Original Article

The politics of evidence on 'domestic terrorists': Obesity discourses and their effects

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Abstract The recent construction of an 'obesity epidemic' has been fueled by epidemiologically-based studies recuperated by the media and suggesting the rapid acceleration of obesity rates in the Western world. Studies linking obesity to ill-health have also exploded with more recipes on how to wage 'a war' on obesity and dispose of 'domestic terrorists.' In this paper, we assert that the fabrication of 'evidence' in obesity research constitutes a good example of micro-fascism at play in the contemporary scientific arena. Favoring a particular ideology and excluding alternative forms of knowledge, obesity scientists have established a dominant 'obesity discourse' within which obese and 'at-risk' bodies are constructed as lazy and expensive bodies that should be submitted to disciplinary technologies (for example, surveillance), expert investigation and regulation. Using a poststructuralist approach, we examine the politics of evidence in obesity science and explore the connections between obesity discourses and the ways in which health and the body are discursively constructed by Canadian youth.
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Obesity and 'Evidence'

Few North Americans will have escaped the avalanche of scientific and public comments about obesity in recent years. Escalating concerns over an 'obesity epidemic' have been fueled by the epidemiological, physiological and medical

literature on obesity, which is now massive (see an excellent overview in Gard and Wright, 2005), and its recuperation by the media, educational institutions, health and fitness practitioners, and public health officials. This crisis, so the general argument goes, 'afflicts' an increasing number of countries in the world where physical activity and dietary restraint are lacking, and threatens a global health catastrophe (WHO, 2000). Indeed, the World Health Organization has even declared obesity a 'disease' and has recommended methods to limit the 'global obesity epidemic' (WHO, 2006). In the United States alone, over 600 obesity-related bills were introduced in state legislatures in the last few years. And in March 2006, the Surgeon General called fat a form of domestic terrorism, insisting that obesity constitutes a greater threat to the USA than terrorism (Tumulty, 2006).

In academic circles, 'obesity science' has recently been submitted to critique from a number of angles. Both social scientists and biomedical researchers have challenged the use of the term 'epidemic' (Gard, 2004; Campos *et al*, 2006; Saguy and Almeling, 2007), the notion of obesity as a 'disease' (Frank and Gaesser, 2003; Oliver, 2006), the burden of disease due to obesity (Gaesser, 2003a, b; Mark, 2005), and the attribution of deaths to obesity (Farrell *et al*, 2002; Flegal *et al*, 2005; Mark, 2005). These authors have also noted salient contradictions in the ways in which obesity is measured, in the so-called causes of obesity, and in the proposed solutions, including the medicalization of those deemed to be 'at-risk' for obesity (Herrick, 2007; Holm, 2007; Komesaroff and Thomas, 2007; Murray, 2007, 2008a). While these debates raise significant questions, for the most part they have taken place away from the public and media stories feeding the obesity 'panic' have continued to flourish. Researchers have documented the explosion of scientific and media reports on obesity in the United States (Campos, 2004; Oliver, 2005; Orbach, 2006), Australia (Gard and Wright, 2005), and England (Evans *et al*, 2004; Evans *et al*, 2008). These authors have invariably recognized a dominant 'obesity discourse.' This discourse offers a mechanistic view of the body and focuses on the presumed relationship between inactivity, poor diet, obesity and health; in the same breath, it presents obesity in moral and economic terms. Obese and 'at-risk' bodies are constructed as lazy and expensive bodies that should be controlled (read disciplined) and submitted to expert investigation (Groskopf, 2005; Monaghan, 2007, 2008).

This dominant obesity discourse has generated new forms of normalizing practices which some have termed 'biopedagogies' (see Harwood, 2009). Informed by Foucault's (1978, 1979) notion of biopower, they have argued that biopedagogies form part of an apparatus of governmentality that centers upon controlling and regulating bodies to reduce obesity or to protect populations from the 'risks' of obesity. Biopedagogies place individuals under constant

surveillance and, through a deeply moralizing discourse, also press them towards monitoring themselves (that is, self-surveillance). Indeed, obesity discourse draws upon a neoliberal notion of individualism that positions individuals as primarily responsible for changing their lifestyle via a range of disciplinary measures and control techniques (Campos, 2004; Foucault, 2004; Gard and Wright, 2005). Within obesity discourse and the biopedagogies it promotes, being overweight is marked as a failure to undertake certain technologies of the self while the thin body is given recognition as reflecting control, virtue and goodness (Evans *et al*, 2004; Rich and Evans, 2005). The World Health Organization's 'Global Strategy on Diet, Physical Activity, and Health' has recommended a variety of control methods to curtail the 'obesity problem,' including instruction, surveillance and evaluation (WHO, 2006). Researchers have also reported how biopedagogies have been encouraged across a range of cultural practices (we can think here of fat leagues, fat maps, fat report cards, fat laps and so on) as well as institutions such as popular media (Burrows and Wright, 2004), new technologies (Miah and Rich, 2006), health organizations (Armstrong, 1995; Lupton, 1995; Groskopf, 2005) and schools (Evans *et al*, 2004; Vertinsky, 2004; Ikeda *et al*, 2005; Gallagher and Fusco, 2006; Wright and Burrows, 2006).

A Foucauldian approach helps us make sense of the ways in which obesity discourse circulates. First, we could say that obesity discourse represents an awesome political power that 'works[s] to incite, reinforce, control, monitor, optimize, and organize the forces under it' (Foucault, 1978, p. 136). This power is fueled by the deployment of a discursive formation centered on the notion of an 'epidemic.' Indeed, the epidemic of obesity has emerged as a product of a socially authoritative discourse – obesity science – in light of which bodies may be mobilized, resources may be dispensed, and tactics of surveillance and regulation may appear to be justified. As a discursive effect of obesity discourse and biopedagogies, obesity scientists and clinicians are presumed to know the 'truth' of obesity and to have the moral and intellectual authority to label it a disease and to prescribe treatment. We could describe such power using Foucault's (1973) concept of the 'clinical gaze' – a panoptic kind of 'expert seeing' that determines in advance what will appear. The authority of the obesity scientist's gaze must be understood as a discursive power that shapes the realm of the possible. This realm is in turn configured by obesity science, which is itself territorialized by an all-encompassing scientific research paradigm – a 'regime of truth' – that ostracizes those with contradictory, and hence 'deviant,' forms of knowledge, labeling them as rebels and rejecting their work as ideologically laden and scientifically unsound.

Obesity science qualifies as 'state science,' to use Foucault's term: it is a tangled web of government lobbies, academia and its research sponsors, service

industries from the human genome sciences to multinational pharmaceutical and agribusiness complexes, the legal-juridical complex, and the insurance industry. Obesity science and its hegemonic norms have instituted a hidden political agenda through the very language and technologies deployed in the name of 'truth.' Obesity science and its dominant discourse act as a 'fascist structure' (Holmes *et al*, 2006), in the sense that they rely on a process that is saturated by ideology and intolerance regarding certain types of evidence, alternative discourses, and non-normative knowledge and ways of knowing (for example, qualitative research). The process at play operates hand-in-hand with prevailing power structures that sustain scientific assertions in the same direction: that of the dominant ideology regarding the physical and the social body.

The most powerfully ideological practices are those that claim that their 'facts' are non-ideological because they are 'scientific.' Such practices have certainly prevailed in obesity science. In this paper, our objective is not to get the ideology out of obesity science but to get ideology out of hiding, to expose it for what it is. In that line of thinking, we should thus see obesity as a construct that is forcibly materialized through time. It is not a simple scientific fact or the static condition of a body, but a process whereby regulatory norms materialize obesity and achieve this materialization through a forcible reiteration of those norms. Granted, the fiction of obesity has material effects and we will offer an example below, drawing on some empirical materials. As a linguistic construction, obesity is not stable, working as it does by always re-establishing boundaries and a zone of abjection – a zone often established through the Body Mass Index (BMI). Obesity also works through the endlessly repeated performative acts that mark individuals as obese or not obese. Obesity can thus be unveiled not only as the violation of an artificial norm but also in reference to a norm that is subject to change.

In brief, most epidemiology- and physiology-based obesity studies have been part of state science while they present themselves as apolitical and non-ideological. At the same time, they have widely circulated an obesity discourse that constitutes a good example of micro-fascism at play in the contemporary scientific arena because they rely on ideological norms of the good, responsible, and thus healthy, citizen. If we were to contrast this state science with the work of feminist theorists, we could say that the latter have made explicit their epistemological commitments and have championed an understanding of the body that is social and political. Their writings on weight and obesity have generally considered the ways in which women negotiate social and cultural ideals of femininity associated with bodily appearance (for example, Bartky, 1990; Bordo, 1993; Orbach, 1988; Smith, 1988). A number of feminist, queer, and disability theorists have also addressed the social constructions of fatness

and have challenged the power relations and oppressive practices associated with such constructions (for example, Sedgwick, 1990, 1993; Butler, 1993; Grosz, 1994; Braziel and Lebesco, 2001; Garland-Thomson, 2005; Murray, 2008b). In sum, feminist scholars have presented a good number of theoretical writings on weight and obesity and these have led to a number of critical social questions that have rarely been answered empirically. Much research is needed to fill this gap and, more generally, to inject contemporary feminist debates concerning 'obesity' with more grounded material.

In the present paper, we present a modest attempt to start filling this gap by looking at the connections between biopedagogies, obesity discourse and youths' constructions of health. Using a critical discourse analysis method informed by poststructuralist theory, we examine the text of individual or small group conversations with 144 Canadian youths. Considering the participants' wide range of social and cultural locations, we also explore the articulation of various identity categories in relation to the discursive constructions of health and the body.

Exploring the Effects of Obesity Discourse: Theoretical Considerations

The research questions of this project are primarily informed by feminist poststructuralist theory (Weedon, 1997; Wright, 2001; Rail, 2002). This positioning allows for an understanding of subjectivity as being made possible through the already gendered, heterosexualized and racialized discourses that deeply inform Western life and values. This proposed framework is underpinned by a number of other key concepts. Using a poststructuralist orientation means we are interested in understanding the ways in which differences – particularly those embedded in modern binaries such as thin/obese, normal/abnormal, masculine/feminine, White/Other – are constructed and maintained within discursive strategies. Our use of the term construction reflects the poststructuralist notion that reality is made and not found. In a similar vein, for our purposes we find that youths construct 'reality' through language and cultural practices (Wright, 2001; Rail, 2002).

We also bring forward the notion of biopedagogies discussed by Harwood (2009), that is, the disciplining and normalizing practices (for example, surveillance, self-assessment, self-monitoring) disseminated widely through cultural institutions (for example, school, media, the Internet, the family, the State) and associated with escalating concerns over a so-called obesity epidemic. Current health promotion initiatives informed by obesity discourse work on the premise that as young people become more informed about the

purported connections between obesity and health, they will behave in ways that lead to their own better health. While we do not support a position that knowledge necessarily leads to the desired behaviors, we would argue that this knowledge still has an effect. Following Foucault (1973), we see discourses as 'regimes of truth' that specify what can be said or done at particular times and places, that sustain specific relations of power, and that construct particular practices (Rail and Harvey, 1995). This generates questions about how power is exercised in the construction of knowledge about obesity and health, about what kinds of knowledge and biopedagogies are legitimized, and about how youth across a range of sociocultural categories (ability, race, ethnicity, language) position themselves as un/healthy or ab/normal within discourses about obesity and, more generally, about health.

We see identity as dynamic and multiple (Tsoldis, 1993). Identity is negotiated in relation to various sets of meanings and practices that youth draw on as they participate in the (bodily and wider) culture and come to understand who they are (George and Rail, 2006). In this sense, identity involves a notion of performativity, a re-experiencing of meanings (associated with gender, sexuality, dis/ability, race, ethnicity and so on) that are already socially established (Butler, 1990, 1997). This theoretical framework draws from writings (for example, Bhabha, 1994; hooks, 1994; Minh-Ha, 1995; Spivak, 1995) that allow us to conceptualize youth's experiences and performances in a postcolonial way, thus avoiding the pitfalls of abstraction and generalization. Finally, with respect to obesity and health, granted the type of research proposed here, we take as given that they are neither static nor 'natural' concepts (Lupton, 1992), although they often are constructed as such. In keeping with a poststructuralist approach, we are rather interested in questions such as how they are defined, by whom, for whom, and with what effects on youth.

Looking into the Effects of Obesity Discourse: Methodological Considerations

Discussing research on youth, Wyn and White (1996) speak of the importance of research that is sensitive to the actual lived reality of young people if we are adequately to understand their cultural worlds. Our empirical study took up Wyn and White's challenge and involved individual conversations (one-on-one) and small group discussions. In keeping with a poststructuralist approach, the qualitative materials were analyzed in terms of the youths' discursive constructions of health. The analysis allows us to contextualize young people's narratives on health and to understand why some discursive constructions have more appeal than others. The general approach was

consistent with an interest in meaning-making and listening to young people while our poststructuralist stance kept us focused on the need to investigate how young people's narratives are connected to wider social and cultural contexts informed by discourses about health, obesity, the body and consumption.

The conversation and discussion guides were our main research instruments. Developed both in French and English, they were inspired by those of Burrows *et al*, (2003) as well as Burrows and Wright (2004). Our participants were from the Ottawa and Toronto areas. Small group discussions were conducted with 13–15 year-old students from Grade 9 physical education classes in the schools participating in the study (20 groups of English-speaking students, 8 groups of French-speaking students, and 8 groups of English- or French-speaking students of Portuguese origin – for a total of 87 participants). In addition, one-on-one conversations were organized with youth (13–25 years old) who are members of support groups advancing the cause of youth coming from the Korean-Canadian community (9 participants), the South-Asian community (10 participants), and the community of youth with a disability (8 participants with mobility impairments). Finally, 30 adolescents (13–16 years old) coming from Black Canadian communities (mainly from Somalian and Caribbean cultures) were interviewed either individually or in small groups. Recruitment and participation conditions (for example, written consent from parents, schools and community groups) were approved by the University of Ottawa Research Ethics Board. The purposive sample (a total of 144 participants – 75 male and 69 female) allowed for the inclusion of youths from a range of social/cultural locations and for the exploration of the ways in which such locations impact on their constructions of health.

As a whole, the study involved an ongoing analysis of the qualitative materials in order to continuously inform the data collection. Conversations and discussions were audio-taped, transcribed (using the pseudonyms that participants chose for themselves) and analyzed using two consecutive methods of analysis. *First*, a thematic analysis took place. *Nud*ist Vivo* qualitative data analysis software was used to help organize the 'data' and regroup fragments of narratives into themes constructed based on their semantic affinity. Following this 'vertical analysis,' transcripts were examined transversally or comparatively between participants. Vertical and transversal analyses allowed for a better understanding of the articulation of life conditions and identity categories with constructions of health. *Second*, a critical discourse analysis method informed by feminist and poststructuralist theory (Lupton, 1992; Denzin, 1994; Minh-Ha, 1995; Wright, 1995; Weedon, 1997; Rail, 1998) was used. We interrogated the narratives to document how participants, as 'subjects' (Butler, 1990, 1997), positioned themselves within competing discourses available to them, particularly discourses on obesity and health. The focus of analysis was on how they

construct health, on the role obesity discourse plays in these constructions, and on the ways in which youth meanings about the body and health are constructed in specific social and cultural circumstances. Attention was also given to how language used by youth reflected and perpetuated (if at all) power structures and dominant ideologies.

Discursive Constructions of Health

Virtually all of the young people in this study were very familiar with the dominant discourses on the body and health. Such discourses were circulated in their narratives and constructions of health. Nine different 'themes' characterize such constructions and the number of times each theme was discussed gives us a very approximate but useful indication of its meaningfulness. Youth discursively constructed health as being physically active (581 mentions including doing sport, exercising, being physically active, not being lazy or a couch potato, going outside and so on), eating well (486 mentions including eating fruits and vegetables, not eating junk food and so on), being neither too fat nor too skinny (445 mentions including being thin, not being fat, having a normal body, having a proper shape, looking good and so on), having other physical qualities (230 mentions including having endurance or strength, being fit, having skills, energy and so on), avoiding bad habits (193 mentions including avoiding smoking, drugs, alcohol, unprotected sex, getting enough sleep and so on), having personal qualities (184 mentions including having confidence, self-esteem, control, being optimistic, funny and so on), feeling good (138 mentions including being happy, content, feeling good, being healthy emotionally and so on), not being sick (72 mentions), and having a healthy environment (38 mentions).

Examining these themes leads us to a few observations. First, and most importantly, we can say that the participants emphasized three themes related to the obesity discourse dominant in Canadian society: being physically active, eating well, and being neither too fat nor too skinny. Second, health was mostly constructed in bodily terms and was either associated with things that are done with the body (being physically active, eating well, avoiding bad habits) or that are associated with the body (being neither too fat nor too skinny, having physical qualities, not being sick). Much less frequently, participants described health in non-corporeal terms such as feeling good and having personal qualities. Third, considering youth-targeted public health campaigns that overemphasize negative messages about smoking, having unprotected sex, using drugs or abusing alcohol, it is significant to find that 'avoiding bad habits' is not prominent in the participants' constructions of health. This seems to be a

good example of government and school messages being eclipsed or displaced by the dominant cultural discourses about the body (that is, the importance of not being fat and of looking good). Fourth and last, the participants' constructions of health integrate the discourse of personal responsibility for health: 'health' is something that they are (thin, confident, positive, fit, not sick), that they do (physical activity, eating well, avoiding bad habits) or that they feel (feeling good). Such integration is quite dramatic when we know that the most important determinants of health in Canada reside at the macro-level (for example, socio-economic status, education, employment, physical and social environment) and that micro-level determinants (lifestyle, genes) have only a modest impact on population health (Raphael, 2003; Wilkinson and Marmot, 1998; WHO, 2008).

In the next sections, we note that while participants' constructions of health are complex and varied, they are nevertheless interwoven with moral and normative narratives that relate foremost to physical issues (for example, physical activity, physical appearance, physical qualities). We also discuss the finding that racialized and gendered notions of appearance and beauty constitute an important understanding of what it is to be 'healthy.' In doing so, we explore the ways in which various subjectivities are performed by participants. Finally, we examine how dominant health and obesity discourses are appropriated or resisted by the participants and with what effects.

Obesity Discourse and the Importance of 'Not Being Lazy'

The most significant element in the participants' constructions of health was 'being physically active.' Being physically active meant participating in organized or unorganized physical activities, exercises, and sports. Within their narratives on physical activity, the participants emphasized the regularity of involvement and attributed positive personal qualities to people who participate in regular physical activity. Tommy, Kimberly, and Maria (Korean-Canadian youths) stated that healthy people keep an active lifestyle, and that this kind of a lifestyle leads to being healthier than people who are not physically active:

> Tommy: He [Tommy's friend with whom he plays basketball] works out, so he is masculine. He plays a lot of sports, too. So, he is healthy.
>
> Kimberly: Being healthy means being basically active whatever you do.
>
> Maria: They [unhealthy people] are mostly overweight, don't really participate in [physical education] classes [like] healthier people, and probably in the gym, they always run slower on running [machines].

In addition to being physically active, the youth emphasized 'not being lazy,' 'not being a couch potato' and other markers of sedentary lifestyles like watching TV and sitting in front of a computer. The obesity discourse was clearly re-articulated in various ways by most participants. The notion of individual responsibility for one's health translated into the notion of self-responsibility for one's lifestyle and the idea that lazy people have lazy lifestyles and are not so healthy. The youths used many moral terms to qualify 'lazy' individuals, but qualifiers used to describe others were not applied to themselves. Interestingly, most participants considered themselves to be healthy despite the fact that few reported being involved in regular sport, exercise or fitness activities.

Whatever their physical practices, young people in the study were very aware of some of the health messages coming from school and community programs. They could easily re-articulate messages linking physical activity to health. That being said, they regarded health activities as accessible (read 'boring') everyday activities (for example, moving, being physically active, eating well), while they associated fitness with performance, perseverance, athletic achievement and uncomfortable physical exertion (that is, activities that were difficult, not enjoyable, and that were not part of their own everyday life). Naomi (Korean-Canadian youth) clearly articulated this idea of fitness:

> Yeah, usually fit people are muscular but, at the same time, I found that they are patient people because, you know, they exercise, right? So they have to keep it up, things like that. So that means that I have to say that you have to have perseverance, so then these people must be very patient.

The participants' narratives also clearly conveyed the sense that fitness is constructed as something within reach only for those people who have specialized knowledge, time, and access to 'the best place to do it.'

Obesity Discourse and the Importance of 'Not Being Fat'

The participants' constructions of health involved a crucial link to bodily shape. For all of them, health meant having a particular body shape and weight and, more specifically, being not too fat, overweight or obese, and being thin or skinny (we should note that 'skinny' individuals were well regarded although those deemed to be 'too skinny' were not since they were considered anorexic). Unsurprisingly, given the dominant discourse linking obesity to ill-health, 'fat' individuals were readily considered as unhealthy while slim people tended to be stereotyped as healthy. The construction of health as a status associated with 'not being fat' was overwhelming, as is evident in Score's (Korean-Canadian young man) narrative:

> [I'm healthy because I'm not fat and] I'm trying not to get fat or anything. Like, I don't really look at my weight as scare-wise, like, fat or anything. I just

> sort of check myself in the mirror and see if my stomach is bulging out – something like that [demonstrating and laughing]. You know you can't have that kind of thing; that's not a good sign. … You know, we all want healthy bodies and we all want to be shaped and have, like, you know, just a nice well-formed body kind of thing.

A majority of participants also constructed health as 'not being too skinny.' For young men, being skinny meant not having sufficient muscles and for young women, it was associated with anorexia and ill-health. Interestingly, most male and female participants regarded themselves as being and appearing 'healthy' even if they did not all appreciate their own bodily appearance. As is illustrated by the following discussion among English-speaking high school students, the participants were also quick to associate certain bodies with health and certain others with ill-health:

> Josianne: But if you see people at the mall, who are the people that you think [are unhealthy]?
>
> Maxwell: Fat people, skinny people, ugly looking people.
>
> Charlie: People with disabilities, people with Down's syndrome or something like that.
>
> Josianne: So you judge them by their appearance?
>
> Charlie: Physical, it's mostly physical appearance cause if you don't go talk to them, you don't know. If it's a complete stranger, then you judge them by appearance.

Other participants offered resistance to the dominant (for example, ableist) discourse that equates health with a particular physical appearance. Indeed, some of them suggested that you could not tell if someone is healthy just by looking at them. Jim (young man with mobility impairment), for instance, explained that his experiences of playing wheelchair basketball with people with a variety of body shapes had shown him that one cannot always tell if someone is healthy:

> I can't describe it [a healthy body]. It's different for everybody. Everybody is healthy in their own way, it doesn't matter what they look like. … Like, I know people who are half a person [laughs], only have half a body but they are still in good shape and they are still healthy people. They just look a bit different and I can't put a face on it or put a shape on being healthy.

In contrast to Jim, a majority of participants constructed health in terms of having a 'normal' body and this 'normality' seemed to be perceived differently by males and females. In general, the young men alluded to the 'normal' body as not fat, muscular, and well shaped. For young women, being slim and toned corresponded to a female's proper body shape. The participants' gendered view of the body was most evident in their consideration of muscles. For instance, when asked if women should have muscles, Abigail (English-speaking high school student) stated:

> Abigail: Yeah, but not too much.
>
> Josianne: Why not?
>
> Abigail: That would be just too much, she would look like she's on drugs or something.
>
> Josianne: Could you describe to me what a healthy guy would look like?
>
> Abigail: He would have a lot of muscles because guys have muscles and less body fat.

While female participants considered big muscles unattractive for women, male participants read muscularity as a sign of masculinity and male health. For all male participants (and particularly the Korean-Canadian young men who resisted the stereotype of the Asian man as small, physically weak, and focused on developing his mind), we could find a concern for the small and skinny body and a desire for a big, physical body:

> The way I feel about my body, I feel fine with my body right now, but I don't feel fine about the way I look right now, because I think I can gain more weight. So I can work out and maybe I'll look better, but sometimes I just look at myself in the mirror, and then just like: 'man, I need to change, there is something wrong.' I don't know… I can't really explain that. (Dragonball, Korean-Canadian young man)

While the narratives about the 'normal' body were highly gendered, it seemed as though the young people's concern was more about 'looking good' or 'not being fat' than about 'being healthy.' As an example, when asked if he cared about his health, Matt (high school student) answered: 'Yeah, I care a little bit right now [emphasizing the word ''little'']. I know I'm gonna care a lot more when I'm older, but right now, I think I'm OK. I'm not too concerned about it, unless I get too fat.' For participants, health as such seemed to be something they more or less already had, whereas 'not being fat' and 'looking

good' seemed to be something they needed to achieve. In that regard, consider the following excerpt:

> Healthy to me means, um, taking care of your body, like maintaining a decent weight, looking presentable, you know, like being healthy and fit. I think if you work on your body, you'll look good, feel good, and you'll also be healthy. (Cindy, young South-Asian Canadian woman)

More so than for the young men, the young women in the study reported subjecting themselves to bodily disciplines to meet the requirements of conventional femininity. Losing or maintaining weight were concerns for most of them. Some emphasized the need for a healthier diet in order to lose weight while others discussed the struggle to maintain their weight:

> Yeah, I'd say I am [concerned about my weight]. Yeah, I wouldn't say I'm obsessed with it, but I'd say I notice when I put on a couple of pounds, and I'm like: 'aw crap, I have to stop eating this junk food.' Yeah, I'd say I'm concerned about it; I'd like to stay the weight I am, try to maintain it. (Mary, young South-Asian Canadian woman)

Women participants used words like 'rolly,' 'chubby,' 'fat,' and 'gross' to indicate the undesirable state that they mainly attributed to a lack of exercise or bad eating. This finding confirms how most participants positioned themselves within the mainstream obesity discourse and its associated biopedagogies.

The various stories we heard about 'caring for the body' were stories constituted with elements of a dominant racist, sexist, heterosexist and ableist discourse of beauty. For instance, Amar (young South-Asian Canadian woman) was asked what other practices she engages in to look and feel healthy. She responded in the following manner:

> Amar: Oh, tons of hair removal.
>
> Tammy: Yeah?
>
> Amar: Man, you name it, I've tried it. Waxing, tweezing, right now, I'm getting electrolysis done.
>
> Tammy: Really?
>
> Amar: Yup, on my eyebrows as well as upper lip area. I also bleach.

In this excerpt, Amar admitted to bleaching (a practice used at times by women of color to lighten facial hair and/or skin). Cultural constructions of white, heterosexual female attractiveness were thus found to have real life

consequences on the women participants' bodies and ideas of health. The idea of attractiveness is invariably racialized and many South Asian Canadian and Black Canadian women's experiences were impacted by racialized aesthetics. Various practices were less about these women wanting to be 'white' than about them wanting to be 'attractive.' Indeed, it may be that in a world that associates beauty with being skinny, blonde and blue-eyed, certain health practices are seen to be imperative for women to succeed in society.

Discussion

In the present study, the participants' narratives about health provided an understanding of how young people construct health using elements of dominant discourses about obesity, health, gender, race and dis/ability. Overall, the participants constructed health in corporeal terms. They emphasized being active, eating well and not being too fat, a re-articulation of obesity discourse and a finding similar to that of the New Zealand study by Burrows *et al*, (2003). The prevalence of corporeal themes in the discursive constructions of health is not surprising given their centrality within medical and mainstream messages about health. What is somewhat perplexing is the fact that the participants in our study knew well the school and public health messages about nutrition and physical activity, but that their behaviors did not necessarily reflect that knowledge. They generally constructed themselves as 'healthy' individuals, yet many reported not doing the things they understood to be part of health (for example, regular physical activity, good nutrition). In fact, the participants did not seem as concerned about health as they were about their bodily weight and shape. This finding confirms that of other studies where it has been established that achieving an ideal body weight and shape is one of the most important health issues among youth (Health Canada, 1999). This finding also speaks to the problematic dominance of obesity discourse.

The participants' overemphasis on 'not being fat' and having a 'normal' body can be traced back to the obesity discourse that saturates their environment. This discourse is particularly oppressive to people with larger bodies or physical disabilities, whose bodies are popularly constructed in opposition to 'normality' and 'health.' Not unrelated to this is the finding regarding the preponderance of the notion of individual responsibility for one's health. Indeed, the participants very much constructed health as something one does (for example, being physically active, achieving a proper body shape, having muscles, eating well, avoiding bad habits, having a positive attitude). They attributed positive qualities to people who regularly take part in what they construe as health practices. Conversely, absence of participation in health practices was attributed to laziness, moral laxity and lack of discipline. Taken together, these results

show the extent to which participants recycled healthist discourses, including the dominant discourse of obesity. Numerous scholars have criticized such a discourse insofar as it conceptualizes health as an individual and moral responsibility (Crawford, 1980; White *et al*, 1995; Howell and Ingham, 2001). Like them, we are concerned with the emphasis on the individual. Such emphasis overshadows socio-cultural and environmental factors that affect health and that reinforce the unequal distribution of health-related resources. In addition, the construction of health as a moral responsibility leads to the construction of illness and obesity as a personal failure in character, thus blaming the individual who falls short of maintaining health or weight (Crawford, 1980; Colquhoun, 1987; Brandt and Rozin, 1997). For so-called 'obese' youth or youth with a disability who are stereotyped and constructed as being 'unhealthy,' this is particularly problematic. This may be why, in the present study, youth with a disability resisted stereotypes of disability through 'performative acts' of the healthy body (for example, walking as much as they could, participating in mainstream sports that have been adapted).

The youth in our study strongly emphasized avoiding obesity or being overweight in their narratives on health. We can easily locate the popular discourse on the 'epidemic of obesity' in the narratives of the participants; repeatedly, they used stock phrases that are generated and that circulate in obesity discourse. Perhaps the most significant consequence of equating health with 'being thin,' 'having a normal body' or 'not being fat' is the fact that our society has very restrictive and narrow ideas of 'normality' and 'normal weight' and that such ideas are grounded in sexist, racist and ableist views. Although most participants mocked the notion of the importance of physical appearance and expressed their frustration with masculine and feminine ideals, they ultimately felt trapped and reluctantly strove for an 'ideal appearance' nonetheless. For marginalized youth (for example, overweight and disabled youth, skinny young men, youth who are racialized), drawing on the dominant discourses to construct their own ideas of 'health' may ultimately lead to uneasiness, shame or guilt since their being part of a marginalized group sets them up for 'failure' in that all may strive, but few will ever achieve the 'ideal' body.

Connecting health with outward appearance and notions of beauty is both interesting and problematic: interesting because some participants saw this as a pragmatic strategy with which to combat racialization, discrimination and marginalization; problematic because constructing health in this manner paradoxically leads to some practices (for example, fasting, dieting, self-induced vomiting, tanning, waxing, bleaching) that do not seem particularly healthy. Indeed, youth are not exempt from being consumers of commercial products promoted by our healthist culture. Since this culture provides discursive resources for making sense of health, youth constructed their own meanings of

health and at the same time their own identities using these resources. They did so sometimes in highly subversive ways, but most often in a reproductive and conformist fashion.

The participants' constructions of health were very much tied up with the larger discourses of conventional masculinity, femininity, and heteronormativity. We do not mean to suggest that young men and women in the study who subscribed to cultural ideals of femininity and masculinity were passive dupes of dominant (white, heterosexist, ableist) ideology. On the contrary, many showed important moments of resistance. However, it has to be said that meanings of health as well as health practices seemed important to the participants as resources in their struggle to understand mainstream (that is, 'Canadian,' able-bodied) masculinity and femininity. For instance, for youth of color the pervasive stereotypes and expectations regarding their gendered 'Asianness' or 'South Asianness' were something which both males and females resisted. Males rearticulated dominant (that is, 'Canadian') discourses of masculinity while some females spoke of their involvement in mainstream physical activity and health practices. These are well known strategies (White *et al*, 1995; Cockerham *et al*, 1997) and these participants used them to differentiate themselves from Koreans or South Asians and to affirm their 'Canadianness.'

That being said, it is crucial to bring attention to how young people actively participate in, negotiate and resist the different 'ways to be' that are presented as discursive practices. We found that the participants did not passively accept their 'identifications' (Weedon, 1997) as 'woman' or 'disabled' or 'Korean-Canadian,' but rather that they drew on cultural/discursive resources through which the world could be seen and understood in particular ways. Although the subjects in the present study are socially constructed in discursive practices, they nonetheless exist as thinking, feeling subjects and social agents, capable of resistance and innovations produced out of the confrontation of contradictory subject positions. Using the notion of 'performativity' (Butler, 1997) and of the fluidity of identity, we have noted how the participants moved in and out of their various subject positions with ease. In discussing health, the participants were generally involved in discursive practices that produced gender, race, or dis/ability as a reiteration of hegemonic norms, although their performative acts also demonstrated fluidity and the possibility of interpellation by alternative and progressive discursive formations.

Conclusions

The feminist poststructuralist approach used here has allowed us to conceptualize the subjects in this study as being de-centered: instead of being the

point of origin of their own constructions of selfhood, they are interpellated or 'hailed' (Althusser, 1971; Butler, 1997) by the subject positions offered by obesity discourse (intersecting with dominant discourses on gender, sexuality, race, ability) and some alternative discourses on the body. This does not take away the human agency of the participants but it does point to the power of discourses to structure their subjectivity, experience and perception. The subjects are in perpetual reconstitution in and through multiple and shifting discourses. In the present study, we found that these subjects locate themselves at the intersection of competing discourses to construct their notions of health. It is also at the crossroads of these discourses that they construct their (however temporary and fluid) subjectivity and position (mostly) as 'healthy' subjects.

Overall, the results of this study point to the importance of socio-cultural contexts in the youth's constructions of health, the body and obesity. The study has also highlighted the fact that despite interesting moments of resistance, racist, hetero/sexist, and ableist discourses are often rearticulated within such discursive constructions. For many youth, such re-articulation constituted a valuable strategy since hegemonic understandings of health can be used as resources through which they may construct their own sex/gender identity and, for those 'hyphenated' Canadians, their own identity as 'Canadians.'

We believe that health promotion programs and literature should include alternative images and discourses of health that resist the discursive construction of health in opposition to obesity, disability or marginalized status. We would argue that consciousness is often borne out of a situation of marginality and that, therefore, we need to privilege the voices of all youth, but especially those who are marginalized: much may be learned from them. Unless dominant discourses (about health, obesity) change or subversive discourses are fostered and given a more prominent place, the acquisition of new subject positions will remain limited, and 'health,' constructed in whatever way, will remain elusive for most young people and particularly for those who are racialized and/or marginalized because of their weight or dis/ability. For change, we need to offer new subject positions, raise consciousness about the deleterious effects of obesity discourse and how it operates, often insidiously, to construct particular subjects. We need to become aware that health (conflated with weight and physical appearance) is constructed by youth in ways that make it seem inaccessible (fitness is too hard), very boring (no junk food, no TV or video games, deliberate exercise like walking and so on), or irrelevant.

We note that health and physical education programs in Canada are producing messages that are heard but often resisted by young people. We could say that governmental and educational imperatives are 'marking' the youthful body, compelling it to obey, in brief 'territorializing' it, to use Deleuze and Guattari's expression (1983/1972). But this body is simultaneously fed by

desires (often created by the mass media, commodity culture, peers) that continuously try to escape prescriptions. Fed by desires, this body retaliates and 'de-territorializes' its surface. In line with the territorializing attempts of the health education institutions, young people 'speak' health as they see it (for example, be physically active, eat well, be thin), but in opposition to the same attempts, they seldom 'do' health conceived their way and they rather keep their body on the edges of intelligibility. We are only now starting to map this process of territorialization and deterritorialization but the findings of the present study point to the importance of shedding light on such processes and their intersection with gender, race, culture and dis/ability.

Finally, we observe the prominence of a very particular politics of evidence surrounding obesity and we note its discursive effects on Canadian youth. We thus note the importance of attempts to deterritorialize the dominant discourse and research agenda on obesity and health. In the end, through this paper, we have unveiled the discursive and embodied workings and effects of obesity discourse, and in so doing, injected the discursive terrain with a text of resistance that contests the existing politics of evidence and the current regime of truth about obesity.

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