry (NWCR), a repository of data on successful weight loss. The NWCR is intended to help experts and others to find patterns in the behavior of successful weight losers in order to help others to emulate them. The NWCR (itself founded by Wing and Hill) has “over 10,000 individuals” (“The National Weight Control Registry”) in its ranks. “Over 10,000” is a large number of people in itself, but is only a drop in the ocean of the tens of millions who, according to the dominant model, needed or ought to have ‘shaped up’ in the time the registry has

existed. Moreover, anecdotal reports shared by both proponents and sceptics of the dominant model suggest that many people who attempt to lose weight do so multiple times, meaning that even those who counted as successes for the purposes of McGuire *et al.* or qualified for inclusion in the NWCR may also have had many failures under their belts before their success.

At the level of expert reports and scientific papers, proponents of the dominant model quite readily admit this high rate of failure. According to a report on obesity treatments by the National Academy of Sciences, “An obese individual faces a continuous lifelong struggle with no expectation that the struggle required will diminish with time. For most people, even a brief abatement in effort will be met with a significant setback in control.” (Quoted in *Rethinking Thin* 6) This message does not always make its way from scientific to popular discourse, however. Popular discourse often presents losing weight as a short-term, once-off undertaking. TV shows such as *The Biggest Loser* only rarely show the everyday lives of former participants. From the viewer’s perspective, the story, in most cases, ends with the final weigh-in, after which the competitor presumably goes on to live a normal, happy, healthy life. Commercial weight loss programs such as Weight Watchers often use so-called ‘before and after’ pictures as part of their advertising. The very use of the term ‘before and after’ suggests that, by the time the ‘after’ picture is taken, the real work of weight loss is over, the person is now ‘after’ that work. However, as we have seen, the difficulty is not losing weight but keeping it off. While most obesity experts now agree that weight loss is a lifelong project and an extremely difficult one at that, popular discussion does not always reflect that consensus. This means that, even though the difficulties of weight loss are well known and widely acknowledged even by dominant model experts, someone like Sarah is still likely to be encouraged to think that weight loss is entirely achievable for her. Indeed, even those

experts who report the likelihood of failure still insist that overweight and obese people must try to lose weight. Proponents of the dominant model may look at people like Sarah with pity at their poor luck in the lotteries of genetics or upbringing, or they may look at people like Sarah with frustration and contempt since they seemingly refuse to do what is obviously to their and everyone else's benefit. Either way, they look at fat people as people who could be thin if they chose to be.

Since fat people could, on this account, be thin if they chose to change their behavior, it follows that they as individuals must bear the primary responsibility for their fatness and its consequences. And this responsibility, some commentators argue, is understood and presented by proponents of the dominant model as moral culpability. Sander Gilman argues that, to contemporary Westerners at least, the increasing prevalence of obesity is primarily a moral panic rather than a health crisis. (2008 9) That is, we are horrified by the spread of obesity not primarily because we perceive it as a threat to the wellbeing of individual bodies or persons, but because we perceive it as “a threat to societal values and interests”. (*ibid.*) Similarly, in *The Obesity Epidemic: Science, Morality and Ideology* (2005), Gard and Wright claim that “The ‘obesity epidemic’ is ... a modern-day story of sloth and gluttony – Western life has produced a never-ending array of temptations which we have not had the self-discipline or moral fibre to resist.” (6-7) Kathleen LeBesco measures the ‘obesity epidemic’ against Stanley Cohen’s criteria for a moral panic, and finds a perfect fit. (“Fat Panic and the New Morality.”)

This analysis, at first glance, poses a challenge to the objectivism of the dominant model. But actually, such interventions tend to glance off the dominant model. Proponents of the dominant model frequently refer to the possible moral causes and

consequences of the ‘obesity epidemic’. But, for such proponents, this is by no means to concede that their positivist and naturalist account of health might be limited. In fact, from the dominant model point of view, it is the medical, physical and objective nature of the problem of overweight and obesity itself that gives rise to the moral panic surrounding the ‘obesity epidemic’. That is, it is because proponents of the dominant model assume positivism and naturalism that they are puzzled and worried by the problem of fatness. Given their assumptions of positivism and naturalism, proponents of the dominant model of fatness view their model not as a conceptual framing but simply as a set of fact claims about the world as it is in itself. From the dominant model point of view, then, it appears to be true that, regardless of what other complicating factors may exist, the *fact* remains that fat people would not be fat if they consumed less and exerted more energy. The very simplicity of the dominant model of fatness renders the continued existence of fat people both mysterious and terrifying. For proponents of the dominant model, fatness is a political, social and cultural problem not in the ‘social construct’ sense of the constructivists (a sense to which I return in the next section of this chapter), but in the rather different sense that mass obesity represents, to one who accepts the dominant model, a mass refusal to do something that is both entirely possible (albeit challenging) and indubitably best for oneself and others.

This mass refusal, in turn, indicates (to some observers) a breakdown of some system or other of shared values. Burry describes the ‘healthy’ BMI range as a “‘virtuous mean’ to which we should all aspire” (quoted in Halse, “Bio-Citizenship” 46), and urges moral authority figures such as clerics and teachers to both model and encourage the virtuous behavior that (it is assumed) will be conducive to the maintenance of a virtuous BMI. Retired U.S military leaders weigh in to warn that America’s youth is becoming “too fat to fight” at a time when (they claim) the country is under greater threat than ever.

(“Too Fat To Fight”) From the dominant model point of view, the terrifying mystery of the ‘obesity epidemic’ is not why so many people are fat – we know that; they eat too much and/or exercise too little. Nor is there any mystery about how to make them thin – we know that too; they need to eat less and/or exercise more. Given the tacit assumptions of positivism and naturalism, these appear to be simple and obvious facts. It is this very simplicity and obviousness that gives rise, in the minds of dominant model proponents, to the real mystery of the ‘obesity epidemic’, that is, *why fat people refuse to be thin*. Is it a matter of individual weakness? Is it due to social and cultural factors like the availability of high-calorie foods? Does the government have the right or the ability to force individuals to lose weight? Do businesses bear any responsibility for the obesity of their customers? Looked at from the dominant model point of view, it does not make sense to say the ‘obesity epidemic’ is a moral panic, but it makes perfect sense to be panicked, morally and otherwise, about the ‘obesity epidemic’.

Thus, despite its concern with the moral, the dominant model approach remains thoroughly objectivist, because it is founded on the positivist and naturalist assumption that fatness and health are matters of mind-independent fact. Regardless of what anybody thinks, says, feels or does, certain bodies are, have been, and will continue to be, in and of themselves, healthier than others. On this model, health is thus understood as a characteristic that some bodies have while others do not, or that some bodies have more of than others. The naturalist focus on scientific measurements like BMI, blood pressure and so on both reflects and encourages the notion that a body whose measurements all fall in the desired ranges would be optimally healthy by definition. Other problems connected to fatness, such as not being able to fit into seats, or costing (thin people) money, supervene on the health problem, which is itself physical. The ill health of fat people may be caused by “poor choices”, but even if the causes are moral, the resulting impact on

health is understood as a physical, material, concrete, measurable fact. On this account, health may have moral, political or social causes and consequences, but health itself is a fact about the body that can be accessed using the methods of the natural sciences. Because of their implicit assumptions of naturalism and positivism, dominant model commentators seem to act and speak as though an expert with sufficient knowledge and equipment could literally look at or into one's body and *see* how much health is in there.

However, if we persist in understanding the body in this naturalist and positivist way, we fail to see the various ways in which Sarah's fatness and her health are not mind-independent facts about the material world. For example, from the dominant model point of view, weight loss is entirely possible, even if it is difficult, so it must be the case either that fat people do not really want to be thin or that they are not willing to modify their behavior in the necessary ways. However, this is at odds with the reported experience of both fat people and other would-be losers of weight, who generally report that they try repeatedly to modify their behavior but it is just too difficult. Changing one's body size, shape and composition appears simple when viewed through the lenses of positivism and naturalism. But, in lived experience, it becomes clear just how problematic it is to view the body as just another physical thing in the mind-independent world. When one looks at the lived experience of weight loss attempts, it becomes clear that one does not 'control' one's body as one might control a machine. In lived experience, the human body is experienced in a radically different way from that in which we experience other material things. As numerous phenomenological commentators have pointed out, every experience one has is given in and through one's own body. The body is thus never merely an object but also always has a subjective aspect. In order to capture this distinction, phenomenologists distinguish between the lived body (*Leib*) and the body as a material thing (*Körper*). (See, for example, *Ideas II* §18.) Any model of health founded on

positivism will always fail to account for this distinction, because in order to generate knowledge claims that meet the positivist criterion, one has no choice but to regard the human body as a physical thing. The positivist criterion demands that we make claims about things in and of themselves, independent of any particular experience of them. But it is an essential feature of the lived body that it is never independent of some particular perspective. To be a lived body is to be the embodiment of a particular perspective. If we think or talk about the body of a conscious person as though it were just another material thing in the physical world, we do not simply overlook ‘part’ of the lived body, rather we fundamentally misconstrue the kind of thing it is. If one neglects the distinction between the body as a material thing and the lived body, weight loss comes to seem very straightforward – hardly any more difficult than it is to put the right amount of fuel in one’s car. This means that there is immense pressure on someone like Sarah to devote significant resources to trying to be thin, even though, as I have noted, it is quite likely that Sarah never will manage to stay thin even if she does initially manage to lose weight.

At the opposite end of the spectrum is the FA/HAES approach, which tends to assume that Sarah’s weight, far from being the result of deliberately-chosen behaviors, is a brute fact of physical biology that is, for all intents and purposes, entirely outside her control. In the next section, I argue that this approach too leads to conclusions that are at odds with lived experience.

Sarah and the FA/HAES model: Anatomy is destiny

The idea that fatness is a matter of individual control is, as we saw in Chapter One, completely rejected by the vast majority of proponents of FA and HAES. From the FA/HAES point of view, Sarah’s main problem is that she is a victim of a fatphobic society which has taught her to hate her body and even herself, and to blame her fatness for all her problems. Some FA commentators, particularly the members of the radical Fat

Underground group active in the 1970s, have gone so far as to present the widespread push for weight loss as a form of genocide since it was, as they saw it, directed at the eradication of fat people. (Solovay and Rothblum 5) While most contemporary FA and HAES advocates would probably not go along with this radical notion of weight loss as genocide⁸, most probably would agree with Shelley Bovey that ‘fat issues’ reveal “the dark side of humanity, the side that seems to have a compulsion to victimise, to oppress, to stamp out.” (Quoted in *Fat and Proud* 142) For them, it is not Sarah’s body that must change (in fact, for most of these commentators, Sarah almost certainly *cannot* permanently change her body size, shape or composition), rather it is American society and culture that must change, since, they believe, it places such an excessive, irrational and unfair value on thinness and since it is so biased against fat people. FA and HAES commentators thus view the high rate of failure of weight loss attempts not as evidence of the immorality or weakness of individual fat people but rather as evidence that long-term maintenance of a change in weight (whether loss or gain) is simply not possible for the vast majority of people. Many FA and, especially, HAES proponents would argue that Sarah, like everybody else, would benefit from healthy eating and adequate exercise, and even that these measures might bring about changes in weight. However, they reject the notion that most fat people would be thin if they just ate less and exercised more.

Significantly, the claim that Sarah would benefit from healthy eating and exercise is typically made on strongly objectivist grounds. Like proponents of the dominant model, most HAES and some, though by no means all, FA commentators draw on empirical evidence to make the case that certain kinds of foods and activities are, in themselves,

⁸ Although Kathleen LeBesco does describe the search for a ‘fat gene’ as a form of ‘consumer eugenics’. (“Quest for a Cause” 65) This is not quite an accusation of ‘genocide’, but it is a pretty strong moral claim.

conducive to health. As Lupton puts it, proponents of these approaches to fatness “adopt a scientific essentialism similar to that offered by the orthodox medical perspective.” (2013 84) Like proponents of the dominant model, they are assuming that there is a mind-independent fact of the matter about health, although they disagree about what that fact is. They regard science as the best possible source of knowledge about fatness, health and the relationship between the two. They typically argue that the scientific method has often been misapplied when it comes to fatness, not that the method itself is flawed. In other words, they reject some of the specific claims of the dominant model, yet they remain committed to positivism and naturalism. They regard fatness as a real physical difference, even though they attribute most of the problems of fat people to fatphobia or to what has been called the ‘tyranny of slenderness’⁹ rather than to fatness itself. From this point of view, the mistake of the dominant model is not that it mischaracterises health but rather than it misconstrues the relationship between fatness and health. Health itself is still understood, on this model, in entirely objectivist terms.

As we saw in Chapter One, however, some FA commentators take a constructivist rather than an objectivist approach. Some FA commentators are, in fact, deeply sceptical of the dominant model understanding of health, not only as it has been applied to fatness, but in itself. As such, these commentators tend to reject naturalism. Charlotte Cooper writes that:

Our arguments about the relationship of health to fatness are based on what we think we know about issues such as disease and the neutrality of medical science.

⁹ The term was introduced by Kim Chernin in her 1981 book, *The Obsession: Reflections on the Tyranny of Slenderness*. Many contemporary FA advocates consider Chernin, like Susie Orbach, to have elided the experiences of fat people by conflating them with the experiences of slim women who considered themselves fat, or who, perhaps, were ‘fat’ only by the standards of high fashion. Nonetheless, Chernin’s consciousness-raising approach to the ‘tyranny of slenderness’, like Orbach’s *Fat is a Feminist Issue*, may be seen as a step on the intellectual road to contemporary fat studies, and her analysis remains influential.

What we accept as the objective truth is more likely to be the result of a complicated system of cultural attitudes and values. (*Fat and Proud* 70)

This is a clear contradiction of the notion that the methods of the natural sciences provide the best or only possible access to the world as it is in itself. Indeed, the very goal of accessing fatness, health or the world as they are in themselves is not the primary one for many constructivist FA critics. Rather, their analysis often focuses on the political, the social and the cultural. LeBesco writes that, “Medicine is a major institution of social control. [...] the language of health and risk has become a repository for a new kind of moralism.” (LeBesco, “Fat Panic and the New Morality.”) For these constructivist commentators, one cannot improve the dominant-model definition of health with a simple “Add fatties and stir” manoeuvre. Rather, that model itself requires radical critique. That critique has been, to a remarkable extent, dominated by Foucauldian analysis, on which fatness, like health more broadly, is seen as a locus of ‘biopower’ or a battleground in ‘biopolitics’. Susan Bordo writes that, “Almost everyone who does the ‘new scholarship’ on the body claims Foucault as its founding father and guiding light.” (*Unbearable Weight* 17). Lupton says that:

From the [Foucault-influenced] perspective, medical and public health researchers and practitioners play an important role in the defining, regulation and surveilling of bodies, pronouncing on what should be considered ‘normal’ and what should be considered liable to expert intervention. Foucault’s analysis of the medical gaze as it constitutes and disciplines patients’ bodies is related in the critical [fat studies] literature to the ways in which medical discourses prescribe the ‘proper’ weight and size of bodies and define certain bodies – including fat bodies – as pathological and others as normal. (2013 25)

On this Foucault-influenced account, health itself comes to be seen primarily as a conceptual way of ordering and understanding the world, which serves to realise and justify the power of some people over others. By labelling fat people as ‘unhealthy’ –

and, in some cases, as wilfully so – it is alleged that proponents of the dominant model disempower fat people and render them ‘docile’. From this point of view, encouraging fat people to persevere in and to self-police their weight loss efforts (and, almost inevitably, their weight loss failures) is a way of disciplining fat people, of training, shaping and schooling them. This argument centers on the idea that, as Lupton puts it:

... the imperatives on managing and reducing body weight that are articulated in government policy documents and state-sponsored health promotional materials are part of the apparatus of neo-liberal state power that seeks to regulate, normalize and discipline its citizens to render them more productive. (2013 39)

Thus, while contemporary FA critics may not regard advocating weight loss as attempted genocide, they still present the medicalized construction of ‘obesity’ and ‘overweight’ as a tool of social control and oppression. They reject the naturalism of the dominant model, with its naïve trust that the methods of natural science can be applied to any field whatsoever. They discuss the ways in which the application of medical science to fat people has failed fat people, and they discuss the social, cultural and political causes and consequences of that failure. This emphasis on the constructed aspects of fatness sometimes occurs at the expense of a full discussion of the physical reality of fatness. It sometimes seems almost as though FA critics avoid discussing the more direct physical experiences of fatness, including those of weight loss, as if to acknowledge these would be simply to arm the enemy. In a sense, they are almost like apostates of naturalism, committed to leaving it behind and yet still understandably superstitious in the face of its power. The underlying failure to deal with positivism manifests itself here too. The idea seems to be that, if there is no *mind-independent* fact of the matter, or if, at least we can have no pure, neutral, objective access to that reality, then there must be no reality, and there can only be, as it were, construction all the way down. On this basis, and like

proponents of the dominant model, many proponents of FA seem at times wilfully to ignore certain aspects of lived experience because those experiences do not fit their theory.

An example of this is the fact that, as Cooper notes, "... a majority of fat people, even among [FA] activists, still desire weight loss." (*Fat and Proud* 172-173) It is mysterious that, even amongst those who profess the impossibility and uselessness of weight loss, there are still some who desire it. Could it be that fat people – even fat activists themselves – are so thoroughly brainwashed into the belief that thinner is better that they cannot overcome the programming? Or is it that thin privilege is so alluring that even those who object to its existence are not immune to its charms? Certainly these may well be factors. However, there is also the possibility that there are people for whom weight loss actually would be beneficial in and of itself, regardless of the political situation in which they find themselves. That is, I think it is possible – even, in fact, likely – that there are people for whom the desire for weight loss is a sane and realistic response to their lived experience, rather than simply a learned or socially conditioned response to the trauma of inhabiting a ‘spoiled’ (see, *e.g.*, “Queering Fat Bodies/Politics”) or ‘othered’ (Lupton 2013 28) identity. Indeed, I would also suggest that, while their numbers may be relatively small, there are people who maintain significant weight loss and who benefit hugely from doing so, and it is a mistake to discount their experience, regardless of whether one considers it possible or desirable for the majority of fat people ever to share that experience.

I believe that the difficulties fat people experience in connection with their fatness cannot all be dismissed as socially constructed. In order to bracket out, temporarily, the controversial issue of the extent to which one can control one’s fatness, consider, for a

moment, Sarah's height. At five feet and four inches tall, Sarah is of average height for an American woman. (McDowell *et al.*) But even if she were much taller or much shorter, nobody would view Sarah's height as being a result of her own behavior. Height is not without cultural significance or socially constructed import – shorter men, particularly in the USA, where the statistical norm for men is relatively tall (McDowell *et al.*), could no doubt attest to that – but it lacks the moral resonance that has come to be attached to weight and, especially, to fatness. Even for women, some degree of tallness is, in many ways, considered desirable (though, it is worth noting the possibility that tallness is valued partly because of its association with slenderness). On the whole, though, “you can't be too rich or too thin” has a resonance that “you can't be too tall” could not hope to match. Also, we know that in some cases, extreme tallness or extreme shortness may be associated with, or even symptoms of, illness, disease or disability, but in most cases, we still consider height to be a matter of normal and natural human variation, the variations forming a bell curve. In short, we understand height much as FA and HAES commentators believe we should understand weight.

Even so, people experience direct physical limitations because of their height. Being at either extreme on the height bell curve conveys disadvantages, and being closer to the middle tends to convey advantages. Being at one extreme or the other may also, of course, bestow advantages in certain circumstances; for example, if one wanted to play professional basketball, being unusually tall would be important. By and large, however, the built environment will tend to favor those closer to the middle of the bell curve. Seats, shelves and mirrors tend to be placed at heights that are comfortable and usable for the majority of people, and this can be inconvenient and frustrating for those at one extreme or the other, even in the absence of any approbation or judgement from those around them. Nobody blames extra tall people for their height, and nobody considers them

capable of changing it; nonetheless most people would probably consider it unreasonable to expect that all airplane manufacturers increase the distance between rows of seating in order to accommodate those over six feet tall. Sarah, being five feet and four inches tall, may have difficulty in reaching top shelves in stores. It has been the case for many years that shorter people have been unable to reach certain shelves. Nonetheless, there has been no major drive, for example, to limit the height of top shelves in stores or to require by law the provision of step ladders for customers. Nobody expects that people like Sarah could or should get taller, nonetheless nobody seriously expects businesses to go out of their way to make every product immediately accessible to her either. This, I suspect, is widely seen simply as a matter of practicality.¹⁰ It is useful for stores to be able to display as many products as possible, even if it means displaying some products out of reach of some customers. Consumers are used to this practice and, if silence and inaction can fairly be construed as unconcern, most don't seem to regard it as a big enough problem to need changing. It is inconvenient to be shorter in a store which puts a lot of products on high shelves. Taller customers will often help their shorter fellows, though, and store employees typically regard it as a routine part of their job to assist if needed. They may even have access to tools to help them do so.

The comparison with height gives insight into the case of fatness. It shows both the strength and weakness of the constructivist FA account of fatness. First, the comparison with height emphasizes the very real impact of the social and cultural understanding of fatness as the result of moral failure. Unlike height, fatness is seen as

¹⁰ This is not to deny or discount all the political and fiscal realities that may be packed into claims about 'practicality' in a consumer capitalist situation like that prevailing in the contemporary USA. One might well make a strong argument for the claim that businesses are not primarily concerned with customer comfort or even with practicality but with profit. My claim here is about how the decisions of businesses are perceived rather than about their actual motivations.

being a matter for individual control, and as such people are not only less willing to help accommodate fat people, but, in fact (as we saw earlier in this chapter with the argument against the use of plus size models), may strongly resist any perceived suggestion or expectation that they should do so. Whereas a tall person may happily volunteer to help a short person get something from a tall shelf, sharing one's seat with a fat person on public transport – especially on an airplane – is now seen as a terrible hazard of modern life. In the case of the high shelf, public sympathy is almost invariably with the short person who cannot reach. He or she is the 'victim' or sufferer of this (usually minor) inconvenience. In the case of the traveller on shared transport, however, popular sympathy is often not with the fat person who has to travel uncomfortably crammed into his or her seat but rather with his or her neighbor, the thin(ner) person who is forced to sit in close proximity to a fat person, and perhaps to have his or her own space limited by the incursion of the fat person's body. It is extremely rare for a person's height to change significantly in adulthood, and almost unheard of for a person's own behavior to bring about such a change. One's weight, on the other hand, is known to be affected by one's behavior. While long-term weight loss maintenance is extremely rare and extremely difficult, it is possible, at least for some people. These facts, taken in conjunction with a widespread cultural antipathy towards fatness and fat people, can make for an uncomfortable travel experience for fat people as well as those around them.

A recent example is the letter written by Australian Rich Wisken to an airline after he claimed to have had to sit near an obese man on a flight. (Shears "Airline Passenger's Complaint") Wisken's letter was widely shared across multiple Internet platforms, with a majority of commentary treating it as a hilarious take on a common inconvenience of modern life. The inconvenience in question, of course, was not that of being a fat person in a world designed for thinner people, but rather that of being a thin person forced to sit

next to a fat one. In the case of height, shortness is (or can be) a problem for the short person and tallness is (or can be) a problem for the tall person. With fatness, on the other hand, it is often the case that both the fatness and the fat person him- or herself are primarily discussed as problems for others. Given this situation, it is understandable that FA commentators choose to emphasize the social, cultural and political context in which fatness is understood, and to treat this context, rather than the fat body itself, as the site of the main problem of fat people.

Second, however, the comparison with height makes it clear that, regardless of the moral, social and cultural baggage around a given type of body, in and of itself, a bodily feature can give rise to both advantages and disadvantages. This highlights a weakness in the FA account, namely, that this account elides the ways in which the fatness of someone like Sarah is, *in itself*, a problem for her. Because it assumes the positivist standard of knowledge, the constructivist FA approach assumes that, unless one can access the mind-independent reality of the material world, one can make no claims about the physical in itself. From the FA point of view, Sarah's fatness is not a problem worthy of discussion, because we don't have access to the kind of neutral, objective information that would be needed to make claims about her fatness in itself. Rather, Sarah's problem is that she lives in a society in which her fatness is arbitrarily and unjustly construed as a sign of moral failure on her part.

But the comparison with height suggests that this does not necessarily capture the full extent of the problem of Sarah's fatness, and that her fatness itself may be a physical problem. For Sarah, her fatness may be said to have disadvantages which would exist regardless of the social, cultural or political climate in which she lived, just as, to take another example, being left-handed can be a disadvantage even though it has largely lost

its ‘sinister’ cultural associations. Whatever their causes, Sarah’s inability to walk quickly, or to run, or to stand up for very long, constitute immediate physical limitations. Insofar as her fatness plays a role in these limitations – and there are good reasons based in lived experience to believe it might – then her fatness can be said to be a problem in itself. A corollary to this point, which I mentioned above, is that FA commentators tend to insist that weight loss just is not possible, and thus to dismiss the notion that weight loss might, for some fat people, be a solution to a problem. It is entirely possible to acknowledge that fatness may be a physical problem without denying the many and obvious difficulties of weight loss, or the social, cultural and other aspects of the problems associated with fatness. Ignoring these aspects of Sarah’s situation can easily start to seem like a determined refusal to acknowledge evidence that does not fit one’s chosen narrative.

It is important at this point to note that FA critics do not universally deny that there are distinctly physical problems attached to fatness in itself, particularly for those at the very highest weights. On the Shapely Prose blog, Kate Harding published a guest post from a pro-FA woman named Heidi who was planning to undergo weight loss surgery, a procedure to which both Heidi and Harding had previously expressed strenuous opposition. In her comment accompanying the guest post, Harding explains that:

I’ve been reading Heidi’s blog for almost a year now. As I said to her in comments way back when, she’s the first person who ever made me believe there are occasional exceptions to the rule that weight loss surgery is *always* a bad idea.

Heidi changed my mind because she was brave enough to write about the painful reality of increasingly feeling like a prisoner in her own fat body, of losing the ability to be independent, to do basic things the rest of us take for granted. I still wish there were a better option than surgery for her -- so does she. But I sure don’t have a better idea at this point. (“Guest Blogger Heidi”)

Many FA writers are themselves, like Heidi, very fat. They know with particular intimacy the difficulties that can accompany extreme fatness. They do not deny the physical realities of these difficulties. Rather, they regard them as largely unavoidable. For them the problem of fat people is political not because the physical aspect of fatness does not ever present difficulties but because the physical aspect of fatness cannot be altered. However, few have taken up this point in the explicit way that Harding does in her response to Heidi. For the most part, the emphasis of FA writers is firmly on the social, cultural and political aspects of fatness. For someone like Sarah, this may make it more difficult to identify with FA, since many of its proponents appear not to share or even to acknowledge her sense of, in Harding's words, "feeling like a prisoner in her own fat body." (*ibid.*) As Cooper points out, they may in fact fully understand why Sarah wants to lose weight and they may even share that desire themselves. For good or ill, however, this is not the party line they typically share with the world.

Ultimately, the comparison with height drives home the fact that the difference between the dominant model and the FA and HAES alternatives is one, primarily, of how they frame fatness as a problem. Each starts with a frame through which they view fatness, and each seems at times to be so wedded to this frame that they continue doggedly to use it no matter what it obscures. The dominant model rests on the assumption that the problem of fatness is, essentially, the problem of making fat people thin, and this is justified by an appeal to an objectivist model of health. From the FA and HAES points of view, however, the problem of fatness is essentially the problem of fatphobia. Objectivist FA and HAES critics argue that, while the scientific method may be sound, scientists, like the population in general, are often biased against fatness and fat people, so that their findings are effectively skewed in favor of the dominant model of fatness. Constructivist FA critics argue that the very notions of objectivity, fatness and

health are themselves socially constructed and must be exposed to the light of criticism rather than taken for granted. Each of these perspectives both captures and loses something crucial about Sarah's situation. The objectivist dominant model captures the physical difficulties Sarah faces as a fat person, but hides the ways in which these may be connected to aspects of her situation other than her fatness, and also hides the fairly limited likelihood that she will actually manage to change her fatness on a long-term basis. The objectivist FA and HAES critics capture the ways in which Sarah's physical fatness may not be the whole of her problem, but they tend to hide the ways in which her fatness itself may be part of her problem, and they all too often fail to address the fact that some once-fat people, albeit a minority, have become thin and experience themselves as all the happier and healthier for it. Finally, the constructivist FA critic embraces completely the need to examine the social, cultural and political aspects of Sarah's situation, while all but ignoring the physical problems she personally connects to her fatness, as well as dismissing her desire for weight loss as so much mystified nonsense.

The shared commitment to positivism and/or naturalism is a significant limitation on all of these models of fatness and health. Commentators on all sides of these debates assume a positivist standard of knowledge, whether they believe it to be achievable (by naturalist means, usually) or not. Unfortunately, this shared assumption means that no participant seems really to push any of the others to account for their ontological assumptions about fatness and health. I believe it is possible to outline a model of health that can make sense of lived experiences like those of fatness, but in order to outline such a model, it is necessary to eradicate the positivist and naturalist assumptions, and start again from lived experience. In the next chapter, I begin this outline, drawing on phenomenological and existential resources, particularly the work of Edmund Husserl and Simone de Beauvoir. Then, in the fourth and final chapter, I will apply that

phenomenological-existential model of health outline to fatness and, in particular, to Sarah, showing how it overcomes some of the weaknesses of the models I have critiqued in this chapter.

CHAPTER THREE: AN ALTERNATIVE MODEL OF HEALTH

Introduction

In Chapter Two, I looked at competing ways of framing fatness as a problem, each of which is founded on a particular model of health. I argued that each of those models of health is limited by its explicit or implicit commitment to positivism and also, in most cases, to naturalism. As I showed, these limitations are made very clear when one applies each model of health to the situation of a particular fat person, because each of these models fails to capture some aspect or other of the lived experience of fatness. I thus concluded that a radically different model of health is needed. In this chapter, I want to use phenomenological and existential resources to sketch such a model. Ultimately, I describe health in functional rather than substantial terms, arguing that health must be understood as an action rather than a state, a characteristic of doing rather than as a way of being.

In the first section of this chapter, I draw on phenomenological descriptions of health and illness, and particularly on the account offered by Fredrik Svenaeus in *The Hermeneutics of Medicine and the Phenomenology of Health* (2001). I will argue for a phenomenological account of health that is somewhat different from that offered by Svenaeus, since I suggest Svenaeus does not go far enough in embracing the active essence of health. In many ways, my disagreements with Svenaeus are centered on the language he uses, which serves to obscure this active nature. Nonetheless, there is much in Svenaeus' description that is insightful and important. In particular, I consider Svenaeus' claim that health is experienced, first and foremost, as a sense of 'being at home in the world', a sense that is largely taken for granted unless and until it is ruptured by illness or disease. I argue that this is indeed a fundamental structure of the experience

of health in oneself. Svenaeus describes this structure of experience in Heideggerian terms, however, I argue that it is also fruitful to consider it from a Husserlian point of view.

There are two main points made by Husserl that I take as central to my description of health. Firstly, I use Husserl's concept of 'attitude' [*Einstellung*] in order to describe the first-person experience of health in oneself. Unlike Svenaeus' language of 'being at home', which suggests passivity, Husserl's account of attitude, I shall argue, emphasizes action. Secondly, drawing on *Ideas Pertaining to a Pure Phenomenology and to a Phenomenological Philosophy -- Second Book: Studies in the Phenomenology of Constitution* (henceforth *Ideas II*), I take up Husserl's description of the lived body as 'an organ of the will' (159). Here again, Husserl's account of embodiment is inextricably linked with action. On Husserl's account, to be an embodied subject is, in large part, to experience one's own body in the mode of "I can", as in "I can walk" or (to use one of Husserl's own examples) "I can play the piano" (*ibid.* 266). On the basis of these Husserlian insights, I argue that action is central to health because health is a mode of embodiment, and action is central to embodiment. In fact, I argue that to 'be healthy' is to be acting in a certain way. However, it remains to give an account of just what kind of action manifests health. For this one requires a criterion by which to differentiate healthy from non-healthy action. To this end, I draw on Beauvoir's account of action in *The Ethics of Ambiguity*.

I use Beauvoir's account of authentic action in order to describe health as the bodily aspect of such authenticity. To be healthy, on my account, is to be striving to will oneself and others free in and through the body. Such striving can only be understood by means of intersubjective experience of a person and his or her life. It is not disclosed fully

either in the person's own bodily experience or in other people's experiences of the person, but rather in both, over time and intersubjectively. Neither the person's own inner sense of his or her capacity for action, nor his or her actual capacity is itself the defining feature of his or her health. Rather, his or her health is manifested in how he or she acts on this capacity and how this action affects himself or herself and others. I refer to this model of health as the 'embodied authenticity' model.

In Chapter Four, I shall return to the example of fatness in order to show how the embodied authenticity model applies to a particular bodily feature. I return to the example of Sarah, the fat woman I described in Chapter Two, as well as drawing on some real life examples, in order to show that this model of health avoids the pitfalls of objectivism without collapsing into constructivism or subjectivism, and is thus a stronger model than those currently available.

Phenomenological Descriptions of Health

In the previous chapter, I criticized models of health that, I argued, fail to account for lived experience. In this section, I highlight some key insights from phenomenological descriptions of health which, I argue, can form the basis of a stronger model. In this chapter, I draw extensively on the insights of Fredrik Svenaeus in *The Hermeneutics of Medicine and the Phenomenology of Health* (henceforth *Hermeneutics of Medicine*). I find Svenaeus' Heideggerian account of illness and health to be very rich. By taking a phenomenological approach, Svenaeus avoids many of the problems I have outlined with naturalism and positivism, yet without resorting to subjectivism or constructivism. His Heideggerian model presents health as a rhythmic, balancing attunement of a person situated in a world, rather than either as a physical feature of some body or as nothing but a social construct. Although I ultimately offer a somewhat different account of health, I

consider it worthwhile to rehearse some of Svenaeus' points and to discuss them in some detail.

In describing health, Svenaeus starts with illness because, he writes, "In many ways the phenomenon of illness seems to be far more concrete and easy to get hold of than the phenomenon of health." (*Hermeneutics of Medicine* 78) Indeed, much of the philosophical debate around health, especially in contemporary times, has centered on the question of defining disease or illness.¹¹ When we take up phenomenology, we suspend abstract theorizing and return to experience. We seek first to describe rather than to explain experience. In this context, at least at first, it may well be illness and disease that push themselves to the forefront, inviting description and analysis, while health fades into the background. In one's own person, illness and disease grab one's attention with "feelings of meaninglessness, helplessness, pain, nausea, fear, dizziness or disability." (*ibid.*) When we perceive others as ill, our experiences often include strong emotional components such as fear, pity and even disgust. Illness and disease command attention, whether we experience them 'from inside' in our own bodies or 'from outside' in the bodies of others. Health, in contrast, tends to fade into the background of experience. Indeed, when we do have strong, positive experiences of health, they often arise specifically in contrast to experiences of illness, for example when we have recently been ill and are feeling better, or when we see another person who is ill and feel a moment of gratitude for our own health. When we perceive ourselves as healthy, there is no

¹¹ Boorse (1977; see especially pages 551-553) draws a distinction between "disease", which is the underling dysfunction of the body, and "illness" which is the individual person's experience of that dysfunction as manifested in, say, pain or nausea. Other writers have followed Boorse in making this distinction. I do not take up that distinction here. In order to distinguish between the disease "in itself" and the person's experience of the disease, one has to make the assumption that illness starts with a dysfunction in the physical body, and that this dysfunction is somehow mind-independent. In other words, one must accept the positivist thesis. At the outset of a phenomenological investigation, one cannot accept any such thesis because there is no experiential basis on which to rest it.

particular physical feeling that clearly and always suggests health in the way that, say, pain and nausea always suggest illness. When we perceive another person as healthy, we do not directly perceive their health, but rather, we perceive some trait or other of theirs (such as their beauty or physical prowess) as a manifestation of health. Such manifestations of health given in experience are always somewhat elusive compared to the insistent, demanding manifestations of illness. But from the phenomenological point of view, this elusive nature of health is not a block to our describing it – rather it is part of what we must describe. Thus, we can say it is a feature of health that it tends to be in the background of experience.

Gadamer goes so far as to say health is ‘hidden’. (*On the Enigma of Health* 107) Gadamer writes that, “Health does not actually present itself to us.” (*ibid.*) He says that, in order to see this, “We need only reflect on the fact that it is quite meaningful to ask someone ‘Do you feel ill?’, but that it would border on the absurd to ask someone ‘Do you feel healthy?’.” (*ibid.* 113) This claim may seem slightly exaggerated, at least from the point of view of an English speaker. It is very common to ask a person who has been ill if he or she feels better or to express the wish that he or she will feel better soon. Of course, in such expressions, what is being invoked is not an absolute feeling of health, but a relative feeling that is ‘better’ compared to illness and so is not quite the same thing as asking a person, out of the blue, as it were, if he or she feels healthy. To ask someone if he or she feels better is really to ask, “Are you still experiencing illness or is that experience now absent?” All this makes it quite clear that health is elusive, perhaps indeed even hidden. However, it is too much to say that health does not present itself to us in experience at all. Health does in fact present itself to us, but not at the level of simple empirical experience of the kind in which illness is given. Health does not present itself with the immediacy of a cough or a sneeze. Rather, health presents itself over time

and intersubjectively. Health is elusive but it *is* given in experience. Indeed, the very elusiveness itself is an aspect of this experience. Health tends to fade into the background of self-experience precisely because when one is at one's most healthy, one is engaged with the world, acting towards goals and projects. Nonetheless, such action itself manifests health – indeed, I go so far as to say it *is* health -- particularly when viewed over time and intersubjectively.

Svenaesus accounts for the elusive nature of health using the Heideggerian concept of homelikeness (*Heimlichkeit*).¹² (*ibid.* See especially pages 92-118.) He writes that:

Health is to be understood as a being at home that keeps the not being at home in the world from becoming apparent. The not being at home, which is a basic and necessary condition of human existence, related to our finitude and dependence upon others and otherness, is, in illness, brought to attention and transformed into a pervasive homelessness. (93)

On Svenaesus' account then, health is, at the existential level, a sense of being at home that draws our attention away from the other, uncanny (*unheimlich*)¹³ aspect of our situation in the world. Or, to put it the other way around, illness forces us to face up to the unhomelikeness of existence. Health, as being at home in the world, manifests itself in a sense (often unacknowledged and pretheoretical) that the world works or fits with us and that we work or fit in the world. However, Svenaesus cautions that:

[Health] should not, however, be confused with other positive moods like well-being or happiness. Such moods also colour [*sic*] our understanding, but in a much more obvious and manifest way than health. Health is a non-apparent

¹²I note that Svenaesus himself says his reading of Heidegger is not 'orthodox'. (*The Hermeneutics of Medicine* 92). Here, however, I draw on Svenaesus' own account of health, and I mean to indicate neither acceptance nor rejection of his reading of Heidegger.

¹³'Uncanny' is the standard English translation of Heidegger's philosophical use of the term '*unheimlich*'. The German word for 'unhomelike' is not '*unheimlich*' but '*unheimisch*'. Nonetheless, the etymological link between '*unheimlich*' and 'unhomelike' is evident and significant in this context.

attunement, a rhythmic, balancing mood that supports our understanding in a homelike way without calling for our attention. (94)

Svenaesus' caution here may be driven by the phenomenological observation that experiences of happiness and well-being demand our attention just as much as experiences of illness. The particular experiences are quite different, but they have the same ability to intrude, to take over our focus and to demand our response. Health, as Svenaesus describes it, is experienced at a different level, according to a different structure. Health manifests itself in a pattern that persists in and through multiple experiences rather than being itself a particular experience.

There are important ways in which Svenaesus' account makes sense of lived experience. In contrast to the naturalist and/or positivist accounts of health described in Chapters One and Two, this concept of health as homelikeness does not rely on the assumption that the human body is a material thing no different than any other, or that the methods of the natural sciences are the best and only means by which to establish the health or otherwise of a given human body. Nor does it reduce health either to a subjective feeling or to a mere social construct. This point is important. As Svenaesus admits, a structure of first-person experience cannot be the essential or defining feature of health. This would amount to the subjectivist claim that to feel healthy is to be healthy. Clearly, such a claim would be problematic. It might escape the trap of naturalism, but it would not manage to avoid the weakness associated with what I have called constructivist accounts of health, according to which there is no truth about health, only various conglomerations of subjective claims and concepts. Above all, it clashes with our lived experience of health, which reveals, sometimes quite dramatically, that it is possible to feel healthy and yet not be so.

As many people know all too well, one may feel on top of the world, but not actually be healthy in the everyday sense of the word. In *Illness: The Cry of the Flesh* (henceforth *Illness*), Havi Carel describes one of her earliest experiences of (what she later learned was) her illness:

[My friends and I] are walking towards the farm we are staying in... I am eager to hit the trail and confident because I have been exercising a lot lately and feel fit and full of life. ... I bounce and walk forwards, happy, energetic, bursting with joy. We walk at a brisk pace, chatting and enjoying the views and the sunshine. The terrain changes and we are now walking uphill. Suddenly, things become difficult for me. I lag behind; I can no longer chat to my friends. ... I am worried: how could I be so unfit? Why isn't my body responding to all the exercise? I thought I'd be leading the group, but instead I am soon labelled the slow one, the struggler. (*Illness* 19)

Here, Carel goes from feeling comfortable, at home and capable, to feeling worried, confused and frustrated. At the beginning of the walk, her experience is characterized by the homelike attunement described by Svenaeus, on top of which she has a strong feeling of well-being. However, the immediate physical reality of illness explodes Carel's sense of homelikeness, forcing her to confront severe limitations.

In response to experiences like those of Carel, Svenaeus emphasises the point that what he calls homelike attunement is not just a matter of how one understands the world, but also of how one is capable of acting in it. To be healthy, for Svenaeus, is not just to *feel* capable of acting in a particular way but also actually to *be* so capable. Thus, phenomenologically, for Svenaeus, the essence of health is given not in Carel's feeling that she can act in a certain way – as she learned all too painfully, such a feeling may not survive subsequent experience – but rather in her actual level of ability to act. In developing his own phenomenological theory of health in the light of this distinction, Svenaeus considers what he calls the holistic theory of health offered by Nordenfelt.

(*Hermeneutics of Medicine* 68-75) This theory of health centers on the potential for action. For Nordenfelt, "...health is the ability to realize one's vital goals given standard circumstances." (*ibid.* 69) But in drawing on Nordenfelt's theory, Svenaeus does not wish to return to a physicalist conception of health; one of the reasons Svenaeus gives for valuing Nordenfelt's theory is that it understands health as a characteristic of persons rather than merely one of bodies. (*ibid.* 68) As such, this holistic theory comes closer to capturing the lived experience of health than do the kind of naturalistic theories I described in the previous chapter. However, as Svenaeus also argues, Nordenfelt's theory still discusses health either in terms of "the objects in the world and the causal connections that hold between them" (*ibid.* 101) or in terms of "the meaning of words used in talking about the world" (*ibid.*). To put it in the terms I have been using in this dissertation, Nordenfelt's theory offers both the possibility of an objectivist account of health and the possibility of a constructivist account; however, it does not offer us an overarching way to explain just how the subjective/constructed and the objective can be different aspects of the same thing. It is just this lack that a phenomenological account aims to fill.

One way in which a phenomenological account can fill this lack is by valuing different manifestations of health without unduly privileging empirical ones. Consider that, in Havi Carel's description above, what first presented itself as an experience of health was quickly followed by a whole succession of experiences of illness. If one looks at Carel's account from a naturalistic point of view, this may seem like proof that medical science ought to be taken as the final arbiter of whether one is healthy or not. Based on her own experience, right up until she found herself struggling to breathe, Carel had no awareness that she might be unhealthy, let alone why or in what way. It may seem, then, to the naturalist that only empirical investigation could have revealed the facts. Thus, the

naturalist concludes that the illness was there at the objective level of facts, but Carel herself did not know about it until her body was investigated empirically. In fact, from this naturalist point of view, Carel was, so to speak, tricked by her first-person experience. A naturalist commentator might thus conclude that Carel thought she was fit and well, but really, at the level of facts, her body was not functioning properly and so she was ill. Presumably, that naturalist might say, there were some moments in the past when Carel had been healthy, but once her body ceased to function in the empirically-verifiable 'proper' way, she became ill. This account of Carel's experience is problematic because it amounts to the claim that how a person feels bears *no* necessary relation to how healthy he or she really is. This goes too far. There may be times, such as that described by Carel, when the ongoing flow of experience reveals that something had already been going wrong with a person's health even while she still felt well. Nonetheless, first-person experience often *does* coincide well with health or illness, though the coincidence is not perfect. Broadly speaking, when we are healthy, we feel well and capable more often, and when we are ill we feel well and capable less often.

Meanwhile, viewed from the subjectivist or constructivist point of view, Carel's illness really only started to exist when she and those around her started to perceive it and have thoughts about it. This, too, is problematic, since it does not give adequate weight to the empirical evidence which revealed that Carel's difficulty and discomfort was connected with a particular bodily state or process. To take seriously the first-person perspective means to take seriously -- if critically -- *all* experiences, including those of the medical experts who undertake empirical investigation of the body as a material, physical system. Such scientific evidence is not (contrary to the operating assumptions of objectivists) always and necessarily more reliable than 'inner' experience of oneself, but nor is it (contrary to the operating assumptions of constructivists) always and necessarily

untrustworthy. Carel's difficulty breathing did not become a problem merely because she started to perceive it as one; rather, her difficulty breathing was one of the first ways in which she perceived the broader problem that existed in her body as a physical thing and not just in her perception. That broader problem was then perceived from a different angle by the various medical experts who considered Carel's body in its physical aspect and drew conclusions about how it was functioning relative to what they would have expected. It is a serious error to treat the lived body as though it were only a physical thing, but it is also a serious error to treat it as though it were not a physical thing at all but only a succession of free-floating subjective experiences and concepts. Of its essence, the lived body is given in different kinds of experience and from different perspectives. Neither the naturalist nor the constructivist approaches to health can make sense of these multiple perspectives on the same thing. As I argued in Chapter Two, this gives rise to serious theoretical and practical difficulties.

Nordenfelt's theory is an attempt to overcome these difficulties. But deep down, it does not really challenge that notion of a chasm between the subjective and the objective aspects of health. And, in the end, as Svenaeus says, "...Nordenfelt's theory stays true to a third-person rather than a first-person perspective." (*ibid.* 104) Svenaeus regards Nordenfelt's emphasis on linguistic analysis to be at the root of this problem. In making this argument, Svenaeus highlights a broader issue with traditional objectivist theories of health. According to Svenaeus, for Nordenfelt, "...it belongs to the meaning of the words 'pain' and 'suffering' that the person referred to is disabled. In the phenomenological theory however, the meaning-analysis extends to cover not only language use, but the entire worldiness of the person." (*ibid.* 101) Svenaeus raises an important point here, one which emphasizes the need for a phenomenological account. Linguistic analysis of discourse on health and illness is no substitute for phenomenological description of them.

In fact, I would suggest that to emphasize the role of language as Nordenfelt does is to misconstrue the relationship between experiences, concepts and language, placing a distance between them that does not occur in lived experience but only in abstract theorizing. From the phenomenological point of view, using terms like ‘pain’ or ‘suffering’ is not merely a way of talking about a kind of disability *caused by* abnormal functioning. Rather, pain and suffering are themselves very often direct manifestations of the disability or abnormal function. In cases of imagined or psychosomatic discomfort, the pain and suffering could even be said to *be* the problem. Indeed, part of the reason such-and-such a mode of functioning is regarded as less than optimal is because it involves pain or suffering of some kind. To take the objectively-observable physical aspect as primary, to assume that it is the ‘real’ cause of the problem, is to make a metaphysical assumption not only about the nature of illness but about the nature of reality as whole. Focusing on lived experience, one finds no basis for the assumption that the empirical is somehow more real than other modes of experience (though nor, *pace* the constructivists, does one find evidence that it ought to be dismissed). Thus, from the phenomenological point of view, when, for example, Carel describes her experience of struggling to breathe and keep up with her friends, she is not explaining how she felt *because* her body was functioning less than optimally; rather, she is directly describing that impaired functioning itself *as it was given to her in experience*. She is describing it from her own point of view, as it first became apparent to her in and through her body. Nordenfelt’s holistic theory, as it is described by Svenaeus, has the advantage that it does not dismiss the embodied first-person perspective. It does not, however, account for the relationship between this perspective and that of a third-party onlooker such as a doctor. Rather, the holistic theory (again, as described by Svenaeus) ultimately privileges the objective or third-party perspective by treating individual experiences of healthy or ill

embodiment as if they were themselves side-effects rather than experiences of health or illness.

Nonetheless, it is fair to say that the holistic theory gives more space to the first-person perspective than do traditional objectivist theories like the dominant model of health I described in the previous chapters. This is partly because of the central role of the concept of goals in the holistic theory. On the holistic account, "...health is the ability to realize one's vital goals given standard circumstances." (*ibid.* 69) However, this implies that, for the purposes of assessing health, whether or not one actually pursues these goals is irrelevant. In other words, from the point of view of the holistic account, ultimately, health still means having a body with certain kinds of physical features, regardless of what one does with this body. In this sense, the holistic theory outlined by Nordenfelt does indeed collapse back into objectivism as Svenaeus notes. Objectivist models of health tend ever more strongly towards a fixation on measurements of the body, tacitly treating health as though it were something that could be measured directly by empirical means. From the holistic theory point of view, the 'healthy' measurements are not valued intrinsically, but rather are valued because they are associated with better human functioning. The more the dominant model of health takes hold, however, the greater the tendency in the broader culture to talk as though this link with better functioning did not exist. As the case of fatness shows particularly well, proponents of the dominant model often talk as though to have the 'right' bodily measurements *is identical with* being a healthy person. The holistic theory may seem on the face of it to resist this identification by emphasizing the importance of goals and potential for action. But still, from the holistic theory point of view, being healthy ultimately means having a certain kind of body, the kind of body that can function to achieve the vital goals of the person conducive to his or her happiness over the long run. And, although he criticizes Nordenfelt for

privileging the third-person perspective, even Svenaeus' phenomenological theory, for all its strengths, still makes this related mistake of privileging the potential to act over action itself.

For Svenaeus, the Heideggerian concept of attunement is central to health. He sums up his Heideggerian account of health thus:

I have proposed that we should look on health and illness as, respectively, homelike and unhomelike ways of being-in-the-world. Homelikeness here refers to the patterns of meaning of the existential (attuned, bodily and articulated understanding) which make coherent transcendence of a self (person) into the world possible. (*ibid.* 114)

This account, as I have noted, has great strengths and certainly offers major advantages over the objectivist and constructivist accounts I have criticized. It quite simply makes much more sense to value bodily features according to how they facilitate meaningful action rather than either to value them based solely on how they relate to some biostatistical norm (the objectivist, naturalist approach) or to treat every valuation of them as equally arbitrary and invented (the constructivist approach). But even this account, which emphasizes the *potential* for action, fails to embrace fully the temporal dimension of health.

In my view of health, it matters what happens next; one cannot capture health in a snapshot, but only over time. Svenaeus himself acknowledges, "...health is not an unchanging state but a process." (*Hermeneutics of Medicine* 98) Yet, in some crucial ways, he still talks as though one can be healthy in a particular moment, if one has, at that moment, the bodily potential to act in certain ways. I thus suggest that this theory, despite its richness and usefulness, still fails to embrace the importance of the temporal dimension of the experience of health. Svenaeus writes that health is a process, but

ultimately still describes it as a state. Thus, we still need to explore further what it means that health is a process. In what follows, I consider the notion that experiences of health are given over time because *health itself unfolds over time*. If health really is (as lived experience indicates) a process rather than a state, then to grasp health, one must see not just a body but a person, and to see a person is to see an ever-changing flow of situations, even, indeed, a life. If this is true, I will argue, a body cannot, strictly speaking, be healthy at all, although it can manifest health; rather, the essence of health is such that a *person* can be healthy, that is, a person can act, do or live *healthily*.

Imagine a person who goes for a routine medical screening and is pronounced to be in rude good health. Every objectivist, naturalist measurement – blood pressure, BMI, cholesterol, and many others – is found to be in the desired range. The person has no illnesses, diseases, impairments or disabilities. Now imagine that this person leaves the medical center and proceeds straight to her home, locks herself inside and refuses to leave for the next six months. She does nothing but sit on the couch all day watching TV, not communicating with anybody, not showing up for work, eating nothing but take-out deliveries. At the end of six months, there is a good chance that a similar set of medical tests would reveal some significant changes, and it is very likely that a decline in health measurements would be noticed. The point I wish to make via this admittedly far-fetched scenario is that, while her body certainly had the potential for all kinds of healthy action, she herself, as a person, did not go on to be healthy. At some point what might have been a simple rest became a process of living unhealthily. If one assumes a thoroughgoing dualism about the person, one might argue that the body was healthy but the mind or soul was not. That is, however, a difficult position to defend on the basis of lived experience, since one does not experience persons as radically separate from their bodies, but rather one experiences both oneself and others in and through bodies. It makes more sense

simply to acknowledge that health is best understood as an ongoing process. The point is not that the person in this example was healthy and no longer is, though one can reasonably put it that way given the everyday usage of the term 'healthy'. In my view, for the purposes of understanding health philosophically, it is more useful to say that she was living in a healthy way and then, perhaps gradually, one decision, one action at a time, began to live in an unhealthy way. Essentially, the change that took her from 'healthy' to 'unhealthy' manifests itself in her behavior, and only afterwards in her body. This is not to say that a person can only be deemed to have been healthy after he or she has lived his or her whole life, but rather that health can only be understood and assessed by taking into account how the person lives in and through his or her body over time and with others. The primary hallmark of health as given in experience, whether first-person or otherwise, is not how one has the potential to act at a given moment, but *how one actually does act*.

This is not to say that potential is irrelevant. Obviously, one can only perform an action for which one has the potential. It is rather to acknowledge that the presence of potential is no guarantee that it will be realized, and thus to suggest that merely having the potential is not the same thing as being healthy. Svenaeus writes that, in order to investigate phenomena like health and illness, we need to focus on "the meaning of human experience situated in the world as acting, attuned and embodied." (*ibid.* 82) This is, in my view, the crucial point, and Svenaeus does not go far enough in developing it. Svenaeus is right that health is experienced in what he calls attunement and embodiment as well as in action. However, when it comes to health, I believe that if we focus on the potential rather than the actual, we may be able to describe certain aspects of attunement and embodiment reasonably well, but we will always end up giving short shrift to action, and thus to the crux of health itself.

By focusing on action, on the other hand, we give due weight not only to the temporal but also to the intersubjective nature of the experience of health. Human action is always essentially *interaction*. The world of our lived experience is essentially a shared world. To act is to act in, through and on this world, and thus our actions affect other people, and their actions affect us. Health, whether our own or that of others, is conditioned not only by the physical realities of our bodies and situations, but also by the other subjects around us. Consider, for example, the fact that, as constructivist commentators on health point out, one culture may construe a particular variation in a bodily feature or function quite differently from how that variation is construed in other cultures. Even if we come to a different understanding of some feature or function, we are always conditioned in some way by the dominant understanding(s) of our culture(s). In the case of fatness, constant reference is made to this kind of cultural variation. It is frequently claimed – and not just by constructivists – that fatness used to be considered beautiful, that it used to be associated with good health, and so on. Opponents of the dominant model of health often claim that this model itself affects in all kinds of ways, including with respect to their health. In “Fat Stigma – Not Fat – Is the Real Problem”, for example, Linda Bacon argues that anti-fat bias is itself conditioning some fat people to be less healthy. (“Fat Stigma – Not Fat.”) An action-centered model of health works very well to explain this kind of interaction between the ‘objective’ and the ‘constructed’ aspects of health, without reducing health itself to either one. There is a constant interplay between the material and psychological aspects of our situations, each shaping and forming the other. In this context, we may have bodily potentials that are not likely to be realized, or we may have action goals that could not be fulfilled with our bodies they way they are.

That is to say, one may have the ability to conceive of a particular goal or action as valuable, and in this sense, one may choose this goal or action. However, there is no guarantee that it will be possible to pursue this goal or action in any concrete way. The world in which one chooses and acts is always a world that is already shaped by the choices and actions of others, such that one will always be confronted with limits when one makes a choice. Even when faced with such limits, however, an individual still has choices. Indeed, any given fact about the world may, depending on one's situation, be either a limit or an opportunity, or both simultaneously. This is a discussion to which I return in the third section of this chapter. For now, the crucial point is that one does not choose or opt in a vacuum; rather, one's possibilities are conditioned by the surrounding world and in particular by the behavior of other people and so merely having the bodily capability to make a choice does not mean one has a real live option in this regard. Merely having the (bodily) potential to live healthily is not the same as living healthily, nor is it any guarantee that one will. Bodily potential is, as it were, a necessary but not a sufficient condition for health.

That said, I do not wish to dismiss the idea that experiences of bodily potential are experiences of – or at least strongly connected to – health. In fact, I do agree that potential is central to health, and that experiences of bodily potential are strongly related to health. In the next section, I draw on Husserlian phenomenology to describe the structures of experience in which bodily potential is experienced. These are crucial to any phenomenological description of health, not only because the experiences themselves are, as it were, significant precursors to healthy action but also because experiences of potential are themselves likely to dispose the person to act in healthy ways and thus, at least in the terms of my model, to be healthy. For my purposes, a significant value of Husserl's description of embodiment is the way it does not focus only on potential itself

but constantly points in the direction of action. Husserl's framework for describing embodiment allows us to describe the potential for health not just as a bodily feeling of well being, but as a bodily feeling of capability, inextricably linked with action and not merely with potential.

The Husserlian perspective

In this section, I employ Husserlian phenomenology in the description of health. In departing from Svenaeus' account in this way, I do not wish to claim that the Heideggerian point of view is without merit, or that the Husserlian approach is the best or only way to describe health phenomenologically. Rather, I simply outline why I think Svenaeus' rejection of Husserl is premature, and then outline the Husserlian resources I believe are of use in describing health.

Svenaeus chooses not to take a Husserlian approach because he views Husserl's account of embodiment as fundamentally inadequate. He imputes to Husserl a "... focus upon consciousness instead of upon embodiment..." (*Hermeneutics of Medicine* 82). According to Svenaeus, while Husserl does offer a theory of embodiment centered on the concept of kinaesthesia, ultimately, in Husserl's account, "The lived body does not in itself texture and structure the acts, by, for example, offering resistance." (*ibid.*) From Svenaeus' point of view then, Husserl's phenomenology does not offer the resources needed to give an account of health and illness. At the level of lived experience, Svenaeus charges that Husserl does not give us the theoretical tools needed to address concrete phenomena such as "pains, resistance [and] shivers" adequately. (*ibid.*)

Svenaeus draws especially on *Ideas I* in his account of Husserl. In *Ideas I*, it is fair to say that Husserl does not give extensive accounts of the role of embodiment in experience. But I suggest it is similarly fair to say that it would make little sense for him

to do so in the context of that work. *Ideas I* is an introduction to the foundational principles of phenomenology. In this work, Husserl is at pains to emphasize the need to take *all* experiences on their merits, rather than filtering them through metaphysical assumptions about their causes or sources. For the purposes of such an introduction, it would be utterly contradictory to distinguish, *a priori* as it were, between experiences which have their root in the body and those which do not, because there would be no way to make such a distinction without bringing in exactly the kind of metaphysical assumption phenomenology is supposed to avoid. There is even a sense in which distinguishing bodily from non-bodily experiences before undertaking description is to move back again towards naturalism or positivism, by assuming that, in order to work as a method of knowledge production, phenomenology must be able to grapple with physical things as they are understood in the context of contemporary science. In *Ideas I*, Husserl is arguing for the need for the phenomenological method and then introducing (one version of) that method. It is in the *application* of the method that the role of the body becomes clear, and indeed Husserl does treat of this role more fully when he describes and discusses particular structures of experience in, amongst other works, *Ideas II* and, later, the *Crisis*. I believe that Husserl does offer valuable resources for addressing questions of the body, including those as concrete as shivers, pain and resistance. However, to make use of these resources, one must begin from a Husserlian starting point, without assuming anything about the metaphysical nature of bodily (or any other) experiences. In particular, I suggest that the fundamental structure of the experience of health can be understood as what Husserl calls an ‘attitude’, one which centers on the experience of the lived body as the locus of “I can”. Understanding health in this way serves to emphasize the centrality of action to health.

Svenaesus expresses the process of health in Heideggerian terms, describing it as an attunement characterized by homelikeness. I suggest that this ongoing ‘homelikeness’ can, however, also be usefully expressed in Husserlian terms as an attitude. “Attitude” is the English word that is generally used to translate Husserl’s technical usage of the German word “*Einstellung*”. In the Vienna Lecture, Husserl says that:

Attitude, generally speaking, means a habitually fixed style of willing life comprising directions of the will or interests that prescribed by this style, comprising the ultimate ends, the cultural accomplishments whose total style is thereby determined. The individual life determined by it runs its course with this persisting style as its norm. (*Crisis* 280)

I suggest that the potential for health is apprehended in first-person experience as a ‘persisting style’ of this kind. I have argued that any phenomenological account of health must have action at its center. Husserl’s concept of attitude, which he characterizes here as centered on the will, is thus a useful concept by which to describe the structure of the first-person experience of health. Ultimately, attitude is not just about how one understands the world, but about how one acts in it. A look at the etymology of the term emphasizes this point. “*Einstellung*” has the literal sense of ‘being in a stance or in position’. (“*Einstellung*”, Oxford Duden German Dictionary.) In German, the word “*Einstellung*” is used in a way that emphasizes action. It is sometimes used to refer to the hiring of employees (note that the cognate English verb “to install” is occasionally used in a related sense, as in to install a friendly ruler in another country), and can also mean “setting”, in the sense of the settings on a computer or another machine, or “focus” in the context of photography. (*ibid.*) Each of these usages emphasizes that the word *Einstellung* does not mean a *static* being-in-position, but rather it also has a more pregnant sense of being in the position *to do something* or, perhaps, to facilitate the doing of something, or

to condition what is done or how it is done. Not every usage of *Einstellung* in German has this strongly active sense, but by and large the word has strong overtones of action.

I suggest that there exists an attitude [*Einstellung*] that corresponds with health. The correspondence is not perfect; as we have seen, it is quite possible to feel healthy and yet not be so. This does not prove that there is no relationship between the feeling of being healthy and health itself; it only shows that direct self-experience as given at any particular moment in time is only one of many possible perspectives from which the health of a person may be experienced. The attitude related to health is a disposition or tendency to apprehend and interact with the world in a certain (*i.e.* healthy) way. The presence of this attitude is no guarantee that one is in fact acting healthily, just as being in the scientific attitude is no guarantee that one is in fact doing rigorous science. The central claim of my argument is that health is something one does, not something one is. Therefore no attitude can fully capture this, since an attitude is a disposition to act rather than an action itself. This, in my view, is the benefit of using the Husserlian concept of attitude to describe the structure by which one apprehends the potential for health in oneself. Describing health as ‘homelikeness’ encourages the idea that health is a state rather than a process. I choose instead to use the Husserlian concept of attitude, because I wish to emphasize the active nature of health. ‘Attitude’ always points towards action. It is not an action, nor does it guarantee action, but it is a structure that predisposes one to act. In fact, since, in English, the word ‘attitude’ still conveys something like a static point of view rather than a tendency to perceive or act in a certain way, I shall use the term ‘disposition’ instead. Thus, the healthy disposition is a structure in which health is made apparent in first-person experience, but it is not the only way in which health is made apparent, nor is this disposition, in itself, the essence of health.

The key structure of the healthy disposition is the “I can” structure that Husserl describes in *Ideas II*. Husserl describes the difference between a mere material thing and a lived body ¹⁴ in the following terms:

Sheer material things are only moveable mechanically and only partake of spontaneous movement in a mediate way. Only Bodies are immediately spontaneously (“freely”) moveable, and they are so, specifically, by means of the free Ego and its will which belong to them. [...] The ego has the “faculty” (the “I can”) to freely move this Body -- i.e., the organ in which it is articulated -- and to perceive an external world by means of it. (Ideas II 159-160; emphasis in the original.)

What marks out lived bodies from material bodies is that lived bodies are essentially connected with what Husserl refers to as a ‘free ego’, which is articulated in the body and perceives the world through it. Crucially, this ego also has the ability to move the lived body freely, immediately and directly, and to act in and through the world by means of this lived body. This, we may conclude, is just what it means to call such body ‘lived’. Thus, this sense of “I can”, this faculty or capacity for immediate movement and direct action is an essential structure of the experience of having a body. My ‘faculties’, that is my abilities and potentials for action, are central to my subjectivity. Husserl writes that:

The Ego, as unity, is a system of the “I can”. ... I have power over my Body, I am the one who moves this hand and who can move it, etc. I can play the piano. But this does not last forever. I can forget how, I can fall out of practice. I exercise my Body. In the case of the most common activities, I do not generally lose my skill. But if I have been laid up sick for a long while, then I have to learn how to walk again, though it comes back quickly. However, I can also have a nervous disorder and lose the mastery of my limbs; “I can’t do it.” In that respect, I have become an other. (266)

¹⁴ In the translation I cite here, Rojcewicz and Schuwer use ‘body’ to refer to a material thing and ‘Body’ (with a capital B) to refer to the lived body.

This accounts partly for the elusive nature of health in self-experience. Much of the time, I do not abstract from my experience the fact that I can do physical things. This ability is so inexpressibly central to my experience of being, and my experience of myself, that it is only in the most rarefied moments of philosophical experience that I think about it at all. Experience of oneself in the “I can” structure is an inner manifestation of the potential for health. It is the attitude that is conducive to health, or the attitude in which we may act healthily, just as the scientific attitude is the attitude in which we investigate the world, and the attitude in which the world gives itself for scientific investigation.

The ‘healthy disposition’ has some important similarities to what Husserl calls the natural attitude, indeed, the healthy disposition may be said to be a part of the natural attitude. (See, for example, *Ideas I*, §27.) In the natural attitude, the world is just there for me; I do not question the existence of the world – I do not ask how or why it is, nor wonder how or why I came to be in it – I just live in it. This is similar to the ‘homelikeness’ to which Svenaeus refers. Similarly, in what I am calling the healthy disposition, I am focused on my action, and not necessarily aware of or reflecting on my ability to act. The healthy disposition is one in which, very often, I, as a lived body, a bodily subject, am immersed in the world and thus focused outward, not inward, doing, not thinking. In the healthy disposition, because I feel ‘homelike’, I am not generally forced to confront my embodied situation by reflecting on my body. Instead, I can just live in and through it, focused on my goals rather than on myself as pursuing them.

The healthy disposition differs from the natural attitude in one key respect, however. The natural attitude is essentially inimical to reflection; to reflect is, by definition, to be in an attitude other than the natural attitude. The healthy disposition, in contrast, does not necessarily preclude self-awareness. One can be aware of the healthy

disposition as a feature of any particular experience, just as one may be aware of oneself as being in a theoretical attitude while one is doing philosophy. While health is typically in the background, as I have noted above, it can be, as it were, fore-grounded under certain circumstances. For example, when engaging in one's favorite sport or exercising outdoors on a beautiful day, one may become aware of a strong feeling of ability and good functioning while remaining in the healthy disposition. One may be aware not only of one's own faculties, one's "I can", but of one's actual healthy action. Similarly, when one has been sick but is now better, one can be aware of the lack of pain and discomfort that had recently been there and notice that one is doing more and better, but this does not mean one is no longer in the healthy disposition. The healthy disposition does not evaporate as one becomes aware of it. Experiences in the healthy disposition may include reflective moments in which I am aware of my own feeling of, as Svenaeus would put it, being at home in the world. The feeling of fulfilling potential may remain in the background or it may come to the fore in a satisfying experience of accomplishment.

However, again, a subjective feeling of accomplishment is not necessarily the hallmark of healthy action. An obvious example is that of the drug addict, who prioritizes acquisition and use of drugs above all other goals. He or she may experience great satisfaction in the moment of getting or using drugs, indeed, may come to feel 'at home' only when using drugs, but it would be hard to defend the claim that an addict is acting healthily by getting and using drugs. Husserl points out that there is a constant interplay between potential and action. What I can do obviously conditions what I do, but what I do also conditions what I can do:

The subject is ever and again active according to its faculties and, in turn, constantly transforms them, enriches, strengthens, or weakens them by means of its own action. *A faculty is not an empty ability but is a positive potentiality...*

Finally, everything refers back, in an understandable manner, to *primal faculties of the subject* and from there to *acquired faculties* having their source in earlier lived actuality. (*Ideas II* 267)

Primal faculties include my direct ability to move my hands. The existence of these faculties allows me to acquire other faculties, such as playing the piano. The addict, particularly while on drugs, may, in the short term, have a very strong experience of heightened faculties. Often, for example, an amphetamine user really does feel increased energy and heightened potential for vigorous physical movement. This increased ability to move, just like the user's euphoria, is real. The difficulty is that it is not sustainable. Over time, the effects may require higher and higher doses or may just diminish inexorably. Moreover, the cost, whether monetary or other, is likely to go up. Eventually, the drug user may find that not only is he or she no longer acquiring new faculties but his or her primal faculties are diminishing. Sometimes, as in cases of addiction, it may well be others who clearly observe these increasing costs before or instead of the addict himself or herself. In other words, it is often intersubjective experience that reveals the true impact of an action on one's health over the long term. The addict himself or herself may feel fine, indeed, he or she may even feel better than before. In the early stages of addiction, his or her body may look quite normal when viewed as a material thing. However, even at a relatively early stage, others may be able to see the unhealthiness in his or her actions. The unsustainable nature of the choices the person is making may be available to intersubjective experience before they become available either to subjective or to objective experience of the person.

The Husserlian account of embodiment in *Ideas II*, and the notion of the healthy disposition that I derive from that account, highlights crucial structures in the experience of health. The experience of oneself as being able to act meaningfully in the world is

strongly related to health. First, it is related to health because this feeling often (though, as we saw with Havi Carel and with the imaginary drug addict, not always) occurs when one is healthy. Second, being in the healthy disposition itself conditions one to act in a healthy way. This attitude disposes one to actualize one's primal faculties in such a way as to acquire further faculties. However, this experience of oneself as being able to act meaningfully may not always correspond with health itself; that is, it may not always be followed by action that is healthy. Husserl's account of embodiment is closely focused on action and thus, I argue, represents a valuable starting point from which to describe health. Even so, describing first person structures of the experience of embodiment, no matter how action-centered, will never describe health itself. Healthy action very often corresponds with the healthy disposition and with the feeling of bodily potential, but it does not always do so. In order to differentiate between healthy action and other action, one needs to consider human action not just at the level of individual faculties, but in the broader context of the intersubjective lifeworld. For this, I turn to Simone de Beauvoir, whose account of action in *The Ethics of Ambiguity* is immensely rich. Beauvoir's account of action centers on the notion of freedom as an absolute value. On her account, actions are ethically defensible to the extent that they are aimed at the realization of freedom both for oneself and for others. In what follows, I draw on this account to argue that freedom ought also to be the guiding criterion by which we differentiate healthy from non-healthy action.

Health as Authentic Embodied Action

I have argued that health is manifested in actions, rather than simply in the potential for action. One may experience oneself as pursuing such action in what I have termed the healthy disposition, an attitude [*Einstellung*] in which one perceives oneself and the world as amenable to meaningful action. But not all action is equally healthy,

even if one experiences it as such. Simply experiencing oneself in the mode of “I can” is no guarantee that one’s action is truly healthy. In order to give a full account of health, we still need a criterion by which to evaluate the healthiness or otherwise of particular actions or patterns of action. For that purpose, I want to introduce Beauvoir’s account of action, and then show how it can provide the necessary criterion. In the next chapter of this dissertation, I will then show how this criterion forms the basis of an account of the relationship between fatness and health that fits better with lived experience.

Beauvoir describes the human situation in terms of freedom and facticity. As long as one is conscious, one always has choices, but one always chooses in the context of a world over which one’s power is not absolute. We have freedom to change the world, but that freedom is limited by facts that we cannot change. Beauvoir argues that the goal of all human action must be to maximize freedom for all human beings, as best we can given the factual situation in which we find ourselves. She writes:

The truth is that in order for my freedom not to risk coming to grief against the obstacle which its very engagement has raised, in order that it might still pursue its movement in the face of failure, it must, by giving itself a particular content, aim by means of it at an end which is nothing else but precisely the free movement of existence. (*ibid.* 29)

Authentic human action is action which makes sense in, and of, our situation, without denial or deception. In order to be authentic, my actions must be ones that I choose to endorse while fully acknowledging the reality of my situation, both what I can do and what I cannot. They must be actions that make sense to me when I am not pretending, to others or to myself, that my situation is other than it is. Unless my choice is made in full recognition of that fact, not only will it be unachievable but even the attempt itself will be empty, resting only a flimsy and easily torn framework of denial and deceit.

Given the way it encompasses every kind and aspect of human action, I believe Beauvoir's conception of action and freedom is an extremely valuable resource for describing health. The biggest problem with the dominant model of health is its objectivism. Beauvoir – inspired, albeit in part and indirectly, by Husserl's anti-naturalism – rejects such a conception of the world. As we have seen, constructivists have long argued that health is not a simple matter of physical biology. But the constructivist ends up inadvertently endorsing the central notion of objectivism – that whatever really exists must be mind-independent, material and (in itself) meaningless. While I reject thoroughgoing objectivism or constructivism, I acknowledge the legitimate concerns raised by proponents of those positions. The objectivist concern that we take seriously the facts of the matter is legitimate. Meanwhile, the constructivist concern that we take seriously the social and cultural aspects is also important. Health, like any other aspect of the human situation, has both factual (objective) and transcendent (constructed) aspects. In discussing the interplay of freedom and facticity, one can address these concerns. Beauvoir's account of action avoids objectivism but also constructivism. She describes action in a way that does not try to reduce reality either to subjectivity or to objectivity but rather acknowledges both aspects. As such, this account can provide a useful criterion for healthy action.

In Chapter Two, I used the example of height in discussing the impact of various physical features on health. I now return to that example. Imagine that I am five feet tall. This is a bodily fact which, for all intents and purposes, I cannot change. This fact has an impact on what bodily faculties (to use Husserl's term) I can acquire. However, this impact may be constituted as a limit or an opportunity. There are things I cannot do at five feet tall that I could do if I were six feet tall. There are also things I can do at five feet tall that I could not do if I were six feet tall. My height is a factual aspect of my situation,

neither necessarily good nor necessarily bad. For many people, unless they are very unusually tall or short, their height is not an especially significant fact in their lives. It provides neither hard limits nor exceptional opportunities. However, there are ways in which it may present itself as a significant limit or opportunity. In the contemporary USA, for example, there is a cultural expectation that men will be taller than their female romantic partners, thus short men and tall women may find themselves under-represented in popular culture or may feel that they are somehow less attractive than those who fall in a more statistically normal height range for their sex. Short people of any sex or gender may find it harder to reach those troublesome top bookshelves. Other things being equal, short people find it easier than tall people to become successful jockeys, while tall people find it easier than short people to make it as basketball players. Some people are so unusually tall that they find it difficult to walk through doors, get into cars, lie full-length in beds and so on. Some people are so unusually short that they cannot reach even the books five feet from the ground, let alone those seven or eight feet up. Being at either end of the bell curve is probably going to impact significantly on the way one functions in the world. If there are disadvantages to being some height or other, usually, one has to find a way around them. This is a matter of transcendence, it is a manifestation of freedom. I cannot do this, but I can do that. For most people, it is possible to live a fulfilling life even if one is much taller or shorter than average. Sometimes being unusually tall or short can offer opportunities that would not otherwise be available. Even in the most extreme cases, freedom still opens up possibilities: One's height is a fact, not a fate.

The same can be said, at least to some extent, of pretty much any physical feature. But some features are more likely to affect one's life profoundly than others. For example, the lung disease described by Havi Carel (sporadic pulmonary lymphangioliomyomatosis) is especially debilitating, because human beings need to take

in oxygen and exhale carbon dioxide all the time just in order to stay alive, and thus every human action is impeded by breathing difficulties. In Husserl's terms, breathing is central to one's primal faculties; if I cannot breathe, my ability to move my body in any way whatsoever is severely compromised. In existentialist terms, one's freedom is significantly conditioned by difficulty breathing. Carel has to make all kinds of adjustments to her life because of the fact that she now gets out of breath so easily. She writes:

I had to start using oxygen. I had to put up with the stares in the street, the nose bleeds, the breathlessness. I had to slow down. I had to ask for ground-floor rooms for my teaching. ... I looked at a hill I could cycle up easily two years ago, with difficulty one year ago, and turned around, knowing full well I couldn't cycle up it at all any more. (63)

Carel has come up against a limit imposed by her facticity. She has to find different ways to do the things she used to do. Some things, she can no longer do at all. These are limitations on her freedom. As Beauvoir shows, freedom always necessarily operates within limits. This is simply a fact of the human condition. But some limits are harder to overcome than others. Because breathing is so basic, so fundamental, so necessary to every life activity, difficulty in breathing is an especially difficult limitation to overcome. This means that, other things being equal, sporadic pulmonary LAM has a bigger impact on health than being five feet tall. For most people, being five feet tall doesn't affect that many life activities, whereas having LAM significantly conditions the choices and options one has.

Both LAM and one's height are empirically observable facts about one's physical body. This Beauvoir-influenced account of health does not, however, rest on a strong distinction between the objective facts and the constructed realities of one's situation. My

choices are not only conditioned by physical facts like my height or my lung function. They are also conditioned by the society I live in, the people around me and the nature of our interactions. It is clear, for example, that being black in an anti-black society strongly conditions one's options in particular ways. This also conditions one's health, since it has a huge impact on the courses of action that are available to one. This impact is in no way less real than the impact of a condition like LAM. In a phenomenological description, it would be a mistake to draw a hard line between the objective and the constructed or social aspects of a situation, because phenomenological investigation reveals how blurry and variable that line is. When it comes to health, the interplay between the physical, mental, cultural, social and political aspects of experience is constant and inevitable. It is a limitation of objectivist theories that they differentiate between physical and mental interactions. From the phenomenological point of view, so-called physical experiences and so-called mental experiences are inextricably linked. For example, an emotion such as anger, fear or joy manifests itself in both physical and mental ways, affecting both my bodily function and movement and also my thoughts. In such a case, the experience is both mental and physical. One is not having two simultaneous experiences, one physical and the other mental. Rather, one is having an experience which has both mental and physical manifestations.

This multi-faceted view of experience allows us to discuss health in terms of action without returning to an objectivist or biostatistical account of functioning. By taking into account all the features of one's situation, we can introduce a criterion for healthy action that centers on the accomplishment of meaningful goals. We can address the example of the drug addict by introducing the temporal and intersubjective criteria. Getting and using drugs is, for the addict, not an action that realizes his or her own freedom or the freedom of others. What makes it unhealthy is that this process

continuously limits one's options more and more, and, indeed, may also limit the options of those around one. In this scenario, by getting and using drugs, the addict is closing off more and more possibilities. It is the actual performance of the action that is the problem. What is unhealthy is the pouring of one's resources of time and energy into the pursuit of this project that is not conducive to freedom. It is no different to a five foot tall person trying to reach an eight foot high bookshelf. It is pointless.

In the previous section of this chapter, I described what I termed the healthy disposition. In the healthy disposition, one apprehends the world as a sphere full of possibilities for meaningful action, and oneself as capable of such action. To put it another way, in the healthy disposition, one feels free. The Beauvoirian account of action that I have outlined in this section, however, makes clear that to feel free is not to be free. I claimed that it is mistake for a theory of health to conflate the potential for action with action itself. Health, I argue, is manifested not in the ability to act but in action. In effect, I am applying to health Sartre's claim that there is no reality except in action. (See *Existentialism is a Humanism*) Beauvoir's account of freedom mirrors this claim: It is not one's theoretical possibilities that define one, but one's actions. What matters is not what one *could do* but what one *does*. Beauvoir's ethics centers on the authentic pursuit of freedom. I wish to suggest that health is best understood as the physical aspect of this pursuit. When a person is acting, as best he or she can, to further his or her own freedom and the freedom of others, he or she is striving for authenticity, indeed, is manifesting authenticity in the only way a person can. Meanwhile, and directly related, his or her body is manifesting health, and he or she is healthy. Thus, a body with the potential to act in a particular way is a crucial condition for the possibility for health – and indeed, for freedom – but having such a body is not itself health any more than being conscious and thus having choices is itself freedom. This is where my account of health departs quite

radically from that offered by Svenaeus. As I have shown, drawing on ideas from Husserl and Beauvoir, health is not just a matter of potential. Rather, it is, essentially, unavoidably, about action and actuality.

Conclusion

I have said that I depart from Svenaeus because I do identify health with authenticity where he rejects this identification. It must be noted, however, that we have quite different senses of the term ‘authenticity’ in mind. Svenaeus rejects Heidegger’s notion of authenticity as a manifestation of health, because, according to Svenaeus, Heidegger uses ‘authenticity’ to refer to a way of understanding the world rather than a way of acting in the world. That understanding of authenticity is quite different to what I have in mind here. I use the term ‘authenticity’ to refer to the clear-eyed embrace of the ambiguity of the human situation advocated by Beauvoir throughout *The Ethics of Ambiguity*. For my purposes, then, to be authentic is to engage in action on the basis that oneself and one’s situation will always be one of both freedom and facticity and thus one will inevitably face failure again and again. Health is, as I argue further in the next chapter, the bodily manifestation of such engagement.

One concern with this account of health is that it is too broad. By describing health in the way I have just done, one might be accused of losing the distinction between health and overall well-being or flourishing. I offer three responses to this concern. First, the perceived need to corral and separate the specifically physical aspects of health may itself be partly influenced by an underlying objectivist notion that facts are to be found at the physical, empirical level, and that if we do not focus on that sphere we lose any hope of objectivity. This privileging of the supposedly objective, as I hope I have shown by now, is a mistake. Second, however, there is a sense in which this concern is legitimate. Quite often, when we talk of health, we are referring to a feature of embodiment and only

equivocally do we apply the term to one's overall well-being. I do not mean to conflate health with general flourishing. Rather, I suggest that we understand health as a way of being *in a lived body* such that one is undertaking projects and actions that are meaningful and conducive to one's own continued freedom and that of others. As I have noted, one cannot neatly differentiate between the physical and other aspects of being in a lived body. Nonetheless, my concept of health does center on the embodied aspects of experience, as I hope to make very clear in the next chapter, in which I apply this model to the case of fatness. Third, and finally, in response to the concern above, I return to the observation that, while illness comes to the fore in experience, health often fades into the background. Thus, while illness and disease often manifest themselves, at least partly, in very clear and discrete sensations that can be located in particular parts of the body, it is part of the essence of health that it is experienced in a broader, less discrete way, as a pattern of acting and doing and living. In short, I am claiming that, to the extent that I am undertaking the physical actions needed to accomplish my authentically-chosen goals, I am healthy. But when I am unhealthy, my body itself is, for some reason or other, a limitation on my options for this kind of action.

I am claiming that health is the bodily manifestation of authenticity. By this I mean, first, that I take health to be an ongoing process rather than a state, a way not just of being in general, but specifically of acting and doing. Second, health is not 'in' the body, nor is it manifested only in physical ways. Third, while empirical investigation of the body gives useful data that can predict bodily functioning, health itself can only be experienced in the context of a person's lifeworld, not in her body. Fourth, not everyone has the same way(s) of being healthy, and not every healthy body looks the same, because what health means for a given person depends on her goals, commitments and values. Fifth, despite the previous point, one cannot simply 'make up' one's own definition of

health, any more than one can simply ‘make up’ one’s own morality; in order to have any meaning at all, any conception of health must stand up to intersubjective critique, or it is just a denial, a fantasy, a resignation. In the next chapter, I return to the example of fatness, and use it to explicate each of these points in more detail. In doing so, I show how my phenomenological-existential model of health avoids the pitfalls of the dominant objectivist model and also those of the constructivist alternative.

CHAPTER FOUR: THE EMBODIED AUTHENTICITY MODEL OF HEALTH APPLIED TO FATNESS

Introduction

Throughout the previous chapters of this dissertation, I have argued for the need for a new model of health that does not rest on the problematic approaches that I have termed objectivism and constructivism. In Chapter Two, I used the example of fatness to argue that neither of these approaches enables an understanding of health that squares with lived experience. In Chapter Three, I argued for a model of health centered on action, which, I argued, avoids the respective pitfalls of objectivism and constructivism. I refer to this model of health as the embodied authenticity model. I described the main structure of the experience of health as an attitude [*Einstellung*] in the Husserlian sense. I called this attitude the healthy disposition. The characteristic structure of experience in this attitude is “I can”. I also, however, argued that health is best understood not as a quality of bodies but of actions. Thus, our focus must shift from potential action (experienced in one’s own body in the “I can” structure) to realized action. To this end, I described healthy action, which, I argued, is the embodied aspect of authenticity.

In this chapter, I return to my example of fatness to show the usefulness of this embodied authenticity model of health. In the first section, I clarify what I mean by fatness by giving a phenomenological account of fatness itself. In the second section, I return to Sarah, the imaginary fat woman I introduced in Chapter Two, as well as drawing on real-life examples, to demonstrate how my model of health applies to fatness. In the third section, I address the notion of body acceptance. I argue that none of the currently available models of health actually allow for authentic body acceptance. Rather, to borrow a distinction Beauvoir makes in *The Ethics of Ambiguity*, they encourage various

kinds of resignation under the guise of acceptance. (28) The dominant model encourages almost every person to see his or her body as somehow inadequate and to resign himself or herself to an endless battle to change it in the hope of making it more acceptable. In the case of fat people, this, of course, means weight loss. The fat acceptance alternative seems to advocate body acceptance, but it often veers off into a bad-faith resignation when it takes it as axiomatic that safe, permanent weight loss is impossible and unnecessary for every person. The HAES model is perhaps more open to the possibility of safe, long-term weight loss, though it still insists that this is not an outcome that can be chosen, but that it can only ever be a side effect of healthy behavior. In contrast, I argue that part of what it means to accept one's body is to accept that a lived human body can change and be changed, even in some cases by direct action on the part of the person. This acceptance is a crucial aspect of healthy action. This does not mean that every person can safely and healthily make himself or herself thin, and as such this acceptance does not place any burden on fat people in general to become thin. It does, however, mean, that body acceptance can be compatible with specific goals for bodily change, including changes to one's body size, shape and composition. In my view, this represents a significant practical advantage of the embodied authenticity model of health.

A phenomenological account of fatness

In applying the embodied authenticity model of health to fatness, I claim that fatness is not necessarily a health problem but that it may be one. In order to clarify this claim, it is useful to start by giving a phenomenological account of fatness itself. From the phenomenological point of view, fatness is neither purely a physical feature nor purely a constructed category. Fatness is a physical feature *as* constituted by people, both fat people themselves and others around them. As many writers have pointed out, in the contemporary USA fatness is amongst the most meaning-laden bodily features. In terms

of how people and bodies are categorized in this context, fatness does not loom as large as race or sex/gender, but it is rapidly catching up with certain other phenomena of embodiment, such as visible disability, in terms of its social and cultural significance. Like visible disability, a person's body size, shape and composition are often regarded as conveying not only the person's level of physical ability but also his or her level of emotional and mental well-being, his or her lifestyle, and perhaps even his or her life history. They can even be taken as a manifestation of his or her moral character. This cultural milieu conditions every particular experience of a given fat body, and indeed it conditions the judgements we make about fatness and fat people in general. It influences how individual fat people are experienced both by themselves and others. There is no question but that our experiences of fatness are conditioned by the culture in which we find ourselves. Nonetheless, fat bodies really are different to thin bodies, and not just because we 'construct' them differently. As I argued in Chapter Two, fatness is not merely a cultural condition; it is a physical difference.

To say that fatness is a physical difference is to say that some bodies, as physical things, have the quality of fatness while others do not. Very broadly, to say that a person is fat is to say that his or her body (or some significant part of it) has a greater than normal amount of adipose tissue. For the purposes of giving a phenomenological account of fatness, I use the term 'normal' here to refer broadly to biostatistical norms for the population(s) of which a given person is part. However, such statistics must always be subject to critical scrutiny. A person may be part of many groups, and any one of these groups may itself be conditioned by social and cultural factors, some of which may in turn be conditioned by understandings of fatness. For example, poor people are more likely to be fat, but there is debate over whether being poor makes you fat, or being fat makes you poor, or both, or neither. (For an overview of the debate, see "Does Social

Class Explain the Connection Between Weight and Health?") Meanwhile, within the population of fashion models employed by agencies, for example, a person could have more adipose tissue than is normal for the surrounding population and yet be very slim by the standards of wider society. In this case, any assessment of the claim that a given model is or is not fat must take into account other aspects of the situation, such as the fact that models are typically chosen for their slenderness and that slenderness is valued perhaps above any other quality in models. Thus, fashion models, as a group, cannot be taken to be representative of the wider population or of humanity as a whole when it comes to body size, shape or composition. Comparable considerations apply when we look at fatness as it is experienced amongst different racial or ethnic groups. The point is that, in making claims about who is fat, one cannot simply measure and go. There is a need for critical reflection on measurements. This does not mean, however, that fatness is *purely* a relative quality, or that it is nothing but a matter of interpretation. The difference between a fat body and a thin one still ultimately comes down to the presence or absence of the actual physical stuff of adipose tissue.

In *Unbearable Weight*, Susan Bordo describes an item on a television show called “20/20” in which young boys are shown pictures of fashion models:

The models were pencil thin. Yet the pose was such that a small bulge of hip was forced, through an action of the body, into protuberance – as is natural, unavoidable on any but the most skeletal or the most tautly developed bodies. [...] These young boys, pointing to the hips, disgustingly pronounced the models to be “fat”. (186)

As Bordo’s analysis of this incident shows, these fashion models in the television show could not reasonably be described as having an unusually large amount of adipose tissue. Indeed, almost no mainstream fashion model at work today could be so described – even

those who are considered “plus size”.¹⁵ But nonetheless the boys were using “fat” in a way that makes sense in their context. In this context, the beauty ideal (especially for women) is no longer merely slender, it has also become, as Bordo puts it, “... a tighter, smoother, more contained body profile.” (*ibid.* 187) Bordo concludes that our concept of fatness is no longer just about size. This makes some sense of the prevalence of fat talk amongst and about young women who are not overweight or obese by medical standards. When such women call themselves “fat”, they are not necessarily labelling themselves as too big or too heavy, but rather as too flabby, too soft, too lumpy. Fatness is no longer just about quantity of flesh, it is now about quality too. This also explains why there is some truth in the claim that, if Marilyn Monroe were alive today, she would be “fat”.¹⁶ While it is not true that Monroe wore a contemporary USA size 16, or that she was ever overweight or obese by modern medical standards, it is true that she has a softer appearance than many contemporary female models or film stars, with a larger bust and wider hips relative to her waist than would now be fashionable in many circles.

I suggest that there are, in fact, three main ways in which fatness is manifested in a physical body. These are size, shape and composition. With respect to size, fat bodies tend, on average, to be larger than thin ones. To be fat is to have more adipose tissue, and thus, other things being equal, to have more mass and more weight than others of one’s height, bone structure or level of muscularity. Admittedly, though, a very short person,

¹⁵ This demonstrates clearly why “fat” and “obesity”, though strongly linked, require separate analysis. There is no way that the models could be called “obese” given their appearance and the meaning that term currently has in the contemporary USA. But, as I argue following Bordo, they *could* meaningfully be called “fat” given one of the meanings that “fat” has in the contemporary USA.

¹⁶The question of whether or not Marilyn Monroe would now be considered “fat” is one that has exercised many people in recent years, particularly on various internet forums. For an overview of the dispute, and arguments that Monroe was not a contemporary US size 16, see “For the last time, What size was Marilyn Monroe?”.

for example, might be fat while still being smaller overall than many other people. This is partly because the fat body differs from the non-fat body not only in size but also in shape. The shape of the fat body often does not ‘echo’ the shape of the skeleton as nearly or as neatly as that of the slender body. A thin arm, for example, will often be narrower between the elbow and the shoulder than it is at the joints, just as the joints themselves are generally wider than the bones they connect. A fat arm, however, can be wider between the joints, narrowing as it nears them. The outline of the ribs is often clearly visible in the abdomen of a thin person, particularly when the person causes his or her ribcage to move by breathing deeply. This is much less often the case in a fat person. This forms a pattern of body shape that is observable in experience. Finally, one can say that fatness is manifested in body composition. Body composition is less visible than size and shape, but even in ordinary everyday experience, there are telltale signs. Like bones, muscles may also be less visible in those who are fat. Both fat and thin people may be very muscular, but the muscles tend to be more visible in those who are less fat. To be fat is not just to have more adipose tissue than others, but to have adipose tissue make up a greater proportion of one’s body.¹⁷ In ordinary experience, this may make for a softer, more rounded appearance to the body.

Clearly, size, shape and composition are not separate in concrete experience. Rather they are different aspects of, or different ways of describing, what is ultimately one phenomenon, the fat body. There is also, of course, a wide variety of body shapes amongst both fat and non-fat people. Some fat people have fat limbs and relatively

¹⁷ As I mentioned in Chapter One, having a high proportion of adipose tissue does not always entail being fat; there are people whose BMI is in the normal range yet who have an unusually high amount of adipose tissue and a low level of muscle. Such people are sometimes referred to as ‘normal weight obese’ or, colloquially, as ‘skinny fat’.

slender midsections or vice versa. Many but not all fat people have more pronounced bellies, larger breasts or fuller backsides relative to their overall size, since these are parts of the body on which adipose tissue often accumulates. What I have described here are patterns that arise in ordinary experience of fat bodies. They are not definitional, nor are they intended to categorize bodies in an absolute or pure way. I see two major benefits to this way of describing fatness. First, it is able to allow for different kinds of fatness, and second (and very much related) it is able to account for degrees of fatness.

One of the weaknesses of the currently available models of fatness is that they do not allow for different kinds of fatness each of which has a different relationship to health. At one level, as Bordo points out, we have come to acknowledge that fatness is not just about quantity but also about quality. Yet when it comes to discussing the relationship between fatness and health, no account is taken of variations in quality of fat. Quantity is taken as definitional. A stronger model of health could account for the significant differences that are given in experience between the fatness of a Japanese sumo wrestler and the fatness of a sufferer from binge eating disorder (BED), even if their weights and BMIs and hip-to-waist ratios are the same. Earlier models of health allowed for such differences by considering different possible causes of fatness. (See Gilman 2008 and 2010) Increasingly, however, as numerical measurements have been taken to define rather than simply to indicate fatness, and as excessive consumption and insufficient exertion have been taken to be the definitive cause of fatness, such nuance has been lost. Now, neither the dominant model nor the Fat Acceptance alternative is really able to account for different kinds of fatness. The dominant model defines fatness in numerical terms and understands it as the direct and invariable consequence of excessive consumption and inadequate exertion. This leaves no room for the notion of healthy corpulence that existed, for example, in the time of Charles Dickens' *The Pickwick*

Papers. To twenty-first century Western eyes, as Gilman points out, everyone in the ‘Phiz’ illustrations of *The Pickwick Papers* looks fat. But Dickens and his contemporaries appear to have made a clear distinction between the fatness of the well-fed and healthy Pickwick, on one hand, and the fatness of Joe, who is clearly considered unhealthy, on the other. (Gilman 2010 5)

Meanwhile, for proponents of FA, there is no connection at all between health and weight, and so there is no room for kinds or degrees in that connection. These commentators often take it as axiomatic that fatness is neither a cause nor a consequence of ill-health. As such, they do not allow for differences between (for want of better terms) a healthy corpulence and an unhealthy obesity. The embodied authenticity model, however, can account for different relationships between health and fatness in different bodies. This model considers the body not just as a physical thing but as a site of human agency, and it considers not only what the person could do but what he or she actually does. Thus, the fatness of the sumo wrestler is different to that of the BED sufferer because they have come about in different ways and have radically different impacts on the agency of the person. This is a point to which I return later in this chapter.

The other strength of the embodied authenticity model for understanding fatness itself is that it can account for degrees of fatness. It is easy to contrast a very fat body which has visible rolls of adipose tissue with a very thin body in which bones are visible, or with a very lean, athletic body in which the outlines of the veins and muscles can clearly be seen. It is much more difficult to draw clear lines circumscribing all those who are thin in one group and all those who are fat in another. It is, in fact, impossible. Nor, however, is it necessary. From the phenomenological point of view, the existence of in-between cases does not negate the categories. Broadly speaking, it is both meaningful and

useful to speak of fat people and thin people as groups, notwithstanding the existence of people who straddle or hover between categories. As I discussed in Chapter Two, the drive to delineate absolute categories is based on the problematic notion that categories must be pure in order to be of any use at all. But, as I argued, this is a mistake. In reality, there are many ways in which categories can be useful even if every individual body does not fall neatly into only one category.

When one describes fatness phenomenologically one of the things that clearly emerges is that fatness admits of degrees. It is gradual. This is the kind of phenomenon fatness is. Just as some people are neither especially short nor especially tall, there are people who are neither especially fat nor especially thin. But, just as with tallness and shortness, there are still many ways and situations in which it is both meaningful and useful to speak of fat people as a group, and even to contrast them with thin people, notwithstanding the fact that some people fall between these two categories. This means that, for the purposes of discussing health, we can speak meaningfully of a relationship between health and fatness even if neither health nor fatness are pure categories and even if that relationship varies considerably from person to person.

Those who wish to deny the usefulness of the categories of fat and thin sometimes point to the seemingly arbitrary way in which the words ‘fat’ and ‘thin’ are used, as in Bordo’s example of the young boys calling the model fat. However, even in cases like this, there is a kind of logic, albeit problematic, to the use of the term ‘fat’. Most models, and women depicted in mass media in general, are extremely thin. They appear to have almost no body fat. Their body shapes follow very closely the outlines of their skeletons. The outlines of their muscles, if they are at all muscular (though very often they are not), tend to be clearly visible. They tend to be at the lower extreme of the weight and size bell

curves of the population. In short, statistically speaking, exceptionally thin women are way over-represented amongst the ranks of successful singers, models, actresses and television personalities. When a woman in this milieu is called fat, it may indeed seem crazy by everyday standards. And, very often, such a use of the term 'fat' does represent the kind of quasi-anorexic and even misogynistic thinking described by Bordo and others. Only by a ridiculously restrictive standard could most of these women be described as fat. But nonetheless, the *difference* that causes them to be labelled fat is the same as that which causes actual fat people to be perceived as such. Their skeleton and musculature are less visible *compared to those of the other women around them* or compared to observers' expectations of what women look like in this context.

I don't mean to defend the application of the term 'fat' to everyone who is not extremely thin. This application is philosophically, politically and practically problematic. I do however wish to point out that this application is not as utterly arbitrary as some critics would suggest. Such application ought not be taken to render the term 'fat' itself meaningless, nor should it be taken as evidence that fatness is *merely* constructed. Rather, the fact that it seems counter-intuitive to label a thin model as fat just shows that we *do* have lived experience of fatness as a real physical difference, as a quality which some bodies have and others do not. It is precisely in the light of that shared lived experience of fatness that we are able judge what we perceive as misapplications of the term 'fat'.

When discussing the relationship between fatness and health, it is important to understand that fatness is a phenomenon in experience and not a mere concept or a pure construction, but also that it is a phenomenon that admits of variation in quantity and quality. There really is such a thing as fatness, but there are kinds and degrees of it. The embodied authenticity model of health, unlike previously available models of health, accounts for the possibility not only that such kinds and degrees of fatness exist but also that each of

them can impact on health in different ways. In order to further explain this claim, I now return to my example of Sarah, and also consider some real-life examples.

Sarah, Fatness, and the Embodied Authenticity Model of Health

In Chapter Two, I described Sarah, an imaginary fat woman. As we saw in that chapter, viewed from the point of view of the objectivist dominant model of health, Sarah is unhealthy because she is fat, and she can only be healthy if she loses weight. Meanwhile, from the point of view of Fat Acceptance, whether in its more objectivist or constructivist versions, Sarah's fatness has no connection to her health, and losing or gaining weight would not, in itself, make her any more or less healthy. As I argued in that chapter, neither of these models captures the relationship between Sarah's fatness and her health.

From the point of view of the embodied authenticity model, however, there is a relationship between Sarah's fatness and her health, although it is complex and only becomes clear in the light of intersubjective analysis of her life as a whole. On the model of health I am proposing, we can only meaningfully call Sarah healthy or unhealthy when we consider Sarah's empirical data and functioning in relation to her own goals, and when we consider those goals from a critical, intersubjective point of view. That is, Sarah's health depends not only on the state of her body, but on the way in which her body conditions her choices and possibilities, and whether that conditioning is or is not conducive to the advancement or achievement of her goals, and whether those goals themselves stand up to intersubjective scrutiny. I have suggested that health primarily manifests itself in action towards a project or goal to which one is committed. In particular, health is thus manifested in the attitude I call the healthy disposition, and more broadly in authentic action. In the rest of this section, I show how each of these applies in Sarah's case.

In the healthy disposition, one experiences the world, in and through one's body, as a situation in which one acts and in which one's actions have meaning and purpose. In this disposition, one experiences one's body in the mode of "I can", that is, as a locus of potential. On the basis of this particular kind of experience of embodiment, one understands oneself as having a broad, though by no means unlimited, range of options for action of a kind that is conducive to one's own goals and projects. As I discussed in the previous chapter, not all bodies are equally conducive to manifesting the kind of self-experience that is characteristic of the healthy disposition. Not every body has the same kind or degree of "I can". A person who suffers from chronic back pain may experience strong resistance when trying to engage in physical activities even as basic (for most people) as standing or sitting upright or taking deep breaths. In this chapter, my concern is specifically with fat bodies. How, if at all, does being fat affect one's experience of embodiment? Does fatness impact on one's range of "I can" potentialities? Can a person be fat but yet be in the healthy disposition?

As I mentioned in Chapter Two, Sarah finds it difficult to walk long distances and, especially, to walk up hills. From the objectivist point of view, and particularly that of the dominant model, this is a direct result of Sarah's fatness. If she were to lose weight, she would find it easier to walk long distances or up hills. From the Fat Acceptance point of view, Sarah's difficulty cannot be said to be a consequence of her fatness because not all fat people experience such limitations. From the point of view of the embodied authenticity model, Sarah's fatness certainly has an impact on her potential. Indeed, from the point of view of this model, every aspect of every feature of a body conditions the abilities and potentials of the person. The question, strictly speaking, is not whether Sarah's fatness affects her potential but rather how it does so. The question is, on the whole, whether it tends to present resistance, or to present opportunity, or both, or neither.

Sarah herself believes that her fatness contributes directly to her difficulty in walking. She recalls times when she was less fat and when walking was easier. In the present, she experiences her own body as heavy. That is, she feels weighed down by her fat, which she perceives as excessive. Certainly, this experience, like any other, is culturally mediated. Sarah is conditioned by her society to perceive her own body as too big and too heavy. However, this social and cultural conditioning is not enough to account for Sarah's experience of difficulty standing up out of a low chair, for example. When she has to get out of a low chair, Sarah experiences her own legs as lacking the physical strength needed to push herself up to a standing position. She needs to use her arms too, leaning on the arms of the chair to help her stand, or even if possible asking a friend to take her hand and help pull her up. Sarah experiences this lack of strength at the most basic, pre-theoretical level. As I discussed in Chapter Three, Husserlian description of embodiment shows that such experience is foundational to all self-experience. No experience occurs in a vacuum, and every experience occurs in a lifeworld, and is therefore conditioned by other experiences. Thus, Sarah's experience of her inability to stand up out of a chair, and her experience of this inability being linked to her fatness, is connected to her other experiences of herself as fat and of her culture's understanding of that fatness. Nonetheless, there is something about this experience that is not reducible to a matter of construction or social conditioning. This is an experience of a specifically *bodily* limitation. Sarah experiences herself and her body in that moment in the structure of "I cannot". And it is not only in reflection that Sarah links this "I cannot" with her fatness. Rather, the physical experience itself includes the feeling that she is, so to speak, too heavy for her own legs, that there is just too much weight there to be lifted in this way. Sarah does not struggle to stand up *and then judge on reflection* that it must have been because she is too fat. Rather, she directly experiences herself as having difficulty

standing up out of the low chair *because she is too fat*. This difficulty in standing up is, in fact, one of the ways in which she experiences her fatness. The ability to stand up from a seated position, whether on the ground or in a chair or simply squatting down, is a very fundamental human faculty. It facilitates many other actions. Moreover, the inability to stand up easily from a seated position is indicative of muscle weakness that probably affects many different basic life activities.

One's tendency to be in the healthy disposition is clearly impacted by such experiences of embodiment, and this in turn strongly conditions one's scope for authentic action. The more one experiences any aspect of one's body in an "I cannot" way, the less one apprehends one's body as a site of possibility. If one experiences one's body more in the mode of "I cannot" than in the mode of "I can", then there is a good chance that one will do fewer and fewer of the kinds of things that draw on, and thus actually increase, the full range of a body's faculties. From the existential point of view, this reduces the range of possible ways in which the person's freedom can be manifested. Thus, the absence of the healthy disposition, on one hand, and the inability to do the physical things one wants and needs to do, on the other hand, constantly re-enforce each other. The more Sarah struggles to get up out of chairs, the less readily she tries to stand up. The more uncomfortable it is for her to walk a long distance, the less willing she is to undertake walks. This, in turn, makes it even more uncomfortable for her to walk. In Husserl's terms, not only does she lose her acquired faculties but, over time, even the scope of her primal faculties -- such as her ability to move her arms and legs -- actually becomes compromised. On the converse side, as Husserl also points out, use of the primal faculties allows one to acquire more faculties, and even after losing one's faculties, they may be quickly regained if one again acts on them. After being laid up in bed with an illness, one may have to relearn how to walk, but this faculty returns quickly. (*ibid.* 266) This means

that, Sarah's choices have a strong and direct impact on her future possibilities. If she chooses to move more, she increases her bodily faculties, that is, her range of physical possibilities. Action that increases one's bodily faculties, and thus one's overall possibilities, is healthy action.

When one is in the healthy disposition, one tends towards such healthy action. The healthy disposition thus re-enforces itself. When Sarah is in this attitude, she feels capable of accomplishing physical things in the world. She thus feels capable of the kind of action that is likely to expand her range of bodily faculties and thus her overall range of faculties, or, as it were, the scope of her "I can". For example, if Sarah were to find that she loves yoga, and yoga becomes important to her, she may wish to have a flexible body. In Husserl's terms, yoga can be seen as a faculty that Sarah could acquire. But her ability to acquire this faculty depends on the primal faculties she already possesses. Having a body that tends towards flexibility might also make it more likely that Sarah would be drawn to and enjoy yoga in the first place. In her current situation, Sarah struggles to reach her feet to tie her shoelaces, so she would probably find it hard to imagine herself getting much out of a yoga class, and so she is probably less likely to take up yoga. Both the presence and absence of the healthy disposition will tend to re-enforce themselves. The less Sarah is able to do, the less she feels able to do and the less she feels able to do, the less she does. In turn, the less she does, the less she is able to do, and so on. When one views Sarah's case from this point of view, it becomes clear that her physical possibilities also condition her possibilities in general.

In fact, there is no clear way to delineate the experience of physical limitation from other limitations. If one's body is limited, one's options are limited, and this impacts every aspect of one's life. Consider a real-life example, that of Christina Corrigan. In her

book, *Tipping the Scales of Justice*, Sondra Solovay relates the tragic story of how Corrigan, a “good capable student” became a “junior high drop-out”:

For a student who needs to avoid stairs, getting to the main level [of the local junior high] requires walking up [a long] hill, rather than cutting across the lawn ... For someone of Christina’s size and limited mobility, neither option was practical. (*Tipping the Scales of Justice*, Chapter 1, “Prejudice in Practice”)

Corrigan’s weight clearly and directly contributed to her inability to complete her schooling, which would have had a massive impact on her future opportunities had she lived into adulthood. Corrigan weighed 680 lbs when she died at the age of thirteen. Her mother was later found guilty of neglecting her. Her inability to climb the hill to school, like Sarah’s difficulty in standing up out of a low chair, seems very likely to have been a direct result of her fatness (even if that fatness itself was caused by something quite other than the usual dominant-model suspects of over-consumption and under-exertion). In this case, Christina’s fatness was clearly limiting her embodied options. The less Christina was able to move, the less she did move, and thus movement became even more difficult for her. Eventually, movement all but ceased to be a live option for her. At the time of her death, it was reported that she had not been outside her house for three months, and that she had been unable to move from the floor on which she was lying. In Husserl’s terms, we can say that Christina’s primal faculties had become compromised by her fatness (again, even allowing for the fact that her fatness may itself have had some other medical cause). Clearly, this limitation was not only physical, but also seems inevitably to have had an impact on her intellectual and social development as well.

According to Solovay, Corrigan’s difficulty in attending school was not just centered on her difficulty in physically getting to the building. It was also exacerbated by the fact that she would have to be “on display” (*ibid.*) while walking into school. The

potential for embarrassment and humiliation thus also constituted a limitation on Christina's options. It does indeed seem extremely likely that a young girl like Christina Corrigan would feel very self-conscious and frightened at the thought of being looked at and seen. Sarah, who is half Christina's size and, unlike Christina, an adult, often finds herself reluctant to be seen in public because of her fatness. Sarah never goes to the beach, for example, because she feels too embarrassed to wear a bathing suit in public but also feels she would stand out too much if she wore anything else on the beach. This feeling of self-consciousness is a common experience amongst fat people. Sarah feels a very strong conviction that she *cannot* allow herself to be seen in a bathing suit. She experiences it as a strong limit beyond which she feels truly unable to go. She may even feel it physically, in the form of a shudder of humiliation when she imagines being seen in a bathing suit. That said, she does not experience this limit in the same way that, or at the same level at which, she experiences her inability to stand up out of the low chair without using her arms. Nor does she experience this limit in the same way that Christina Corrigan would have experienced her inability to walk up the hill to school. Being seen in public in a bathing suit seems unbearably humiliating to Sarah, and this expectation of humiliation is something that limits her options. However, she does not experience this limit directly or only in her body. Her bodily faculties are not compromised. That is, it does not immediately or directly impact her bodily experience of herself in the mode of "I can". She is not under the illusion that she is physically incapable of being on a beach while wearing a bathing suit.

In fact, for a person like Sarah, fatness may give rise to a strong sense of alienation from her body, and this in turn does indeed condition her situation in ways that impacts her health. At the most basic level, Sarah's fear of humiliation may condition her behavior and choices in such a way as to limit her bodily faculties over time. Just as the

wider society ‘others’ fat people, treating them as monstrous, treacherous and dangerous, so the fat person sees his or her own body the same way. The notion that every fat person has a thin person trapped inside him or her¹⁸ is a cultural manifestation of this alienation, with its suggestion that adipose tissue is like a disguise or a covering that is imposed upon or worn, however reluctantly, by the true inner person who is always thin. This kind of alienation may well make individual fat people less likely to want to participate in the kinds of physical activities that both require and develop bodily faculties. It is all but impossible at the level of lived experience to differentiate between the purely physical and the social, cultural, emotional and psychological experiences that may also shape a person’s situation and thus impact his or her bodily faculties and health. From the point of view of the embodied authenticity model of health it is neither possible nor necessary to draw such distinctions. The point is to observe the patterns of lived experience and how they condition one’s bodily actions, and how these actions are or are not conducive to the pursuit and realization of meaningful goals.

Clearly, alienation from one’s body is not an experience peculiar to fat people. There is, however, a particular kind of alienation, experienced very distinctly in the body, that is more likely to arise for fat people (though it is not unique to them in every particular), and that is the experience of not fitting in. This experience has a direct impact on one’s attitude. It conditions one’s experience, making it much less likely that one will be in the healthy disposition, and making it more difficult to engage in authentic action not only in strictly physical terms but in a broader understanding of action. If one’s primary bodily experience is more “I cannot” than “I can”, one is less likely to engage in

¹⁸ Consider, for example, the subtitle of *Weight Loss Surgery: Finding the Thin Person Hiding Inside You*, a 2003 book aimed at those seeking weight loss surgery, or the film *Shallow Hal* (2001), in which Gwyneth Paltrow plays a fat woman whose “inner beauty” is depicted as a thin version of her.

any kind of activity, and that can lead to marginalization, depression and certainly to ill health. Fatness can – even though it does not necessarily – condition one to experience oneself in the “I cannot” mode.

Fat people often experience themselves as unable to fit in, both physically and figuratively. Often, in the USA, the phrase ‘fit in’ is used figuratively to indicate a person who functions successfully with others in a given situation, behaving in such a way that he or she has, or appears to have, a good deal in common with those around him or her. For many fat people, however, this phrase is not only metaphorical but literal. They don’t fit in figuratively, *because* they don’t fit in physically. Although the specific experiences vary depending on the person’s situation and on the size and shape of his or her body, many fat people share the experience of feeling, and indeed of being, too big for their surroundings. Not fitting through turnstiles, in restaurant booths, or in the aisles or seats on buses or airplanes are all common experiences, as is not fitting into clothes. This literal not fitting in contributes to a broader mental and emotional sense of otherness and difference, a sense that one does not fit in socially and culturally as well as physically. Every time one fails to fit in a seat or a pair of jeans or whatever it may be, one is reminded in the strongest way that one does not fit in figuratively either. In Chapter Two, I mentioned that Sarah would like to support her local independent movie theater, but she cannot fit comfortably in its seats. This means that she rarely gets to go to movies with her friends. They share her reluctance to patronize the large chain cinema, and she is too embarrassed to draw attention to her fatness by pointing out that she cannot fit in the seats, so she just tends to avoid the issue. Under these circumstances, it is difficult – though not, of course, impossible – to perceive one’s body as a site of possibility. This remains true regardless of any other bodily features or potentials one might have.

In the context of all this social pressure, it is understandable that Fat Acceptance proponents emphasize the need for fat people to accept themselves and challenge the social and cultural milieu rather than constantly trying to change themselves. When one considers cases like that of Christina Corrigan, it is particularly understandable that these commentators wish to challenge the notion that all consequences of fatness are entirely the fault and responsibility of the individual fat person. A more recent tragic case is that of Vilma Soltesz, who died when the airline that had flown her out of the USA and multiple other airlines all failed to fly her back home because their European bases did not have the equipment needed to help her board a flight. (“Airlines settle \$6M lawsuit”) In the face of such an appalling case, it is easy to understand and identify with the anger directed at airlines and others by FA activists. It is also easy to understand their insistence that it is social attitudes to fatness that must change, rather than the bodies of fat people themselves. Ultimately, the FA perspective sees no responsibility on the part of any fat person – or any person at all – to change his or her body, while placing all the responsibility on the society and culture at large to accommodate every person’s body. One of the strengths of my embodied authenticity model of health is that it can make sense both of the individual person’s responsibility to adapt to his or her situation in ways that enable meaningful action while also acknowledging the responsibility of others, including institutions and groups, to facilitate meaningful action of as many kinds and by as many people as possible.

Beauvoir’s ultimate criterion for ethical action is the notion that each of us has a responsibility to will oneself and others free. That is, each of us has a responsibility to act in such a way as to maximize both our own and others’ potential for meaningful action towards authentic goals. When we apply this criterion to health, it becomes clear *both* that individuals have a responsibility to cultivate health in their own bodies *and* that

corporations, groups and societies have a responsibility to accommodate individual's bodies as they are where at all possible. In the case of Sarah, she does have an ethical responsibility to seek out ways to maximize her ability to do the things that matter to her. This may involve getting fitter and stronger (though not necessarily thinner) so it is easier for her to get up out of chairs and walk long distances, for example. However, this individual responsibility does not negate the responsibilities of her friends, her community and her society to help her maximize her ability and to refrain from putting needless hurdles in her path. This particular apportioning of responsibility may be unpalatable to some FA commentators, particularly those who strongly resist the notion that there is any ethical onus on the individual to be healthy. In my view, however, refusal to acknowledge this ethical obligation renders would-be empowerment into cold comfort, would-be authenticity into bad faith, and would-be acceptance into resignation.

Acceptance versus Resignation: The dominant model, FA and HAES reconsidered

In the contemporary USA and elsewhere, many people share a concern with fostering body acceptance, particularly on the part of women. There seems to be a widespread belief that it is undesirable, indeed, that it is unhealthy, to hate one's body. However, I believe that none of the currently available models of health allow for true body acceptance, especially on the part of fat people. Under the dominant model, it makes no sense for a fat person to accept his or her body as it is, because it is unhealthy to be fat and it is possible to change it. The dominant model typically chimes with the sanitized version of body acceptance manifested in Dove's Campaign for Real Beauty. In this advertising campaign, Unilever's beauty product brand Dove used models with a more diverse range of body sizes and a more diverse range of races and ethnicities. ("The Dove Campaign for Real Beauty.") In this campaign, which has now been ongoing for ten

years, fat women have been represented, but in most cases they have been only slightly fat and have, in every other respect, matched up with the dominant contemporary beauty ideal. The message seems to be that it is okay to accept your body as long as your body is basically acceptable¹⁹. If it is *too* fat, then of course you cannot and ought not accept it.

In contrast to this approach, FA activists tend to advocate strongly for body acceptance by people of *all* sizes, shapes and compositions. They argue that most fat people cannot become thin and that even if they did, this would not make them healthier, and that anyway, there is no moral onus on anybody to be healthy. This, however, is not acceptance but resignation. HAES advocates come closest to advocating true acceptance, because they advocate healthy actions and choices, and regard a ‘healthy’ body as an effect of such actions and choices. However, they still insist that, over the long term, one’s body size, shape or composition may be side effects of personal activity but are not outcomes that can be deliberately chosen. I do not believe that this is always necessarily the case.

This choice of emphasis is, as I have said, understandable, but it is problematic in light of the fact that some fat people *do* get thin as a result of their own choices and actions. Certainly, it seems to be true that most weight loss attempts fail in the long-term. But some succeed. Surely given this fact, and taking it in conjunction with fat people’s own testimony about their perceived desire and need to be thinner, it is worth

¹⁹ Of course, inevitably, even these slightly-less-than-skinny women’s bodies were unacceptable to many commentators, who were quick to make this known as publicly – and apparently, in many cases, as cruelly – as they could. As Jennifer L. Pozner wrote, “The tone of this debate turned nasty, quickly, with women’s self esteem in one camp and men’s fragile eyes in another as typified by a second Sun Times writer’s comments that these ‘disturbing’ and ‘frightening’ women should ‘put on clothes (please, really)’ because ‘ads should be about the beautiful people. They should include the unrealistic, the ideal or the unattainable look for which so many people strive.’ Besides, wrote Lucio Guerrero, ‘the only time I want to see a thigh that big is in a bucket with bread crumbs on it.’” (“Dove’s ‘Real Beauty’ Backlash.”)

investigating further those comparatively rare cases of successful weight loss. For example, FA critics are quite right to point out the lack of evidence for the assumption that all fat people over-eat, and to further point out that not all fat people are fat because of such over-consumption. But there is evidence to suggest that at least some fat people do over-eat and that at least some fatness is caused by over-eating. One of the benefits of allowing for a range of different relationships between fatness and health is that it allows for the possibility that some people might be living very healthily when their size, shape and body composition truly is in the fat range, while others may be fat for other reasons that are not conducive to their health. On this basis, we can empower individual fat people to decide, in the light of intersubjective self-reflection, whether the particular kind of acceptance advocated by FA or HAES is the appropriate response to *their* fatness. This involves, amongst other things, acknowledging that it matters why a person is fat and how they got that way.

To speak as though no fat person can ever get permanently thin, ignoring or discounting the minority who do, is to encourage resignation rather than acceptance. In phenomenological terms, it represents a failure to take lived experience seriously, and, in existentialist terms, it is an instance of bad faith. Earlier, I discussed Husserl's account of embodiment in *Ideas II*. Here, Husserl offers a convincing description of the central role that action plays in embodiment. To experience oneself as embodied is to experience oneself as having a range of potentials for action in the world, such as, "I can walk across the room" or "I can pick up that cup." (*Ideas II* 266-7) What I can do, and what I perceive myself as being able to do, is inexpressibly central to my self-understanding. These abilities and perceptions are given in direct bodily experience, not only in reflection. Another way of expressing this is that we experience our bodies in and through our sense of "I can" or, indeed, our sense of "I cannot". For example, to suggest that Sarah's

difficulty getting out of chairs is not related to her fatness is to fail to take seriously her experience of her own embodiment. Her difficulty in getting up out of low chairs is one of the ways in which she experiences her body, and it is one of the ways in which she experiences her fatness. It does not follow from this that everyone who shares similarities of body size, shape or composition with Sarah must also share this experience. Consider the example I mentioned earlier of a sumo wrestler. Sumo wrestling is an athletic endeavor, demanding rigid adherence to a program of training and nutrition that, in the experience of participants, increases rather than decreases their physical potential. In the case of the sumo wrestler, his fatness is directly experienced as a benefit to him, at least in competition. The difference between Sarah's fatness and that of a sumo wrestler, in terms of health, does not lie in the fat itself but in how it came to be there and how it conditions their respective bodily faculties. To admit that Sarah's fatness is limiting her bodily potential and therefore her freedom is not to insist that every fat person is similarly limited by his or her fatness. Sarah might be better off to explore possible ways of changing her body size, shape and composition. But it does not follow that a successful sumo wrestler also could or ought to make such changes. This is a matter that must be considered by the individual, in the context of his or her life, in consultation with those around him or her, and in light of his or her goals and values.

From the existentialist point of view, one cannot authentically 'accept' the lived body as though it were a brute object incapable of change. To accept one's body, for a human being, is to accept that one's body is subject to change. Furthermore, authentic body acceptance must acknowledge that this change is sometimes the result of one's own chosen behavior, and this change may include changes to one's body size, shape or composition, sometimes short-lived but sometimes – admittedly in fewer cases – long-lasting. True body acceptance means accepting the possibility of change and deciding

what kind of change one wants to pursue and what resources one is willing to devote to that pursuit. For many fat people, true body acceptance may well mean acceptance of the fact that, in their particular case, thinness simply requires more resources than they are willing to give, that it may, for example, require constant hunger or tiredness or many hours a day exercising. In such a case, pursuing thinness is, to use Beauvoir's analogy, like beating one's fist against a stone wall.²⁰ (*Ethics of Ambiguity* 28) But this is not always necessarily the case. FA and, especially, HAES writers do us a valuable service when they point out that not all fat people are unhealthy. However, when they argue on this basis that fatness and health are unconnected, they are failing to take seriously the testimony of fat people, just as proponents of the dominant model have done. Many, many fat people report themselves as feeling unhealthy, or as feeling uncomfortable, awkward, in pain, despondent or depressed. Often, the fat people themselves consider that their weight is a contributing cause, if not *the* cause of, these feelings. Certainly, as I discuss above, a proportion of this discomfort is born of living in an anti-fat world. But it is a mistake to conclude that *all* the discomfort is so born, and that there is no inherent physical difficulty associated with being fat, that is, I think it is a mistake to conclude that the ill health associated with fatness is *only* a social construction. This is just as inauthentic as is the notion that every fat person can become thin and that this will result in better health in every case. This mistake is a direct result of the all-or-nothing dualism

²⁰ Beauvoir clearly means this as an example of a behavior that is futile. She describes it as 'a useless gesture' that 'debases itself in a vain contingency.' (*Ethics of Ambiguity* 28) However, there are forms of martial arts training in which one deliberately beats ones hands over and over against a stone wall or similarly unyielding surface. In that case, the goal is actually to strengthen the hands in order to increase one's capabilities. In such a case, the action is quite compatible with Beauvoir's ethics. This demonstrates, first, the impossibility of any action being inherently and necessarily inauthentic, and, second, the centrality of the goal in evaluating an action. If my goal is to move the wall, beating it with my fists is pretty futile. If my goal is to toughen up my hands as part of my martial arts training, however, it is an action that is entirely defensible.

of the positivistic understanding of health, whereby health – or, indeed, any aspect of reality – either must be utterly mind-independent or must be ‘all in our heads’. In practical terms, eliding individual experiences of fatness as a problem is, ironically, a kind of victim-blaming in itself. The dominant model holds fat people culpable for choosing to be fat, but the FA alternative holds them culpable for wanting to be thin. On the dominant model, fat people could choose to get rid of their problem by getting thin; on the FA alternative, they could do so by choosing to view their fatness as a neutral physical feature and not as a problem.

Neither of these options is as straightforward as some of its proponents would have us believe, though. In fact, as I noted in Chapter Two, even amongst FA activists, there are many who wish and even strive to become thin. That is, even those who advocate the acceptance of fatness at a social and cultural level sometimes find it difficult to accept it at a personal level. In the light of all this dissonance between the aspiration and the actuality of acceptance, one might ask whether what is being advocated is acceptance or resignation. This is an important question both from a philosophical and a health point of view. From the philosophical point of view, resignation is different from acceptance. Resignation is the sense that one must take things the way they are because there is no possibility of change. Beauvoir writes:

In the face of an obstacle which it is impossible to overcome, stubbornness is stupid. If I persist in beating my fist against a stone wall, my freedom exhausts itself in this useless gesture without succeeding in giving itself a content. Yet there is hardly a sadder virtue than resignation. It transforms into phantoms and contingent reveries projects which had at the beginning been set up as will or freedom. (*Ethics of Ambiguity* 28)

From the FA point of view, trying to make a fat person thin is a stupid kind of stubbornness. In *Lessons From the Fat-o-sphere*, Harding and Kirby write that ‘giving

up' dieting is not the same thing as settling. They explicitly encourage self-development and challenging oneself and pursuing various goals, however they insist that weight loss ought not to be one of those goals:

You will probably never be permanently thin, unless you are already, but other than that, the sky's the limit. You can be anything or anyone you want to be, in theory. ... And that person trapped inside you really might be cooler than you are right now. She's just not thin. (*ibid.* 221)

They present this not as resignation but as acceptance. "There's a big difference between saying you *can't* be anything other than what you are right now and you *don't have to be* anything other than what you are right now." (*ibid.* 220) However, the surrounding discussion makes it pretty clear that, for these authors, if you are fat, you *cannot* be thin, at least not in the long run. This discussion encompasses both the FA point that it is acceptable to be fat, and also the HAES point that one's body might change as a result of health but that this will always be a side-effect at most.

From the embodied authenticity point of view, the health value of Sarah attempting weight loss depends on a number of factors. It depends on how important it is to Sarah to be thin(ner). It depends on what it will 'cost' her to be thin(ner) in terms of time, energy, money and other resources. It depends on how thin it is possible for her to get and how she feels about this outcome. Presumably pretty much anybody can get fairly thin if he or she is willing or able to starve for long enough. It is possible that some fat people would die of starvation before getting into the 'normal' weight range, however most people probably could get very thin if they were able or willing to reduce their caloric intake enough. But the resultant starvation would most likely cause at least as many problems as it would solve in the body. Ultimately, starvation leads to death. If the result of pursuing thinness is that one dies, then it cannot be an authentic goal, because it

is self-defeating. While there may be rare exceptions, most people who want to be thin want to be alive and thin. That is, they want to be thin but also able to do other things. They want to be able to live while thin, not just lie on their deathbeds or in their graves thin. To pursue thinness to the point of death is thus to contradict oneself and to defeat and negate one's own goal and therefore one's own freedom.

Beauvoir uses the term "serious" to describe the experience of values as external and objective. Taking such values seriously is an example of bad faith or inauthenticity. Sarah is in bad faith to the extent that she takes the most extreme anti-fat ideas seriously in Beauvoir's sense. If she treats these values as somehow present in the universe itself, independent of any mind or society or culture, then she is ignoring the fact that she herself has choices in how she responds to these values, thus she is denying her freedom. On the other hand, she can take these values as an aspect of her situation to which she is free to respond in various ways. She may take the FA line, and simply reject these values whole cloth, and, with them, reject any notion that she can or ought to change her body. Of course, this is to assume that Sarah could in fact choose to change her attitude to her fatness by an act of will in the first place. As Murray (2005) points out, this assumption does not square with the lived experience of embodiment, which shows that the body itself shapes and conditions our attitudes. But even if she could manage to effect this change of attitude, Sarah would still be in bad faith. As Beauvoir notes, "...the body itself is not a brute fact. It expresses our relationship to the world... ." (*ibid.* 41) This echoes Husserl's account of embodiment. To be in a lived body is to have possibilities for movement and engagement with and in the world. Simply to be embodied is to have such possibilities and these possibilities place a responsibility on us to choose the better possibilities. Viewed from the point of view of the embodied authenticity model of

health, Sarah can really only accept her body if she is willing to accept that she is capable of changing her body.

Conclusion: Fatness, Health and Freedom

If one's body is subject to change as a result of one's choices and actions, then it follows that one is responsible for one's body. On my model, it is possible to act in such a way as to increase one's potential for healthy action. It is also possible to choose to act healthily. On my model, by definition, such action is conducive to the freedom of oneself and others. As such, based on this embodied authenticity model of health that I propose, one can be said to have an ethical obligation to be healthy. FA and HAES commentators have resisted the notion of an ethical obligation to be healthy since this notion has been used as a stick with which to beat fat people in so many circumstances. In order to avoid facilitating such use, many FA commentators have gone so far as to insist that health is a morally neutral matter. Often, this insistence rests on a liberal assumption that 'my body is none of your business'. (See, for example, "Do I Owe It To Anybody To Lose Weight?" and "Fabulously Fat Friday: But What About Your Health?") However, if Beauvoir's claim is true, and we have an ethical obligation to will ourselves and others free, then there is an ethical obligation on us not only to try to be healthy ourselves but to foster the health of others where it is possible for us to do so. On Danceswithfat blog, Ragen Chastain writes that:

In my dream world everyone would have full and easy access to non-biased information about food and nutrition available to them, and would have access (including affordability, cooking method and time to prepare and the ability to learn the skills to make) the foods that they would choose to eat, and live in an environment where they are not judged for their choices. ("The Food Morality Thing")

From the point of view of the embodied authenticity model, Chastain is entirely right, up until the point at which she says that, in the ideal world, nobody would be judged for their choices. If by judged, she means shamed, bullied, ‘othered’ or mistreated, then she is quite right. However, it cannot be said that one has no right to critique the food choices of another. Beauvoir, writing of the difficulties that arise when we attempt to intervene in the life of another, says that:

We blame a man who helps a drug addict intoxicate himself or a desperate man commit suicide, for we think that rash behavior of this sort is an attempt of the individual against his own freedom; he must be made aware of his error and put in the presence of the real demands of his freedom. ... It is no more necessary to serve an abstract ethics obstinately than to yield without due consideration to impulses of pity or generosity... (136-7)

Under certain circumstances – for example, with a loved one – one has not only the right but the responsibility to critique another person’s food choices with the goal of helping that person make the choices that are most conducive to his or her freedom. Indeed, as Beauvoir points out, very often the reason we are in a position to intervene in the life of another is because we already have a concrete bond with them. As she puts it, “... love authorizes severities which are not granted to indifference.” (*ibid.* 137) It is true that, at many times and in many ways, the concept of health has been used as a guise under which to smuggle anti-fat prejudices into various discourses. It is also true, as FA critics point out, that the bodies of fat people, especially women, are often ‘policed’ by those around them in ways that are not warranted by the relationship obtaining between the people involved. However, it does not follow from this that nobody has any right to attempt to influence the health of another in any way, or to expect that another should strive to be healthy. There is a qualitative difference between a close friend expressing concern about Sarah’s continued weight gain, on one hand, and a stranger on the street

shouting at her to, ‘Go on a diet, fatty!’ The latter is unjustified, on the embodied authenticity model of health, because it shames and upsets Sarah and is overwhelmingly likely to limit rather than to expand the range of options that Sarah has available to her. It shuts down rather than opening up her paths to freedom. The stranger on the street has no responsibility to intervene in Sarah’s health, let alone a right to mistreat or abuse her. Moreover, shouting at somebody in the street renders him or her passive and offers only limited and undesirable options for response. Her friend, on the other hand, has a genuine concern for Sarah’s wellbeing. The friend wants what is best for Sarah. The friend is willing to speak to Sarah in a respectful and open way, and to listen to what Sarah says in return, and to support Sarah afterwards in whatever choices she makes. The willingness not only to point out the problem (as one sees it) but to help with the solution is important in Beauvoir’s schema. As she says, “... a man whom I snatch from the death which he had chosen has the right to come and ask me for means and reasons for living.” (*ibid.* 137)

From the point of view of the embodied authenticity model of health, intervening in the health of another is permitted at the time and in the manner most conducive to the overall freedom of the person. One may, for the right reasons and under the right circumstances, critique the health and health-related choices of another. On this model, such critique is not a matter of arbitrarily attaching judgement by linking health with some outside, constructed criterion. Rather, this ethical impulse is already inherent in the embodied authenticity model of health. If we take health to be manifested in the embodied aspect of authentic action, then it becomes impossible to separate health concerns from ethical concerns. However, it also becomes impossible to insist on a one-size-fits-all approach to health, because the body (or diet, or medication, or whatever) that is conducive to authentic action in one person may not be in another. In this way, the

embodied authenticity model allows for a concept of health that is shared by everybody without being arbitrarily or wrongly imposed on anybody.

Thus it is clear that freedom is central to the embodied authenticity model of health. This model of health centers on action. One is healthy, on this model, to the extent that one is acting in a way which is conducive to one's freedom and that of others. This is intended to evade the problem with those functionalist models of health which rest on the notion that a particular set of life activities is inherently valuable for every single person. In the next and final chapter of this dissertation, I explain in more detail what Beauvoir means by freedom, and why she thinks freedom ought to be regarded as an absolute value, capable of grounding an ethics. I argue that, if health is manifested in action, then freedom must also be the guiding principle on which we distinguish between healthy and non-healthy action. On this basis, I argue that one does have an ethical obligation to strive for health. However, as I have noted in this chapter, that does not translate to an ethical obligation to be thin or, indeed, to have any particular kind of body. As such, highlighting this ethical obligation encourages and empowers individuals to take responsibility for their health without making them ashamed of and guilty about their bodies.

CHAPTER FIVE: CONCLUSION

In the previous two chapters, I have outlined what I refer to as the embodied authenticity model of health. On this model, a person is healthy when he or she is engaged in authentic, embodied action. In defining authentic, embodied action, I draw on both Husserl and Beauvoir. Husserl points out that, in essence, action begets potential and thus further action. On the basis of this account of embodiment, I argue that to be embodied in a healthy way is to be undertaking the kinds of physical action that will tend to increase one's long-term potential for physical activities of many kinds. Simply being able to perform many physical tasks, however, has little intrinsic value aside from the pleasure of movement. Such ability, on its own, is not enough to constitute a standard against which action may be not only measured but evaluated. Drawing on Beauvoir's ethics, I argue that the value of healthy physical activity is that healthy action is conducive to freedom. Freedom, then, is a crucial theme of this dissertation.

In this concluding chapter, I thus explain further what I mean by freedom, and how freedom functions as a criterion for healthy action. Finally, I return once more to my example of fatness, concluding that, when we view freedom as central to health, we need not abandon the concerns either of proponents of the dominant model or of FA and HAES critics, but in fact we can address the respective legitimate concerns raised by each group.

Freedom in *The Ethics of Ambiguity*

In *The Ethics of Ambiguity*, Beauvoir describes human agency and freedom as fundamentally ambiguous. She argues that the human situation is always, necessarily, such that we are both free and not free. For Beauvoir, we are in some respects all but unlimited in what we can think, dream and imagine. But we are also situated in a shared world, which is in many ways beyond our control and which, as a result, places limits on

our potential for action. The fact that I am limited and conditioned by my situation does not negate my agency or potential, however, but gives it meaning. The fact that I can walk through the door is meaningful and useful partly because I cannot walk straight through the solid wall easily and without hurting myself. Indeed, it is only in light of my goals that any particular thing or fact in the world comes to be a limit or a site of opportunity, and any given thing in the world might be a help or a hindrance depending on one's goals. The door that, when opened, allows me access to my home can also be closed to keep intruders out.

As Beauvoir notes, it is tempting to think that, 'really', in our true nature or essence, we are either free or not free, and, according to her, most philosophers have succumbed to this temptation. As she puts it, "As long as there have been men and they have lived, they have all felt this tragic ambiguity of their condition, but as long as there have been philosophers and they have thought, most of them have tried to mask it." (*ibid.* 7) Philosophers, that is, have looked for theories that make it seem possible to evade or escape ambiguity. For Beauvoir, however, freedom is the manifestation of human transcendence amidst facticity. Freedom and facticity are inextricably, necessarily linked in the human situation. Beauvoir says, "The will is defined only by raising obstacles..." (*ibid.* 28) That is, we only get the opportunity to be free when we have something to choose or decide about. Freedom is not something that exists in us prior to action, it is something that becomes manifest only when an occasion arises in which one must exercise it. Freedom, on this account, can be said to be intentional in the phenomenological sense of that term. That is, there is no freedom in the abstract; to be free is to be free *to do* some particular thing or set of things. To put it in Husserlian terms, freedom and facticity constitute one another. Without a factual situation against which to 'push', I cannot manifest my freedom. Meanwhile, it is its ability to condition freedom

that gives something meaning as a fact. In short, as difficult and uncomfortable as it is for us to grasp, we are *both* essentially free *and* essentially unfree.

According to Beauvoir, it is not possible to evade this ambiguity. We may, through dishonesty and bad faith, *attempt* to do so, but we can never *really* do so. The very attempt to evade freedom is itself a manifestation of that freedom, since it is a choice. Thus, the only authentic choice is to ‘take up’ freedom by choosing to will it. Only ‘willing oneself and others free’ ultimately makes sense. This means that, for Beauvoir, the only valuable and justifiable way to realize one’s potential is to do so with the clear-eyed intention of maximizing future possibilities and future potentials not just for oneself, but for others too. To choose in this way is to accept one’s ambiguous situation in all its complexity and contradiction. Beauvoir is critical of previous philosophical attempts at ethics which, in her view, have tried to evade ambiguity, because, as she sees it, these philosophies, taken to their logical conclusion, make morality impossible. In her view, it is only by embracing freedom itself that we can actually be moral. She writes that: “Freedom is the source from which all significations and all values spring. The man who seeks to justify his life must want freedom itself absolutely and above everything else. . . . To will oneself moral and to will oneself free are one and the same decision.” (*ibid.* 24) Freedom is the means by which we manifest all other values. It is the condition for the possibility of our striving for goods and goals, whatever we take those to be. To put it crudely, if we want the human community to be more moral, we must want it to be more free, since freedom is the precondition for morality. In fact, this is the only desire that can be authentic in the face of facticity. The facts of our situation are that we cannot force others to be moral, but we can foster their freedom. This, in turn, makes it possible for them to choose freely to be moral themselves. Rather than trying to insist that everyone ought to behave according to a

particular set of ethical rules, Beauvoir argues that individual people ought to take responsibility for their own actions and seek creative solutions to what they perceive as problems. For Beauvoir, we cannot make each other be moral, because nobody can take up the freedom of another, but we can enable each other, as much as possible, to take up our own freedom. Without freedom, our 'morality' would be meaningless anyway; there can be no such thing as enforced morality. By treating freedom as the end of action, Beauvoir avoids dogmatism while yet maintaining that there is a criterion by which some kinds of human striving may be justified over other kinds.

This criterion is not one of success in the traditional sense. For Beauvoir, even when we embrace freedom as a goal, we must accept the inevitability of failure and the essential limitedness of the human situation. We can never be purely free, and thus our attempts to take up freedom are always doomed to fail. Indeed, it is always necessarily the case that, by giving myself a goal, I am also creating an obstacle for myself. My choosing a goal is a manifestation of my potential, and therefore my freedom, but it is also necessarily conditioned by the factual limitations of my situation. For one thing, when I choose a goal, I'm creating the need for the work it will take to achieve that goal. Then, also, the work I need to do to achieve that goal will take my time, energy and resources, none of which is unlimited, so that by choosing to do one thing, I am also limiting myself with respect to other goals. I am putting obstacles in the way of my pursuing other alternative choices. Moreover, the work I do to achieve my chosen goal will also have consequences I cannot foresee and cannot control. By choosing a goal, I am committing myself to a desire for the world to be a certain way. But the world will never turn out exactly the way I want it to be, so in some sense, I will always fail. But this does not have to render my choices meaningless or my actions pointless. That only happens if I assume that the sole value of my goals is in their perfect accomplishment. I

need not see things this way. If my action itself is meaningful and valuable to me, if I can throw myself into the attempt, accepting the inevitability of failure and accepting (to the best of my knowledge and ability) every other aspect of my situation, then my choice is authentic because it is truly free, and there is value in the realization of the corresponding action. For Beauvoir, one might say not that virtue is its own reward but that the exercise of freedom is its own fulfilment.

Freedom and embodiment

Our embodiment is central to the ambiguity of the human situation. The lived human body, unlike other material bodies in the world, is a site of consciousness; it is a subject as well as an object. As such, the body is a site of both freedom and facticity. As Sonia Kruks puts it, for Beauvoir, “The materiality of the human condition is what both enables us to engage in free, creative action in the world and constrains us and delimits what we may do.” (*Simone de Beauvoir and the Politics of Ambiguity*, 7) The lived human body, unlike other material bodies in the world, is inherently and essentially ambiguous. It is only in and through our particular concrete bodies that we can be free, even though, paradoxically, these bodies also limit our choices. Freedom, for Beauvoir, is not some metaphysical power of the mind or soul of to choose one option over another. It is the ability to act concretely -- that is, in and through the body -- towards some goal or project. Thus, Beauvoir’s theory of action is embodied through and through. As Iris Marion Young writes:

[In existentialist theory] The person always faces the material facts of her body and its relation to a given environment. Her bodily organs have certain feeling capacities and function in determinate ways; her size, age, health, and training make her capable of strength and movement in relation to her environment in specific ways. Her skin has a particular color, her face determinate features, her hair particular color and texture, all with their own aesthetic properties. Her specific body lives in a specific context ... (“Lived Body Vs. Gender”, 16)

As one of the founding mothers of this tradition of existentialist theory, Beauvoir does indeed offer such a concrete account of the human situation. Beauvoir's theory of action - and her ethics -- can thus be applied to specific individual actions.

To return to the example of height²¹, if I am only five feet tall, I cannot, without help, reach the top shelf of a bookcase that is eight feet tall. On the other hand, being a conscious human being, I can find a way around this. I can stand on a chair, or ask someone taller to help, or keep all my favourite books on the lower shelves. I am conscious, and this consciousness gives me the power to transcend the limitations put on me by facticity. My potential to act is not just a matter of how my body is, but also of my mental states, beliefs, and the various other aspects of my situation that condition me one way or another.

To will myself and others free, I must choose actions that seem conducive to freedom given the facts of my situation. To choose as though my situation was other than it is would be to fall into bad faith. If I have convinced myself that I am over six feet tall, then it makes sense, in light of that conviction, for me to keep trying to reach the top bookshelves unaided. Furthermore, if I have also convinced myself that reaching those shelves is incredibly important, I could spend hours reaching and reaching, trying to get those books. But honest, intersubjective appraisal would quickly cast doubt on the value of these actions. Isn't there some other way I could store my books that would free me up to do other things? Aren't I just limiting myself unnecessarily by choosing to devote all this time to high-shelf-reaching? Being only five feet tall, I will never reach those books by myself, and I am wasting my time by trying. I am effectively creating a factual

²¹ Again, as in Chapter Two, I use this example precisely because it does not have the same amount of socio-cultural 'baggage' that some other bodily features, including weight, do have. It is often constituted as 'just' a physical feature.

obstacle in my life where there need not be one. I am, in Husserlian terms, constituting as a limit something that I could quite well choose to constitute as a site of opportunity.

Above all, in practical terms, I am pouring resources into a project that can never succeed and that, even if it did, would not be very satisfying to me or anyone else. This is deeply inauthentic because I would only do this if I were not facing my situation honestly. It is an action that only a person in denial would choose.

But simply giving up on the books is not authentic either. Maybe I suddenly come to a realization that I simply cannot reach those books unaided, and so I decide to act as if they don't matter to me at all, regardless of what is in them, how much I want to read it or any other possible value those books may have to me. This is not acceptance but resignation, and, as Beauvoir says, "There is hardly a sadder virtue than resignation. It transforms into phantoms and contingent reveries projects which had at the beginning been set up as will and freedom." (*ibid.* 28) The childish retort characterized by "Well, I didn't want that silly book anyway" is a denial as much as the insistence on acting as if I am over a foot taller than I really am. The problem with such choices, as Beauvoir sees it, is not that they flout some objective moral value, because that would require the existence of mind-independent morals in the world, a possibility she rejects. (*ibid.* 14-15) For Beauvoir, however, freedom itself is a universal value, and throwing oneself into such choices is an attempted abdication of freedom. For Beauvoir, "What is the point of this action?" is not a rhetorical question, but a genuine, ethical challenge to oneself or to another person. The central criterion of Beauvoir's ethics is the idea that one ought honestly to be able to answer, "Freedom" to that question. In my model of health, this criterion is applied specifically to the bodily aspects of action, so that health is understood as embodied authentic action.

Thus, it is more than analogy that links freedom with health. Freedom is only realised in and through the body, and thus to be maximally free is to operate optimally in and through the body -- in other words, by ordinary usage of the term, to be *healthy*. This means, amongst much else, that one has an ethical obligation to be healthy. This claim is, on the face of it, abhorrent to many in the FA and HAES movements. However, in the next section, I show that this claim, when explained in terms of the embodied authenticity model of health, is actually entirely consistent with the liberatory aims of FA and HAES.

Freedom, Facticity and Fat

As I discussed in the conclusion of the last chapter, it is all but axiomatic for many in the Fat Acceptance and Health at Every Size communities that there is no moral onus on anybody to be healthy. Kate Harding and Marianne Kirby write:

... despite what this culture often suggests, health is not a moral imperative. You are not a bad person if you just don't like working out or eating vegetables, if you have priorities other than trying to live to be one hundred, or if you have a disability that keeps you from ever truly feeling "healthy". (*Lessons from the Fat-o-sphere* 18)

The resistance to the notion of a moral imperative to health is no doubt driven at least in part by the desire to resist the moralizing of fatness that has often been used as an excuse for the inhuman treatment so often meted out to fat people. This desire is wholly understandable, even laudable. However, it is a mistake to conclude that there is no moral imperative on anybody to be healthy. Rather, from the point of view of my embodied authenticity model of health, each of us is responsible for our own health and indeed for the health of those around us, since to will a person healthy is to will a person free. I suspect that those who are critical of the notion of a moral imperative to health might, in fact, find little to object to in this Beauvoirian claim.

Consider the following claim, again from Harding and Kirby:

We're so conditioned to believe not only that broccoli is good for us and ice cream is not, but that broccoli will make us better people, and that ice cream will make us worse. You're going to have to remind yourself over and over again that this is *bullshit*. For starters, ice cream is full of protein, calcium, and vitamin A. If your blood sugar is low, your body will welcome the carbs in it. Likewise, if you're really hungry, your body will welcome the filling fat. Does this mean ice cream is "good"? No. It means ice cream is food, which is morally neutral. ... It is fueling your body—and if what your body really needs at a given moment is a big dose of calcium or protein, then ice cream is actually a much better choice at that moment than broccoli would be. (*ibid.* 31)

The central claim here, as I see it, is that since it is sometimes better to eat ice-cream and sometimes better to eat broccoli, there can be no absolutely 'good' or 'bad' foods, and thus there is no basis on which evaluative or moral judgments can be made about food choices. As with the definition of the fat body, we come up against the constructivist notion that if we cannot have pure categories and absolute principles, we may not have categories and principles at all. As I argued in Chapter Two, this is a serious theoretical error. From the point of view of both lived experience and nutritional data, it makes perfect sense to argue that broccoli is, on the whole, a more nutrition-dense food than ice cream, but that, under certain circumstances, ice-cream would be the better food choice. There is no contradiction there.

More crucially for my purposes, however, Harding and Kirby also make the mistake of suggesting that if we cannot have absolute, invariable lists of 'good foods' and 'bad foods', then food in itself must be morally neutral. But actually, what we eat affects what we can do. Our food choices thus have direct impact on our freedom and facticity, conditioning our scope for choice and pursuit of goals. If there is a moral imperative to will oneself free, then there is a moral imperative to act towards one's health, as best one

can given one's factual situation. Thus, from the point of view of the embodied authenticity model of health, there is a moral imperative to pursue one's own health, but this does not mean that there is a moral imperative always to eat broccoli and never to eat ice-cream. As Harding and Kirby make clear, that would be silly. Rather, the moral imperative is to eat -- and, indeed, to exercise, wash oneself, and do whatever else is needed to maintain health -- in the way that seems, on honest reflection, to be the most conducive to one's long-term freedom and that of others. It is hard to see how Harding and Kirby or other FA and HAES advocates could object to that, given their clear and heartfelt desire to liberate fat people and others.

In fact, when it comes to fatness, the embodied authenticity model of health put into practice would look a lot like HAES. HAES emphasizes action -- exercise, eating and so on -- that is conducive to well-being. It regards the physical measurements of the body, particularly size, shape and composition, to be side effects of one's choices and behaviors. This is also, for the most part, how I imagine the embodied authenticity model would play out. One chooses what is conducive to freedom for oneself and others. As long as one is engaged in an ongoing way in healthy action, and as long as one is pursuing one's authentically chosen goals in and through the body, then whatever kind of body one has is, and *must be*, a healthy body.

One difference, however, is that the embodied authenticity model does not insist that everyone must treat changes to the body as always and only unintended side effects. Rather, one may choose to change the body -- or, rather, to attempt to do so. The moral imperative is to choose authentically, in light of honest intersubjective critique, goals that are conducive to one's ongoing freedom and that of others, and to pursue these goals in similarly freedom-oriented ways. There is nothing wrong, in this framework, with

choosing thinness as a goal, or, indeed, with choosing fatness as a goal. The moral problem would arise only if one chose to pursue this goal at the expense of freedom. So, if I could be thin only by starving myself to the point of constant exhaustion and illness, then it would be morally wrong for me to continue to pursue thinness, or for others to force me to do so. Pursuing thinness in this way is like spending all my life trying to reach those high bookshelves that are too tall for me. It is a waste of time, a denial of facticity, and thus a travesty of freedom. On the other hand, if I have good reasons to believe that changing my body size, shape or composition would contribute positively to my freedom, or to that of others, then I do have the moral responsibility to consider that option. In Husserl's terms, it may be the case that I can increase my bodily faculties by acting to change my body in some way. There is nothing wrong with such attempts to change. In short, I wholeheartedly agree with the FA and HAES point that there is no moral onus on anybody to be thin. However, there is a moral onus on everyone to act in ways that are (or seem) most conducive to having the freest possible body, and there is no reason, in principle, why that could not include deliberate attempts to change one's body with respect to size, shape or composition.

None of this in any way negates the important political points raised by FA and HAES advocates. In response to a reader question about why she does not 'allow debate' about the merits of Fat Acceptance on her blog, Ragen Chastain wrote:

The truth is that fat people have the right to exist in fat bodies without shaming, stigma, bullying or oppression regardless of why we are fat, what it means to be fat, or if we could become thin. There are no other valid opinions about that. Our rights to life, liberty, the pursuit of happiness and basic human respect should never be up for debate.

In this, Chastain is absolutely correct. Those who have used the concept of health to justify the abuse and ill-treatment of fat people, or of any group or individual, are not only mistaken about health, they are, willy-nilly, working against health. On my model, the best way to facilitate the health of others is to maximise their freedom. Thus, while I argue that there is a moral imperative to be healthy, I also insist that this can never justify mistreatment of an individual or a group on the grounds of their ill-health. Indeed, to mistreat someone because you take them to be unhealthy is akin to throwing gasoline on somebody because you take them to be on fire. It is, at very best, misguided and counter-productive. Beauvoir's ethics centers on the claim that to will a person moral and to will a person free are one and the same thing. For the embodied authenticity model of health, to will a person healthy is another manifestation of the same will, and it is defensible on the same grounds.

Conclusion

At the end of Chapter Three, having introduced the embodied authenticity model of health, I listed five claims that are central to this model. By way of summary and conclusion, I now return to these five claims, commenting on how each applies to fatness. First, I claimed that health is an ongoing process rather than a state. This means that one cannot simply measure a person and make inferences about his or her health. Thus, it is quite correct to say that there is no range of weights that is optimally healthy for every single person. Second, I claimed that health is not 'in' the body, nor is it manifested only in physical ways. This means that when we discuss health we need not and cannot limit ourselves only to physical features or, but we can and must also consider the social, cultural and political situation of the person, using these to inform our understanding of the person's health. Thus, any assessment of the health of fat people in general or of any particular fat person in the USA today must properly take into account the social context

of the ‘tyranny of slenderness’ and the moral panic about the ‘obesity epidemic’. Third, I claimed that health itself can only be experienced in the context of a person’s lifeworld, not in her body considered as a physical thing. This means that the closer one is to a person, the better placed one is to give an overall assessment of his or her health.

Empirical investigation by experts is of use in understanding certain aspects of health, but the person and his or her loved ones ought to be taken as the last and best arbiters of his or her health. Thus, whether a person is too fat is a qualitative question that can only be answered by means of intersubjective reflection by the person him- or herself together with those who are intimately involved in his or her life in some way. Fourth, I claimed that health differs from person to person in the sense that what health means for a given person depends on her goals, commitments and values. Again, this means that one is too fat if one’s fatness is impeding one’s pursuit of one’s authentically-chosen goals.

Empirical data may be of use here in helping a person to consider his or her situation in comparison with that of others, but it is only one piece of data, and it is less important than the intersubjective reflection mentioned above. Fifth, I claimed that despite the person-relative nature of health as embodied authenticity, one cannot simply ‘make up’ one’s own definition of health and then insist that one is healthy on the basis of this definition. It may not be possible to measure the health of an individual empirically, but it is possible to evaluate a person’s health by reflecting on how he or she is acting, in and through his or her body, in pursuit of goals that are of genuine value to him or her and are conducive to his or her freedom and to the freedom of those around him or her.

These claims, taken together, mean that the embodied authenticity account of health avoids the pitfalls that I have identified with both objectivist and constructivist models of health. Applied to fatness, I believe this model makes more sense than either the dominant model or the FA or HAES alternatives. This is not to say that I advocate for

a whole-cloth rejection of empirical investigation of health; as I have said, the data yielded by such investigation is useful in helping people to make informed (and thus authentic) choices. Meanwhile, as I discuss above, I also see much of value in FA and HAES. It is my hope that the embodied authenticity model allows one to make use of the strengths of the previous models but without falling into their errors.

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