

Beleaguered Bodies: Illness and Obesity in Neoliberal Australia

Abstract Half a century of unprecedented wealth and prosperity has, somewhat paradoxically, resulted in growing numbers of Australians living with chronic illness, overweight and obesity. The foregrounding of individual responsibility within the nation's healthcare ideology has resulted in those whose bodies do not conform to the healthy, slender ideal being blamed and subject to stigma. In this chapter, I explore neoliberal constructions of the body through Paleo dieters' lived experience of illness and obesity. I argue that the popularity of the Paleo diet is the result of both the internalisation of and resistance to neoliberal values. This is insofar as Paleo is an individualist response to perceptions of a failing food system that prioritises market freedom over human health.

Keywords Paleo diet · Illness experience · Obesity · Neoliberalism · Anthropology

In 2009, Sharon was diagnosed with polycystic ovarian syndrome (PCOS). She was in her late thirties and trying for a baby, so her doctor suggested she see a dietician to assist with weight loss to ease her PCOS symptoms, and improve her chances of conception. Over a coffee in Coburg in Melbourne's northern suburbs in late 2014, Sharon laughed heartily when describing the flatulence triggered by the Optifast breakfast bars recommended by her dietician. She recounted her fear of unrelenting hunger that accompanied the portion control advice she

received, particularly in relation to the ‘tiny’ amount of rice and pasta recommended per meal; foods which she had been consuming in abundance until that point. While some of the dietary advice she found helpful, overall the highly processed meal replacements and strict portion controls were neither satisfying nor sustainable for her in the longer term.

Sharon’s decision to go Paleo has its provenance in what she describes as her ‘*annus horribilis*’. In the course of 2012, her grandmother passed away, soon to be followed by her mother, who had suffered motor neurons disease. After years of trying, Sharon fell pregnant, but was devastated to lose her baby at 10 weeks. She was then made redundant from her job of four years, before being diagnosed with endometriosis, on top of the PCOS. As a result of the psychological and physical stress of the year, she gained weight. On her doctor’s advice, she attended a gastric-banding information session, which she described as follows:

This was a real turning point for me. Every person there was much more overweight than me, and it was going to cost about \$6000, and then \$12000. It’s the same with IVF... It made me think, you know, human beings have lived for thousands of years without needing this stuff. What’s the problem? So I started to look into Paleo... Seeing my Mum; it was a genetic thing. People say genetics can be affected by diet... so getting diagnoses of these kinds, Mum getting sick, I just thought, I’ve got to do something. I’ve got to change.

Paul, another participant, similarly undertook the Paleo diet owing to ongoing health issues. For years, he experienced periodic debilitating diarrhoea, ulcers, bloating and abdominal pain, invariably accompanied by depression. He saw numerous doctors and specialists in attempts to find a solution to his gastrointestinal issues. After years of misdiagnosis and advice that at times exacerbated his symptoms (such as high fibre diets in times of flare-ups, and medications containing sulphites, to which he has since discovered he is highly allergic), he was relieved, albeit distressed, to receive a diagnosis of either mild Crohn’s disease or ulcerative colitis. Three weeks after commencing treatment under a leading Sydney gastroenterologist, his online research into the potential side effects of the medications he was taking for his inflammatory bowel disease (IBD) alarmed him, and resulted in his abandoning of both the treatment and his doctor. Instead, he began to spend a great deal of time

conducting online research to try to make sense of both his own illness and the loss of several close family members to cancer over the years. The Dr. Mercola website—which is much maligned by the medical fraternity and state regulatory bodies—was his starting point into the alternative health scene, from which he has now sought over many years to heal himself. This has entailed regular exercise of bare-foot running and a weights regime, attempts to reduce his family’s exposure to household toxins and extensive dietary experimentation, ranging from strict elimination protocols to vegetarianism, juice fasting and supplementation. He has had limited success with these diets, most of which impacted his lifestyle profoundly, and in some instances aggravated his symptoms. He eventually learned of the low FODMAP (fermentable, oligo-, di-, mono-saccharides and polyols) diet (see Monash 2017), which he has pursued in conjunction with Paleo principles for several years now. He reports having far fewer flare-ups when he strictly adheres to a low FODMAP Paleo diet, and he takes pride in the fact that his own research has enabled him to manage his disease effectively.

On social media platforms, Paleo diet transformations are represented visually through before and after photos. Through unpacking the aspects of Australia’s contemporary economic, political and social environments that are fuelling the diet’s popularity, this chapter aims to serve as a kind of ‘before’ shot. As with Sharon and Paul, the majority of Paleos I encountered undertook the diet on account of persistent illness and/or weight issues. Anthropologists have long recognised ‘the hold of disease upon the human imagination and, conversely, of the imagination’s use of disease in symbolising the problem of order’ (Murphy 1987: 31). In this chapter, I explore the lived experience of illness and obesity among Paleo dieters in order to demonstrate the ways in which prevailing neoliberal economic and political policies, and resistance to them, are being played out through the body and dietary choices. I describe how in Australia neoliberalism has entailed, among other things, deregulation of the corporate sector, privatisation of public services, the growth in precarious employment, and a shifting of the burden of responsibility for public health away from the government and towards the market and individuals. This is through constructing people as responsible for the prevention, and in some instances treatment, of their illnesses and weight issues. Such ideas have largely been enculturated within the Australian community, resulting in those bodies that do not conform to

the healthy, slender ideal being stigmatised and shamed. It is these experiences, along with the internalisation of neoliberal individualism, that have fuelled the popularity of alternative health movements, including the Paleo diet. Ample evidence demonstrates, however, the ways in which structural factors are contributing to obesity prevalence and chronic illness, which I explore in order to challenge the simplistic, and highly detrimental, culture of individual blame predominating. Through this discussion, I aim to illuminate the ways in which our bodies serve as key sites for negotiating and contesting neoliberal ideologies.

HEALTH AND ILLNESS IN AUSTRALIA: DIET AS A REFLECTION OF SOCIETAL MALAISE

The report card on Australia's health in the contemporary period is somewhat conflicted. On the one hand, Australians enjoy among the highest life expectancies in the world, with a girl born in the period 2012–2014 likely to live to 84.4 years, and a boy to 80.3 years (ABS 2015a). Not all Australians enjoy such longevity, however, with Indigenous Australians living around ten years less than their non-Indigenous counterparts (AIHW 2017). The disease burden has decreased in recent years, not least because the nation has one of the lowest rates of smoking globally, and it measures up relatively well when it comes to cancers, heart disease and suicide (AIHW 2016: 17). Yet, Australians drink more alcohol and have higher rates of obesity than the OECD averages (AIHW 2016: 17). In addition, around half of all Australians have a chronic disease, and one in five suffers from multiple chronic conditions (AIHW 2015). So while the longevity of our lives has increased, chronic illness has too, as medical technologies and treatments keep us alive, but prolong our suffering at the hands of diseases that can be managed, but not cured (Cassell 2004: xi).

Across history, human health has been impacted by the prevailing modes of production. According to Egger et al. (2015: 235), hunters and foragers were 'predisposed to the elements and injury', while zoonotic diseases plagued agriculturalists. The shift to high-density urban living in the industrial revolution triggered an increase in pestilence-borne diseases, while in contemporary neoliberal societies, 'lifestyle has become the dominant etiology' (Egger et al. 2015: 235). This is certainly the case in Australia, where alcohol and tobacco use, high body mass, physical inactivity and high blood pressure are held responsible for at least one-third of the overall

disease burden (AIHW 2016: 59). Such human-generated substances and behaviours resulting in poor health have been coined ‘anthropogens’, of which Egger et al. (2015) identify eleven categories: poor nutrition (particularly excess energy, fat, sugar and salt); insufficient physical activity and excessive sitting; widespread stress, depression and anxiety; adverse effects of technology; inadequate sleep; environmental pollutants including ‘endocrine disrupting chemicals’; physical and psychological issues stemming from normative work practices; consumption of drugs, cigarettes and alcohol; inappropriate sun exposure (ranging from skin cancers to vitamin D deficiencies); relationship challenges; and social inequality. Paleo dieters tend to be hyper aware of these anthropogens. The prevalence of disease has come to symbolise their perceptions of societal problems, which are embodied through illness experiences, and that their diet and lifestyles explicitly aim to remedy.

Paleo dieters are not alone in this perception, and medical anthropologists have observed a tendency in diverse communities to construct disease as indicative of social disorder, with the breakdown of the body reflecting problems at the level of ‘macrosocial forces, be they economic, political, institutional’ (Kleinman 1988: 6). For Paleos, this extrapolation is the result in part of their conceptualisation of the body as a ‘complex system’, with no absolute boundaries in relation to the surrounding environment (Martin 1994: 121). This plays out in myriad ways, from the metaphoric and indirect, to the literal and direct. Regarding the latter, a Victorian woman in her sixties—who described having dropped five dress sizes, along with alleviating eczema, headaches, sleep issues and various other maladies through going Paleo—claimed that getting rid of her television was an important part of her journey to better health. She found that watching the news would trigger insomnia, with her anxiety about the various social and ecological crises unfolding globally impacting her health and wellbeing directly through loss of sleep. For other Paleos, it is the ingestion of the commodities of late capitalism, particularly junk food and medications, through which the embodiment of societal ills is played out (cf. Guthman 2015: 2528). Such senses of corporeal permeability are heightened when bodies are ailing, and are exemplified in the evocatively termed condition ‘leaky gut’. One man described this condition as ‘the doors of the gut not being properly closed’, and in this way allowing toxic matter from the external environment to enter the blood stream. Symptoms of leaky gut are said to be bloating, abdominal pain, gassiness, diarrhoea and malabsorption of nutrients. One middle aged

man described his multiple chronic illnesses as stemming from his work in the military, and the physical and emotional traumas experienced (and embodied) in the course of his career. He believes that his many years of exposure to: overcooked, carbohydrate-heavy army food; vaccinations prior to every deployment; opioid painkillers following several surgeries for work-sustained injuries; and long term anti-depressant use have together resulted in his leaky gut. His experiences make evident the perceived vulnerability of the body to transgression by macro-social forces, which play out through the corporeal processes of ingestion, digestion, excretion and, ultimately, deterioration.

Illness Experiences among Paleo Dieters

Illness experiences are diverse among Paleo dieters and range in severity from terminal cancer through to minor skin irritations. Those most strongly represented in the Paleo community, however, are sufferers of illnesses not easily diagnosed and/or treated by Western biomedicine, including gastrointestinal conditions and auto-immune diseases. Several of my key informants had been diagnosed with IBD, including Crohn's Disease and Ulcerative Colitis. IBD is distinct from the more common Irritable Bowel Syndrome (IBS), which is a less serious disease characterized by functional disorder, as opposed to IBD's bowel damage, chronic inflammation and ulceration. For the sick person, chronic illness can be all consuming; it impacts an individual's self-perception, relationships and capacity to conduct day to day activities in work and leisure. Paul's wife, Lisa, describes the impact of living with IBD on her husband:

I think he very much identified as this sick person, who needed to be fixed. Being someone who in life is very academically intelligent, and had always had a, I guess, 'Western' definition of success in his life; career-wise, money and things like that. And then the illness coincided with a lot of those things changing, and a lot of loss of money due to other reasons. So I think at the time when the illness was at its worst, he was really struggling with a sense of having failed in life; that he was a failure in more ways than one. And then he couldn't get the answers to the illness at that point. I think it knocked a lot of confidence out of him... That was a really horrible, dark time for him.

While the biomedical model constructs disease as a physiological issue, as is clear in Paul's situation, the illness experience tends to be understood by the sufferer in relation to broader life events, which infiltrate

and determine how the sick person sees themselves intrinsically, and in relation to their social worlds.

Paul and Lisa went on to detail an emotional trajectory encompassing fear, demoralisation and a sense of injustice around Paul's illness (cf. Manderson and Warren 2016; Kleinman 1988). Not being able to depend on your body lends readily to generalised and pervasive senses of mistrust, inadequacy and failure, resulting for many in a profound loss of confidence. These factors often lead to social isolation. Never knowing when a flare up may occur renders it very difficult to plan ahead, and for fear of seeming unreliable, it is often deemed easier to avoid commitments (Garro 1994: 784). Many of those suffering chronic illness need to curtail their work participation, resulting in further social isolation, and in some instances significant financial impacts. Relationships are also affected, as even when an ill person is surrounded by loved ones, the sense of isolation tends to continue. In his powerful account of experiencing spinal cancer, anthropologist Robert Murphy (1987: 64) describes how his family's awareness that no matter what they did for him, he still felt alone, led to considerable 'hurt and bewilderment'. Lisa similarly describes being shut out in times of Paul's flare ups:

Sometimes it's like a wall that you just can't break through... Sometimes I say "you know, I understand you're feeling really this or that". And he'll say, "no. There's no way you could really know". And when he gets down and out like that, he withdraws. He's not an overly social person anyway, but he certainly closes off to the world more, is less likely to make a phone call to a friend, or is even less likely to answer the phone.

The isolation is not all self-induced, however, and a growing body of research documents the stigmatisation of sufferers of chronic illnesses (e.g., Gibson et al. 2016; Phillips 2015). 'Whatever the physically impaired person may think of himself' writes Murphy (1987: 113), 'he is attributed a negative identity by society, and much of his social life is a struggle against this imposed image'. Consider even the common cold, and the animosity people express to a colleague who turns up to work ill. Fear of infection fuels such stigmatisation, and this phenomenon extends to chronic conditions where existential fears of mortality meet with compassion fatigue, visceral disgust at physical decay, and at times resentment for the burden of care. Perhaps the worst affected are those suffering

mental illness, alongside those with lifestyle diseases, such as lung cancer and type 2 diabetes, who are frequently cast as to blame for their conditions. Wilkinson (2013: 126) contends that suffering in the current period is constructed as meaningless, to be avoided, and as something that should be eliminated or minimised wherever possible. This conceptualisation of suffering arguably contributes to the stigma people are exposed to when they have chronic conditions.

In turn, stigmatisation exacerbates feelings of shame, and during the low points of his illness, Paul's wife describes his 'strong sense of failure. The crux of his identity, [was] that he was sort of physically dysfunctional on some level'. A sense of shame can have profound implications, and as an extreme example, colon cancer campaigns in the USA aim to reduce the number of people 'who literally die of embarrassment, too ashamed to speak of the symptoms of "below the waist" cancers' (Jain 2013: 152). A gastroenterologist confirmed the persistence of an 'image problem' in Australia around what he called 'south of the equator' diseases. He suggested anything to do with the genitals or bowels makes people deeply uncomfortable, with considerable implications in terms of sufferers not seeking either medical attention or community support on account of feelings of shame: 'A lot of patients, they suffer in silence. They don't talk about it. They don't look sick. And so they don't have that support.'

OBESITY IN AUSTRALIA

There are several parallels between the illness experience and that of obesity in terms of impacts on identity, loss of confidence, social isolation and stigmatisation. With two-thirds of Australians currently deemed overweight or obese, Australia is ranked the fifth weightiest OECD nation after the USA, Mexico, New Zealand and Hungary (OECD 2015). Overweight and obesity rates have increased rapidly in the past thirty years. In 1989, 44% of adults were overweight or obese, while the percentage rose to 63% in 2011 (NHPA 2013). Indigenous Australians have higher prevalence still, with an Indigenous person 1.6 times more likely to be overweight or obese than their non-Indigenous counterpart (DPMC 2014). While obesity rates continue to grow, the pace at which this increase is occurring has slowed, however, which suggests it may be plateauing (ABS 2015b). Obesity is a major public health focus in Australia on account of its association with increased risk of

diseases including heart disease, stroke, Type 2 diabetes and some cancers (AIHW 2016: 149). A recent analysis of data from 239 studies conducted across four continents by a large consortium of experts suggests ‘associations of both overweight and obesity with higher all-cause mortality were broadly consistent in four continents. This finding supports strategies to combat the entire spectrum of excess adiposity in many populations’ (The Global BMI Mortality Collaboration 2016: 776).

Obesity studies remain a highly contested field, however, with a number of scholars positing that objectivity is scant around issues as morally fraught as weight. Concerns regarding the health implications of excess weight are said to be disproportionate, while public campaigns are proving not only ineffective, but also highly damaging. A powerful voice in this debate, Julie Guthman (2011: 44) argues that ‘the obesity-disease connection has been established by reductive measures, correlative reasoning rather than causal determination, and rhetorical devices that leave out as much as they tell’. For example, contradictory to the consortium’s study cited above, a survey into the deaths of 2.3 million Americans found ‘excess overall mortality [to be] associated with underweight and obesity but not with overweight’ (Flegal et al. 2007). Such findings would suggest that simplistic equations of fat with poor health elide the complexities of the relationship. Further, the body mass index (BMI), which is used in diverse contexts with profound implications, is critiqued for being a measure of body size and ‘phenotype’ rather than an indicator of the presence or absence of disease (Guthman 2011: 25). Consequently, the BMI ‘has redefined obesity away from a question of impaired functionality and toward one of form’ (Guthman 2011: 27). Detractors from the dominant discourse, including Guthman, concede the importance of understanding why obesity is on the rise, and what the implications may be for individual and public health. Yet, they rightly remind us to be wary of culturally determined biases in this fraught field, while recognising the detrimental impacts of campaigns that construct a significant portion of the population as physiologically, aesthetically and morally problematic. There is, after all, no doubt that representations of fat as fuelling a public health crisis ‘make competing frames of “fat” as a neutral and positive form of biological diversity more difficult to promote’ (Saguy and Almeling 2014: 119). Moreover, the major investment in public health campaigns in recent years has had little success in reducing obesity prevalence (Ghosh et al. 2016), yet, has served to legitimise stigmatisation around body size.

Body Image in Australia

The majority of the Australian population lives in cities and regional hubs around the nation's coastline. The weather is mild to hot in much of the country for much of the year (though less so in Melbourne and the southern regions), so bikinis and board-shorts abound. In conjunction with the cultural obsession with sports, this beach culture produces norms that epitomise the broader Western ideal of thin, fit, strong bodies. The flipside of this is a high proportion of people in Australia struggling with issues around body image. The implications of such concerns are considerable and range from low self-esteem, through to eating disorders. The 2015 Mission Australia Youth Survey found that body image ranked in the top three issues of personal concern among the 18, 994 fifteen- to nineteen-year-olds surveyed, with 26.5% of respondents indicating high levels of angst about their body size and shape (Cave et al. 2015: 17).

The prevalence and intensity of body image issues were found in the Youth Survey to be substantially higher for young women than men. In Australia, as elsewhere, women are bombarded with images across all media of thin, often sexualised, women as the embodiment of the feminine ideal. Susan Bordo's (1989) description of the vast amount of time women spend on grooming, managing and disciplining their bodies in order to meet societal expectations continues to resonate: 'Through these disciplines, we continue to memorise on our bodies the feel and conviction of lack, insufficiency, of never being good enough' she writes (Bordo 1989: 14). In a phone interview, a counsellor on Sydney's Northern Beaches described these sentiments among her clients:

I've had girls come in that do not look like they're overweight, and they have such a negative body image. They actually identify that when they walk down the street, there's just this constant gaze that they have upon themselves, measuring themselves up against the next girl and, you know, that they're always not as skinny, not as pretty, not as sun-tanned. So even for those who on paper you'd think wouldn't be struggling with those issues, I mean especially around here, you walk down the [Manly] corso, and the young girls just wear their bikinis now.

As is clear in these comments, the slender, fit body continues to be an 'ideal whose obsessive pursuit has become the central torment of many women's lives' (Bordo 1989: 14). The moral panic around obesity has

further exacerbated these issues, with women at all ages and life stages feeling the pressure. This has manifested in recent years in injunctions for pregnant women to maintain fitness to ensure their offspring are of healthy weight, indicating that pressures to be within a certain weight range are even projected onto unborn foetuses (Johansson and Andreasson 2016: 160; Maher et al. 2010: 307).

While the burdens of body image are widely agreed to be greater for women, perhaps unsurprisingly given that they are pursuing a rigid dietary regime, a high proportion of the men I worked with also expressed such concerns. Notwithstanding his IBD (which can lead to weight loss when symptoms are chronic), Paul says he puts on weight easily and throughout his lifetime has exercised and imposed dietary restrictions to ensure he keeps his weight in check. In a conversation we had one night over a roast pork dinner with Lisa and their children in their home in Sydney's Northern Beaches, he critiqued vegetarianism, saying: 'you're never going to look fit and muscly like a gym guy, because you just don't have the protein. So you're never going to look like a fit, cool dude. You're going to look a bit skinny'. The balance men are required to strike between avoiding excessive weight, on the one hand, and having adequate musculature to avoid being 'skinny', on the other, is clear in Paul's comments. As we walked through his extensive veggie patch, another participant described how algorithms on Instagram latched onto his keywords around health and well-being in order to bombard him with constant advertising around fitness programs that would give him an abdominal 'six pack'. Moral imperatives for mastery and control have long been aligned with masculine ideals (Bordo 1989: 19) and continue through these modern mediums to pressure men about appropriate body form.

Stigmatised Bodies: The Lived Experience of Obesity

After a lifetime of exposure to these body ideals, many Paleos, and indeed Australians more broadly, describe having been consumed their whole lives in a battle with weight. Bec is in her late thirties and grew up on Sydney's Northern Beaches. Her Dad's side of the family tends to be tall and readily gains excess weight, whereas her mother's side is petite in both length and breadth. Her sister is 5 ft. 9 and size 8, even after having four children, while Bec is 5 ft. 2 and currently 140 kilograms. She says her sister can eat what she likes, while if Bec so much as 'thinks

about a doughnut, [she] gains a kilo'. A lifetime of dieting started at age six, when her parents put her on the 'army diet', which consisted of a boiled egg and slice of dry toast for breakfast, salad for lunch and a tiny piece of boiled chicken with brown rice for dinner. In high school, the largest available uniform was too small, so she did the best she could and wore pants in the school colours. As a consequence of this 'uniform violation', she was denied access to her Higher School Certificate exam timetable, and had to piece it together from various friends taking the same units. Such victimisation has continued into her working life, with one of the Registered Nurses (RN) she worked with consistently addressing her as 'Nurse Fatty', mocking the way she walked and allocating her numerous additional duties each shift. This continued until another RN reported the bullying to management and a formal warning was issued.

Strangers also feel entitled to insult Bec about her size. She describes as inevitable the 'beached whale' comments she faces each beach trip, and being yelled at incessantly from cars by people 'mostly just informing me that I'm fat'. A new low was recently reached when Bec was on her daily walk and a woman threw a packet of biscuits at her, shouting: 'keep walking, fat cunt!' The cruel paradox of being under intense pressure to exercise and lose weight, but experiencing abuse and insults while attempting to do so, was raised by several of my interlocutors. The disdain with which another young woman was treated at her local gym led to her exercising under the cover of darkness in a park with free outdoor equipment, despite her sense of vulnerability as a woman out alone late at night.

Bec is an extraordinarily resilient and positive person, but of all these terrible experiences, the most hurtful she describes as when her daughter began to refuse to hug her goodbye at preschool, on account of the other kids teasing her about her 'fat Mum'. In her own words:

The thing is most fat people are fat because they have had some messed up stuff going on in their world, and they haven't coped in a healthy way. Society tends to perceive fat people as being lazy, stupid and undisciplined, and treats them as such, but don't take the time to understand or know an individual's journey, or the psychology that's involved in gaining weight... As an adult I went from being a big girl, which is my natural state, to being morbidly obese, mostly due to an abusive marriage—and a few trips through hell after—that I comfort ate my way through. I hit 179.6kg at my biggest in 2014, am currently 140kg, and slowly getting it back down by living a healthy lifestyle.

As with Sharon and Paul's illness histories, Bec's weight issues are experienced as inextricable from her broader life trajectory, with negative events embodied, and in turn perpetuating further challenges. Kleinman (1988) describes how in various historical moments across different societies, particular illnesses or conditions become focuses of attention and subject to stigmatisation, which is most acutely felt where its source is visible. Obesity fits the bill in the current moment, not least because of the media's generation of a moral panic through its relentless reporting on these issues. This has resulted in a 'culture of fear' that constructs not only obese individuals as at risk, but also the broader society, on account of perceived impacts of obesity on public health budgets (Boero 2014: 37). Stigmatisation follows, and a substantial body of work documents the discrimination faced socially and economically by those deemed too large (e.g. Greenhalgh 2016: 545; Pollock 1995). On the social side, Bec describes being told by a man she dated briefly that she was his 'perfect girl', but that he could not continue seeing her as his mates would relentlessly tease him for dating an obese woman. This is by no means an isolated incidence. Of their 76 research participants across Victoria, Thomas et al. (2008: 326) found that more than half described 'poor mental and emotional health outcomes associated with their obesity. These included low self-esteem, eating disorders, depression, social isolation and an inability to form and maintain intimate relationships'.

On the economic side, stigmatisation is aggravated by the correlation between thin bodies and wealth, on the one hand, and large bodies and lower socio-economic status, on the other (Guthman 2011; Bourdieu 1984). Significantly, the data do not always support this association. While women living in areas of greater disadvantage had higher rates of obesity in 2014–2015 in Australia, the same was not true of men, whose obesity prevalence was similar regardless of place of residence (ABS 2015b). Nonetheless, perceptions of this correlation persist and lead to denigrating rhetoric around lack of control, with unruly, undisciplined behaviour attributed to both those of lower socio-economic standing and the overweight and obese. Fat-shaming plays out in different ways across varying convergences of geography, gender and cultural and class backgrounds. For example, in Sydney, Bec has found that:

Eastern suburbs is the worst, followed by the [Sutherland] Shire, then the Northern Beaches, city, then out west. But the way they go about [fat shaming] is different to out west. It is more in your face with bogans,

while on the Beaches it is snider. Culturally, though, there is a big difference. My African and Polynesian friends are much more accepting of plus size than Asians and Caucasians in general.

Fat-shaming in its various forms has significant implications, with discrimination against larger people in education and the workplace demonstrating that ‘socioeconomic status can be an outcome of size as well as a cause of it’ (Guthman 2011: 192).

In addition to the reprehensible shaming to which obese people are subjected, research suggests that fat stigmatisation is resulting in increasing levels of body dissatisfaction and disordered eating across the weight spectrum. Of her students in a southern Californian university, Greenhalgh (2016: 551) describes how:

troubled eating was so normalized among the young people featured as to be simply ordinary behavior... In the 160 essays, 74% of the subjects engaged at some point in potentially dangerous weight-loss practices such as self-starvation, bingeing and purging, use of extremely low-calorie diets, use of weight-loss pills, laxatives, and/or diuretics, use of cocaine or other strong drugs, and severe dieting coupled with excessive exercising... Almost everyone who was—or thought he or she was—overweight reported emotional disturbances such as depression, anxiety, guilt, and low self-esteem.

The situation in Australian schools is much the same, with young people bombarded with messages about disciplining their bodies to avoid overweight and obesity (Carey et al. 2013). In addition to contributing to the prevalence of *Anorexia nervosa* and bulimia, anxieties around body image are fuelling the growing prevalence of *Orthorexia nervosa*, the pathological pursuit of healthy eating, which I discuss in the final chapter.

NEOLIBERALISM, INDIVIDUALISM AND THE BODY

How is it that people come to feel that it is valid to cast judgement upon and discriminate against people because of their body size? And why are people feeling ashamed of experiencing chronic illness? To answer these questions, we need to take a step back and consider the broader economic, political and cultural contexts in which these constructions of the body, health and illness are taking place. Over the past forty years,

successive Australian governments, and the Australian community more broadly, have been enthusiastic in their embrace of neoliberal policies and values. In the words of the concept's doyen, David Harvey (2005: 2), '[n]eoliberalism is in the first instance a theory of political economic practices that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets, and free trade'. In its Australian iterations, the adoption of neoliberal policy approaches has resulted in one of the largest privatisation programs globally of the erstwhile public sphere, including primary services, such as water and electricity, health insurance and education, with significant implications in terms of cost for users (Chester 2010: 315). Neoliberalism in Australia has entailed the adoption of market-based logic in governance, the implementation of policies ensuring market freedoms through the deregulation of industry, and a strong shift towards individual responsibility (Mayes et al. 2016). However, it is important to note that the neoliberal shift has not resulted in the diminishment of state power, with the role of the government continuing to be multifaceted, at times interventionist, and increasingly one of enabler and supporter of industry (Chester 2010; see also Peck 2010; Wacquant 2009).

The shift to neoliberalism has been clearly evident within the nation's food system, which I will use to briefly illustrate how the policy abstractions described play out in practice. Rather than subsidising agriculture as many nations do, the Australian government has sought to support the industry through liberalising the market and opening it up to international trade (Richards et al. 2016: 65). Australian farmers produce a substantial surplus beyond domestic needs, and some 76% of the gross value of agricultural produce derives from the export market (Lawrence et al. 2013). On the domestic front, a lack of market regulation has enabled agricultural production to increasingly be subject to the control of the supermarket duopoly, Coles and Woolworths, who together hold a 70–80% share of the retail market (Richards et al. 2016: 65). A succession of investigations into the conduct of supermarkets in recent years has stemmed from 'growing concerns from actors along agri-food production chains (farmers, manufacturers, processors and consumers) that the major supermarkets [are] abusing their dominant market presence' (Richards et al. 2012: 250). In relation to the increasing commonality of such complaints across all sectors of society, Harvey (2005: 38) echoes the sentiments of a growing number of commentators in noting the

‘authoritarian, forceful, and anti-democratic’ turn that neoliberalism has taken in the new millennium.

While an over-reliance on neoliberalism as an explanatory model has been rightly critiqued in the health literature (Bell and Green 2016), it is difficult to avoid in a discussion of the Paleo diet. This is because it has not only determined the politico-economic context in which the diet has flourished, but neoliberalism has infiltrated Australian cultural values, with individualism and market logic in particular, having become normalised and deeply entrenched. This will become evident in the final chapter, where I argue that the Paleo diet, despite its self-styling as oppositional to the status quo, is very much a product and perpetuator of neoliberal values and practices. Neoliberalism’s reign is also blatant in the field of public health, particularly through policies (and the internalisation of values) that support the shift of responsibility for health away from the state, and towards the market and self-care. Australia has not taken this to the same lengths as the USA and, alongside a strong private health industry, retains universal health care through Medicare. In addition, the government funds the Pharmaceutical Benefits Scheme, through which a range of prescription medications are subsidised. Nonetheless, the neoliberal shift has been marked. In particular, decreased state funding has led to the dependence of medical research and education on related industries, most particularly pharmaceutical and medical equipment companies. This has raised questions around conflicts of interest in medical research and patient care (see Mayes et al. 2016: 259). Funding cuts have also resulted in efforts at increasing efficiencies through the streamlining of many services, and the privatisation of others, with user-pays or joint payment models increasingly widespread. Most notably, taxpayers make substantial contributions to Medicare through the compulsory Levy of 2% of an individual’s taxable income, with an additional surcharge for the underinsured. Regarding the latter, the coercive Lifetime Health Cover policy adds a 2% loading for each year over the age of 30 an individual does not have private health insurance, should they take out cover later in life. As the government website explains: ‘if you take out hospital cover at age 40 you will pay 20% more than someone who first took out hospital cover at age 30. The maximum loading is 70%’ (Aus Gov 2017b). Through this policy, the government has pushed responsibility for health insurance on to the individual.

Questions of Causality, Responsibility and Blame

The individualist orientation marks a major shift in medical world view, which has occurred alongside the growing prevalence of lifestyle diseases (Finerman and Bennett 1995). A consequence of this shift is that questions of causality, responsibility and blame haunt the chronically ill and overweight. Such questions can be counterproductive, as they can lead to the division of obese/ill people into those whose weight/sickness is beyond their control (i.e. ‘good’ fat/sick people), and those whose lifestyle choices have resulted in their position (i.e. ‘bad’ fat/sick people). Yet, it is critical to understand the broader politico-economic factors that are impacting our bodies, while deconstructing the discourse of individual blame that elides these factors. Blaming the individual disregards the complex aetiology of disease, lends to stigmatisation and senses of shame among those afflicted and allows the state and corporations to abdicate responsibility for the impacts of their actions. For this reason, it is critical to shine a light on discourses and practices around causality.

Where responsibility for health is delegated to the individual, it follows that the consequences of one’s actions ‘will have been self-inflicted in the case of failure’ (Beck 1994: 16). Such sentiments prevail to varying extents in regard to both the prevention and treatment of illness and obesity. With chronic diseases such as cancer, government-driven early intervention campaigns place the onus on the individual to remain vigilant to the disease’s onset, which distracts from the failure of the state to address cancer’s well-known environmental and occupational causes (Jain 2013: 66). The rhetoric of individual responsibility is pervasive, even among organisations developed to support victims, such as Ovarian Cancer Australia. Their website (OCA 2014) provides a series of statistics outlining the low survival rate of a woman diagnosed at an advanced stage, as compared with the high chance of living if the cancer is detected early. ‘Every woman needs to know the symptoms of ovarian cancer. Make sure you do’, the page implores. It then goes on to suggest ‘If you are not comfortable with your doctor’s diagnosis or you are still concerned about unexplained persistent symptoms, you should seek a second opinion. You know your body better than anyone else, so always listen to what your body is saying and trust your instincts’. While this is certainly sensible, well-intentioned advice that could save lives, the implications of these kinds of discourses, which construct the individual as responsible even where doctors have failed, can be distressing for the

ill. In her book detailing her own experience of cancer, medical anthropologist Lochlann Jain (2013: 22) writes:

One of my retreat friends with terminal ovarian cancer learned to respond to the constant, distressed inquiry, “But didn’t you have a Pap smear?” Her community wondered whether her imminent death wasn’t her own fault, whether their own medical obedience could save them from her fate. Discussing how she took that question as a nearly physical attack, Alice fretted, “A Pap smear has nothing to do with ovarian cancer” [it is a test for cervical, not ovarian, cancer].

Notions of blame also arise in relation to the mind/body relationship in cancer. Jain (2013: 31–32) recounts the poignant story of a woman who feared her failure to laugh sufficiently in life had caused her metastatic colon cancer. Jain also describes the widespread belief that a positive attitude is required to be a cancer survivor, which again suggests a failure of will among those who do not survive. The language of ‘beating cancer’ or ‘succumbing to it’ makes this evident, where survivorship is framed as a battle between equal agents.

Blaming the individual is even more pronounced in the case of obesity, which is routinely portrayed as simply a problem of weak will, overconsumption and laziness. Pollock (1995: xiv) points to the ‘focus by western societies on control of the body as a demonstration of the superiority of the intellect, mind over matter’ which in turn results in a situation whereby ‘regulation of diet is a means of demonstrating control by the mind over the body. Where such control is not exercised, a person is labelled as obese, or out of control’. Such moralistic viewpoints neglect to recognise obesity’s roots in a convergence of complex environmental, economic, political, sociocultural, genetic and psychological factors. Nonetheless, the individualist orientation continues to dominate, particularly in the media. Saguy and Almeling’s (2014: 113) research into media translations of scientific articles found that 98% of news stories emphasised individual responsibility, despite only 40% of the science they were reporting on doing so. Genetic causes for obesity were, by contrast, mentioned far less in news reports than in the scientific articles. Unsurprisingly, individual behaviour change was cast as the solution in the media far more often than policy interventions.

The impact of this individualist orientation on those struggling with weight issues is great. Of putting on weight as a result of PCOS, Sharon

said: 'I can honestly tell you it's an awful feeling, because you think "I'm so greedy, I'm such a pig". And then when you discover it's got to do with your blood sugar levels, it's such a relief! ... It's not just me! It's not my fault! There is a reason for it'. The internalisation of the discourse of blame is readily apparent in Sharon's comment, as is the huge sense of relief she felt upon discovering there was in fact a physiological explanation for the weight gain, as opposed to some kind of moral failing. For many others, though, there is no blame-shifting diagnosis, and shame is deeply felt on account of internalisation of the dominant discourse.

In their media analysis, an exception to the rule of individual blaming was found in the case of childhood obesity, where blame tends to be shifted to the child's parents, particularly mothers, their schools and society more broadly (Saguy and Almeling 2014: 114). Government guidelines induce parents to 'keep children active, feed them appropriately and resist pressure from children for unhealthy food, inappropriate snacks and video games' (Maher et al. 2010: 306). In this vein, I found mother-blaming to be a repeated theme in my research. A Melbourne man I interviewed suggested his obesity was the result of his birth by Caesarean section, which he believes inhibited the healthy development of his gut bacteria, resulting in his propensity to gain weight. Among my interlocutors, blame was cast at mothers not only for obesity, but also at times for chronic illness. I asked Paul how his diet has changed from childhood to the present, to which he replied:

My Mum was no great cook and continues not to be, and so we ate a lot of stuff that was from a packet or from a tin. Probably because we were poor, it would be like a lot more carb based; so a lot of noodles, a lot of rice, sausages, so many additives, so many preservatives. And I'm allergic to sulphites, and I would have been eating it in droves. I believe that how I became allergic to that is through not being breastfed. It's not a genetic thing; it's basically a developmental defect. It's happened in the early formative years, my digestive system just didn't develop properly, and hence I've always got it. Just like a plant that hasn't been fertilised with the right nutrients. You can't fix it.

Even though Paul's mother, sister and now his teenage daughter have persistent gastrointestinal problems, in this comment, he explicitly rejects genetics as a causal agent, while blaming his allergy and poor health on not being breastfed, and subsisting in his early years on poor quality

foods. Yet, he certainly sympathises with the challenges his Mum faced as a single parent trying to get by with two children on a low income, and their relationship in the current period is a relatively close one.

Notions of parental culpability persist for Paul in his role as a father, where his children's health is a constant cause of concern. In Lisa's words:

He expressed anxiety about when we were having a baby, like worrying about whether the baby was going to be like him. And I think he meant not only physically, but also the emotional ups and downs he goes through. He encouraged me every morning to be being healthy, and taking my Vitamin D, and going for a swim and all that stuff. I reckon there's a little part of him that dies inside when he sees [their eldest daughter] having some of the same issues.

This last statement demonstrates that even while he has done everything within his power to provide a healthy start to life for his children, he still carries a sense of blame for their health challenges. In this sentiment, and in other discussions about his family's underlying susceptibility to dietary triggers, Paul does in fact acknowledge the role of genetics. Lisa believes that his emphasis on diet above genetics as a causal agent perhaps enables him to maintain a sense of hope that a cure is possible, in the face of what otherwise may appear to be a losing battle.

Internalisation of Blame

Given the ubiquity of the casting of blame on families and individuals, it is perhaps unsurprising that people with chronic illness and obesity internalise such ideas, albeit alongside recognition of some of the structural determinants of health. In the case of obesity, Khye is a real food activist living in rural Victoria, who advocates for the revival of self-provisioning through growing vegetables, hunting, keeping poultry and foraging. He previously worked in high-level management for a major supermarket, but today uses social media to campaign against their policies and practices, which he sees as contributing to poor health in Australia. In a recorded discussion at his home in June 2016, he commented:

I hate that fact that my body got to an obese state, because it takes so much effort to repair it. I've done a complete lifestyle change, for what 6 or 7 years, and I still look like a sack of shit. I'm healthier, but you know

I still look in the mirror and see all my scars. And I find that terribly frustrating, it's taken years to repair my health, and if that stuff wasn't on the shelf, I wouldn't have bought it.

While he recognises the complexity of the issues, and particularly the role of the unregulated proliferation of junk food, he returns ultimately to the notion of individual responsibility:

There was a report written in 2008 basically saying this is our obesity problem... And it's a really good report, saying it's a really difficult issue, because there's so many different social groups that have different reasons for why obesity's crept in. But really the report should have just been: 'stop eating fat and sugar'.

In the same vein, I asked Bec what role she thought government should play in issues around obesity, to which she replied:

Teach whoever wants to learn the skills to get healthy, and provide public spaces to get fit. I think they should ban things like Maccas [McDonalds] from pushing their products to kids. More protection should be given to children in relation to junk food being marketed to them; give them a fighting chance to break the cycle. At the end of the day, though, I'm a grown adult. If I choose to do something, it's on me.

A sense of distrust fuels the individualist orientation for others. Another woman who has enjoyed great weight loss success with the Paleo diet described how she felt she had been duped by low-fat and vegetarian dietary campaigns; practices which she feels have exacerbated her weight and health issues. She says her current success is attributable to incorporating healthy fats and protein back into her diet, while eliminating all refined carbohydrates and sugars. She firmly believes it is incumbent upon the individual to: 'read, read, read! Everyday! We are the only one's responsible for our health, and we are in control'. Thus, even while she believes misinformation abounds around dietary recommendations, rather than laying blame on those promulgating the information, she holds firm to the sentiment that it is up to the individual to do their own research and find out what works for their bodies.

By pointing out the individualist orientation of obesity discourse, I am not suggesting that individuals do not and should not play a key role in managing their diet and health. Rather, my aim is to shine a light on the

complexity of the issues, and some of the problems of the individualist approach. As Shugart (2014: 142) points out:

locating health exclusively or even primarily within the realm of personal responsibility obfuscates myriad social, structural, and institutional factors that contribute to health and illness in powerful and complex ways, ranging from demographic factors such as class, gender, race/ethnicity ...to (often interrelated) literal matters of access: for example, to information, resources, and health care. Furthermore, casting health in terms of personal responsibility summarily deflects a consideration of the role of institutions in addressing those social and material considerations.

Moreover, the personal responsibility orientation suggests that the obesity epidemic can be overcome at the level of the individual, and yet such approaches have to date been unsuccessful. Every one of the participants in Thomas et al.'s (2008: 324–325) Victorian obesity study had repeatedly attempted to lose weight over the course of their lives, while a quarter stated that *all* their lives they had been engaged in dieting. They reported investing substantial amounts of time and money on ‘fad diets’, while more than half the women and a third of the men described relentless thoughts about their weight, and strategies for losing it. In addition to dieting, most participants had taken pharmaceutical medications, predominantly amphetamines and herbal supplements, in the course of weight loss efforts (Thomas et al. 2008: 325). Bec similarly describes how she has:

tried so many different things it's not even funny... Jenny Craig, Weight Watchers, Gloria Marshalls, detox diets, naturopaths, herbalists, dieticians, USANA, Optifast, the list is extensive... I can get to a size 12-14. To do that I have to eat an extremely clean diet and exercise at least 3 hours a day.

If she deviates from this regime in any respect, the weight is rapidly regained. Being a single Mum who works long hours (as a nurse, so on her feet all day in any case), it is not realistic for her to maintain such a heavy exercise regimen every day. US data demonstrate a parallel situation: ‘for most individuals, there are few if any safe and reliable ways to achieve long-term weight loss. Despite this dismal truth, most Americans believe that weight is under individual control and that anyone can lose weight if he or she tries hard enough’ (Greenhalgh 2016: 549). While

certainly people can and do lose weight, more often than not, the weight is eventually regained.

Illness and Obesity as Reflections of Societal Issues

Rather than simply an individual issue, Guthman (2011: 9) argues that obesity must be understood as an ‘ecological condition’ determined by the cultural, political and economic environments in which we live. Neoliberal policies have resulted in the decline in trade unions and workers’ rights in Australia, and an increase in insecure livelihoods in the form of part-time, contract and casual work (Beer et al. 2016). With 25% of employment in casual positions, Australia has one of the largest insecure labour forces in the developed world (Wilson and Ebert 2013: 268). For many families, longer working hours and juggling multiple jobs, alongside raising children and other care responsibilities, leaves little time for home cooking, making processed and frozen convenience foods increasingly desirable (Donghi and Wennerholm 2014: 49). Insecure livelihoods and the burdens of care increase stress, which in turn has been found to contribute to obesity susceptibility. ‘In the hours to days after the onset of an ongoing stressful event (e.g., infection, bereavement), glucocorticoids in the bloodstream are elevated’ write Sominsky and Spencer (2014: 2). When glucocorticoid levels are high, visceral fat accumulation increases, as does the appetite, and particularly the desire for high-reward foods, namely those high in fat and sugar (Sominsky and Spencer 2014: 2).

Numerous Paleo dieters described their own histories of stress and overwork as resulting in poor dietary patterns. Paul recalls how the frantic pace of his work in the dot-com boom resulted in his consumption of ‘heaps of takeaway, heaps of junk food. I was always in a rush, always too busy’. He was under intense pressure at work, single-handedly managing multi-million dollar accounts, and prioritising work above all else. It was during this period that his IBD issues began in earnest, eventually leading him to take better care of his body. Balancing the demands of work with a healthy lifestyle is a constant challenge, and a frequent topic of conversation on Paleo forums, particularly given the diet’s emphasis on home cooking, with staples, such as bone broth, requiring lengthy cooking times (up to 24 hours). In an online Paleo forum, a woman posted an image of a brand of powdered bone broth she was enjoying. She apologetically acknowledged the superiority of preparing the broth from

scratch, but pointed out that she worked three jobs, along with studying full time and raising a family, so could not always find the time to do so. This is one of countless examples of how even for those prioritising health in their daily lives, the reality of juggling long working days with family responsibilities presents challenges in upholding ideals.

In addition to recognising the role of society's economic structures on their health, a number of Paleos attribute the growing prevalence of chronic illness to what they see as the deterioration in Australia's socio-cultural dynamics. Sharon occupies what she describes as the somewhat awkward position of being both a Christian (and creationist), and a fervent Paleo advocate. She expresses concerns regarding the breakdown of community that she sees as resulting from the lessening influence of religious affiliations:

I think a lot of people are disconnected... Even people putting their parents in homes. I mean I've heard stories about people eating terrible food in residential care homes. They just get fed biscuits all the time, and their mental and physical health just deteriorates, because they just feed them cheap food.

Going a step further, Martine provides a critique of Australian society framed in relational terms, as while she has lived in Australia all her adult life, her childhood was spent between Sweden and Israel:

Australia's history, a lot of it is broken families, you know, the early convicts. Convicts would not have come from a place of cooking and stuff like that, and Britain is not a high cuisine culture... I come from a Jewish background on my father's side, and on my mother's side my grandmother was very into cooking. I'm not saying all Australians, but I've been amazed with the laziness. I'm amazed at the lack of creating a moment. Like in Israel, Friday night is this warm family moment, you know, you light candles and have a beautiful meal together every Friday night. In Sweden, there's a word called *mysig*, the closest in English is "cosy", but it's this idea of comfort and nurture and food... Australians just don't have that.

While formalised weekly traditions may be absent (the Sunday roast is perhaps an exception), counter to this claim, many Australian families do connect warmly over food, and perhaps increasingly so, given the contemporary obsession with 'foody' culture in Australia (see de Solier 2013). However, Martine's belief in the impact of early settler

experiences has some historical resonance. Markey (1987: 500) writes that, unlike the French, the British have historically prioritised cheapness and ease of preparation within their foodways. Great significance was not attached to developing a fine, sophisticated cuisine, he suggests, and this sentiment was imported to the colonies. For Martine, her experience of contemporary reverberations of this historical cultural trajectory has been augmented, no doubt, by her work as a counsellor among disenfranchised youth, as well as her own two broken marriages, and sense of alienation prompted by her mobility, not only internationally, but also in multiple moves within Australia. Her negative experiences appear to have contributed to her symbolic mobilisation of food as both cause and effect of a community and society in a state of breakdown. It is against such a pattern that she constructs her own ideals of family, community and the foodways that can nourish them.

Government, Business and Questions of Regulation

In addition to changes in work patterns and social dynamics, the state and corporate interests—and the relationship, if not collusion, between them (see Mooney 2012)—are profoundly impacting our bodies. Part of the trouble with the paradigm of individual blame for illness and obesity is that it shifts culpability away from these central actors. In stark contrast to dietary practices of the past, today across the globe some 75% of food sold is highly processed (Stuckler and Nestle 2012: 1). Even more disturbing is the fact that ‘the largest manufacturers hold over a third of the global market’ (Stuckler and Nestle 2012: 1). Consequently, our diets are to a considerable extent determined by a handful of multinational corporations.

In Australia, food-producing companies are legally obligated to deliver the greatest possible profits to their shareholders, regardless of the health impacts of their products (Mooney 2012). Not only clever marketing (see Cairns et al. 2013), but appetite stimulants including colour and taste enhancements aim to make junk food irresistible. Supermarket chains in Australia are filled with these nutrient void, calorie-dense foods and beverages that the government is more than aware are making us ill, yet fail to sufficiently regulate. As Freudenberg (2014: viii) argues in his powerful book:

In a global economy that focuses relentlessly on profit, enhancing the bottom line of a few hundred corporations and the income of their investors

has become more important than realizing the potential for good health that the world's growing wealth and the advances in science, technology, and medicine have enabled.

Paleo dieters recognise this reality, and regularly bemoan the pervasiveness of junk food in their suburbs. In an online forum, a twenty-five-year-old woman described her struggle to eat well: 'It's so hard especially as the bad stuff is ALWAYS shoved in your face wherever you go, and money is always an issue', she wrote. Another woman asking for some motivation to help her stick with Paleo received a stream of advice, ranging from tips, such as weekend meal planning, through to threats, such as 'stick with Paleo, or get diabetes and have limbs amputated'. Another commenter neatly encapsulated the resistance trope, replying: 'Don't let the processed food companies win!' Such sentiments demonstrate a growing recognition of the structural factors determining poor health among this sector of the community.

The detriments of our food system are epitomised for Paleos in relation to genetically modified foods (GMOs). A discussion unfolded on a Melbourne-based online forum in late 2014, when a woman posted the following: 'Please sign this petition to prevent Monsanto GMO'ing grass!! It is a way of getting GMO's into people who only eat grass fed meat ☺'. A flurry of comments followed in the next hour, many of which evidenced the ways in which this issue symbolises broader concerns about our politico-economic system. As one young woman wrote:

I just hate this shit... it makes me feel so helpless as a human being. Remember the Tacoma issue with the citizens protesting against a McDonalds?... 90% of the community protested against it yet they went ahead and did it anyway. With GMO we've got people all over the world protesting... but they keep tampering with more and more things... I just hate the influence that money has on politics. It's a joke to say that countries like the USA and Australia are democratic countries cos as people I feel like we're just complete pawns.

Disillusionment with the failure of government to regulate unhealthy foods is clear here and demonstrates the ways in which foodways are held as symbolic of broader frustrations with the politico-economic structures of neoliberalism. Significantly, the desire for greater regulation of junk food extends beyond Paleos to the wider Australian

community. A recent study conducted by the Royal Children's Hospital (RCH 2016) in Melbourne suggests the majority of Australians want greater government intervention in the food system. Of their 2113 randomly selected participants across Australia, 76% expressed support for obesity prevention interventions: 'The highest level of support was seen for the introduction of compulsory daily physical activity in primary schools (88%), followed by a gradual ban on the advertising of junk food aimed at children and teenagers (79%), and the introduction of a tax on sugary drinks (61%)' (RCH 2016: C, 1). Moreover, economic modelling of taxing junk foods while subsidising fruit and vegetables shows that the benefits in terms of healthcare spending, and quality and longevity of life, render this approach one the government should be seriously considering (Cobiac et al. 2017). While certainly a step in the right direction, approaches such as this are, arguably, merely tinkering around the edges. So long as economic growth continues to be the nation's primary goal, some would argue there is scant hope of addressing the massive ecological and health challenges posed by our contemporary politico-economic system (Alexander 2016; Webb 2012).

The question of regulation (never mind whole-of-system change), is a complex one, and as Sidney Mintz (2002: 27) reminds us, there is a need to balance protections with freedom of choice. To date, however, governments have been hesitant to intervene between powerful food companies and consumers, despite the health issues resulting from poor diet being among the highest contributors to the nation's disease burden (IHME 2010). A non-interventionist approach is defended on the grounds that limiting advertising, and taxing or banning unhealthy foods, unfairly harm businesses and damage the economy. In addition, individual freedom is, of course, a core value of neoliberalism, so intervention is construed as paternalistic and inhibiting of individual agency. Thus, the government continues to restrict its input to soft policy measures via labelling systems, such as the recent health stars initiative for packaged foods. This is somewhat of a toothless tiger, however, as corporations are not compelled to use it, and where they do, they are responsible for calculating their own ratings (Aus Gov 2017a). The majority of government interventions are education-oriented, as in the case of the Australian Dietary Guidelines. Yet, widespread knowledge of food industry funding of nutrition research, and critiques of the reductive and problematic nature of dietary advice (Scrinis 2013), is resulting in the public becoming increasingly sceptical and distrusting of such guidelines. In a recent

study, 70 of the 76 industry-funded studies investigated reported ‘results favorable to the sponsor’s interest’ (Nestle 2016: 13). The implications of biased research and reporting have been profound, as made clear by the recent unearthing of correspondence demonstrating that the sugar industry’s research program in the 1960s and 1970s intentionally promoted the notion that fat was a high risk factor for coronary heart disease in order to obfuscate the hazards of sugar (Kearns et al. 2016).

Paleo dieters are highly sceptical of the government’s dietary advice. At one level, there is frustration with what are seen as shifting goalposts. ‘When you look at the history of what we’ve been told is healthy and what isn’t over the last 100 years, who can trust their advice? They flip flop all over the place’, one woman complained. Paul is similarly sceptical about the government’s regulation of food, food safety and the dietary guidelines. Through trial and error, he discovered he was allergic to sulphites, about which he says:

When it was first put through the FDA [the US Food and Drug Administration], it was rejected as not suitable for human consumption. So then they did another study through somewhere different, and it got through. So it’s obviously at best borderline, and these scientists knew it was absolute rubbish. It is companies just doing stuff that they know is dodgy, but they don’t give a shit because it’s extending shelf life. So that probably cemented in my head that you can’t trust most of the stuff you read when it comes to health. Like the food pyramid, all the stuff you read at school, it’s all rubbish. Very little science backing it up.

I ask him why he thinks the government would spread misinformation in the food pyramid, and he replied:

Commercial motivation. I believe that political pressure, farming lobbies impact what’s in the food pyramid. And that’s why grains are more than anything else in the food pyramid. It’s just pressure and funding, and that’s what it comes down to. There’s actually very little science saying why it should be at the bottom, and there’s actually a lot of research suggesting it should be tipped the other way, which would be more like the Paleo food pyramid.

There are certainly major conflicts of interest within industry funding of research, which have been well documented (Nestle 2013; Lesser et al. 2007). However, the dietary guidelines are based on the review by

a team of medical and nutritional experts of more than 55 000 journal articles (ABS 2016). While corporations have vested interests in selling their unhealthy products, the Australian government spent an estimated \$155 billion (9.8% of our GDP) in 2013–2014 (AIHW 2016: 23) on health care, so at the very least, the state has a strong economic motive to ensure the best possible health of the population. Moreover, in critiquing the efficacy of dietary guidelines, Paleos fail to acknowledge that the vast majority of people fail to actually follow them. ‘In 2007–2008 only 10% of women and 7% of men ate the recommended daily intake of five serves of vegetables... Australian children received an even more dire report card from the statisticians, with 6% of children aged 5–17 and only 4% of children aged 5–7 consuming the recommended intake of vegetables’ (Eyre and de Jong 2011: 14). Thus, my own concerns are less around the government’s dietary advice than the broader issues of the relentless growth orientation of the economy, inadequate corporate regulatory measures and the culture of individual blame.

Toxic Environments, Illness and Obesity

Paul’s point about the inclusion of dubious ingredients in foods is an important one. Nancy Langston’s (2010) *Toxic Bodies* traces the histories of several synthetic chemicals to which we are frequently exposed that interfere with our hormones and the environment. She goes on to describe the legal loopholes and research gaps that prevent the government from regulating businesses profiting from their circulation (see also Phillips 2015). Significantly, with the public health focus on the consumption side of our diets, the many toxins entering our systems through cheap food production are routinely overlooked. Guthman (2011) reviews the growing body of research that shows how exposure to synthetic toxins (pesticides, BPA, PCBs, DDE and many more), through our food, water, household items and atmosphere, is causing profound interference in the endocrine system, which in turn is contributing to the rise in obesity prevalence. Based on the evidence presented, she argues that ‘the increase in size is not all about soda, fries and video games. Rather, much of this upward trajectory in BMI values appears to be a consequence of exposures to a set of barely regulated chemicals and food substances’ (Guthman 2011: 111). A number of Paleos cited such theories when explaining their preference for organic foods, and efforts to minimise other forms of exposure. When I asked Bec what factors

she felt had led to the increase in the girth of the population in the past thirty years, she replied: ‘Life style: people don’t move as much, we’re more sedentary than ever. And we need to go back to real, whole foods, rather than convenience foods. Trans-fats and preservatives mess with our body’s ability to function, as well as the ongoing chemical onslaught on our endocrine systems, causing our bodies to barely function’.

In addition, certain technologies are viewed as suspicious by Paleos in terms of their impacts on health. Being ignorant of the microwave taboo early in my research project, I offered to heat up the leftovers of a meal I had cooked the previous night for the hungry Paleo partner of a friend of mine who was visiting. He is a Sydney-based personal trainer, who is fanatical about his health, and he leapt up in horror and grabbed the meal from my hands, insisting on eating it cold rather than contaminating it with the microwave’s radiation. (He did not articulate it as such, but rather feigned a desire not to inconvenience me further.) Technology taboos are, however, selective for the Thermomix-wielding, compulsively instagramming Paleo community. As I discuss in the final chapter, without the Internet, the community would be a fraction of its current size, and most people have gained most of their health knowledge from online groups and programs. Yet, for Paul, even while he has built his career upon information technology, like the personal trainer, he will not touch food that has been in a microwave, there is not a plastic container to be found in his kitchen and he insists his wife and children use ear pieces so as not to hold mobile phones directly to their ears. He avoids fluoride by filtering his water and making his own toothpaste from bicarbonate soda and peppermint oil. He runs barefoot to circumvent the perceived detriments of shoes, while making his own cleaning products and cosmetics. In keeping with Paleo doctrine, many of these actions are about harking back to a pre-technology era. Lisa has accommodated all these changes, despite the inconvenience, as she understands the broader concerns fuelling Paul’s decisions:

He’s had a lot of relatives die of cancer... and they say that ulcers are the earliest stage, that down the track it turns into cancer. I know that he is afraid that he is going to die of cancer, and that’s his lot in life. So his hyper-vigilance around this stuff, it infuriates me at times, but I tend not to pull him up on it, because I get where it’s coming from. Yeah, but I think initially when we started doing things, such as back in the day when he was like, “we’re not eating out of tin cans anymore, they’re toxic,

they're full of BPA". And at first I was like, "holy shit, seriously?" But now I'm just used to it, and I'm happy to go along with it, if it keeps him feeling safer in the world.

A number of anthropologists have written of cancer's powerful grip on our imaginaries. Kleinman (1988: 20–21) captures these fears and their origins precisely:

Cancer is freighted with meanings of the risks of invisible pollutants... These menacing meanings meld ancient fears of contamination with the great modern threat of man-made catastrophes that poison the environment with toxic wastes. They disclose our inability to control the effects of technology.

Murphy (1987: 31) similarly describes fears of cancer as evoking a common paranoid belief that 'beneath surface appearances of normality, a destructive force is quietly gnawing away at the foundations of society or the self'. Yet, there is no lack of evidence of the environmental and occupational sources of many cancers (Clapp et al. 2006). Consequently, the fears articulated by Paul and other Paleos are not necessarily ungrounded, even while a preoccupation with them may result in compromises to their quality of life. For those suffering with cancer, Jain (2013: 23) describes this process as happening in reverse, whereby the ill agonise over which of the countless carcinogens to which they have been exposed, might have caused their sickness. A diet and philosophy oriented around food seen as pure and natural is, consequently, highly appealing against the backdrop of such fears.

CONCLUSION

Irrespective of the unprecedented wealth and associated life expectancy gains enjoyed by many Australians, non-communicable diseases have flourished in recent years, and a growing proportion of the community is living with chronic illness and obesity. Australian public health discourse constructs individuals as responsible for their health and weight, despite a growing body of evidence that points to the complexity of the economic, political and physiological factors underpinning these challenges. Blaming individuals for illness and obesity leads to stigmatisation, with fat in particular triggering revulsion both on the level of cultural

aesthetics, and on account of its construction as the manifestation of moral weakness. Stigmatisation is mobilised with the intent of modifying behaviour (Wacquant 2009: 288), and community members, in turn, are responding to these pressures through experimentation with alternative health and dietary practices. Paleo is particularly appealing as it feeds into the widespread cultural myth of an idyllic, pure and simple past, contrasted with an unnatural, hyper-technologised and toxic present. It also encapsulates the spirit of resistance growing out of disillusionment with traditional forms of authority, with the state and medical authorities seen as being in collusion with profit-driven corporate interests. In the next chapter, I suggest that Paleo can be seen in this light as a form of protest, which I seek to make sense of through the lens of the growing global phenomenon of populism.

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