

## Unfit Women: Freedom and Constraint in the Pursuit of Health

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*Feminist phenomenology has contributed significantly to understanding the negative impact of the objectification of women's bodies. The celebration of thin bodies as beautiful and the demonization of fat bodies as unattractive is a common component of that discussion. However, when one turns toward the correlation of fat and poor health, a feminist phenomenological approach is less obvious. In this paper, previous phenomenological work on the objectification of women is paralleled to the contemporary encouragement to discipline one's body in order to pursue better health. Similar ideologies of free choice in the face of bodily habits run through discussions of health and beauty. The paper uses the work of Merleau-Ponty and Beauvoir as well as the contemporary feminist phenomenologists Diaprose, Bartky, Bordo, Young, Grosz, and Carel to explore how women are constrained by health testing and health normalization. It argues that despite the apparent benefits of a focus on modifying health habits, feminists have good reason to be wary of the good health imperative.*

### *Introduction*

The demonization of fatness has reached its historic zenith due to the correlation of obesity with poor health. In order to justify blaming and shaming the fat, it must be the case that fat people are culpable for their size. This educates both fat and thin alike to discipline their behaviors to either not acquire the dreaded extra flesh or, if having acquired it, to rid oneself of it. Someone who fails to properly limit her own size is viewed as both irrational (who would want the ill health associated with fatness?) and immoral (all people have a duty to make the most of their health).

Feminist phenomenology articulates how models of beauty and norms of female embodiment have shaped women's experiences and self-evaluations. When it comes to looks, writers have stressed the negative implications of considering one's body as a never-ending aesthetic project that needs to be molded, shaped, and managed into appropriate attractiveness. However, in turning to the role of health, this paper finds that a correlated, but more insidious, set of disciplining practices exists in the fight against fat. The good-health imperative, similar to the beauty model, implies continual improvement for one's body as a goal, but it is additionally strongly moralized providing little room for rebellion. One

can decide to refuse to wear high heels as an empowering act, but can one refuse to pursue good-health?

This paper refers to the works of Maurice Merleau-Ponty and Simone de Beauvoir as well as the contemporary feminist phenomenologists Rosalyn Diaprose, Sandra Lee Bartky, Susan Bordo, Iris Young, Elizabeth Grosz, and Havi Carel to explore the implications of the good-health imperative on female embodiment. I argue that the good-health imperative curtails women's freedom by reducing them to beings caught in an endless cycle of bodily maintenance. In particular, the use of testing to determine health makes it impossible to be sure one's health and one's experiences coincide. The lack of any discourse that violates the good-health imperative indoctrinates women to psychologically internalize its demands. In conclusion, this paper finds that while body modification in the pursuit of health is a possible goal for some women, it should cease to be a moral imperative any more than beauty should be one. I argue that feminists should continue their skepticism about others intruding in the bodies and choices of women even when such actions are purportedly in their own best interests.

*Objectification: Women's Bodies as Sexual Objects*

Feminist phenomenology has helped elucidate how the objectification of women not only affects how women judge themselves, but also how they move and live in the world. A common focus is how discrimination and sexism impacts the bodily habitus of women. A habitus is often referred to in the description of the bodily constitution of a disease, such as the habitus of multiple sclerosis. This analogy works well since as with disease, being affected by a sexist culture is not a "choice," but a long process of enculturation. Like the progress of an illness, one might be able to intellectually identify causes and contributing factors, but one's dispositions and behaviors in the world are transformed whether or not one is a willing participant. One can rail against the sexism inherent within the cult of beauty, but if one has grown up in a society where a repeated and directed equation between a woman's value to her looks is drawn, one's bodily comportment will show signs of this enculturation. Illness often causes one to feel distanced from the body and also more tied to its demands. A sick woman is both more frustrated and separated from her body that thwarts her plans, yet at the same time she is more hindered by it and thus tied to it. Likewise, insistent demands to modify one's appearance make the body an enemy

to be conquered. Yet the more one spends time disciplining the body, the more one's life is tightly tied to appearance monitoring.

When it comes to fatness, contemporary women are defined by a similar estranged relationship with their bodies.<sup>22</sup> Given that fatness is coded as unattractive and as a sign of ill-health, a fat woman's body is both her enemy as well as her most defining feature. It is almost difficult to enumerate the ways in which fat women are coded as lying outside the realm of possible attractiveness: the lack of fat women as sexually active women in television and movies, the overwhelming acceptability of making fat jokes, and the clear coding of beauty as thinness. Fat women are also labeled as unhealthy. While fat women themselves receive the lion's share of shaming from the medical establishment as well as the media (and very often from friends and family), all women are impacted by the focus on fatness. If one is not fat, one is supposed to be on guard against it constantly, including extending that concern to one's children and family members. Before this paper expands upon the connection between fat and health, it looks at the general features to how women's appearance is objectified.

Women are strongly evaluated on their looks in situations ranging from dating to job interviews to walking down the street. Women are trained to constantly consider how they appear to the gaze of the other, rather than how they are embodied in a particular situation. When it comes to the demonization of fat women and the struggle most women have with their fat, women learn that their bodies are not acceptable as they are, or as they will likely tend to be over time. What a woman learns from "battle of the bulge" is that there is something amiss with her appearance. As Sandra Lee Bartky explains in *Femininity and Domination: Studies in the Phenomenology of Oppression* (1990)

It is a fact, that women in our society are regarded as having a virtual duty "to make the most of what we have." But the imperative not to neglect our appearance suggests that we can neglect it, that it is within our power to make ourselves look better—not just neater and cleaner, but prettier, and more attractive. (29)

Dieting and exercise are tightly connected to the demand for self-improvement devoted toward making oneself more appealing to others.

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<sup>1</sup> This paper's research is based in empirical studies of American women.

For this to make sense, women must be convinced that they are not good enough already; how they appear to others is a problem, a problem that they can fix. Even a woman whose appearance is considered to fit the ideal of weight, skin tone, hair luxuriousness, and curvaceousness is under no less pressure. She too must engage in rituals of defense against aging, working constantly to maintain and perfect her look. Fat is a common enemy since its distribution is rarely ideal on most women's bodies. The average woman in the U.S. weighs 165 pounds, is 5'3", and is about a U.S. size 14. Whereas, the average fashion model weighs 117 pounds, is around 5'10", and is about a size 2 (CDC, Body Measurements). For most women, fat reduction or guarding against fat gain is a necessary beauty ritual. Even thin women rarely have the ideal fat distribution of full breasts, thin thighs, high rounded buttocks, and flat stomachs. Thus, women in general are in need of "improvement": body modification aimed at "redistributing" fat and muscle appropriately.

What women learn from an early age is that one's worth is tightly connected to one's appearance and this constrains one's embodiment in situations far removed from the catwalk or the cover of a magazine. One becomes limited by considering what one looks like to others, one does not direct action outward to a world, but instead reads into the future what such action would appear like if viewed from an ever-present gaze, like a camera fixed and documenting every roll of fat and every bad hair day. To know that the evaluation of one's worth is tied to the evaluation of one's appearance makes women self-conscious in situations where such concerns limit their free behavior. In "Throwing Like a Girl" (1990), Iris Marion Young describes how this habitual self-consciousness affects basic bodily motility from throwing to confidently jumping over a stream. While pleasure exists when one imagines approval from the critical gaze, in other words from a good performance, one's bodily habitus causes one to be self-conscious in situations that demand the opposite.<sup>23</sup> Embracing objectification can produce pleasure, but it does not provide an "out" to find spaces and times in which objectification is not present.

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<sup>2</sup> Simone de Beauvoir (1989) discusses the ways in which women enjoy being reduced down to immanence, to the role of an object to be observed, in *The Second Sex*. For Beauvoir, women learn as young girls to see themselves as objects (335-336). There is some enjoyment for many in this new doubling of the self as lived and the self as observed. As an object, the woman is no longer free, but also is no longer responsible. Bartky discusses feminine narcissism in *Femininity and Domination* (1990, 33-44). She admits that there is pleasure to be had in enjoying one's objectification, but argues that it is a "repressive" satisfaction (42). Repressive satisfactions chain us to the dominant power structure.

In *Unbearable Weight* (1995), Susan Bordo highlights how the obsession with “perfect” managed bodies increases women’s sense of seeing their bodies as something to be molded and beaten into submission. Models of beauty teach not only certain static aesthetic values—the shape of the ideal body, clothes, hair—but also how to act as a woman—sexual but vulnerable, flexible, fashionable, and, above all else, attractive. But being attractive is increasingly a project and not a natural gift. In a typical woman’s magazine, the images of beauty are not simply photos; they are accompanied by instruction manuals regarding how to make one’s own body approximate the model or celebrity. To be a valuable woman is to be engaged in projects of body manicuring, shaping, and sculpting.

Female objectification is based in the view of women as sexual objects. Beauty is about sexual attractiveness. The ways in which men’s appearance is marked tends to draw attention toward codes of competence, such as height (tall) and skin color (white). These are likewise unjust but they do not imply that men in general are sexual *objects*—rather it is about looking “professional” and in charge. Objectification might be universal, but it still needs to be analyzed along gender lines or it will fail to be comprehended fully. As Linda Fisher (2000) writes:

An account that fails to recognize that its descriptions omit particularities of women’s experience, such as pregnant embodiment, betrays the underlying (masculinist) assumption that the generic (male) account sets the standard and encompasses all possibilities, and in this manner functions to diminish and marginalize the experience and perspectives of women. (24)

For women, looking appropriate means some relationship to the ideal model of the sexually attractive woman. Female objectification is tied to the male heterosexual gaze. As Bartky notes above, it is not sufficient for women to merely meet certain standards of hygiene. Women must be appealing: i.e., appealing as sexual objects. Women consider how they appear to others even when the others who wait in judgment are not likely or potential sexual partners. Applying for jobs, walking down the street, waiting for a professor’s evaluation are all situations in which one is self-conscious.

When Beauvoir (1989) writes about becoming a woman, she notes that the endless prescriptions about how to be a woman imply that it is a project that does not always end in success (267). One can fail. If one has succeeded, that success is precarious and always possibly threatened. In a similar vein, being an appropriately attractive object of attention is an unstable position. Fatness or the possibility of fatness is to be avoided at all costs since it takes one out of the realm of acceptable attractiveness. What the objectification of women creates is not only women feeling observed and separated from their bodies, but also women believing in a tremendous amount of agency on their part to achieve any body. It is only their lack of sufficient effort, willpower, or the right combination of diet, exercise, and body modification that is holding them back. The immensely powerful rhetoric of “empowerment” suggests that any woman can (and thus should) improve her looks. This model of plastic, infinitely moldable bodies, increases the sense of deficiency as the ideal becomes further and further away from the reality of real, living women.

*Healthism: The Good-Health Imperative*

Bringing to light the ways in which women have been conditioned to view their bodies as projects for continual improvement based on the need to appear attractive to others is not only important for understanding female embodiment, but also it can provide a place in which to turn back and become critical of such models. As Elizabeth Grosz (1994) writes, without phenomenologies of female embodiment, “without some acknowledgement of the formative role of experience in the establishment of knowledges, feminism has no grounds from which to dispute patriarchal norms” (94). The obsession with female appearance makes a woman’s experience in seemingly innocuous situations a test of her appearance. Without considering how a woman’s habitus is modified by a culture where their bodies are objectified, it would be difficult to call for change given that many women appear complicit in objectification. As noted above, the objectification of women explains how body modification is not just one “choice” among many activities that a woman might participate in, it is central to the definition of what a valuable woman is.

A woman who feels obligated to constantly manage her

appearance might read works by feminists such as Beauvoir (1989), Bordo (1995), Diaprose (1994), Young (1990), and Grosz (1994) as valuable aids to understand this split self she feels. She subsequently can rebel against this socialization. She might strive to spend less time viewing herself from the point of view of the male gaze and more time invested in her projects. Feminist theory has long helped women find space outside the cult of beauty and its incessant demands toward lives with better priorities. Yet, when it comes to fat bodies, a more insidious aspect of body modification arises—that of health. The fat body is increasingly associated with ill health and not just a failure to be attractive. Ceasing to wear make-up can be seen as an act arising from a feminist rejection of one standard of appropriate appearance, but how should feminists label the refusal to modify one's diet to a healthier form?

Parallels between the conditions of being encouraged to work on one's looks and the increasing interest in working on one's health are apparent in the focus on combating fatness. While the practices may differ, one might take a questionable drug to lose weight if one has no interest in health, whereas if one is dieting to lose weight for one's health, one might work on changing "good" for "bad" foods. However, in general, the practice is one of discipline over the body with a key measure of success being the reduction of fatty tissue measured by scales and tape measures.

Some pushback against the demonization of fat exists, such as the Health at Every Size (HAES) movement (Bacon, 2008). HAES and other researchers critical of the war against obesity argue that dieting is largely deleterious for one's health, rarely successful, and that little evidence exists that proves fat women are doomed to lives of poor health (Gibbs, 2005; Kolata, 2007; Oliver, 2006). Contrasting with the war against obesity's focus on using weight as a measurement for health, critics stress healthy activity and eating for all people of all sizes and draw attention to studies that indicate the link between health and weight is not as conclusive as is often argued.

Insofar as the rejection of the hysteria over fatness is construed as the healthier model (not dieting is better for you than dieting), HAES and other anti-diet initiatives remain within the same good health imperative paradigm. They argue that the pursuit of good health should be the guiding goal of behavior and criticize the mainstream obsession with dieting. In this sense, traditional models of dieting for health and HAES are structurally similar. The way to settle certain arguments about

lifestyles would be to discern what results in the healthiest individuals. If one includes an embodiment approach, where one doesn't treat the body as a machine that one feeds and exercises, but as one that is engaged in projects, ambitions, and deeply intertwined in investments with others and the world, then it would be hard to view a strictly mechanistic biological approach to health as valuable. It might be true that a very strict diet would result in the best health outcomes for an individual, but given that any individual has pressures and limitations on her time and money, perhaps the healthiest option will be one that is "good enough." In common language, this would be the idea that one must consider psychological health as well as physical health, although most phenomenologists would prefer to avoid this dualistic language.

Women may engage in various healthy models, such as ones that accept occasional "failures" as not only normal but also as healthy for one's greater well-being. Occasionally having a piece of cake or using mass produced food after a long day at work might enable one to live more happily in one's situation. Pursuing the healthier food or activity option at every decision one makes in a day is impossible or destabilizing for many. In such more expansive models, the traditional focus on food and activity—those assumed to most directly affect weight—would need to be considered in the context of a variety of choices, activities, obligations, and desires. While such a model is certainly more reasonable than a model that pushes the maintenance of weight as a priority regardless of the woman's circumstances, I argue that it still presents health as an imperative (albeit a more holistic view of health). Gone is the emphasis on weight alone, to be replaced by a model focusing on all types of healthy behaviors. Both the traditional model, where weight is seen as a primary indicator of good-health habits, and the holistic model, where good-health habits are about behavior rather than weight, emphasize a view where the individual has agency to "manage" her health appropriately. She is encouraged to see her life as a series of choices to be made. Below, a phenomenological approach to freedom is outlined and then the way the good health imperative influences a woman's embodiment is explored.

### *Freedom in Beauvoir and Merleau-Ponty*

Understanding freedom from a feminist phenomenological



viewpoint requires that one step outside the poles of determinism and free will. Evidently one's embodied status is not entirely free; but it is also not determined what path one takes since one has many possible trajectories. Why one chooses one direction over another is a matter of a complex situation—one's intellectual deliberation, elements of past and present situations, habits, and sedimented relationships with others will all influence one's behavior. When one realizes that one's value is falsely tied to one's looks approximating some impossible beauty standard, one cannot immediately cease being influenced by the long history and current reality of living in such a society. One has long lived in a world where appearance and value are linked and one's bodily habitus is not so easily changed. Yet, one can take steps in different directions, habits are not set in stone, and new possibilities always arise in the complexity of the lived situation.

Maurice Merleau-Ponty (1996) points out the difficulty of change by writing that if one has long engaged in certain practices that are confirmed by one's milieu, it is possible, but unlikely, to alter one's behavior:

But here once more we must recognize a sort of sedimentation of our life: an attitude towards the world, when it has received frequent confirmation, acquires a favoured status for us. Yet since freedom does not tolerate any motive in its path, my habitual being is at each moment equally precarious, and the complexes which I have allowed to develop over the years always remain equally soothing, and the free act can with no difficulty blow them sky-high. However, having built our life upon an inferiority complex which has been operative for twenty years, it is not *probable* that we shall change. (442)

The inferiority complex that dictates that women are unattractive and insufficiently healthy makes it difficult to imagine them “blowing sky-high” this indoctrination. Political advocacy for greater acceptance of a diversity of body shapes and lifestyles is an essential part of any project designed to provide more freedom for women since finding freedom would be more common in worlds where more paths were considered viable alternatives. But, when it comes to the discussion of health, one might assume that since health is a bodily state *and* a bodily experience,

it would always fit well within a phenomenological analysis of freedom. In other words, what is healthy would always augment freedom. If it is healthier to refuse to live according to ridiculous standards of bodily manicuring, building such a life would reduce the inferiority complex and thus widen one's range of possibilities.

Are behaviors that promote health better tied to understanding freedom's connection to embodiment? Could one argue that the woman who acts to better her health is more likely to find a wider set of possibilities in her life than a woman who does not? Diaprose (1994) expands upon Merleau-Ponty's idea of freedom by emphasizing that projecting into the future is not a conscious choice but a projection of one's corporeal schema:

Intentional activity is not directed by a choice in the form of a representation or voluntary deliberation. Rather, the action is directed towards a future through projection of a corporeal schema and the future (and hence the choice) is constituted or actualized through the body's activity. (105)

While it might appear to me that I am deliberating about a choice and it is this deliberation that will resolve my future behavior, what underlies that deliberation is an imagination that is fully bodily and hence draws with it sedimented habits and affective relationships. For example, it is difficult to distance oneself from a fight with a family member because one's embodied reality is so constituted by the other person. A fight over who last emptied the dishwasher becomes excessive not because one is necessarily so invested in the justice of dishwasher emptying, but because one has to live with the other, and live in the future with the other. Bad health habits, such as overeating or failing to exercise, are likely as entrenched as bodily habits and related to a variety of interconnected situations—where one lives, what others in one's life do—and are hard to alter. The woman who enjoys good health could enjoy an embodiment that is as entrenched in her lived situation, but one that has more possibilities of projecting alternative corporeal schemas into the future. In illness, one's life becomes narrowed, everyday activities become challenges.

The freedom to alter an illness is quite different than the possible freedom to alter a bad health habit. Illness is not usually thought of as

a problem of the individual not possessing the right amount of self-control. Some illnesses are not open to personal choice or modification. Some have no cure; some require external aid. In this case, there are some parallels to be drawn with bad health habits. Many blame health woes on our genetic heritage, coming from a long prehistory of scarcity into a contemporary situation of food abundance, our bodies have no sense of when enough is enough. Thus, overeating isn't a problem of agency but of evolution. One might also stress a psychoanalytic interpretation where food compulsions are the result of complexes that lie within the unconscious mental life of the person and thus are not easily, if at all, open to change.

Despite this difficulty of imagining change, Beauvoir in *The Second Sex* (1989) remains firm on the possibility of free action, even in the case of women who have been raised, educated, and socialized in a limiting fashion. For Beauvoir, what limits freedom in a situation is also what makes possible the very existence of freedom. Since one is not constituted by a straight line of causality but influenced and shaped by a multitude of different relations and situations, one is not determined to perform any particular action. "But a life is a relation to the world, and the individual defines himself by making his own choices through the world around him" (Beauvoir, 1989, 49). It is true that an alienation from a woman's own body exists—a sense of being constantly judged externally and a pressure to make sure she lives up to often impossible standards—but she is not compelled to always and without exception behave a certain way.

I shall place woman in a world of values and give her behavior a dimension of liberty, I believe that she has the power to choose between the assertion of her transcendence and her alienation as object; she is not the plaything of contradictory drives; she devises solutions of diverse ranking in the ethical scale. (Beauvoir, 1989, 50)

If one was but the product of genetic and psychological drives that are molded by the social world in which one finds oneself, change would be impossible. One would expect a strong uniformity of behavior across any group that is biologically similar and present in roughly the same culture. Instead one finds a diversity of reactions to the objectification of women in any group. In principle, a phenomenological approach to embodiment emphasizes the difficulty of change given the situation one lives within

and the pressures on and limitations of the body, but it does not foreclose the possibility of freedom.

### *Health and Disembodiment*

Returning to health, is the choice that entails less condemnation to being determined, to being caught in immanence (being but a thing in the world determined by factors outside one's control), the choice that promotes one's health? At first glance, as mentioned above, the answer would appear to be yes. One could see the limiting forces of a world saturated with unhealthy foods, limitations on activity, and obsessions with excess as detractions from a life that better promoted freedom as an inherently embodied experience, not a cerebral one. Continuing with Beauvoir's assessment of freedom, one could assert that even if there are genetic drives that encourage overindulgence, one is not condemned to live those drives out. Freedom in the face of objectification and freedom in the face of fat is possible.

Yet, if one considers a phenomenology of a contemporary woman's relation to health this answer is far less obvious. First, in the developed world, whether or not one is healthy is largely determined by one's results from a series of tests and one's behavior based on various large-scale studies. Is this woman healthy? To answer this question those in charge of determining health would ask: What is her cholesterol level? What is her BMI? What is her blood pressure? Does she smoke? One might *feel* fine but score outside the range that has been determined to be healthy. This is often the complaint of the HAES movement and fat activists who say the insurance industry standards of weight are unrelated to health. Or, alternatively, one might feel poorly but score well in a battery of tests. (The solution to the latter in the U.S. tends to be more tests.) Health increasingly is determined by "objective" measurements of one's body. When one reads an alarmist story about the growing weight of Americans, one isn't reading a story about the feelings and attitudes of fat Americans, but rather a story of biostatistics (CDC, 2011).

My employer—the State of Tennessee—has changed our health care options to include a program called "The Partnership Promise" (Partners for Health, 2011). Although the cost of health insurance is rising for all state employees, being part of "the Promise" permits one to pay slightly less for health insurance than the other plans. What one is required to do is to undergo a series of tests and then sign a form

promising that you will take action as recommended regarding these tests. I signed up and went to the large room in our university center where employees were shuffled around from station to station taking simple tests such as blood sugar, blood pressure, weight, and cholesterol. One then sits in the middle of a room until the results are obtained thereafter one must have a “counseling” session regarding one’s results. There was no privacy for this counseling so I was able to overhear the people before me being told to engage in more activity and consume less fatty foods.

Luckily I “passed” the tests and thus did not have to listen to a person who looked no older than 18 tell me to eat more vegetables. Discussing this process with friends I found that many saw nothing wrong with it since after all, one could “opt out” by paying more monthly for one’s health care. In addition, as a state with abysmal health standards, is it really that terrible to encourage better health habits? This kind of intrusion by sticks and carrots (examples of “sticks” are paying more for insurance, being refused insurance; examples of “carrots” are free gym memberships, rewards for achieving weight loss goals) into one’s health habits is becoming more commonplace and is viewed as positive and needed to help control health care costs and promote a healthier populace.

But I do not experience the factors that document my healthiness directly. I do not experience my BMI as BMI or my cholesterol level as a cholesterol level. I can be in an eye exam and tell the doctor if I can read a set of letters, but I cannot answer meaningfully what my BMI is by considering my bodily state. If you tell me the number of my cholesterol level it is hard to say it corresponds to how I experience my body in the way in the way that I know I cannot see objects clearly at a distance. I can ask myself “can I read that sign?” but I cannot ask myself “what is my cholesterol level today?” and receive an answer. One can be surprised by findings if one lacks any symptoms of illness that are associated with “unhealthy” levels. Of course, the argument from health care providers (and for economic reasons from health insurers) is that even if now you feel fine as an overweight woman, eventually you have a higher risk of correlated diseases and thus it is imperative that you engage in practices to lower that possible future risk.

One might say that good health always has experiential correlates and thus one needs to “tune in” to one’s body to figure out if one’s health in addition to undergoing medical testing (or perhaps even in place of

medical testing). Certainly one can say that one feels well, but does that mean one feels “healthy”? What does it mean to *know* one is in good health? One option would be to say if a woman feels well, then she is healthy. But this feeling of wellness might be illusory; a checkup might reveal a malignant tumor even though one had no experiential symptoms to suggest the body is ill. Another option would be to say that a healthy woman is someone who does not have any pain or discomfort. But athletes and those engaged in strenuous physical pursuits have discomfort. If one hears heartbreaking news she will feel pain directly even though it would seem her health would not have changed. Good news can alter one’s embodiment dramatically causing a sluggish, tired, even pained person to feel energized and well. Knowing when one is “healthy” is elusive; hence the medical profession must use tests to document health. But a gap exists between these numbers on a doctor’s report and one’s embodied existence.

This disjunction between testing and embodiment particularly impacts women as they are the biggest consumer of the products of the health-centered diet and exercise industry. In addition to a woman’s value being attached to her own perceived proper self-care, the proper care one’s dependents is a key criteria to being viewed as a good mother. Like Beauvoir’s discussion of the condemnation of women to immanence in the domestic sphere, the good-health imperative results in a similar condemnation to a peculiar kind of immanence—that of the maintenance of the body based on medical testing. Following Bartky, one finds that psychological oppression is particularly trenchant in women based on concerns about health. In addition, the strong tie to good health as being a moral requirement for good caregiving makes it impossible to see health as a personal choice, like one’s fashion sensibility might be. Both of these oppressions curtail the freedom of women by presenting choice as a binary between good, moral, reasonable healthy choices and bad, immoral, unreasonable unhealthy ones.

Beauvoir (1989) writes in reference to housekeeping that “the battle against dust and dirt is never won” (451). While one may take some pleasure in housekeeping, it is an endlessly repetitive task and one in which it is difficult for Beauvoir to see much of the individual’s own spirit reflected in its execution. There are, after all, only so many innovative ways to mop a floor. She writes how in contrast shopping is often seen as a joyful activity simply because the hunt for ideal item or

bargain does permit a modicum of individual achievement.

This discussion of housekeeping appears distanced from the discussion of fatness and the good health imperative, but I argue that a strong similarity exists. The fight against fat is also a task that is never won. Even if one has obtained the ideal weight, constant and never-ending vigilance is required since the weight could creep back on. When one forgets to dust, the final result—a dusty house—might easily be perceived, but one does not perceive it as it accumulates. In weight gain, tighter pants might be a sign after sufficient weight has “accumulated” but without this signal or the preferred one, the scale, one does not perceive the gain as it happens. Unlike the immediate pleasure of a good meal, the immediate pain of a twisted ankle, weight gain is gradual.

Modern women may feel less anxiety over the assessment of their housekeeping abilities, but they feel extraordinary pressure over the assessment of their weight regulation abilities. And unlike a house that potentially could be cleaned before the boss comes to dinner, one’s body cannot be made healthy in an afternoon. Dieting and exercise for health become a woman’s major life project. This also distinguishes women from men. In *The Second Sex*, Beauvoir writes regarding marriage that “...no young man considers marriage as his fundamental project” (1989, 431). A similar parallel can be drawn between marriage and the good-health imperative as between housekeeping and the good-health imperative. Modern mores on marriage are changing rapidly from Beauvoir’s time and even in my own conservative state of Tennessee, I meet few female students who consider marriage as their only important goal in life. However, the maintenance of one’s weight is a central and fundamental project for most women.

The weight and health of a woman is tightly tied to a perception of her competence. In contemporary U.S. politics, the Republican governor of New Jersey—Chris Christie—is fat. He has received some mocking about his weight and has commented upon it himself, usually jokingly (Marcus, 2011). However, it is impossible to imagine such a fat female candidate even being considered for any office. Hillary Clinton (U.S. Secretary of State) and Sonia Sotomayor (U.S. Supreme Court Justice), neither of whom are fat women, were criticized for their weight. In the case of Sotomayor, it was wondered if her type-one diabetes should disqualify her for the U.S. Supreme Court (Shapiro, 2009). While fat men certainly suffer discrimination, women who are seen as unhealthy are seen as incompetent. As Diaprose (1994) points out, “I think the central issue in redressing women’s social subordination within patriarchal

social relations is not so much male control of women's bodies as the ways in which women's bodies are socially constituted in relation to men" (119). In the case of weight maintenance the fat woman who does not make it a fundamental project will likely suffer the same kinds of discrimination which the woman who had "failed" to find a mate fifty years ago received.

Recognizing that one can have a fulfilling life without an immaculate house or without a husband is empowering for a woman. But when health comes into the equation, that same woman might willingly fully integrate the betterment of her health as a central ambition. The shift in diet campaigns toward the idea of "wellness" and away from "being bikini ready" is often articulated by dieters as family and other-centered rather than beauty-centered. Dieters will stress their desires to run around with their children and grandchildren, as needing to lose weight so they can be there for their families. Bartky (1990) writes that psychologically oppressed people stop sensing that they have the capacity to be autonomous. "Oppressed people might or might not be in a position to exercise their autonomy, but the psychologically oppressed may come to believe that they lack the capacity to be autonomous whatever their position" (29-30). No room exists for a woman to reject the good-health imperative as a guiding goal. This is particularly the case for a woman who fails to meet the standards of health. She will be cajoled by doctors, lambasted by the public, and penalized by insurance companies. The more she "fails" the more she is likely to internalize the oppression, seeing herself as without freedom to reject, or resituate, the goal of health.

Bartky (1990) discusses how in sexual objectification, women suffer from both "fragmentation" and "mystification." Fragmentation is the splitting of the person into parts, "which, in stereotyping, may take the form of a war between a 'true' and a 'false' self" (23). In a culture that demands dieting and exercise for health, the true self is the one who successfully controls the wayward body, the false self is the one who gives in. Mystification is "the systematic obscuring of both the reality and agencies of psychological oppression so that its intended effect, the depreciated self, is lived out as destiny, guilt, or neurosis" (23). Under the good-health imperative, few if any are successful since there is always some action, no matter how small, that can be interpreted as unhealthy: that bite of cake, the day one took the elevator, one's lack of sleep. One is unable to reject the good-health imperative as one can reject the obsession with a certain model of beauty. Who doesn't want to be healthy? Only



the unreasonable, the mentally ill, or the depressed would express such a desire. One must want to be healthy. Thus, any time one fails to engage in actions that further that goal, there must be something psychologically wrong. The authority that imposes the good-health imperative on women has been obscured and women are left with internalized failure and guilt.

### *Bodily Maintenance and Ill Bodies*

The most self-righteous voices that ring out against fatness draw attention to the host of illnesses that have a high correlation with obesity. Heart disease, hypertension, diabetes, sleep apnea, asthma, fatty liver disease, osteoarthritis, and polycystic ovary disease are related to obesity, and individuals have shown improvement when they lost weight (Malnick and Knobler 2006). Such concerns are interesting to consider in light of the model of illness and agency and the idea that an ill life is always a reduced and deficient one.

Merleau-Ponty (1996) supports the idea that when the body becomes an object of attention due to illness, the subject's embodiment has become broken. He writes that in illness, the intentional arc "goes limp" (136). When one is ill, one no longer directs oneself outward toward a world of possibilities, but rather one's body demands that one spend attention on it. As Diaprose (1994) writes in illness, "The structure of the self becomes disrupted when part of the body becomes an object of attention such that normal functioning becomes impossible" (108). Both Merleau-Ponty and Diaprose focus on the way in which illness that are not seen as caused by bad health habits, such as the brain damaged patient Schneider, affect one's embodiment and thus one's agency.

In illness, freedom is not eradicated, but merely limited and curtailed. For each individual, the nexus of possibilities and choices and the way in which an illness limits her would be complex and divergent from others. The medical model, in particular one that is based in charts of "good" and "bad" scores, tends to pass over these important differences. Diaprose (1994) writes that, "The phenomenological model not only reinstates the dignity of the patient by stressing that the fabric upon which biomedicine works is the self, but also highlights the specificity of that person's condition, however common that condition may appear to be" (110). A more phenomenological approach to illness would attempt to view illness in terms of the embodied person's plans and projects, her relationships, her habits, and her environment. It would

not seek so much to classify and cajole but to find a connection to the ill person's own agency.

In Havi Carel's revealing book *Illness* (2008), she explores phenomenologically her own life-threatening illness lymphangioleiomyomatosis (LAM) for which no cure has been found. She describes how her bodily capacities are severely limited and how the knowledge of suffering from a disease that will likely end her life in her forties affects her embodiment. But this book does not merely consider illness a closing but also a meditation on restricting and reframing one's embodied life. For example, as she writes in her dedication to her husband that he has helped her make "a disaster into an obstacle" (2008, x). Her discussion of illness reveals a better approach to considering the highly individual nature of embodiment and points us toward a less moralizing approach to health and health habits.

Carel understands her illness to expose painfully the truths of embodiment. She writes that illness "is an abrupt, violent way of revealing the intimately bodily nature of our being" (27). In a project that absorbs one, one's body can recede further and further into the background, making one ignorant of it and even to imagine one holds complete dominion over it. But in illness, one is reminded that one is not a disembodied will only tangentially tied to a body. After becoming ill, Carel's previous habits and plans are no longer possible. Bicycling, travelling, having children all ceased to be possible projects and hence her entire life required reorganization. Illness does not just impact the body, but it creates a global restructuring, and in the case of progressive illness, a continual restructuring, of the "way the body experiences, reacts and performs tasks as a whole" (29). Yet, surprisingly to the healthy, in researching the chronically ill phenomenologically, interviewees found that some saw themselves as healthy and happy and some who stressed the sorrow, frustration, guilt, and anger at their illnesses (Carel, 2008, 79). It is interesting here to note the divergence of experiences and, as Carel notes, "the limitation of the medical approach" (79). How the restructuring occurs remains largely divergent. While the progression of a disease may be predictable, the patient's reaction is not.

Carel's illness does not have any of the moral ambiguity that illnesses associated with bad health habits do. Insofar as it portrays a far richer account of the nature of living with illness, it is valuable, but it might be seen as irrelevant for the discussion of the good-health

imperative since it was not due to her “failing” at eating healthily or not exercising sufficiently. What Carel adds to the considerations in this paper is pointing out that one still has individual agency even in the face of significant bodily illness, but also that all bodies are far more limited by their situations than one’s hubris might suppose. Carel (2008) writes that she learned “to respect two things: that the laws of cause and effect governing the universe may generate suffering over which we have no control and that everything, including myself, was ephemeral” (65).

### *Conclusion*

A phenomenological inquiry indicates that the pursuit of health by modification of bad health habits is not an unquestionable goal or good for women. It promotes even more insidious alienation from a woman’s own body than the beauty ideal does because no space is provided in which to reject it. The way in which tests work in monitoring the public and the idea that the individual is free to “choose” to be healthy or not encourages a sense of battle with the body. While this indoctrination into “healthy lifestyles” often appears to have a kind of patina of empowerment, there is little room for discourse about refusing it. In particular, if one is involved in caregiving for others, one’s “refusal” to conform to health standards is seen as immoral and possibly pathological.

Health has come to so shape the moral evaluation of our activities and is so often used as a trump card to end disagreement that it is time to consider it in context of lived bodies, not tested bodies. Yet, this paper does not disagree with well-researched medical advice, nor does it offer a different model of health. It does not suggest that willed body modification is necessarily deleterious to a woman’s sense of value. It is unreasonable to suggest that based on critical concerns about the overreach of the medical model, one divorce oneself from the extraordinary benefits of an advanced medical system and from its findings and suggestions for healthy behavior. Some of one’s health can be understood through introspection of one’s sense of wellness, but medical testing remains highly valuable. In addition, the pursuit of better health for women has greatly improved the lives of women around the world. Making it possible for women to pursue better nutrition and have active lives is not a trivial concern. In the U.S., a country of abundance,

one finds a lack of fresh, healthy food and safe outdoor spaces for being active in poor communities. This curtails the freedom of individuals to imagine their bodies in different lifestyles and condemns them to being determined by their economic situation.

Modifications upon what a healthy body is, such as HAES, are also important but ultimately fit neatly into the idea that health is an unquestionable goal and should guide individual behavior and public policy. Instead of suggesting that the concept of health needs to be revised, this paper asks if there is a feminist position that erases good health as an *imperative*. This is not to say it suggests good health is not one of many possible reasonable ambitions for some women, but it is to argue to reject health as an imperative as feminists reject beauty as an imperative. No feminist would deny that a full, meaningful life can be led without one's appearance being a central concern; might this not also be the case for health? Drawing a parallel to phenomenological discussions of illness, one can see that the idea that ill bodies are deficient bodies condemned to lives of limitation also encourages the view that the worst thing that can happen to one is to become ill. Instead, illness does require restructuring of one's lived body but it does not foreclose agency or reduce the individual to a life that will always be diminished. In the case of behavior modification, to allow good health to be an imperative pushes women into a position of placing health as a priority that trumps all other ambitions and concerns. It relegates "good" behavior to "healthy" behavior. It encourages the view that women who are not engaged in good health habits have failed, like pre-feminist views that argued a woman's success was dependent upon a male partner, a child, or her beauty. To question the good health imperative might seem to invite bad health habits. But this kind of false dichotomy (if one questions a moral stance, then one must be suggesting that the inverted position is good) severely limits critical thought. Feminists have long had reasons to reject the intrusion of others into their bodies and into their choices. This paper argues that feminists should not let down their guard simply based in an unquestioned assumption that good health must unequivocally be both a good and a goal.

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