

THE HUNGRY SELF: BIOMEDICINE, BUDDHISM, AND THE MANAGEMENT OF CRAVING



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Abstract

This dissertation imagines food attachment as a visceral and relatable manifestation of the existential craving elaborated in Buddhist philosophy. The work examines the accelerating biomedical epidemic of food-related diseases through Buddhist notions of craving, attachment, and addiction, and the potential for their alleviation. Data for this qualitative study was collected through participant-observation at two institutions in a field site: Hennepin County Medical Center and Common Ground Meditation Center in Hennepin County, Minneapolis. The results of this research establish that the biomedical response to food attachment reinforces suffering, and the Buddhist conceptual framework of craving elucidates both the perpetuation and potential for alleviation of this suffering.

Overeating and its corresponding illness conditions constitute the majority of doctor visits within the clinical context studied. The demise of cultural regulators of food leaves eaters confused and stressed in their decisions about what to eat. Patients

consistently turn to their physicians for advice about problematic eating, extending the jurisdiction of the medical establishment into the daily technicalities of eating behavior. Doctors, reticent to engage in these conversations to the extent desired by patients, approach food attachment problems from the interventionist frame, relying on referrals, medication, surgery, and a future-based narrative of illness and fear to motivate behavior change. Buddhist thinking, in contrast, regards food attachment as one appearance of the ubiquitous, nonpathological craving that is a predictable part of human existence.

From the Buddhist framework arises myriad mindfulness-based interventions, many of which offer relief from countless symptoms, as evaluated by biomedical (empirical) metrics. However, these efforts are ultimately self-limiting. Rather than incorporating an understanding of the attention needed to root out the craving that leads to suffering (of which food attachment is merely one form), biomedicine folds mindfulness interventions into the same self-based symptom-reduction view that increases suffering in the face of chronic illness. Biomedicine reduces Buddhist *practices* to the smallest clinically implementable parts (i.e. mindfulness interventions). Instead, considering Buddhist frameworks for *understanding* craving better informs the inadequate biomedical response to food-related, and other forms of, chronic suffering.

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Chapter 1

Introduction

In the fluorescent, bustling elementary school cafeteria, my friends and I would sit and make food trades with friends during lunchtime. Only rarely did I achieve a successful trade for the most coveted lunchroom food: Lunchables. These came in several varieties, but the most desirable was the box containing doughy bread rounds, neon sauce, and shredded cheese that could be assembled into a *pizza* on the spot. My mom never purchased Lunchables, despite a few feeble attempts exerted at the grocery store by my sister and me. They were too expensive for too little food, she said; they had too much packaging, and besides, they were a snack, not a meal.

Instead, she packed us fresh meals for lunch, always complete with fruits and vegetables. At breakfast and dinnertime too my mom always had something prepared for everyone in the family to eat. Food was a matter of both love and insistence. The expectation to eat at home seemed, at the time, like a constraint, as friends helped themselves throughout the day to sodas and snacks, a situation that seemed unfathomable to me. Even today, my mother beseechingly, enthusiastically, and sometimes aggressively offers up a constant supply of fresh nourishment any time my sister and I are at our parents' house, and I often come back to my house from a night at the hospital to find a grocery bag of fruits and vegetables on the porch. Now, as an adult, I have a greater understanding of what a monumental endeavor it must have been to sustain this

type of attention to feeding our entire family, by her standards of quality and nutrition, for decades.

Meanwhile, as I passed through my teens and twenties, food took on an increasingly adversarial role. By high school, again in the cafeteria, a close friend started cutting her food into small pieces and pushing her lunch around her plate, barely taking any bites. During college, other friends gained weight and social activities turned from boisterous antics outside to seated meals and beer, always beer. Discussion centered around diets, calorie counts, food intolerance, and elimination diets, as our social life continued swirling between bars, restaurants, and takeout at home. I felt increasingly confused about what to eat. As I continued through medical training, vegetarianism, extreme sleep-deprivation, and stress meant many of my meals became variations of cheesy bread in the hospital cafeteria.

At the hospital, we confronted the frightening effects of food every day as patients came to the hospital with serious illnesses that our team attributed to poor diets. Even when patients agreed that food was the source of their medical problems, they had great confusion and difficulty about *how* to change their eating habits. I started noticing that people with straightforward, uncomplicated relationships with food were few and far between. I was curious and reading about Buddhism at the time, and the repetitive linking of craving with suffering in these texts made me pause. There seemed to lie therein a link with the kind of bodily suffering that I had been noticing more and more throughout my personal and professional life. In the clear descriptions of how craving operated, there seemed to be a potential for release from these circuitous discussions and the incapacitating overload of information and emotions about what to eat. At the outset, I

intended with this dissertation to explore Buddhist notions of craving in order to see whether they could be of any relevance to obesity.

Through this research, I learned how exceptional (i.e., not the norm) my mother was in her influence in singlehandedly managing the eating of her family. The powerful, interconnected systems of healthcare and food production exert tremendous control over the eating of many, requiring taxing effort to resist. My hope is for this work to engage well-articulated Buddhist ideas about craving, suffering, and the interdependence of phenomena to illuminate some new ways of thinking about how we are enmeshed in pernicious cycles of craving, making eating—our basic form of sustenance—a matter of painful complication. I have learned about the many systems that perpetuate painful relationships to food, and also about people within the same context who have achieved freedom from these painfully limiting patterns. Through acknowledging, addressing, and reversing craving-motivated cycles, our healthcare institution can begin to bring about some of the guidance and healing that patients seek, and many providers hope to provide.

Defining key terminology and concepts

Biomedicine

In this work, the term *biomedicine* (also called Western medicine or allopathic medicine) refers to the system of healing that is considered the standard or mainstream medical treatment within my fieldwork context. Biomedicine operates on the basis of specific diagnostic categories that are applied to problems, informing the types of

treatments that are administered to patients. Biomedical practice is highly specialized, with each provider typically attending to one aspect of the body. Compared with other forms of healing, biomedicine is technocratic and interventionist, favoring procedures over an understanding of the interconnection between health and lifestyle. Nevertheless, there are some subfields within biomedicine, such as functional, integrative, and holistic medicine, that resist the standard, super-specialized biomedical frame.

Food attachment

For the purpose of this dissertation, I define food attachment as an inordinate preoccupation with food that has a detrimental effect on one's life (relationships, finances, health). Here, I am not using a pre-existing biomedical definition, but rather using "attachment" as a provisional term, an *ad hoc* analytical category. I use a particular word ("attachment") in order to label a notion of destructive preoccupation because it usefully aggregates an array of mental processes that are not fully flushed out in biomedicine's descriptions of various disease pathophysiologies, yet these processes are increasingly understood as a driver in many of the most salient problems facing the biomedical system today. The term "attachment" is selected because it provides an easily understood link between other categories that are discussed in biomedicine: health and frank diseases (e.g bulimia, anorexia, binge eating). The concept of attachment connects an area of theoretical limitation in biomedicine with a highly developed body of ideas in Buddhist thought.

The limitations of operating within fixed disease groupings without treating the corresponding mental processes preceding full-blown disease has been recognized in certain branches of biomedicine. Contemporary research on the “transdiagnostic theory” (Fairburn 2003) of disordered eating stems, in part, from the recognized ineffectuality of conceptualizing treatment from within pre-existing disease categories. Traditionally, addressing disordered eating within the biomedical system depended on first placing an individual within a diagnostic category. Diagnoses such as anorexia nervosa, binge eating disorder, bulimia, and orthorexia nervosa (pathological obsession with eating “healthy” or “correct” foods) were issued, and in cases that the patient did not fit squarely in one of the of the precisely defined constellation of symptoms, the diagnosis of eating disorder “Not Otherwise Specified” could be applied. Recent work in transdiagnostic models of disordered eating loosens (and sometimes facilitates the abandonment) of categorical models for understanding disordered eating.

The transdiagnostic theory seeks to understand the causes and results of complications in eating behavior across diagnostic categories. In other words, the theory “is concerned with the psychopathological processes that account for the persistence of the full range of severe eating disorders” (Fairburn 2003, 510). The authors found similar underlying psychological mechanisms operating in what were previously understood as distinct disease entities. According to Fairburn et al., “in the case of eating disorders shared, but distinctive, clinical features tend to be maintained by similar psychopathological processes (Fairburn 2003, 509). The research results show that over time, patients do not remain within one diagnostic category but rather that the destructive

thoughts and behaviors about food manifest as different diagnostic categories throughout a lifetime.

According to the researchers, “The significance of this migration of patients across the diagnostic categories of anorexia nervosa, bulimia nervosa and the atypical eating disorders has received surprisingly little attention” (Fairburn 2003, 520). They go on to argue that “*common mechanisms are involved in the persistence of bulimia nervosa, anorexia nervosa and the atypical eating disorders*” (Fairburn 2003, 520, italics original). The factors described by these researchers are over-evaluation of eating, shape and weight, and their control. Beyond research on disordered eating, this highlights a move to understand and treat processes that are shared between distinct diagnostic categories.

In fact, part of the authors’ treatment paradigm shift includes treatment in which “the patient’s specific eating disorder is not of relevance to the treatment” (Fairburn 2003, 522). Understandings of the interrelated processes that externalize as diverse diseases allow for more sophisticated treatment paradigms aimed at the underlying mechanisms, rather than superficial presentations of eating related illness. The concept of food attachment facilitates discussion of a set of thoughts, concepts, mechanics, and behaviors that contribute to diverse disease, a need increasingly recognized in biomedical research.

By my definition of food attachment as a degree of preoccupation with food that detrimentally affects one’s life, a significant cross-section of society suffers from food attachment and related illnesses. This is intentionally a broad, wide-sweeping definition. I define food attachment this way, rather than listing specific criteria that can be used to

include and exclude individuals with precision, because utilizing an expansive definition, while precluding formal clinical diagnosis, enables two things: (1) a clearer understanding of the processes that constitute various manifestations of food attachment, and (2) awareness of parallels between different types of dis-ease (mental and physical) borne of complicated relationships with food.

The issue of what constitutes problematic eating is of course highly subjective, but the ethnographic research methodology is suitable for its genuine investigation. Specifics about ethnography and its role in this work will be addressed in the “Methods” section of this chapter. Certainly, the quantitative disciplines have clear-cut definitions of what is “normal” and what is “abnormal” (and thereby problematic). This categorization does little to facilitate responsiveness to the intricate mechanisms enmeshing real, complex individuals within their patterns and behaviors.

Mindfulness

In this dissertation, I define “mindfulness” as a specific quality of awareness. Mindfulness is discussed in many spiritual traditions; however, the most prominent leaders of movements popularizing mindfulness in the US attribute their findings to Buddhist thought. Jon Kabat-Zinn, founder of the Mindfulness-Based Stress Reduction (MBSR) clinic at University of Massachusetts, said “American mainstream mindfulness is described as non-judgmental awareness of the present moment” (Kabat-Zinn 1994). In the US, it is typically a skill that individuals cultivate through mindfulness meditation

exercises. Chapter 6 contains an extended discussion of the foundations and uses of mindfulness in the clinical and Buddhist contexts.

Conceptual debates

Whether obesity is a disease and whether food can be an addiction are two highly contested debates; however, while they will be acknowledged here, they will not be resolved in this dissertation. Both questions factor prominently into discussions of obesity in contemporary biomedical and anthropological literatures, as well as in the popular media. The first pertains to whether obesity (having a body mass index above 30.0) necessarily portends categorically negative health outcomes for obese people. The second relates to whether food addiction falls within technical biomedical definitions.

While these are salient—and inescapable—questions for academics and study participants alike, their framing proves problematic for a number of reasons. First, taking the individual human body as the unit of analysis assumes a particular individualistic, empirical ontology that underpins the biomedical system. This assumption will be challenged in this dissertation through examination of ideas such as the Buddhist concept of the Law of Dependent Origination (also known as dependent arising). Second, insistence upon specific positioning within biomedical diagnostic categories asserts the dominance of biomedical (precise, exact, categorical) conceptions of diseases. In the next section, I will discuss some of the salient features of these debates, which are part of the cultural background of the discussions in this thesis.

Obesity as disease

The necessity of investigating biomedical interpretations of obesity in this ethnography stems from the hegemony of these understandings throughout influential institutions: medicine, corporate America, media, etc. In the 1980s and 1990s, mainstream social rhetoric portrayed fat as bad, harmful, dangerous, and irresponsible. Subsequently, biomedical discourses in the media and in individual clinical encounters transmit certain “truths” about eating and obesity. As biomedical discourse has unequivocally promoted the idea, in various forms and articulations, that “fat is bad,” major public health campaigns dedicated to decreasing weight and increasing physical exercise are described as matters of dire national importance. Medical institutions, such as Stanford Health Care, define obesity as a disease in itself: “Obesity is a serious, chronic disease that can have a negative effect on many systems in your body” (SHC 2017).

More recently, fat activism and fat acceptance movements have decried framing obesity as inherently detrimental to health, challenging both the social and biomedical status quos regarding obesity. These efforts include insistence upon reexamination of the facts comprising the biomedical stance. Statements such as “Fat but Fit” and “Health at Every Size,” urging abandonment of weight loss and instead adopting lifestyle changes for well-being, spurred a wave of research publications and media headlines such as “Fat but fit is a big fat myth” (BBC 2017) and “It’s impossible to be ‘fat but fit’, study of 3.5M people finds” (Fox News 2017). These discussions cite a study, conducted by Dr. Rishi Caleyachetty at the University of Birmingham, that concludes that people who are “healthy obese” (pertaining to the medical category of “metabolically healthy obesity”)

are still at higher risk of heart disease and stroke compared to the general population. The study is under peer review at the time of this writing, and the published study is forthcoming.

Discussion of fitness and metabolism raises important questions about the relationship between obesity and physical exercise. It is critical to note here, at the outset of this dissertation, that any discussion of obesity that does not include physical activity is inherently limited, as eating is only one part of the energy balance. However, while physical activity is critically important to discussions about systemic solutions to obesity, it is outside of the purview of dedicated discussion in this dissertation.

Food as addiction

The question of whether foods can be addictive manifests two underlying concerns: therapy and agency. While the categorization of certain foods as addictive might have relevant treatment implications within the biomedical paradigm, assigning obesity the status of an addiction manifestation does not further nuanced, careful consideration of the problematic attachments that can form around eating. Focusing on formalizing the status of certain types of eating as addiction or nonaddiction forms a false dichotomy within which many powerful parties have vested interests. It is not in the interest of food manufacturers, particularly those who produce Highly Palatable Foods (HPFs, foods engineered to contain particular ratios of fats, sugars, and salt that trigger brain reward systems and increase food intake), for food to be considered addictive, while certain biomedical institutions such as weight loss and bariatric interventions stand

to profit substantially by enfolded eating addiction into treatment paradigms. Like the health implications of obesity, various facets of the “food as addiction” conversation will provide critical context for traversing between medical texts, clinical interactions, and lived experiences: namely, what constitutes an addiction, what forces facilitate strengthening attachments to food, and what are the most effective ways to manage detrimental cravings to food.

Bounding Buddhism(s)

In order to form the Buddhist analytical lens most relevant to my participant group, I allowed ethnographic data to guide the types of literature that would be included. This was an opportunity “to follow the flows [of US Buddhism] wherever they lead” (Tweed 2015, 23). Participants in the ethnographic field site (who will be described in detail in the forthcoming “Methods” section) intermediated between local practices of Buddhism and biomedicine, so the types of texts that most pervaded their practices, serving as textual authorities for local practitioners, merited analytical consideration. To this end, I ultimately endeavored to construct a cohesive, relevant account of Buddhist principles that maintained integrity to the *major* Buddhist foundations that remain consistent between the various traditions, and that surfaced time and again in readings and teachings at Common Ground Meditation Center. Concepts such as the Four Noble Truths, the Noble Eightfold Path, and the Law of Dependent Origination, for example, are ubiquitous in their appearance throughout various forms of Buddhism.

The majority of the texts referenced by Common Ground participants and in the *dharma* talks fall within the Western Insight Meditation (Vipassana) tradition. I incorporate ideas from texts written by the founders of this movement, finding them useful in their accessibility to lay Buddhist practitioners and medical practitioners, as well as their salience to Common Ground practitioners. In general, I rely most heavily on Insight Meditation texts that stem from the Theravada branch of Buddhism, because these texts are available in English, are relevant to my study population, and are the medium by which Buddhism has been transmitted into the two realms I study.

Here, some information about *vipassana* (insight) meditation serves as useful context. In *The Origin of Insight Meditation*, Lance Cousins writes, “It is easy to get the impression from reading the literature that the principal form of meditation current today in Theravada Buddhism is a particular type of insight meditation (*vipassana*) one which is keenly recommended by adherents” (Skorupski 2004, 35). Indeed, my fieldwork did leave me with the impression that *vipassana* was the Buddhism most relevant to this ethnographic context. In describing the prominence of *vipassana* (as well as Zen) in the modern-day United States, Sharf says, “The reason for their stature in the West is no mystery: partisans of both *vipassana* and Zen have been largely responsible for perpetuating the image of Buddhism as rational, humanistic, contemplative creed that eschews magic and empty ritual. And it was this image of an enlightened spirituality based on experience rather than faith that attracted many scholars to Buddhism in the first place” (Sharf 1995, 233). Indeed, both the “rationalism” of this modern Buddhism and the lack of inclusion of what is perceived as “empty ritual” are precisely the

characteristics that allow for this form of Buddhism to have relevance in my ethnographic sphere, and to have potential within the biomedical sphere.

In his work, Sharf outlines both the history and the key characteristics of what he calls a reform of Buddhism. Regarding the latter, he writes, “In brief, the Theravada reform emphasized: (1) the values of individualism, which included the affirmation of worldly achievement coupled with “this-worldly asceticism;” (2) a rational or “instrumental” approach to Buddhist teachings, which often involved the repudiation of the “supernatural” or magical” aspects of Buddhism, the rejection of “empty” ritual, and the insistence that Buddhism is a “philosophy” rather than a “religion;” (3) a new “universalism,” accompanied by a rejection of the authority of the clergy; and (4) a renewed interest in the scriptural legacy of Theravada Buddhism” (Sharf 1995, 252). (4), he argues, was facilitated by Western Orientalists. The Theosophists, lay Buddhists who functioned outside the temples and monasteries, also played a key role in the proliferation of vipassana.

Lance Cousins also traces the history of the propagation of vipassana meditation. In his piece *The Origin of Insight Meditation*, he selects the school Mahāsi Sayadaw as his archetype of a vipassana training center because “is perhaps the most influential single school at the present time and, more importantly, is probably one of the more extreme in its advocacy of insight and distrust of concentration” (Skorupski 2004, 42). The school advocated for a direct path into insight, rather than insisting upon prior cultivation of skills in concentration and achieving meditative trance. This was a departure from preceding Buddhist traditions. Cousins writes, “In the Canon the development of insight after the *jhānas* is certainly the normative pattern, where a full

process is described at all” (Skorupski 2004, 56). Sharf also elaborates on the role of the Mahāsi school in developing the vipassana method. He says, “For our purposes it is only necessary to highlight two features of Mahāsi’s teaching: first, Mahāsi’s technique claims to provide the practitioner direct entry into the path of *vipassana* (insight into the Buddhist truths) without the need for prior training in concentration exercises (*samatha*) or mastery of advanced states of meditative trance (*jhāna*)” (Sharf 1995, 253). The process of reaching significant results with Mahāsi’s methods are also said to be very quick, often less than a month.

According to Sharf, “The claim that *nibbana* can be reached in the course of a month or less is truly remarkable, given the widespread view among the traditionalists that it is almost impossible for anyone to become an *ariyapuggala* in modern times. Aside from these significant methodological departures from traditional Buddhism, “Mahasi Sayadaw provided the Theravada world with more than simply an easy-to-learn meditation technique; he also provided a model of an urban meditation center that became a catalyst for the spread of meditation among the laity” (Sharf 1995, 256). His techniques and meditation center model continue to serve as the archetype for many western *vipassana* centers.

This dissertation examines and applies a “Buddhist framework” or “Buddhist lens.” Also to this effect, I use the phrases “Buddhist philosophy” and “Buddhist ideology.” As these are key constructs with a variety of potential interpretations, this terminology requires further delineation here. Spaces within my academic (Oxford, UK) and research (Hennepin County, US) sites regularly invoke Buddhism as a secular practice divorced from ritualism. However, this characterization

oversimplifies the traditions and practices that arose from the Buddha's teachings. Buddhism's long-established practices are broad, spanning myriad religious and philosophical traditions. In the US, Buddhism has not been static but dynamic, having a highly contested identity, and has been considered a "vital religious movement" (Prebish 1999, throughout). The question of what constitutes an American Buddhist forms the core of extensive scholarly debate, and the discussion evolves as various Buddhist values continue to collide with the ethics of American modernity. In this dissertation, I have chosen to lean heavily on a body of Western (primarily Vipassana) interpretations within the expanse of Buddhist literature. Failure to explicitly position this work amidst the complex traditions ensconced within terms such as "Buddhist thought" would fundamentally misunderstand the particularity of conceptualizing Buddhist practices in utilitarian terms (as in secular mindfulness) and as a set of ideas that can be secularized and Westernized (Western Vipassana) amidst the immense diversity of distinct, yet related, Buddhism(s).

Articulating a cohesive framework of "Buddhism" that would be meaningful in my ethnographic context proved an iterative process. I began by examining secondary literature during my Master of Studies (M.St.) course in the Study of Religion, under formal instruction by Stefano Zacchetti in the Faculty of Oriental Studies at the University of Oxford. This study involved weekly tutorial papers covering a wide range of fundamental topics within the Pali Canon. This academic phase concluded with a master's thesis I wrote about Buddhist notions of craving and the implications of these notions in understanding the obesity epidemic.

A major limitation of this period of study was my lack of training in the languages required to read primary Buddhist texts (e.g. Pali, Sanskrit, Chinese, etc.). I also did not follow a demarcated Buddhist tradition (in terms of geography, chronology, tradition, or lineage). While this decision precluded some depth of understanding, it was deliberately undertaken in consideration of ultimate research aims of deep interdisciplinarity.

After submitting and defending my master's thesis, I constructed a literature review for this doctoral dissertation. In this work, I endeavor to be "bilingual" in two frameworks (biomedicine and Buddhism) and to examine the contours and limitations of both. Taking the language analogy further, "conversations" between these epistemologies requires flattening of some of the nuances or "dialects" contained within each, both from the pragmatic perspective of what an academic work of this scale can encompass, and in considering which level of particularity enables the most conceptually useful analysis. It soon became apparent that, again, following linguistic, historical, or traditional lines would not be most effective in ascertaining a system of ideas sufficiently broad and translatable to meaningfully interact with contemporary urban Americans. Outlining a coherent (albeit flattened) outline of Buddhist ideas in the early chapters of this dissertation, which then serve as the backbone of analysis in the latter chapters, required a discriminatory process for considering which type(s) of texts warranted inclusion. Given the aforementioned language limitations, I rely on translations and secondary literature to establish the system of ideas that comprise what I refer to as the "Buddhist framework." At times, I incorporate imagery or examples from a particular tradition (e.g., the Hungry Ghost concept, most prevalent in Chinese Buddhism and Taoism), but these are integrated for illustrative, rather than analytical, purposes.

Methods

This project compares the lived enactments of Buddhism and biomedicine, two distinct philosophies. During this study, I was immersed in two (interrelated) cultural environments, which provided a nuanced understanding of the enacted ideologies, relationships, and stakes in each of these systems, as well as the ways in which they influence and mutually reinforce one another. This research employed ethnographic field methodology. Ethnography—the study of culture through simultaneously participating in and observing a community (a method known as participant-observation)—proved a particularly suitable framework for this type of investigation for a number of reasons.

Since food and eating served as the topical entry point for investigation of deeper issues of craving and the systems that accelerate it, this project required a methodology that would be expansive enough to allow for investigation of the myriad, sometimes unforeseen, influences on how and why people make particular food decisions. This necessitated a qualitative approach that attended to action (eating and behaviors), interpretations (the way people process and describe their behavior), and influences (the myriad contextual factors affecting action and interpretation). Ethnographic fieldwork afforded opportunities for robust observation of the subtleties of eating behavior through participation in the daily life of the clinic, hospital, and Buddhist center. My ethnographic research also included semi-structured interviewing, casual interactions around town, and shared meals with both medical patients and Common Ground practitioners.

During 14 months of participant-observation, I lived in Hennepin County,

Minnesota in close proximity to the institutional foci of this research: Common Ground Meditation Center, Hennepin County Medical Center, and Whittier Clinic. Before beginning this fieldwork period, I obtained formal ethics approval from both the Minneapolis Medical Research Foundation (#14-3855, approved January 12, 2014) and the Oxford Tropical Research Ethics Committee (OxTREC) (#551-14, approved November 13, 2014). In accordance with standard ethical practices, reasonable measures were undertaken to protect participant anonymity: names have been changed and participants deidentified. The exclusion criteria for the study, as outlined in my Institutional Review Board (IRB) application, were as follows:

Participants must speak Spanish or English as their primary language (due to the principal investigator's language limitations). Vulnerable populations as defined by the MMRF (Minneapolis Medical Research Foundation) Institutional Review Board or by CUREC [The Central University Research Ethics Committee, University of Oxford] will not be included in this study. Only participants over the age of 18 who are capable of consenting for themselves will be recruited for the study. (Sury OxTREC 2014)

No vulnerable populations (children, pregnant women, prisoners) were approached for the study, and financial incentives were not provided for participation.

In addition to the formal ethics approval processes, I discussed the scope of the project and obtained permission from the leadership of Common Ground Meditation Center to conduct research within the Minneapolis meditation center and the rural retreat centers. In these spaces, unlike in the medical context, research is less common, so the terrain for standard research practice is not as clearly charted.

During the participant-observation period, I inhabited the public spaces in close proximity to the aforementioned institutions as frequently as possible, with the aim of developing the broadest possible perspective of the ethnographic context. Within this

comprehensive milieu, I utilized several specific techniques in order to ascertain particular types of information. I arrived upon the approaches that I ultimately used to collect and synthesize field notes during daily participant-observation through a combination of studying field techniques (with the book *Writing Ethnographic Field Notes* [Emerson et al. 2011] serving as an invaluable resource), reading about approaches to fieldwork in the methods sections of ethnographic monographs, and using trial and error to see which methods allowed sustainable documentation of observations that I made during this time period.

I typically carried a small notebook throughout the day and jotted down key phrases about observations, conversations, and images that caught my attention. I found abbreviated note-taking to be more practical than recording extensive real-time notes due to the sensitive nature of many of the interactions (medical and meditative) I was observing. Writing extended notes often felt intrusive when participants in the healthcare setting were relaying intimate, personal details about their health. Participant-observation at Common Ground presented a different challenge for real-time note taking: the sound of a pen scratching was conspicuous in an otherwise silent room, drawing attention to my presence. To avoid these intrusions, I wrote brief phrases during the day and aimed to translate short-form notes and annotations into extended annotations on a daily basis. I found that waiting more than a few hours to transcribe observations resulted in hazier, less descriptively compelling impressions because so many of the observed nuances dulled over time. I analyzed and synthesized these extended field notes on a regular basis, compiling them into brief field reports, which I sent to my supervisor, Dr. Hausner. We discussed various analytical themes as they arose.

Silence and the consequent limitations of nonverbal communication complicated fieldwork within the meditative spaces. During this time, the focus for participants was private and personal, and the usual access points to the subjectivity of others (speech, interaction, play, etc.) were precluded by the social structure of meditation. Pagis, who conducted ethnography at Vipassana meditation retreats, in which “it is about silence: silence in meditation courses, silence during meditation, silence regarding participants’ experiences and progress,” wrote, “for the ethnographer, this silence soon turns into a methodological obstacle. Every ethnographic study includes a dimension of entering the minds of others” (Pagis 2010, 310). Conducting ethnography in largely silent spaces indeed produced unique obstacles. I turned to anthropological literature on the intersubjectivity of silent spaces to facilitate a better understanding of the analytical capabilities and limitations of analysis that occurred within silence (Goffman 2008; Pagis 2010).

The necessity of attunement to the semiotics and interpretations of unspoken exchange required by meditative spaces later proved surprisingly useful in ethnographic spaces in which spoken word is the more obvious point of entry into subjective experiences of others. Attunement to the nonverbal afforded insight into multiple levels of detail easily overlooked amidst the words. However, I appreciated opportunities to challenge assumptions I made during these silent observations through conversation with participants. Ultimately, I found that alternation between observation and conversation facilitated iterative arrival at conclusions that accurately reflected the experiences of participants. I frequently followed up with people after meditations or retreats for semi-structured interviews, where we could discuss our experiences of what had occurred

during previous silent times and confirm or test the assumptions I had during silent participant-observation before these assumptions formed the basis for analysis.

Gathering information

In order to arrange the semi-structured interviews, I approached participants in the field site who said or did something that caught my attention. This occurred in a variety of circumstances: after a meditation session, following the completion of a silent retreat, in the waiting area of the clinic. In the clinical context, the main challenges involved approaching strangers who were in the space for a specific purpose (a clinic appointment) and asking them to direct their time to a project in which they were often not interested. Patients were often on cell phones in the waiting room, and it was awkward to interrupt people who appeared busy or very ill.

When a patient did seem willing to participate, I gave a brief overview of the project along with the participation consent form and asked whether they might be willing to meet for a more extended discussion. The consent form contained specific information about the research and details about what participation would entail, including the risks and benefits of participation. I also requested meetings with people who were influential in each of the ethnographic spaces, either through a position of leadership or through a level of involvement, for more formal discussions. For example, I met with the guiding teacher and involved participants at Common Ground, and interviewed several physicians working in addiction medicine, psychiatry, and family medicine.

For each semi-structured interview, I came to the conversation with a list of questions. These included open-ended questions about the participant's family life, what had brought them to the clinic or the meditation center, and their past and present eating habits. Conversations often deviated far from the questions I prepared, and tended to be largely guided by the participant. I strived to remain broad-minded in considering which types of information might be relevant, and rarely redirected conversation topics that participants wanted to discuss. This meant that the semi-structured interviews were lengthy, generally between one and several hours. Some were one-time meetings, and others evolved into key-informant relationships. In total, I conducted about 20 semi-structured interviews with biomedical patients and practitioners and had approximately 25 conversations with Buddhist participants. I specifically sought a subgroup that overlapped between these two realms: patients and medical practitioners who also practiced Buddhism. In the biomedical context, I spoke with patients, doctors, and medical trainees in the hope of ascertaining divergent perspectives on medicalization through discussion with participants with varying types and levels of involvement in the biomedical realm.

I usually arranged for initial meetings to occur at cafés and restaurants. On several occasions, a participant invited me to his or her home for tea or for a meal. The presence of food during an interview facilitated conversation about food and related topics, and illuminated unspoken behaviors and preferences (sometimes as simple as offering to share). I usually asked to record these conversations on a voice recorder, and later transcribed the interviews. I used NVivo software in order to code the interviews and to extract ethnographic themes. As the purpose of the coding was to ascertain major themes

for my own analysis, rather than to quantify the qualitative data, I did not recruit a second coder.

In addition to using these qualitative methods, I asked participants to complete a quantitative survey on their level of food addiction (the Yale Food Addiction Survey, used with permission of Dr. Ashley Gearhardt). The survey served as a starting point for discussion in the semi-structured interviews (as patients often had follow-up questions or comments after completing the survey), and also provided a way to roughly cross-check my qualitative analytical conclusions. This quantitative data is available for me to analyze for future projects.

Positionality

Arthur Kleinman, arguably the father of medical anthropology, wrote in his book *Writing at the Margins* (1997), “I occupy the margin not out of refusal to choose sides, but because I am bound to both, and at the point of their engagement, in order to discover what they are (or are not) and I am, or am not” (3). In intentionally occupying two epistemological spaces in an effort to understand their possibilities and limitations in understanding craving, I indeed felt bound to both.

My dual role as a medical student, then resident and ethnographer created a unique positionality in the biomedical spaces. The most obvious benefit from this was straightforward: access to the entirety of the medical institution, including the physical spaces, personnel, resources, and power. This overcame a challenge articulated by many anthropologists working in the medical setting. Gaining access to key personnel was also

relatively easy, as I was perceived both as “one of them” (as a medical student), and an uncritical party (as a learner/trainee), which eased potential tension and invited openness of communication with medical personnel. When recognized as a medical student, I was unquestioningly invited into restricted areas and into patient interactions.

However, these dual roles within the same space during the same time frame necessitated assertive self-identification (Jacobs-Huey 2002). I had to be very clear with both providers and patients when I was purely at the hospital for research that my role was as a researcher and not as a medical provider, meaning that I would not be involved in patient care during certain research periods. Proactivity and specificity were required to ensure that the patients did not feel obligated to allow me into their private spheres, thinking that their care would be contingent on talking with me. Depending on the doctor with whom I was working, maintaining that I was present purely in an observer role occasionally proved tricky when it interfered with their expectations of me.

Sometimes, I was at the hospital as a medical student but wanted to write research observations. Medical student days at Hennepin County Medical Center were long. My role, as per most medical students, was often ambiguous. Swaths of time during which I did not have specific obligations yet was required to be at the hospital were ideal opportunities for observation, but my attention was split between attention to the minute details required of clinical practice and more social and systemic ethnographic observations. Additionally, my observations during my role as a medical student were marked by the power hierarchy in which I was explicitly a part. I was aligned with the “care team,” the powerful side of the clinical interaction, and these interactions were not on my own terms regarding time or content. However, my role as a medical student on

the wards often rendered me somewhat invisible, sanctioned to be within the space, fitting within the intellectual parameters and expectations, and yet often perceived as harmless.

In terms of positioning my “voice” in relation to the participants in the study, it is important to recognize that I have been trained or “formed” in the biomedical tradition alongside anthropological study, meaning that my biases and blind spots are likely more pervasive than those of an anthropologist who has not been so disciplined through biomedical training. During the latter part of the write-up phase, I began my internship training in emergency medicine, meaning that some of the latter analysis occurred while even more all-encompassingly immersed (often upwards of 80 hours per week) in the biomedical setting. This surely affected my self-reflexivity with regard to the medical system, as I experienced firsthand the fatigue and demoralization that resulted from the rigors of the residency training schedule. At the same time, I was also regarded as a more critical part of the patient care team and began to be privy (as an employee) to the institutional communications, providing a greater depth of exposure to the inner workings of a US hospital and the modes of training, as well as the content of communication, that form medical trainees.

The participant–observer dynamic was much more straightforward in the Buddhist context, where the setup lent itself easily to silence and observation. However, this dynamic also shifted gradually throughout the duration of my involvement. On the first few retreats I attended, my time felt split between multiple agendas as I went back to my room and wrote and typed notes while others (presumably) rested, meditated, and read books relating to the *dharma*. As time went on, I began to value more immersive

involvement with the retreats, doing less writing during them, and expanding my participation in retreat activities.

Overall, the trajectory of my involvement in both the biomedical and Buddhist spheres arced from the observer to the participant side of the spectrum over the course of my fieldwork and writing. The lines between “self” and “other” blurred as I became more enmeshed in each of these research contexts. The deepened perception of being on the “inside” of both contexts increases both the extent of access and potential bias. This bias became the object of analysis during the write-up phases of my work, will be discussed in Chapter 7, and in turn has informed my clinical practice.

Dissertation structure: Chapter outlines

In Chapter 1, I have laid out the methods by which the literature study, ethnography, and writing processes were conducted. Key concepts and debates about obesity and addiction have been discussed. Chapter 1 has positioned this work amidst existing research, articulating its analytical aims. As an interdisciplinary work cutting through several branches of knowledge, this chapter has articulated the contours of the work, acknowledging several fundamental tensions.

Chapter 2 will examine the interrelated cultural structures that influence the way people in the field site approach food. Historically limited by availability and culture, eating in the US has become an unregulated enactment of individual values each time one considers eating. The role of cuisine in regulating eating and the intricacies of eating that disproportionately burden women will be elaborated in this chapter. Food advertising

both depends upon and exploits the absolute uncertainty experienced by Americans about what to eat.

Chapter 3 will investigate the orientations of biomedicine and Buddhism with regard to craving, attachment, and addiction. By outlining the foundational assumptions that comprise epistemological structures of each discipline, I will explain the function of each in understanding the mechanisms underlying eating and other detrimental behaviors that are held responsible for vast human suffering in this ethnographic context. In this chapter, I will discuss how fortification of the sense of a self with personal problems in need of fixing attenuates potential for liberation from suffering from the Buddhist perspective. I will also examine the potential overlaps and the divergences between the theoretical foundations of these two systems.

Chapter 4 uses medical ethnography to illuminate the relationship among biomedical texts, interactions, and enactments. By including observations of discussions in the clinical context, and then broadening the scope of observation to the personal lives of patients outside the clinic parameters, I will provide a mechanism for following the translation of biomedical “fact” (texts and teaching) to the lives of patients who are experiencing food-related difficulties. This chapter will emphasize that medicalization of food is one corollary of the breakdown of cultural eating regulation. The result is that patients seek eating advice that biomedical practitioners are not trained or comfortable to provide. The tensions that result from this mismatch of expectations will be discussed within this chapter.

Chapter 5 will explore the ethnography of the Buddhist center, which will provide a window into the lived experiences of individuals in Hennepin County who are

purposely engaging in an “alternative” epistemology within the same capitalist milieu that influences biomedical patients. The transmission of Buddhist texts and teaching informs a view that diverges from that of the self as a separate entity, while rituals reinforce teachings through retreat and personal practice. Buddhist practitioners describe changes in their worldview as the instigating factor for behavior change, rather than an extraction of Buddhist practice such as mindfulness training.

Chapter 6 will track the secularization of mindfulness and its implementation into the biomedical sphere. Mindfulness interventions have been increasing in both prevalence and popularity, and are a common feature across corporate and healthcare settings. I will argue in this chapter that these mindfulness interventions are structured in a self-limiting manner, in contrast to the expansive potential of adapting ethical frameworks described by participants in Chapter 5. In essence, secular mindfulness interventions are subsumed within the capitalist logic of affecting change in a “self” using a “minimal therapeutic dose,” ideas of efficiency and atomization that stand at odds with the mechanisms that affect behavior change in the Common Ground space.

Chapter 7 will describe the interrelated hegemonic systems that facilitate craving within this ethnographic context. The chapter will use autoethnography to elucidate the ways in which these interrelated systems function to limit caring capacity during medical training. This chapter will ultimately argue for the incommensurability of remaining beholden to profit-driven corporations with addressing craving at the root level required to alleviate suffering.

Chapter 8 will discuss ways in which the biomedical system facilitates fear, which in turn strengthens craving. I will then examine possibilities for transforming behavior

change motivation from fear to an inclusive, holistic, nonself-centered view. This chapter will synthesize several of the main ideas discussed in this dissertation.

Chapter 2

Eating: An individual's responsibility within a system of pressures

For days, conversations with my patient Louise consisted of speaking to her and hearing only the beeping machinery of the intensive care unit in response. Following her major abdominal surgery, heavy folds of fat strained at her surgical incision from either side, causing the wound to separate in a healing failure known as wound dehiscence. Obesity is a major risk factor in this surgical complication, and Louise's condition was further compromised by an infection that started in her wound and overwhelmed her body, necessitating intensive care. Upon regaining consciousness one morning, her first response in our conversation was, "Can you get me a bag of Flamin' Hot Cheetos?"

In the Tibetan Wheel of Life (a popular Mahayana visual depiction of the cycle of existence) the hungry ghost (*preta*) is an image of excessive attachment. In these depictions, the ghost is portrayed as a teardrop shape, with a neck too thin to comfortably pass food. However, this does not stop the attempted fulfillment of desire by eating, despite the pain caused by ingestion. These beings are constantly driven to consume, and are unable to exist within a present moment free from their detrimental compulsions. To

me, Louise was like a human living in the realm of the hungry ghosts: literally unconscious, awaking to crave and consume a substance responsible for her physical pain.

In the Buddhist purview, human beings, unlike the hungry ghosts, are not beholden to these painfully binding attachments. All humans are subject to craving; however, unlike hungry ghosts cursed with a limiting physiology and mental capacity, humans can transcend cravings through concerted training of the mind.

Louise clearly suffers physically from the physical manifestations to her extreme attachment to food. For other patients in Hennepin County, the parallel is subtler. Yet many patients intuit in their behaviors hints of the pain-inducing attachments represented by the hungry ghosts. These insights are invoked in patients' pained descriptions of their various issues: Eating foods despite the excruciating spasms of the bowels that follow; drinking alcohol until the poisoned body begins vomiting; eating massive meals despite an intimate familiarity with the deep sluggishness that follows, and counteracting the sluggishness with caffeine, resulting in shaky hands and racing hearts. Such consumption cycles cause, for many, a sense of dis-ease and discomfort long before manifesting as diagnosable diseases.

In this chapter, I explore how the relationship between so many Americans and their food became so fraught, complicated, painful, and disease-inducing. I examine the types of systems that previously bound the ways in which Americans ate. While these have historically included natural constraints (such as seasonal and regional availabilities of foods), my focus here is on social systems, such as cuisines and religious regulations, that served to circumscribe eating. The dissolution of these systems in the contemporary

urban US, and the stark individualism of eating-related decisions, produce a state of high anxiety regarding food decisions. This tension is more pronounced for women, who typically assume a more central role in feeding their families, thereby taking on more nutritional responsibility than men for food decisions. Additionally, as women face inordinate social pressure regarding weight as it relates to their physical appearance, food contains much higher-stakes relevance in a woman's enactment of both her morality and her identity.

Obesity as one manifestation of food attachment

Obesity is considered here as one widely discussed expression of what is theorized to be, in part, a problematic attachment to food. In this context, in which obesity proves problematic at the level of the individual, (equating obesity with personal difficulty), the medical institution (associating obesity with disease) and society (ascribing obesity major roles in economic loss and healthcare expenditure), it is essential to examine the various factors that facilitate overeating—one of the contributors to obesity. Previously predominated by solutions enacting linear cause-and-effect thinking to inform weight-loss interventions, the obesity research sphere has broadened in recent years to characterize obesity in systemic, rather than atomized, terms. Thus, the social and psychological dimensions of eating have come into the purview of obesity research and interventions. Consequent to efforts, such as the Foresight Report, a project that examines “how we can respond to rising levels of obesity in the UK” (Great Britain and Foresight 2007), that illuminate the immense complexity of factors contributing to

obesity, piecemeal interventions have fallen out of favor. However, alternative solutions to food attachment have not forged enough of a stronghold against the interconnected systems of food production and commercialization to produce an appreciable impact on the ever-expanding obesity epidemic.

While obesity is one of many potential eventualities of food attachment (see full discussion of food attachment manifestations in Chapter 1), it is by far the most pervasive, as well as the most widely discussed, in my ethnographic field site. This is likely connected to the percentage of the population that is obese, as well as the many biomedically identified links between obesity and disease. The Minnesota Department of Health has commented on the prevalence and corollaries of obesity, calling it “one of the most serious public health concerns facing our state today” (Minnesota Department of Health 2008, 3). The “Minnesota Plan to Reduce Obesity and Obesity Related Chronic Diseases” describes the effects that obesity has on both personal and economic impacts across various groups throughout the state, deeming that obesity is pervasive and growing in both prevalence and consequence, while the effects are wholly negative. The report sums up the issue of obesity as follows: “Simply said, we have an epidemic of obesity that is negatively affecting our health, our quality of life and our future. The clock is ticking; we need to act now” (Minnesota Department of Health 2008, 3). The departmental report calls Minnesota lawmakers and healthcare providers to action, stating that the incidence and prevalence of obesity-related disease in Minnesota mirrors the nationwide obesity trend, with a prevalence growing at an alarming rate over the past 25 years.

Within the medical context, attitudes in Hennepin County correlated with the

concerns articulated by the Minnesota Department of Health. Obese medical patients described in great detail the losses that they attributed to becoming obese, including social status and opportunities for sexual expression; self-confidence regarding romantic love; social prestige; the respect of others and consequent feelings of having to overcompensate for fatness; and economic opportunity in the cases of disease and disability. Though I engaged with the fat-positivity and the fat-acceptance movements on a theoretical level in researching this dissertation, the attitudes towards fat that I encountered in the medical context were largely negative, characterizing obesity as antithetical to health.

Throughout my medical training, many physicians described overeating and obesity as responsible for their most salient clinical challenges. Coronary artery disease, sleep apnea, depression, stroke, and type 2 diabetes are among the myriad diseases wherein obesity is one of the most serious risk factors. When I was working in the hospital as a medical student, the preceptor on my internal medicine rotation (one of our foundational training experiences) would routinely cross out the entire “Past Medical History” section, which was a list of the patient’s diseases compiled by interviewing the patient and painstakingly combing their medication lists. She would then replace the entire list with the word “OBESITY” scrawled in red ink in large capital letters. Despite the conspicuousness of obesity in the biomedical domain, physicians struggled to guide patients in losing weight and managing the diseases that medicine defines as an eventuality of obesity.

Innumerable theories explain the various facets of human proclivities to overeat. For example, the thrifty gene hypothesis posits that humans adapted to environments of

food scarcity, in contrast to the abundance of high-sugar, -salt, and -fat foods whose wrappers float around even the most impoverished streets in the US. This intermittent scarcity meant that human beings needed to be able to conserve energy during times of abundance in order to continue to live and reproduce even during times of food scarcity. As advances in technology and transportation allowed food constraints, such as scarcity and seasonal and geographic limitations on the availabilities of certain foods, to be surmounted, cultural regulators of eating behaviors became an important safeguard against consistent overeating.

Michael Pollan, an American journalist and activist, wrote extensively about the role of culture in regulating eating in his book *The Omnivore's Dilemma*. He explained human beings' confusion and difficulty in attempting to discern what is safe to eat as follows:

While our senses can help us to draw the first, elemental distinctions between good and bad foods, we humans rely heavily on culture to keep it all straight. So we codify the rules of wise eating in an elaborate structure of taboos, rituals, manners and culinary traditions, covering everything from the proper size of portions to the order in which foods should be consumed to the kinds of animals it is O.K. to eat. Anthropologists may argue whether all these rules make biological sense, but certainly a great many of them do, and they keep us from having to re-enact the omnivore's dilemma at every meal. (Pollan 2004, 3)

Cuisine, one example of a cultural mechanism that regulates eating, has proven critical in navigating the social and psychological complexities of eating. Cuisines provide guidance in the overwhelming landscape of deciding *what*, *when*, and *how* to eat.

Breakdown of cuisine makes eating a personal problem

The term *cuisine*, while vaguely intuitive, requires further clarification given its conceptual variability, ranging from a list of specific foods to approaches to cooking and attitudes binding the way food is eaten. Sidney Mintz, a preeminent anthropologist of food, has defined cuisine not only as a set of foods, but also a sense of authority borne of intimate familiarity with these foods. He wrote,

I think a cuisine requires a population that eats that cuisine with sufficient frequency to consider themselves experts on it. They all believe, and care that they believe, that they know what it consists of, how it is made, and how it should taste. In short, a genuine cuisine has common social roots; it is the food of a community—albeit often a very large community. (Mintz 1996, 96)

The salient features of cuisine as described by Mintz are the confidence borne of commitment to a specific kind of eating over time, and the sociality of a shared understanding of food within a group of people. Mintz (1996) elaborated on the social element: “I do not see how a cuisine can exist unless there is a community of people who eat it, cook it, have opinions about it, and engage in dialogue involving those opinions” (117). This notion of a cuisine specific enough to be socially embedded on such an intimate level necessitates the inclusion and exclusion of particular foods.

American eaters lack a cuisine, in the fullness of the descriptions discussed above. While there are certain foods that would be considered “American,” such as hamburgers, pizza, and fries, this selection of foods is not confidently treated as a cuisine. Mintz (1996) elaborated, “In the United States, people rarely talk about ‘American cuisine.’ If the term ‘cuisine’ is used at all here, it seems mostly to take on an ethnic or national character: French cuisine, Indian cuisine, Thai cuisine, Chinese cuisine” (94). More consequential than the absence of specific foods comprising American cuisine is the total lack of regulation or structure characterizing American eating. There are very few taboos

precluding eating in the US. Eating in the car, eating alone, snacking frequently between meals, and eating in front of the TV or computer screen are examples of permissible actions in the mainstream US that would be unacceptable in many cultural contexts. In other words, eating in the US is characterized by its individualism. According to Dr. Paarlberg, a professor whose research focuses on international agriculture and modern technology, “Individualism leads to eating behaviors less disciplined by social or family routines. Once modernity makes food ubiquitous and continuously available, unstructured eating and in some cases nearly continuous eating becomes a problem in individualistic societies” (Paarlberg 2015, 129). For people with near-constant high-calorie food availability, cuisine and culture serve as necessary boundaries around eating, but are missing from mainstream US culture.

Cuisine helps to navigate the potentially daunting tasks of deciding which foods to ingest and which to avoid. Throughout the course of the day, these decisions can be made dozens or even hundreds of times, and cuisine helps manage the amount of mental energy that goes into this onslaught of choices. Without cuisine, each decision about what to eat remains an open-ended question. Maria, a medical student who participated in this study, said of the exhausting complexities of deciding what to eat,

So *that's* what I'm so intrigued by, is that internal debate. Every time you decide to [eat] or not eat something. And so, you know, because sometimes [the decision of what to eat is] so easy. The debate is short and easy. And sometimes it's this horrible thing. And sometimes it's this thing where it's horrible, but you ultimately decide to make a healthy choice for yourself, and it's like this *crazy* thing.

Claude Fischler, a French sociologist and anthropologist, explained the role of a cuisine aiding dietary decision-making:

To identify a food, one has to “think” it, to understand its place in the world and therefore understand the world, and in particular to distinguish, order and classify the elements of which it consists. A culinary system provides criteria that can be used in these mental operations or provides, as it were, a prefabricated matrix. (Fischler 1988, 7)

Abiding by a culinary system achieves much of the “work” of understanding individual foods and their respective contributions to one’s overall diet and health. In other words, eating within a specific cuisine simplifies the complex calculus of deciding what and when to eat. French eating has been widely studied as an example of culinary stability. Despite the accelerated worldwide dietary shifts incurred in the past two decades of fast- and processed-food globalization, French eating remains, at least in the global imagination, a cohesive culinary tradition.

During my semi-structured interviews, Della, a 32-year-old Common Ground practitioner whose mother was born and raised in France, described her mother’s adherence to “the French way,” and how this shaped her entire family’s orientation towards food. The “French way” determined both the content and structure of what her family would eat. Della explained that her mother emphasized cooking with “natural foods, unprocessed, cook your own foods, that sort of thing.” In terms of *how* to eat, Della said, “I was going to say, the French are super structured.” She explained that it was very important to her mom for everyone to sit at a table to eat, and to eat together and only during particular times of day. There was a time and space dedicated exclusively to eating, and trying to combine mealtime with another task apart from focusing on the meal and the dining companions was not permitted.

Della continued, “And that’s one thing I was gonna say about my mom, she does follow the tradition. It was like... growing up, it was all about what they do in France.”

She said their mother would emphasize the French way of eating “Until we [Della and her younger sister] were rolling our eyes. It was like... it was so important to her, and it was so important to do it right. Whereas here [in the US], its like... yea... not so much.” Della still adheres to many of the values that her mother taught her through the structure of French eating, but finds that it is difficult to follow through with some elements of how her family ate since she is not around people who do not have the same disciplines about eating. Now, she often feels pressured to accomplish other work during her mealtime, without the protected time afforded by her family, who communally recognized meals as time away from other obligations. In terms of her family’s preference for fresh produce and whole grains, she explained, “with my family it sort of became second nature where nobody would have to think about eating much, but with friends everyone has different preferences and values and I don’t like to be the one to say ‘no’ all the time.” Della felt much more comfortable structuring her eating in a particular way when it was in the company of others who shared the same understanding of what and how to eat, where she did not act as a solitary enforcer.

Fischler’s (1988) explanation of French dietary practices mirrors the experiences that Della described with her family. Fischler (1988) wrote that the French diet consists of a highly structured regimen that exerts control over behaviors and functions as a comprehensive system: “Through recipes or diets the aim is to reintroduce a normative logic into everyday eating” (12). He continued that a cuisine consists of “a coherent system of reference, a rule, in short, an order. Modern French terminology states this with great clarity: one needs a régime [diet], a regimen, a term which, in its full meaning, implies complete control” (12). The highly controlled rules create a frame (*cadre*) by

which the day is patterned. Such a comprehensive system alleviates the chronic ambiguity surrounding the question of when to eat and what types of foods to eat. There is no perpetual question of whether eating is a good idea (thus, none of the constant “crazy” internal debate that Maria described) because eating is patterned to occur at very specific times of day, generally in the company of other people. Everyday actions that are “directed” by such a system do not require the constant vigilance of the individual to make the “right choice.”

Making the “right choice” can be a lonely, shame-filled, and prolonged process in a culinary culture that values individual choice above all else. Maria described the specifics of one particular “raging internal debate” that she recently experienced. She said,

What I would often do, probably up until six or eight months ago, is I would go to Target and buy like Wheat Thins and cheese. So like Wheat Thins, and then spray cheese. And then something sweet so I could have my salty and my sweet. And I would eat it. And I would buy everything else healthy. And then I would sit in my car, and I would eat.

She said that she would finish the entire box of crackers in the car while reading a book.

She described the realization that this eating was completely unsatisfying. She said,

And then one day, I was like, I bought all that stuff, and I was sitting in my car. And I turned off the radio. I put my book away, because I always like would read when I did this. And I just sat there. And I was like, “What am I doing?” And I went back and forth with myself about what I should do. So I brought all the food home. I brought it into the house, and I ate it all over the course of like two weeks.

While she felt a vague, diffuse sense of shame and guilt when she ate in her parked car (which she drowned out by turning on the radio and reading a book), there was also nothing inherently culturally abnormal about either eating in the car or eating packaged

food such as cheese and crackers. For Maria, realizing the ways in which her eating habits were hurting her was a long, lonely process that required tremendous mental energy. She didn't have specific rules about eating, but painstakingly developed a few on her own.

Fischler (1988) characterized the type of eating that Maria described (in the car, alone, conflicted, devoid of boundaries) as highly problematic. In fact, he described "The Modern Food Problematic," writing that,

The socio-cultural frameworks... which traditionally governed and constrained food have been considerably eroded by economic and technical changes and changes in life-style. This has opened up a gap or crisis in the socially recognized criteria regulating eating habits, which are increasingly abandoned to individual choice. (11)

The breakdown in culinary and cultural regulators of food has left American eaters perplexed, confused, and often stressed about what to eat.

Dietary dualism: Do-it-yourself culinary regulation

Culinary confusion manifests in clinical encounters in a variety of ways. One method of managing confusion about what to eat externalizes as dietary dualism, or insistence on placing foods in "good" or "bad" categories. This tendency surfaces time and again in clinical food discussions. Patients interviewed for this study often categorized descriptions of their dietary patterns as "being good for this visit" or being "bad" or "naughty." Further, questions such as, "Is papaya good for me?" and "sometimes I feel like I have some bloating and have read that gluten can be bad. Do you think I should cut out wheat products only or oats as well?" highlight the

conceptualization by patients of certain foods as inherently beneficial and others as detrimental. More detailed questioning repeatedly revealed the frequency with which patients (inevitably temporarily) “cut out” foods that were deemed “bad.” Information for classifying food into these categories was ascertained from internet research; personal (or anecdotal) experiences; and engagements with physicians, dietitians, and other healthcare providers. Rather than receiving social direction from a cuisine to which a group of people adheres, “healthiness” of individual foods must be considered and categorized.

In particular, popular media ubiquitously portrays food along this strict divide. A cursory Google search on “healthy eating” draws up articles with titles such as: “Kids’ guide to food: Good foods, bad foods, and your health,” “20 Foods that are Bad for Your Health (Avoid Them!)”, “Choosing Healthy Fats: Good Fats, Bad Fats, and the Power of Omega 3s.” Biomedical food rhetoric also reinforces a dualistic conceptualization of food. In various biomedical forums, foods are placed within categories of “healthy” or “unhealthy.” Renowned institutions such as the Mayo clinic have created “10 Great Health Foods” lists, with apples, red beans, and broccoli classified as healthy food. These types of lists extol the benefits of “healthy foods” with no discussion of the detrimental effects of excessive consumption of them, or the possibility of their being incongruous with one’s constitution. On the other hand, many patients regard entire categories of food (such as fats, salt, and even calories) as “bad” and to be avoided. This becomes a conceptual shortcut when patients consider eliminating particular foods from their diet.

The push towards eliminating certain foods to improve health is furthered by and reflected in the rapid rise of tremendously popular “lifestyle blogs,” such as Deliciously Ella and OhSheGlows. The Deliciously Ella tagline, “Love Your Life, Love Your Food,

Love Your Self,” is paired with sections on how “delicious healthy food is—it’s so much more than bland salads and iceberg lettuce” (Deliciously Ella 2016). In a section entitled “So What Does This Mean I Eat Less Of,” Ella responded, “I’ve listed below the things I try to eat less, or none of, I know it may look like a long list but as I said don’t feel you need to overhaul anything overnight, or even ever, simply make some healthier choices when you can” (Deliciously Ella 2016). The list of food includes meat, fish, eggs, dairy, “almost all supermarket products that are labeled as ‘healthy’,” refined foods, sugar, and wheat.

In an article entitled “The Unhealthy Truth behind ‘Wellness’ and ‘Clean Eating,’” Ruby Tandoh critiqued the reinforcement of diet culture by blogs such as Deliciously Ella that deny weight loss as an agenda, instead touting “wellness” as the guiding paradigm. Tandoh argued in an online article entitled “The Unhealthy Truth Behind ‘Wellness’ and ‘Clean Eating’” that despite the difference in rhetoric, “wellness blogs” intensify proclivities to dietary extremism. Tandoh wrote,

[Wellness blogs give] rise to a kind of all-or-nothing approach to nutrition where all the delicious nuance of cooking, eating and pleasure is brusquely swept aside. When I asked dietitian and advocate of the “Health At Every Size” campaign, Michelle Allison, about this dichotomy, she explained: “There is no third option presented by diet culture—there is only black or white, good or bad, dieting or off-the-wagon... And many people flip between the two states like a light switch, on or off, for more or less their entire lives.” Nobody sums up the totalitarianism of wellness better than Deliciously Ella herself, though. “It’s not a diet, it’s a lifestyle.” And that’s just the catch (Tandoh 2016).

For some, this desire for “health” and “purity” becomes problematically totalistic, leading to a paradoxical decline in health, at which point it can be characterized as a form of disordered eating. In 1997, Dr. Steven Bratman introduced the term “orthorexia nervosa” after working with a group of yoga students and observing what he described as a

pathological obsession with healthy/pure eating. The term (which is not an official psychiatric diagnosis in the *Diagnostic and Statistical Manual* [the pre-eminent psychiatric diagnostic guidebook], but rather a conceptual description with specific diagnostic criteria that has been peer reviewed in the journal *Eating Behaviors*) stems from the Greek (*ortho*: correct; *orexis*: appetite, longing, desire) and refers to a pathological focus on eating “healthy” or the “right” foods. In this syndrome, the central focus is not weight loss but a diffuse concern with “eating/being healthy.” People with orthorexia nervosa, unlike anorexia or bulimia nervosa, are predominantly concerned with the quality of their food, rather than the quantity, and tend to emphasize “pure eating.”

On the medical practitioner side, the early and deep rooting of dualistic thinking with regard to diet was clear during a cooking course for medical students, a pilot that was offered during my final year of medical school training, then discontinued due to lack of funding. Driven by the prevalence of diet-related diseases and the lack of confidence expressed by many physicians regarding dietary recommendations, Dr. Leslie (an internal medicine physician) and a local chef, Jody, collaborated to pilot a course called “Food Matters for Doctors.” During the course, the medical student participants, who persistently sought more specific and quantitative rules on what to eat and what to recommend to patients, often met the general refrain of “eat more plants” with open skepticism, expressing that the concept was too general to serve as a useful foundation.

In a subsequent meeting at a cafe, Chef Jody, who spent many years as a Minneapolis chef and now regularly teaches undergraduate cooking classes, bemoaned this orientation of her students towards food. She stated that she consciously resists the

language of describing food as “good carbohydrates” and “good fats and bad fats.” She said, “We live in a culture where everything is good, bad, black, white, and I hate that.” Despite her explicit dedication to nondualistic language, she said that students sometimes interpret her message as “organic or nothing” (as one undergraduate student articulated on the end-of-semester course evaluation form). She reflected, “You have to be so careful about presenting information in a way that’s not about judging the person, but inevitably people will translate it [as] that anyway.” She construed this type of reaction to be a result of the constant “all-or-nothing” food messaging that creates an interpretive filter for incoming information about food.

On the other hand, Alyssa, a second-year medical student, wrote in her post-class evaluation, “I saw food and food choices as black and white—a should or a shouldn’t, a good or a bad... Food choices are no longer a good or bad, but are part of a broader context (who am I eating with, what’s my mood, why am I eating, etc.) and I’ve learned to accept these complicated aspects of food as part of normal life.” For Alyssa, this loosening of a strict dichotomy meant the ability to more frequently make “better” decisions, rather than oscillating between “totally healthy meals” and “total junk.” Armed with more information about what constitutes a nutritious diet, along with techniques for consistently preparing these foods, alleviated some of her anxiety about food. In forthcoming chapters, I will explore how all-or-nothing thinking is understood to facilitate craving in the Buddhist purview.

Culinary uncertainty creates chronic food anxiety

Chronic anxiety about what to eat is particularly pronounced for those responsible for feeding their families (often women), and for people suffering from the myriad illnesses in which diet is a significant contributor. Michael Pollan (2004) called this persistent stress about food decisions “America’s national eating disorder:”

One way to think about America’s national eating disorder is as the return, with an almost atavistic vengeance, of the omnivore’s dilemma. The cornucopia of the American supermarket has thrown us back onto a bewildering food landscape where we once again have to worry that some of those tasty-looking morsels might kill us. At the same time, many of the tools with which people historically managed the omnivore’s dilemma have lost their sharpness, or simply failed, in the United States today. As a relatively new nation drawn from many different immigrant populations, each with its own culture of food, we Americans find ourselves without a strong, stable culinary tradition to guide us. (3)

Pollan’s assertion that Americans experience more stress about food decisions compared to people who are part of more robust culinary systems is supported by the research of Paul Rozin, a University of Pennsylvania psychologist (who preceded Pollan in coining the term “*omnivore’s dilemma*”). Rozin et al. (1999) studied food-related anxiety in their work on cross-cultural attitudes towards the role of food in life. They ascertained attitudes towards eating in four countries (the US, France, Flemish Belgium, and Japan), concluding that of these groups, Americans worry most about what they eat and derive the least amount of pleasure from food. They wrote, “There is a sense among many Americans that food is as much a poison as it is a nutrient, and that eating is almost as dangerous as not eating” (Rozin et al. 1999, 166). Indeed, with such a significant percentage of the US’s medical diagnoses directly attributable to diet, Pollan’s and Rozin’s assessments reflect a literal return to constantly confronting the potential deadliness of many omnipresent foods.

Additionally, Rozin et al. (1999) concluded from their survey research that

women cross-culturally internalize significantly more anxiety regarding the consumption of food than do their male counterparts. They concluded that in the countries they studied, “the gender effects align with the country effects, in that females are more like Americans (negative/health oriented) and males are more like French (pleasure/culinary oriented).” They noted that “gender effects are bigger than country effects” when it comes to concern about food, while “The combined effects of gender and country cause French males to be the most food/pleasure/culinary oriented group, and American females to show the same orientation in the lowest degree” (170). Rozin et al. attributed the gender differences regarding food anxiety to increased female concern about weight, and the fact that women do more of the cooking, bear the “greater concern for issues of nurturance,” and spend a greater amount of time preparing food for the family.

Rozin et al.’s (1999) study provided a quantitative complement to the ethnographic data indicating the uneasy relationship many US women have with their food. In my field site, women were far more willing than men to discuss their eating habits. They pursued more wide-ranging conversations about food, including their physical and social concerns about foods. In our conversations, women ascribed many more layers of *meaning* to food, while men generally focused on their food preferences, rather than going into detail about the emotions (including worry) accompanying food selection and eating.

Thinness as a woman’s social mandate

Here, I discuss contributors to the network of factors complicating women’s

relationship with food. The social responsibilities to be thin, to feed one's family, and to manage body size through weight-loss disciplines were selected as themes for investigation because they arose repeatedly during my ethnographic interviews. In the US, women are evaluated by stringent, often impossible beauty standards. Thinness continues to be one of these values, and excess weight makes women vulnerable to judgment, social stigma, and discrimination, while medical discourse correlates excess fat with poor health. In other words, women are socially charged with maintaining a particular physique, while the attainment of this elusive physical goal remains an individual responsibility. Dieting is one way to manage the social risk associated with being overweight; however, food is an inescapable requirement for survival, particularly for women who shoulder more responsibility in feeding their families. Competing interpretations of food—on the one hand as a source of risk to one's social standing and health, and on the other as the supply of necessary nutrients—positions women in a difficult situation of constant vigilance amidst ideological conflict.

The stigma against fat is one example in a long history of beauty ideals that position women “at war with their bodies” (Seid 1989, title). Bleaching dark skin, tanning light skin, foot binding, and cosmetic surgery are examples of global interventions in service of culturally mandated desirability. In the contemporary US, slenderness is a beauty ideal that proves difficult to accomplish in a society in which where two thirds of women are overweight or obese. Braziel and Le Besco (2001) described common associations with fat as follows: “Aesthetically, fat is the antithesis of the beauty ideal of the day: tight, lean, and toned. Viewed then both as unhealthy and unattractive, fat people are widely represented in popular cultures and in interpersonal interactions as revolting—

they are agents of abhorrence and disgust” (75). The mismatch between the ideal body shape and the bodily reality facing most women can be grounds for self-evaluation and critique any time a woman considers eating, which, in the absence of cultural eating regulations, may be any time.

Susan Bordo, an American feminist philosopher, articulated how these factors create a tyrannical psychological state for women:

It has been amply documented that women in our culture are more tyrannized by the contemporary slenderness ideal than men are, as they typically have been by beauty ideals in general. It is far more important to men than to women that their partner be slim. Women are much more prone than men to perceive themselves as too fat. (Bordo 1993, 204)

Of course, “perceiving themselves as too fat” is not a value-neutral assessment, but rather is tied to highly negative characterizations and ramifications. Hesse Biber (1996) wrote, “Though the standards [of beauty] are artificial, they are clearly real in consequences...In contrast [to thin women], women who are fat face a stern moral evaluation. Americans hate fat people, finding them sinful, sloppy, lazy, weak-willed, and morally lax” (4), as cited in (Ratcliff 2008, 129). This moral evaluation is not limited to the mainstream, but permeates the health professional realms as well.

The medical and public health sectors contribute an additional layer of moralizing narrative. In addition to the theoretically “value-neutral” and “scientific” facts, health infrastructure casts obese individuals as unhealthy, inevitably diseased, and an inordinate burden on the healthcare system. Obese individuals are often characterized as “nonadherent” or “noncompliant” with medical recommendations (to be thinner). According to Gard and Wright (2007),

The people most difficult to challenge are often those who believe that they have

the “best interests” of fat people at heart, such as doctors, educators, health workers, and health promoters. But these are the very people ... who through their pathologizing of fatness, are most likely to contribute to the ongoing stigmatization of the fat body. (165)

It has been widely documented that both medical students and fully trained physicians perceive obesity in a negative light, as ascertained in studies of both their implicit and explicit biases (Phelan et al. 2014; Sabin et al. 2012). A study of medical students entitled CHANGES (Phelan et al. 2014) found that “Explicit attitudes were more negative toward obese people than toward racial minorities, gays, lesbians and poor people.” Disparaging comments about obese individuals were found to be commonplace in the hospital, clearly illustrating that discrimination related to weight was considered openly acceptable in medical spaces in which many other forms of prejudice had been denounced. The study found that while implicit weight bias decreased over the course of medical school, explicit (conscious) bias increased.

When medical providers express conscious bias against obese people, this surely translates into interventions focused on weight loss. According to Gard (2007), “The dominant ideologies associated with obesity allow practices that marginalize a large group of people and set up situations where they can be pathologized, discriminated against, mistreated, and abused” (163). The biomedical institution condemns excess body weight wholesale, risking injurious attitudes and behaviors towards a large cross-section of the patient population.

It comes as no surprise (given the synchronicity of health interpretations with other social narratives about women’s bodies) that these health imperatives against obesity have a stronger impact on women than on men. Rozin et al. (1999) found that

women are much more concerned than men with the health implications of their food choices, despite the fact that men suffer proportionally more diet-related diseases:

We note two other ironies. One is the greater concern of females about consuming low cholesterol foods and their greater association of fried eggs with cholesterol. Women are less vulnerable to the cardiovascular risk of high blood cholesterol, yet are more concerned about it. Second, considering that women presumably still do more cooking than men, it is surprising that they are less likely than men to make culinary (as opposed to nutritional) associations to foods. (177)

Thus, for women, fat is a critical concern from the perspective of both beauty and health ideals.

Managing fat

According to the women I interviewed, the ideal of slimness is directly tied to attempts to deal with fat (for both aesthetic and health reasons) by losing weight. Weight-management solutions included dieting, seeking medical expertise, exercising, undergoing bariatric surgery, and enacting a plethora of self-injurious behaviors such as extreme dieting (to the point of disordered eating), and laxative and diet pill use. Each of these solutions internalizes the “problem” of excess body weight within the individual body, making the onus of finding a sustainable solution also the responsibility of each person. Sidney Mintz (1996) elaborated on moral implications of managing one’s weight, stating that eating is a critical component of embodying one’s identity:

The extent of the individual’s ability to control and manage and discipline the body—not in all societies can such verbs be applied so matter-of-factly—is considered a reflection on individual self-control. Every act of eating can thus be made into a test of will. Since eating is morally colored, it is not surprising that half of the American people—and 90 percent of American women—are said to be on diets at any one time. To the extent that this is a gender-marked phenomenon,

anorexia and bulimia may come to look like no more than merely the flip side of the self-constructed beautiful You. (7)

As Mintz articulated, American women begin at a young age to see the body as something to be “managed” through individual decisions about what kinds of food to eat. Failure to create and maintain a socially sanctioned body frame leads to significant social consequences. For many women, maintaining an “appropriate” and attractive (read: thin) figure turns out to be one of their most consequential forms of embodiment. As the punishments for overweight women include judgment, decreased earnings, and perceptions of moral impunity, along with a host of other threats to well-being, perpetual concern for the attainment and maintenance of slenderness has been *the* rational response within this sociocultural milieu.

In the course of my study, women were more likely to mobilize professional expertise, routinely disclosed to medical doctors a desire to lose weight, and sought professional advice on how to achieve a particular physical appearance. Men, even those who were obese or being treated for an illness secondary to obesity, were far less likely to discuss attempts to manage their weight with me or with the physicians with whom I worked. While this might be a matter of communication style rather than degree of concern, qualitative research has drawn an unequivocal distinction in the gendered prevalence of dieting. Dr. Feeley-Harnick, a professor emerita of anthropology at the University of Michigan, wrote, “From a sociological point of view, American women’s prodigious dieting should be recognized as a clear-eyed, pragmatic response to systemic social prejudice” (576). According to the Boston Medical Center, 45 million Americans diet each year; however, many women find that dieting does not achieve the desired

social aims, because they are ultimately “unsuccessful” in losing weight. Additionally, weight-loss strategies are frequently expensive and can be dangerous to health. Approaches such as purchasing laxatives, diet food, and diet pills, as well as specialized weight-loss packages, profit the corporations selling these products, while at times jeopardizing the physical and financial well-being of clients. As Ratcliff (2008) wrote, “Not only is dieting behavior especially prevalent among females, but female dieters are more likely to diet in ways that seriously endanger their health” (135). Additionally, weight-loss programs and fitness centers are often immensely profitable. Figures estimating the net profits of the weight-loss industry vary widely, averaging to about US\$60 billion per year that Americans spend on weight-loss products and services (MarketData Enterprises 2015). Ratcliff (2008) added, “a panel at the National Institutes of Health examined such programs and other components of the diet industry and found profits for the companies but failure for the consumers” (132). Women are disadvantaged by a social mandate to maintain a slender body without the communal backing of stable cuisine, but in the context of strong corporate incentives for promoting weight-loss interventions.

Resistance to fat shaming

Consequent to this collusion of detrimental pressures, women have led efforts to form conspicuous counter-movements aimed at subverting the dominant ideologies regarding obesity. Fat theorists, fat activists, and often feminists, have presented alternative interpretations of the obese body, shifting the discourse from fat people as

vectors of disease accelerating their own imminent demise. The fat acceptance movement (also called the fat liberation movement) has tried to overcome the stigma against bodies that are larger than the “norm.” Fat acceptance continues to be a minority movement in my ethnographic context, and only one of my participants had engaged with the movement personally, having heard about “the power of acceptance” in her cognitive behavioral therapy sessions.

Open enactment of fat acceptance by way of this movement continues to position women precariously. Gard (2007) explained,

The social prejudices against fat are so deeply embedded and so naturalized ... that confrontation, through language, through imagery and performance, often requires enormous amounts of courage. When the desire for so many fat people is to be invisible, it means becoming very visible, drawing attention to fat bodies, producing discomfort and risking shame. (165)

Instead of working to subvert anti-fat ideology, many women try to lose weight.

Achieving and maintaining slenderness despite the difficulty of losing weight was a concern consistently articulated by many of my participants. Again, it was almost exclusively female patients and Common Ground practitioners who expressed this category of concern.

Systemic understandings of obesity

New knowledge about the varied contributors to obesity have perplexed the individualistic, self-deterministic model of enacting linear interventions (diets) in order to decrease weight. The paradigm for understanding obesity is shifting from simplistic models focusing on the energy-balance component of excess weight to examination of

the systemic relationships that facilitate excess weight gain. The Foresight map (see Appendix) is perhaps the most well-known pictorial depiction of these relationships. The exceedingly complex figure shows interrelated threads that contribute to obesity, visually demonstrating various elements that necessitate consideration in effective obesity therapy. The report accompanying the map reviews comprehensive information across multiple contributory aspects to weight gain. Biology, behavior, the living environment, and economics of food production are some of the examined factors.

Further, the report asserts the importance of considering many or all of the highlighted aspects in tandem, rather than prioritizing one or a few. The report says, “The system map, together with scientific and other evidence, confirms that energy balance (or imbalance) is determined by a complex multifaceted system of determinants (causes) where no single influence dominates” (Great Britain, and Foresight 2007, 7). Taken together, the systems facilitating obesity-promoting behaviors are called the “obesogenic environment,” which the Foresight report articulates as the “Combination of physical space, production, technology, lack of mobility in the everyday, [and] highly palatable foods [that] ‘expose the biological vulnerability of human beings’” (Great Britain , and Foresight 2007, 3). Researchers for the Foresight report conceptualized weight gain as an inherent human vulnerability that has been exacerbated in recent years by a complex web of factors:

An unhealthy weight is often seen as a result of individual choice on diet, exercise and lifestyle. However, this report maps the complex web of societal and biological factors that have, in recent decades, exposed our inherent human vulnerability to weight gain. If we fail to tackle this “obesogenic environment” the consequences for individuals, families, communities and society as a whole are grave. (Great Britain 2007, and Foresight, 3)

While there are more than 100 individual “nodes” (factors contributing to obesity) in the Foresight map, the report groups these into four major human vulnerabilities to weight gain. These are: (1) “Primary appetite control in the brain,” (2) “The force of dietary habits, [which are] keeping individuals from adopting healthier alternatives,” (3) “The level of physical activity,” and (4) “The psychological ambivalence experienced by individuals in making lifestyle choices” (Great Britain 2007, 8). These areas of inquiry still largely focus on factors affecting individuals. In this chapter, I have investigated the force of dietary habits, and the psychological ambivalence (and, I argue, consequent anxiety) that people experience when deciding what to eat.

The Foresight report, along with other prominent research on obesogenic systems mapping, focused more heavily on the material than on intangible contributors to obesity. However, the research team that wrote the report readily acknowledged the limitations of engagement primarily with material, individual factors. They highlighted social and psychological conditions as important directions for future research:

Different types of environmental influences may also operate across these multiple domains, encompassing not only physical characteristics (those connected to built and natural environments) but also those associated with social, cultural and policy environments. Most studies to date have focused on the characteristics of the physical environment, but we may have good reason to believe that other environmental domains may also exert important influences. There is a need for the research community to focus more strongly on the problems of identifying relevant environments, and for new research to examine associations with alternative environmental definitions. (Government Office for Science, 2007, 33)

Another network of factors capitalizing on human vulnerabilities on both the biological and psychological levels is the corporate production, marketing, and sale of food. The creation of HPFs—processed foods containing the specific combination of salt, sugars,

and fats that trigger brain receptor pathways in ways increasingly understood to mirror addiction—exemplify the marketing of substances that make it very difficult to overcome the human proclivity to overeat.

Advertising facilitates food sales, capitalizing on the fact that every meal is essentially a *de novo* exercise in “thinking” what to eat. According to Pollan (2004),

Food marketing in particular thrives on dietary instability and so tends to heighten it. Since it’s difficult to sell more food to such a well-fed population (though not, as we’re discovering, impossible), food companies put their efforts into grabbing market share by introducing new kinds of processed food, which has the virtue of being both highly profitable and infinitely adaptable.

One prominent marketing tactic is direct advertising to children, who are in the formative stage of developing food habits. A 2012 report by the Federal Trade Commission estimated that of the US\$1.29 billion worth of food ads directed towards youth, 72% were for “Quick Service Restaurant (QSR) foods, carbonated beverages, and breakfast cereals.” Part of the challenge of attempting to constantly improve profit margins is the continuous creation of new foods that meet particular “needs,” and the evolution of such needs requires a constantly changing diet, which erodes culinary stability. Pollan (2004) wrote, “Big Food (with some help from the microwave oven) has figured out how to break Mom’s choke hold on the American menu by marketing directly to every demographic, children included. The result is a nation of antinomian eaters, each of us trying to work out our dietary salvation on our own.” However, direct advertising to children does not absolve mothers from the media-induced pressures to make correct choices on behalf of their children. Advertisements simultaneously target mothers. According to Katherine Parkin, professor of history at Temple University, “Food advertising continued to hold women responsible for their family’s health, status, and

satisfaction because they claimed that, in the hands of women, food is love” (Parkin 2011, 11). Corporate interest in selling more food creates multiple competing family dynamics that further destabilize culinary confidence.

Because advertising caters specific food imagery to different individuals within a family, food ads further fragment social cohesion around food. The production and manufacturing of HPFs, which are widely acknowledged as an addictive formulation of processed food, adds to the difficulty in “thinking” food. The very intentional and systematic process through which these individualized advertising messages are conveyed was made clear to me when a well-known advertising agency reached out to me during the course of this research and asked me to attend a meeting regarding an ad campaign for a company producing packaged food (I was not paid for this participation and did not participate in further efforts by the advertising agency). My main takeaways from this meeting were the malleability of the consumer preference in terms of food purchasing, and the specificity with which various dietary and cosmetic trends were targeted by this ad agency.

Conclusions

The US lacks cultural and culinary regulatory systems, making eating a concern that each individual must navigate alone. This lack of social regulation facilitates a perpetual anxiety about what to eat—a stress that inordinately affects women due to the disproportionate social pressure women face to maintain a slender body habitus in the context of widespread media and health narratives pushing women to “manage” their

bodies. This management occurs through interventions such as sorting foods into “good” and “bad;” maintaining particular, self-enforced diets; and joining costly weight-loss programs. Food advertisers use American dietary uncertainty to further sales of foods by marketing foods to individuals. The concept of an “obesogenic environment” perturbs the mainstream ideas that obesity is a personal problem necessitating intervention solely at the level of the individual, yet many of the social factors named in the Foresight report have yet to be elaborated. In the next chapter, I will further examine the ways in which biomedicine treats craving as a problem located within an individual, while Buddhism regards it as an impersonal, universal experience.

Chapter 3

Biomedical and Buddhist notions of craving

This chapter considers theoretical frameworks for understanding craving within two distinct systems: the Western biomedical addiction medicine paradigm, and Buddhist thought. Both systems are concerned with experiences of craving and its implications. In the addiction medicine domain, craving is important because it is assumed to contribute to pathological consumption of substances, addiction formation, and hindrance of drug-abstinence efforts. In Buddhism, craving is understood as a critical impediment to freedom from suffering, necessitating deep and systematic consideration of the causes of craving, as well as strategies for the management and eradication of it. The motivations for mitigating craving diverge in these two systems. In this chapter, I explicate each of these frameworks of craving separately, ultimately illuminating the contours and limits of each approach throughout the remainder of the dissertation.

Craving and addiction in biomedicine

In the first half of this chapter, I will discuss the importance of craving both as a subject of biomedical research and as a subjectively salient part of the experience of addiction. I will then discuss the conceptual indistinctness of craving within biomedicine. I paradoxically attribute this imprecision to biomedicine's persistent dedication to empiricism (the measurement and quantification of craving) that dictates that craving be examined from disparate super-specialized perspectives that fail to cohere into a

conceptual whole. While critical for the development of anti-addiction drugs, the resulting understandings of the disparate micro-facets of craving offer limited utility in motivating behavior change.

Theories concerning craving feature prominently in the field of addiction medicine, the medical specialty dedicated to the treatment of addiction. Addiction, as described in the *Diagnostic and Statistical Manual*, is characterized by tolerance (needing increasingly more of a substance to reach desired effect), and continued use of a substance despite realization of the problems caused by substance used. The treatment scope of this specialty—historically limited to alcohol, tobacco, and illegal drugs—is expanding to incorporate other addictive substances, and, notably, behaviors that do not involve drugs. These include gambling, sex, and eating.

In the sphere of addiction medicine specifically, and biomedicine more broadly, cravings for particular substances are understood to both contribute to the development of addiction and impede the maintenance of abstinence, making understanding craving an urgent addiction research priority. *Segen's Medical Dictionary* defines craving as, “A strong desire to consume a particular substance—e.g., of abuse (cocaine) or food (chocolate); craving is a major factor in relapse and/or continued use after withdrawal from a substance of abuse and is both imprecisely defined and difficult to measure” (*Segen's Medical Dictionary*, n.d.). This simplified medical definition illuminates several important points about ideas of craving within the medical realm: (1) craving and consumption are conceptually linked, (2) measuring and defining craving proves challenging, and (3) food (in the above case chocolate) falls within the medical purview of potentially problematic craving.

Experiences of craving

In clinical addiction therapy discussions, craving is a frequent topic of focus brought forth by both patients and practitioners. Many patients described recent food binges or substance abuse as a result of the strong cravings they experienced. Addiction medicine literature has reflected the importance of craving as a concept. In an article entitled “Phenomenology of food cravings,” Elston (1990) wrote, “The term ‘craving’ captures some of our most intense and ubiquitous experiences with drugs and food” (3). In addition to its pervasiveness in the experience of addiction, practitioners and patients alike understand craving to have major impacts on treatment efforts. Acknowledgment of craving forms part of formal addiction treatment. The National Institutes of Health (NIH) National Institute on Drug Abuse (NIDA) explained the importance of discussing craving early in the treatment of (in this case cocaine) addiction:

Because craving is such a difficult problem for so many cocaine abusers, this topic is introduced very early in treatment. Episodes of intense subjective craving for cocaine are often reported weeks and even months after the inception of abstinence. This experience can be both mystifying and disturbing to the abuser and can result in cocaine abuse if it is not understood and managed effectively. (NIDA Publications)

In the above, NIDA explicitly recognized the subjective experience of craving as a critical intervention point to be “understood and managed effectively” in treatment. However, the “mystifying” experiences of craving are not well understood in a cohesive manner within practice frameworks, such as in the addiction medicine paradigm.

In order to better understand the important but enigmatic phenomenon of craving to enable “management” of its stronghold, addiction researchers have investigated the destabilizing characteristics of craving. According to Skinner, a leading addiction researcher, “The amassed evidence suggests that craving is an indispensable construct, useful as a research area because it has continued to perturb and destabilize many patients seeking treatment for substances” (Skinner 2010, 621). The scientific literature overviewed in this chapter has directly and specifically implicated craving in a number of disease processes, with a collective tremendous impact on public health.

Elston (1990) quantified the prevalence of craving in some of these conditions, providing a sense of scope and urgency:

Craving for cigarettes is the most consistent and dramatic symptom of cigarette withdrawal (Glassman et al., 1984; Hughes & Hatsukami, 1986; Shiffman & Jarvik, 1976; West & Schneider, 1987; West et al., 1989). Almost all alcoholics report experiencing cravings for alcohol (Ludwig & Stark, 1974). Anywhere from 43% (Schuman et al., 1987) to 97% (Weingarten & Elston) of people report food cravings. About 50% of overweight women report carbohydrate cravings and identify this experience as an impediment to weight loss (Bjorvell et al., 1985). Over 70% of bulimics attribute their binge eating to food cravings (Mitchell et al., 1985). Craving for alcohol (Marlatt, 1978) or cigarettes (Shiffman, 1979) is reputed to be a major factor leading to relapse in abstinent alcoholics and smokers. (3)

The review illustrates the wide-ranging implications of craving in diverse pathologies, ranging from food-related illnesses to alcoholism to substance abuse, and affirming that the subjective salience of craving makes this difficult concept critical to investigate.

In an effort to gain another angle of insight into the phenomenology of craving, I explored online communities dedicated to discussing experience with it. These communities were subdivided into cravings for a particular substance, with member participants describing their encounters with craving in first-person narrative form, and

responding to one another's questions and commentary. The following excerpts are from a "thread" on Reddit (a website with countless "threads," or forums, with similar content) entitled "What does it feel like to become addicted to cigarettes?" Two "community" members write in their posts:

13lah: I quit ten years ago after smoking for about 6 years. I started at 16 too. It was the hardest thing I've ever done. It took years for me to stop craving it and to this day I can still smell cigarette smoke from a mile away. I probably tried twenty or thirty serious attempts at quitting before I was finally able to. Shit is hard enough in your teens without having to deal with addiction.

SoulCircuits: Smoked for 10 years. Your post hit the nail on the head. I tried e-cigs to quit but your brain always ends up craving the real deal. I ultimately went to a hypnotist and was able to quit that way.

As illustrated by these comments, the word "craving" is fundamental to communicating ideas of addiction formation from a first-person perspective. In my fieldwork, which will be discussed in depth in subsequent chapters, many participants additionally articulated their experiences of craving as being "pulled," "desiring," and "not being able to stop" their consumption. While the importance of craving is clear, and subjective descriptions of craving abound, systematic, multilayered, cohesive, and robust understandings of the causes and effects of craving continue to elude addiction researchers.

Conceptual haziness of craving in biomedicine

For a concept so abundantly used both in common parlance and in addiction medicine, the notion of craving in Western biomedicine is both imprecise and equivocal. Despite the clinical necessity of understanding craving as a construct, given the

overwhelming experience so many people report while facing addiction, there is no clearly agreed-upon definition of craving within biomedicine. Within the biomedical framework, the most fundamental clinical questions about craving remain highly controversial, or unanswered, despite the many strong assumptions about craving that form the undercurrents of addiction research and therapies. Some of these fundamental questions include: What is craving? What makes it stronger? Does it actually result in increased consumption of the craved substance?

Numerous methods have been proposed to answer each of these questions, but they diverge from one another and the resultant data does not add up to holistic or parsimonious theories. This lack of clear agreement about what, exactly, craving means challenges addiction treatment efforts. While craving is a subjectively intuitive, and often subjectively articulated concept, the translation of this intuition to the precise definitions, measurements, and metrics required for the creation of effective medical interventions is lacking. Hughes wrote, “the variety of meanings for the construct of craving precludes its utility.” In 1954, the World Health Organization, one of the most influential public health organizations in the world, convened a conference specifically to discuss utilization of the term “craving,” finding the term “confusing and inappropriate” in its clinical usage (Skinner and Aubin 2010). In the following decades, remarkably little changed to clarify the conceptualization of craving. One major difficulty in achieving a firmer grasp on a useful definition of craving has been the requirement for precise measurement.

Measuring craving

Ascertaining a definition of craving with utility in the biomedical realm requires precise quantification in order to fit within the empirical framework. This requirement hinders the development of a robust yet cohesive notion of craving. Marlatt articulated this issue, stating, “from a scientific perspective, craving is a superfluous concept” (Marlatt, cited in Elston 1990, 232). Many scientists have agreed that craving is too subjective a construct to usefully translate into meaningful quantitative research outcomes.

However, given the clinical consequence of craving, it continues to be an important research subject. As asserted in a paper entitled “Craving’s place in addiction theory: Contributions of the major models,” “Nonetheless, craving remains today of considerable interest to researchers despite the absence of theoretical consensus” (MacKillop and Monti, 2007). This interest is reflected in the tens of thousands of quantitative studies that appear in a PubMed search for “craving.”

Attempted quantification of craving in the biomedical paradigm generally takes one of two forms. The first is measurement of craving in broad, conceptual terms, relying either on self-reports or on measurement of substance consumed in order to work backwards to elucidate strength or frequency of craving. In the second approach, researchers have tried to identify and describe a very narrow element of craving. Such attempts to manage the conceptual haziness of craving by elucidating its constituents has contributed to extremely specialized, fragmented understandings of the biology of craving, in which the general concept is broken into ever-smaller parts.

The former type of craving quantification (at a general conceptual level) typically uses self-reporting tools. For example, surveys such as the Daily Urge Record Sheet

(Stritzke, Roitzsch, and Gregory 1997) function to assess incidence of craving, as well as an individual's affect while experiencing craving. Beyond the widely recognized limitations in ascertaining unbiased, accurate information through self-reporting methodology (Del Boca 2003; Fenton et al. 2001; Harrison 1997), the self-reporting of craving is challenged by the definitional uncertainty about what qualifies as craving. What one person rates as a strong craving might be interpreted by another as a weak craving, or not a craving at all. In an article entitled "The measurement of drug craving," Sayette et al. (2000) outlined five major challenges in the general measurement of craving:

1. Differing scopes of defining craving.
2. Debated timeframes of the duration of craving.
3. The degree of "desire" that constitutes craving.
4. The possibility of craving existing outside the realm of awareness.
5. The uncertain degree to which craving and drug use should be conceptually linked.

Taken together, these theoretical roadblocks highlight that nearly every facet of the subjective experience of craving proves difficult to translate to quantitative measurement in an accurate, precise, and replicable manner—i.e., via the three characteristics that comprise empirically valid results.

The technique for quantifying craving involving measurement of consumption of the craved substance and working backwards to ascertain degree of craving implicitly assumes that craving directly leads to consumption—a highly contested idea in the craving literature. As Elston (1990) articulated, measuring consumption as a proxy for

craving results in logical circularity: “How do you know how much a food was craved? Measure how much of it was eaten. Why was so much food eaten? Because it was so much craved! Many commentators on the craving concept recognize the circularity of this logic” (Elston 1990, 3). This tautological reasoning clearly limits the ability of this approach to shed new light on the concept of craving.

A third and widespread tactic for addressing the methodological challenges of measuring craving is fragmenting conceptual questions about craving into clear-cut, defined parameters. In other words, researchers select an element of craving that is so specifically circumscribed that it can be reliably measured with precision and accuracy. This scope of inquiry leads to study titles such as “Food cravings, food addiction, and a dopamine-resistant (DRD2 A1) receptor polymorphism in Asian American college students” (Yeh et al. 2016). This work very specifically delineated a particular receptor (DRD2 A1), a certain manifestation of craving (food cravings), and a highly defined research subject population (Asian American college students). Another recent study culminated in an article entitled “Serum insulin levels are reduced by intravenous ghrelin administration but do not correlate with alcohol craving in alcohol-dependent individuals” (Haass-Koeffler et al. 2016) which again specifies a hormone (ghrelin) under investigation, a manifestation of craving (alcoholism), and a specific subset of the population (alcohol-dependent individuals). The specificity of these studies along all research axes restricts researchers from summing these findings into coherent wholes that can then be applied to a patient/person experiencing a different manifestation of craving.

The resultant body of biomedical literature on craving consists of innumerable studies on distinct causes, factors, mechanisms, and pathways contributing to craving. These studies have been put forth, using varying methodologies, in the fields of neurobiology, pharmacology, psychology, public health, and other disciplines. Biotechnological advances have facilitated the acquisition of new types of quantitative information about craving. Through Positron Emission Tomography scans and other advanced brain-imaging technologies, it is now possible to visualize the parts of the brain that are activated when a patient experiences a subjective craving. The precise neural pathways, neurotransmitters, and hormones that are implicated in various phases of craving are elucidated with ever-greater specificity.

Neurobiological models investigate neurotransmitters such as dopamine, gamma amino-butyric acid, and serotonin, and their associated neural pathways, mapping craving through distinct regions of the brain. The dopamine model provides one example of understanding craving in terms of neurobiology. Dopamine is a neurotransmitter, or a chemical messenger, that carries information through the brain. Volkow et al. (2013) wrote,

Of all the signals implicated in the effects of food and drugs, [dopamine (DA)] has been the most thoroughly investigated. Experiments in rodents have shown, for example, that DA signals through both D1 receptors and D2 receptors (D2R) in the dorsal striatum are necessary for feeding and other eating-related behaviors (28). (3)

Dopamine pathway inputs are diverse, synthesizing signals from various brain locations, meaning that many factors can influence the amount and timing of dopamine release.

Drug use and consumption of highly palatable foods are both reinforced by the dopamine pathway. The production of dopamine in relation to consumption can be

accelerated or inhibited, which influences the degree of reward perceived by the brain when craved substances are consumed. The dopamine model, like other models attempting to elucidate the pathological circuitry of the addicted brain, endeavor to measure, observe, and even visualize the physical structures implicated in craving. This illustrates the aim of understanding craving as a discretely localizable pathology that is positioned within the brain and body of an addicted individual.

Treatment implications of biomedical approaches to craving

Despite purporting to be a “biopsychosocial” discipline, teaching of addiction medicine elevates individual neurobiology. At a weekly didactic session that is a required component of my medical training, an addiction medicine doctor, who is also the medical director of a treatment facility, presented one of the morning lectures. The purpose of his lecture was to teach us about the medicine of addiction and to challenge some of the common frustrations that physicians in our department express when confronted with treating “another addict.” He opened his talk by saying that “Addiction is a disease, addiction is chronic. Addiction is a chronic, relapsing disease of the brain.” (Harris, Carson 2017. Lecture, St. Paul, Minnesota). He then presented a number of slides that illustrated how the brain responds to pleasurable stimuli. He polled the audience to ask what everyone’s favorite food was; the doctors and medical students listening to the talk muttered indistinctly. Finally, one doctor raised his hand and said “Wendy’s” (a fast food restaurant). “Wendy’s,” the presenter responded, chuckling. “You got a little squirt of

dopamine even from just saying that,” he said, highlighting the potency of neural reward pathways.

The content of the presentation echoed the medical school training we received about what constitutes an addiction and its treatment, focusing on the brain anatomy and the activation of neurotransmitter pathways via reward stimuli. This was set in the context of the historical “waves,” or movements, in thinking about how to treat addiction. The doctor described the first two waves of treatment as having to do with modifying parts of the brain related to addiction formation. The third wave, he said, was Cognitive and Behavior Therapy (CBT), and the fourth (contemporary) is “mindfulness.” While he did not elaborate on what is involved in CBT or mindfulness treatment, addiction medicine research studies on the efficacy of mindfulness in addiction treatment on PubMed have typically used the “standard” eight-week mindfulness training course model (with programs with slightly varied content and names, such as Mindfulness Oriented Recovery Enhancement and Mindfulness Based Relapse Prevention [Garland et al. 2017; Wietkiewitz 2010; Zgierska et al. 2008]). These and other models of clinically applied mindfulness will be discussed in detail in Chapter 6.

In the US, doctors specializing in addiction medicine typically train first in either internal medicine or psychiatry, and subsequently complete fellowship training specifically on the treatment of addictions. Detoxification, medication therapy, recovery models (including the 12-step model), and psychosocial support for patients experiencing addiction are some of the topics addressed in addiction medicine fellowship training. Addiction medicine teams are frequently multidisciplinary, with variable levels of involvement from physicians. Often, other members of addiction treatment teams include

psychiatrists and psychologists to treat mental illnesses that frequently co-occur with addiction, and to care for the psychological causes and aftereffects of addiction. Social workers are frequently part of addiction treatment teams and work to coordinate treatment placement, help patients navigate addiction triggers outside of treatment, and facilitate securing housing and job resources. Many treatment facilities also employ nurse practitioners and nursing staff.

In the Midwestern US, addiction treatment takes place in a variety of locations: there are inpatient consult services within hospitals; inpatient residential facilities where the patient (often referred to as the “client”) lives for the duration of their treatment; and partial hospitalization programs that involve large portions of the week being spent in structured treatment at an institution, but sleeping at home. Outpatient treatment programs are diverse, and typically happen through clinic appointments and counseling. While the theoretical goal of these programs is ideally to prevent subsequent drug use, with relapse following addiction treatment previously considered a treatment failure, addiction has been reconceptualized in recent decades as a chronic disease (Dennis and Scott 2007; McLellan 2002). As such, the management of craving is a long-term concern.

Pharmacotherapy remains a mainstay of addiction therapy. Effective pharmacological intervention (using medication to treat a health condition) requires locating pathology within an individual. Medications play a prominent role in biomedical treatment for alcohol, tobacco, and opioid addiction, with increasing interest in and investigation of drug therapy for the treatment of food addiction. These medications work by interfering with the brain receptor sites that are affected by the addictive substance. For example, Naltrexone, a commonly used medication in the treatment of opioid

dependence (such as heroin addiction), competes in the brain for opioid receptors, reducing craving by occupying the brain receptor that the heroin would have modulated. This competition for receptors affects the entire neural feedback mechanism, theoretically making abstinence from heroin use easier.

The increasing nuance with which scientists understand the biochemistry of craving facilitates the development of pharmaceutical agents that interact with the brain circuitry implicated in craving. Increased specificity of understanding about receptors (such as the dopamine receptor) involved in particular addictions helps to more precisely target pharmacological treatment, which in theory can reduce the side effects that occur when administering medications that unnecessarily affect receptors that are not involved in the particular addiction. The problematic financial incentives for framing research questions in order to develop pharmaceuticals will be thoroughly discussed in Chapter 7. Rather than furthering comprehensive understanding of the complex systems facilitating craving that would be useful in behavior modification methods, biomedical research focuses on how the circuitry (neurobiology) inside each individual's brain can be modified, particularly through medication.

The limitations of this kind of research become apparent when considering that all addiction treatments require behavior modification in addition to biological intervention (medication). NIDA has emphasized the importance of the behavioral elements of addiction therapy as follows:

Behavioral approaches help engage people in drug abuse treatment, provide incentives for them to remain abstinent, modify their attitudes and behaviors related to drug abuse, and increase their life skills to handle stressful circumstances and environmental cues that may trigger intense craving for drugs and prompt another cycle of compulsive abuse. (NIDA 2016)

In substance abuse treatment, behavioral therapy is often focused on avoidance of the problematic substance.

Behavior modification proves even more complex, and also more essential, in food addiction therapy. There are limits to understanding “food addiction” as an extension of drug, alcohol, or nicotine addiction. Humans do not require any of those three substances to survive, so total abstinence is a viable approach. Food, of course, is essential to survival, so total elimination is not an option. Eating selectively and in moderation can be much more difficult than total avoidance of a substance. Even if food craving is significantly reduced by a medication, cognition and behavior continue to affect the daily decisions that must be made about food. Thus, behavioral therapy must comprise a facet of treatment for food addiction, and should involve recognizing, understanding, and managing cravings to navigate the complex terrain between normal/necessary and problematic food consumption.

Fragmented and often contradictory craving constructs built from disparate biomedical data complicate determination of a view of craving robust enough to be clinically consequential as a framework for behavioral modification. On a behavioral level, Skinner and Aubin (2009) stated, “It is well accepted that no single model explains craving completely, suggesting that a solid understanding of the phenomenon will only occur with consideration from multiple angles” (1). It is not, however, that a single model *could not* powerfully contribute to understanding craving; rather, the focus on pathology as a discrete (and therefore pharmacologically intervenable problem), as well as epistemology favoring the acquisition of precisely measurable units of information, forms

a mutually reinforcing conceptual loop that precludes the elucidation of integrative (and therefore behaviorally useful) insight into craving.

New pathways in Biomedical craving research

Since the first iteration of this dissertation, biomedical research on craving reflects a move towards more comprehensive, less fragmented understandings of craving. While craving research in biomedicine still pertains to certain craved substances (drugs, alcohol, food) and experiences (sex, gambling, internet use), the intensity required for craving to be considered clinically relevant has broadened considerably. Biomedical studies (including randomized controlled trials and meta-analyses) consider the relevance of craving in everyday eating behaviors and in behavioral pattern formation rather than exclusively in pathological (illness) states. Studies published in the last 2 years (2016-2018) consider incorporation of evolving conceptualizations of craving into the treatment paradigms.

The following highlight a number of the recent biomedical studies examining the relationship between an advancing understanding of craving, and its implications on eating: A meta-analysis examining food cue reactivity (with 45 published reports involving 3,292 participants) showed that reactivity to food cues and cravings led to increased eating and weight gain (Boswell and Kober 2016, 1). The study concluded that that food cues (photos and videos of food) trigger reactivity, a conditioned response with both physical (salivation, hormone secretion) and behavioral (eating) implications (Boswell and Kober 2016, 12). A study by Blau et al also examined craving's role in

mediating eating. They wrote, “We sought to examine the role of food craving frequency as a mediator in the relation between emotional eating and excess GWG” (Blau 2018, 12). In this recent iteration of studies, the pathways through which some individuals crave more intensely are examined in the context of craving being considered a human neuropsychobiological universal, rather than a categorically distinct pathological state.

Despite the common experiences of craving, intensity of craving varies between different people, and for the same person at different times. According to Richard et al, “There are also marked and stable interindividual differences in the frequency and intensity of food craving experiences, suggesting that some individuals think more frequently, crave more intensely and—as a consequence—likely consume more snack foods than others” (Richard et al. 2017, 216). In each of these studies, craving is examined as a state that could trigger eating, but not as an inherently pathological, or intense. The studies focus on what makes a person act on these cravings, rather than framing the cravings as inherently problematic.

The work in developing more robust and nuanced understandings of craving has led to re-considerations of treatment paradigms for eating-related illness. In talking about past addiction treatment frameworks, Brewer et al. write, “A growing understanding of the behavioral and neurobiological mechanisms that underpin habit formation may explain why this approach has largely failed, and pave the way for a new generation of nonpharmacologic interventions” (Brewer et al. 2018, 1). Craving is now a point of consideration in behavioral interventions. In a meta-analysis studying the effect of calorie restriction on craving, the authors conclude, “Calorie restriction is associated with reduced food cravings supporting a de-conditioning model of craving reductions. Our

findings should ease the minds of clinicians concerned about increased cravings in patients undergoing calorie restriction interventions” (Kahthuduwa et al. 2017, 1122). This degree of acknowledgment craving’s pervasiveness and influence in craving is a dynamic shift from previous biomedical understandings, making comparison with the well-elaborated articulations of craving in Buddhism ever more rife with potential clinical relevance.

Conclusions

Craving is a crucial concept in addiction medicine, the field concerned with the treatment of addictions. Despite the conceptual centrality of craving in the subjective experiences of patients experiencing various addictions, biomedical notions of it are specialized and disparate, predicated on a dedication to quantification and pharmacotherapy. The biomedical epistemology has elucidated a mutually reinforcing relationship between addiction and neural circuitry, locating craving primarily as a neurobiological pathology. The economics of pharmaceuticals that interact with brain receptors to diminish cravings incentivize maintaining the concept of craving and addiction as diseases located within individuals’ brains. While biomedical research has enabled the development and implementation of pharmaceuticals that interact with brain receptors to diminish cravings for particular substances, the biomedical concepts of craving are too fragmented, disparate, and contested to create a cohesive framework for informing deep, systematic behavior change interventions. Beginnings of a more holistic

framework are beginning to emerge from the most recent biomedical literature on craving.

Buddhist notions of craving

In this section, I explore craving's centrality in causing suffering, as explicated in core Buddhist teachings. I will outline several key Buddhist doctrines regarding the prevalence, causes, and solutions to the suffering that pervades human experience. I first discuss the centrality of craving in the Four Noble Truths, then discuss the specific concept of *tanha* (translated as craving, desire, or thirst) and describe its various forms and manifestations as presented in Buddhist literature. In Buddhist teaching, the magnitude of *tanha* and related suffering experienced by human beings is impersonal, ubiquitous, and arises in relation to a variety of "causes and conditions," as further elaborated in the Law of Dependent Origination. Though the manifestations of suffering are diverse (including the eating-related suffering explored in this dissertation), Buddhist teachings starkly expose the common foundations of suffering. Since, according to Buddhist philosophy, craving is a universal and impersonal facet of life, instructions for overcoming suffering consequent to craving (contained in the Noble Eightfold Path) comprehensively outline practice elements that can be applied in a variety of contexts, cutting through our customary suffering through interdependent development of moral conduct, discipline, and wisdom. Buddhist thought asserts that eliminating craving at the deepest level proves necessary for freedom from the suffering of everyday existence, and outlines means of carrying out this process.

The Four Noble Truths

The description of craving and its character deeply permeates the Four Noble Truths. These form the core of Buddhist teaching, and the centrality of these concepts is difficult to overstate. The first Noble Truth is that life is suffering; the second characterizes this suffering and directly cites craving as its root; the third is that it is possible to attain freedom from suffering; and the fourth maps the Noble Eightfold Path of freedom from suffering. Gethin (1998) described *tanha* (craving) as it is addressed in the second noble truth:

The second truth suggests that we must recognize that the mind has deep-rooted tendencies to crave the particular experiences it likes, and that this craving is related to a fundamental misapprehension of “the way things are:” the idea that lasting happiness is related to our ability to have, to possess and take hold of, these experiences we like. (75)

The third and fourth truths acknowledge that there is a path of freedom from the suffering facilitated by craving, and outline this Noble Eightfold Path. The various elements of this path are integrated, and simple solutions involving only individual components of the path are understood to be superficial and self-limited. Thanissaro Bhikkhu (1997) translates the Noble Eightfold Path as explained in the Nagara Sutta as “right view, right aspiration, right speech, right action, right livelihood, right effort, right mindfulness, right concentration.” The analogy of the Buddha as a physician is widely employed with reference to the Four Noble Truths, with each of the truths referred to as illness, diagnosis, prognosis, and prescription, respectively (Gethin 1998, 63–64). Foundational to this system is the notion that every human has the possibility of transcending suffering caused by craving, despite being subject to the vicissitudes of craving. Within the

Buddhist framework, the human condition is characterized by suffering; nonetheless, even individuals who manifest the most extreme forms of suffering (as in an addictive state, for example) can access an effective way out through the same mechanisms as any other human being through developing wisdom (via practices that will be discussed in latter sections of this chapter).

The cause of suffering is craving

The idea that “craving is the root of all suffering” is echoed throughout other Buddhist texts. The *Dhammapada*, a collection of Buddhist doctrinal verses and a prominent scripture in Buddhism, provides lyrical natural imagery about the nature and effects of craving. Here, craving is described as multiplying sorrow and eradication of suffering is dependent on the successful elimination or transcendence of craving. The *Dhammapada* states:

335: Whosoever in this world is overcome by this wretched clinging thirst, his sorrows grow like Birana grass after rain.

336: But whosoever in this world overcomes this wretched craving so difficult to overcome, his sorrows fall away from him like water-drops from a lotus (leaf).

338: As a tree cut down sprouts forth again if its roots remain uninjured and strong, even so when the propensity to craving is not destroyed, this suffering arises again and again.

(Walpola 1990, 135)

According to the *Dhammapadda*’s characterization, a life ruled by craving results in a person thrashing about, suffering, from sorrow to sorrow. The expression rendered as

‘propensity to crave’ is translated in another version of the *Dhammapada* as ‘the latent tendency to craving’ (Norman 2000, 49). The same concept is also discussed in late Theravada *Abhidhamma* (Anuruddha and Bodhi 2007, 222). This interpretation clearly asserts that craving is not recognized only at certain intensities but can also be a subtle, or even latent state. As such, craving must be eliminated at the deepest level and superficial measures taken to eliminate craving are inconsequential, as they result in the effects repeating themselves in suffering. In addition to desire being the root of suffering, the various (emotional and physical) appetites are seen as impediments to liberation. Gombrich (1988) elaborated on the problem of desire as the root of suffering: “The Buddha seems to stand in the tradition (predominant in the ascetic milieu) which considered the emotions and appetites as the obstacle to liberation and the root of all evil” (63). Because elimination of craving at the deepest level is one of the primary objectives of the Buddhist paths, Buddhist thought provides a nuanced vocabulary for conceptualizing craving in its various forms.

Buddhist lexicon of craving

The word *tanha* translates from Pali literally as thirst, but is often interpreted as craving or desire. The English word “craving” does not encapsulate the complexity and nuance contained within the word *tanha*. Even the single word *tanha* falls short of adequately describing the various facets of craving (craving pleasant sensations, separation from painful feelings, a reality distinct from the present, etc.) that arise in a human being according to Buddhist philosophy.

Despite the conceptual complexity of *tanha*, Buddhist thought asserts that *tanha* is not an ambivalent quality, but rather is inherently dangerous and self-centered. Ajahn Sucitto (2010), a Theravada monk, described *tanha* as springing from a “black hole of need,” constantly needing attention and never satisfiable, despite incessant attempts to satiate this craving (943). Stemming from this “black hole of need,” different types of *tanha* are responsible for the formation of strong attachments and aversions, particularly attachment to prolonging pleasurable experiences and aversion to painful ones. The *tanha sutta* (part of the *Anguttara nikaya*, the fourth of the *sutta pitaka*), describes the detrimental character and quality of *tanha* as “an ensnarer, trapping and smothering an individual into deprivation, woe, and bad destinations” (Bodhi and Nyanaponika 1999, AN 4.199). The mechanism of this ensnarement is further understood by conceptually subdividing *tanha* further into three categories, which are interrelated characteristics or facets of the same underlying quality. These are *kama-*, *bhava-*, and *vibhava-tanha*.

Kama-tanha is sense craving, or desire instigated by the sense organs. This is the most tangible and powerful of the cravings, and presumably the most relevant when engaging in discussion of eating. *Kama-tanha* is in operation when one takes a bite of food that is delicious and immediately desires another bite, regardless of hunger or physical need. The other two aspects of *tanha* are more metaphysical in nature. *Bhava-tanha* is craving for “becoming,” or for existence. This can be understood as an ambition or desire for attainment, an attachment to becoming something other than the present reality. According to the *Dhammacakkappavattana Sutta* (said to be the Buddha’s first teaching after he attained enlightenment) *Bhava-tanha* stems from a mistaken perception of eternalism and the striving that can result from this impression. *Vibhava-tanha* is the

opposite, craving for “nonbecoming” or “nonexistence,” and the desire to rid oneself of certain qualities, experiences, or realities due to the fact that they are deemed “bad” or unpleasant. It is craving that occurs in conjunction with a nihilistic mindset.

Relationships between craving, attachment, and suffering

Once ensnared in craving—as most of us are to varying degrees—the consequent suffering is never-ending, unless craving itself is effectively rooted out. Cravings escalate over time, and their attempted satisfaction manifests as injurious objects of obsession, with intensifying attachments to particular thoughts, conceptions, and relationships, often resulting in injurious patterns of behaviors and consumption. Although many actions pursued by an individual aim to satisfy cravings, these attempts are ultimately futile, since *tanha*, by its very nature, is an abyss that remains undiminished despite efforts to fill it. Gethin (1998) elaborated on the cyclical nature of craving that turns into attachment: “At first desires may be like the trickle of a stream, but they grow into a river of craving which carries us away like the current of a swiftly flowing river” (71). Once carried away, we form attachments to attempting to possess the things we crave. As craving leads directly to attachment (and vice versa), the latter, too, is seen in Buddhism as a critical impediment to liberation. This is because humans inevitably form attachments to things, ideas, people, and thoughts, which are impermanent. The concept of attachment is inextricably tied with the Buddhist notion of craving on the one hand, and to *dukkha* (suffering or dissatisfaction) on the other. This is because sentient beings form attachments to the things we hunger for, thinking that their attainment can

ultimately satisfy our desire. However, as *tanha* is a kind of craving that can never be satisfied through attainment, these attachments are misguided and unproductive.

Within this framework, all humans experience craving, which can both arise from and escalate to attachment, forming a mutually reinforcing cycle of craving and attachment. In light of this view, training the mind to see the world as it really is, particularly the futility of attaching oneself to ever-changing and impermanent people, objects, and experiences, constitutes an essential undertaking for all people seeking liberation from the infinite loop of craving and attachment. Fortunately, humans have the ability to train their minds to free themselves from the tendency towards attachment to various desires, which result from ignorance or lack of training, rather than a fundamental and insurmountable flaw.

Concept of “self” perpetuates suffering

Suffering is exacerbated by strong attachment to the illusion of a fixed, unchanging “self,” which facilitates constant craving through the perceived importance of attainment for its maintenance. While Buddhist scholars across geography and throughout time have diverged significantly in the importance afforded to the concept of “no self” (*anatta*, Pali *anatman*, Sanskrit) and its implications in terms of eternalism, nihilism, and individual morality, diverse schools of Buddhist thought agree on the impermanent character of human beings, and that there is not an unchanging, personalized essence (“I” or “me”) contained within a person. In his book *What the Buddha Taught*, Rahula (1990) explicated the absence of a “permanent, unchanging

entity or substance like Self or Soul (*atman*).” Rather than consisting of an unchanging entity (an eternal, autonomous, independent “self”), a person’s qualities arise out of various causes and conditions.

Given this view, any endeavor that contributes to “I-making” or “my-making” (strengthening the conception of a fixed, personal identity) is regarded as unskillful or counterproductive. Gethin (1998) argued that thinking of the self as unchanging is a problem with language that “fools us” into thinking that there is something more permanent (such as a soul) than an interconnection between our various experiences. He said, “Our everyday linguistic usage of terms such as ‘I’ amounts in practice to an understanding of self as precisely an unchanging constant behind experiences” (135). Instead, Buddhist thinkers and writers often use varying descriptions of the word *Santana* (meaning continuity of consciousness), articulating the cohesion of our experiences with words like “stream,” “current,” etc. Gethin (1998) stated, “In reality ... for Buddhist thought there is only their ‘connectedness’—nothing besides that” (139). He continued,

For Buddhist thought terms like “self,” “being” and “person” are conventional labels for what in reality is a mass of constantly changing, causally connected physical and mental phenomena. The problem is not with the words in themselves but with what we understand by the words: we are misled by their conventional usage into thinking that selves, beings, and persons have an ultimate existence in their own right. (146).

Beyond a mere linguistic problem, “selfing” also occurs when misunderstanding the meaning of relationships between our various experiences. In many strands of Buddhist thought, life energy consists of the constantly changing Five Aggregates: the body, sensations, perceptions, mental activity, and consciousness. It is through the various relationships among these different components that we experience the world.

While there is not a fixed, eternal self, there is commonality between the circumstances we experience, which is not incidental, but rather deeply interconnected. Understanding the interrelationship between our experiences through the five aggregates plays an essential role in seeing the world as it is, and also in understanding cause and effect. However, over-attachment to any of these Five Aggregates leads to problematic construction of a sense of a fixed self. Despite all the diversity and change in our daily experiences, we can problematically impose an unchanging entity “I” or “me,” rather than more accurately perceiving that the continuity is a set of experiences bound by deep interconnection. A passage in the Majjhima Nikaya, known as the Middle Length Discourses of the Buddha, warns against this type of identification. It says,

Therefore, monks, all body... feeling... recognition... volitions... conscious awareness whatsoever, whether past, present or future, whether gross or subtle, inferior or refined, far or near, should be seen by means of clear understanding as it really is, as “this is not mind, I am not this, this is not my self.” (Gethin1998, 137)

Maintaining awareness of the interconnectedness of experience while avoiding identification with and clinging to any of the Five Aggregates and affixing them with any sense of permanence is an extremely challenging proposition, particularly because of their relationship with craving.

The aggregates are also called the Five Aggregates of Clinging. As they shape our experience of the world, they also form the basis for all of our clinging. The Samyutta Nikaya, Buddhist scripture also known as the Grouped Discourses, contains an illustrative example of over-identifying with the body, one of the Five Aggregates, as

self. As one of the Five Aggregates, the body¹, which is viscerally experienced as shifting, changing, and outside the realm of direct control, provides a concrete example of the problem of over-identification. The passage reads,

Body is not a self. If body were a self then it might be that it would not lead to sickness; then it might be possible to say, “Let my body be like this, let my body not be like this.” But since body is not a self, so it leads to sickness, and it is not possible to say, “Let my body be like this, let my body not be like this.” (Samyutta Nikaya iii, 66–7, as cited in Gethin 1998, 136)

The passage demonstrates the potential for clinging to the body and associating it with the desires that spring from a fixed, unchanging sense of self. This is a case of mistaken identity, confusing a coherence of experience with a situation that can be possessed or controlled. This insight proves progressively more tenuous in the subtler of the Five Aggregates, sensations, mental activities, and consciousness. However, it is activity of the Five Aggregates at all of these levels, individually or in combination, that creates a deep-seated and dangerously pervasive sense of self.

Misapprehension of experience as self not only results from a faulty understanding of the world, but is also a craving-based view. Gethin (1998) wrote, One’s sense of “self” springs not only from delusion, but from the desire to identify and claim some part or parts of the universe as one’s own, as one’s possession, and say of

¹ Interpreting *rūpa* as “body” fits within the definition of Buddhism used in this thesis (discussed pp 19-20 of this work), but is too limited a definition in other Buddhisms through history. Vetter describes the interpretation of *rūpa* as having morphed over time from the physical body to the mental impressions created by physical sense experiences. Eventually, “[*rūpa*] only gradually came to include the trees a monk saw in the wilderness, the sounds of birds he heard, up to; all phenomena (*dhamma*) he could think of” (Vetter 2000, 21). This is definitional uncertainty is true of the other *khandas* as well, in that what constitutes each of the aggregates varies through history and tradition. While the phenomenologies arising from different interpretations of *skandas* vary widely, the important concept to be maintained through “flattening” these understandings is that the *skandas* are not permanent, and clinging leads to suffering (Steinkellner 2012).

them “this is mine, I am this, this is my self.” To identify with the five aggregates, either collectively or individually, is a kind of conceit—the conceit “I am” (*asmi māna*). (146)

Thus, in the Buddhist purview, the self is borne of ignorance, delusion, and excessive clinging to facets of our changing experiences. This inherently flawed concept of the “self” then leads to more craving; for example, craving to be a certain type of person (*bhava-tanha*).

This misperception of self leads to cravings for and attachments to acquiring certain types of possessions, life status markers, and other forms of mental, spiritual, and physical possessions that we affiliate with being that certain “kind of person.” Existing within a fixed sense of personhood, within the conceit of “I am,” the kind and scale of craving required for maintaining that “self” places individuals in a trap requiring perpetual acquisition in order to defend this construct. Like all activity borne of craving, these forms of acquisition lead to suffering, with the concept of “self” serving as a powerful justificatory catalyst. Buddhist thought very firmly establishes the necessity of dismantling the illusion of “I” through a deep and holistic understanding of the way things are (impermanent, interdependent) as a necessary condition for the transcendence of suffering.

Dependent origination

Buddhist philosophy also outlines a system of interconnected causes that can either perpetuate or dissolve cycles of suffering. While Buddhist teachings at large emphasize the importance of holistic understanding of the way things are as a requisite

for freedom from suffering, perhaps no Buddhist concept speaks as directly to the systemic nature of reality as the Law of Dependent Origination (also called dependent arising), a well-elaborated and complex mapping of interdependent factors contributing to cause and effect. The teaching is often depicted visually as 12 “links” that are interconnected, with no primary or first link. These “formations” are (1) ignorance, (2) formations, (3) consciousness, (4) mind and body, (5) six senses, (6) sense-contact, (7) feeling, (8) craving, (9) grasping, (10) becoming, (11) birth, (12) old age and death (*Paticcasamutpada*). These “links” are often visually depicted as a complex schema, as in the outer rim of the Tibetan Wheel of Life (*bhavachakra*), a graphic found in most Tibetan Buddhist temples in order to help laypeople understand Buddhist concepts.

Elaboration of each of these “links” is extensive, and falls outside the scope of this work. In its totality, this account of existence establishes ontology based on sets of relations. In the schema of dependent origination, each phenomenon or link exists in the presence of, and is influenced by, all other events and factors. These occur in cyclical networks, in contrast to the linear cause-and-effect rationale predominating Western thought. The factors of dependent origination are mutually reinforcing, with any of the factors bringing other factors into being and into cessation—an interrelationship that is succinctly summarized in the Samyutta Nikaya as follows: “When this exists, that comes to be; with the arising of this, that arises. When this does not exist, that does not come to be; and with the cessation of this, that ceases” (Bhikku Bodhi 2000). Wisely comprehending the “way things are” and the way that cause and effect operates in the universe requires clear awareness of interconnection, more than understanding mental or physical events themselves.

The 12 formations, or links, are relevant in their implications for the cessation of suffering, as this ending is also interdependent. Buddhist thought articulates, through the Law of Dependent Origination, a description of cause and effect that is always at play regardless of one's awareness of it. However, awareness is essential for ending suffering, as practitioners can facilitate its dissolution by creating conditions to break down the cycle of suffering. In addition to describing the consequence of interdependence, Buddhist thought specifies a prescription for creating conditions to end suffering, the Noble Eightfold Path.

The Noble Eightfold Path

The Noble Eightfold Path, also called the Middle Way, was the first teaching given by the Buddha after he attained enlightenment, according to hagiographic accounts. While the Four Noble Truths provide a doctrinal groundwork for understanding core Buddhist concepts, the Noble Eightfold Path sets out a schema for translating concept to practice. According to Bhikku Bodhi (2013), "In the structure of the teaching these two principles lock together into an indivisible unity called the *dhamma-vinaya*, the doctrine-and-discipline, or, in brief, the Dhamma." In this teaching, the Buddha outlines the way out of suffering, which is also the "middle" realm between overindulgence in and attachment to earthly pleasures, and the opposite, self-mortification. As Buddhist thought posits that experiences are interconnected, it follows that a Buddhist path out of suffering would be holistic, addressing aspects of our existence on several levels.

The Noble Eightfold Path is grouped into principles of moral conduct (right speech, right action, right livelihood), discipline (right effort, right mindfulness, right concentration), and wisdom (right thought, right understanding). The term “right” is a translation from the Pali word *samma*, which translates to “complete,” “full,” or “perfect,” rather than referring to a dichotomy between right and wrong. The Noble Eightfold Path serves as a guide that one should test and evaluate for oneself, rather than a list of rules that must be followed. Cultivation of one aspect of the eightfold path contributes to a positive feedback loop and sets in motion the conditions for development of the others.

As the Noble Eightfold Path essentially serves as the Buddhist prescription of a way out of suffering, the Pali Canon contains many texts elaborating on means of fostering the various forms of moderation outlined in the path. Thus, the path provides a practical guide to the enactment of Buddhist teachings in accordance with both a deep understanding of “the way things are” and the causal effects of various forms of mental and physical activity. The components of the Noble Eightfold Path are not understood to develop in a linear fashion, progressing from one to the next; rather, they can develop simultaneously. Paying attention towards, and developing skills in, one area of the Noble Eightfold Path “sets into motion” (*Dhammacakkappavattana Sutta*) the causes and conditions for development of others. In this way, practitioners experience the interdependent arising of various factors. The particularities of enacting the Noble Eightfold Path vary greatly between the Buddhist traditions, and often directly reflect the cultural milieus in which they play out. Chapter 5 will elaborate the ways in which

development of the Noble Eightfold Path is taught and practiced within the ethnographic context of this research.

Due to Buddhism's central concern for liberation from suffering and the paramount role of craving in contributing to this suffering, craving and attachment have been deeply considered in Buddhist texts. Buddhist philosophy extends from describing (diagnosing) the root causes of craving to treatment, or transcendence, of craving cycles through specific practices. The Buddhist lexicon for describing craving and the corollaries of craving form a holistic and sympathetic understanding of an individual ensnared within his or her detrimental cycles. As such, the Buddhist conception of the ideas of craving and attachment offer an individual a means of gaining robust insight into his or her own affliction, as well as transforming a current state of suffering. Many Buddhist practices aim to facilitate a state of nonattachment, to create a break in the state of continual craving.

Conclusions

In this chapter, I have examined two distinct systems in which craving is a prominent focus of investigation. Through blind parallelism, both systems have categorized craving as a major contributor to dis-ease. In the discipline of addiction medicine, craving is thought to contribute to pathology through promoting consumption of problematic substances and destabilizing abstinence efforts. In Buddhism, craving is a pervasive, impersonal force that is the direct cause of suffering. In response to the potency of craving and its hindrance of central aims of each system (health through discontinuation of substance abuse on the one hand and liberation from suffering on the

other), each has evolved theories about the mechanisms of craving and offers solutions based on these understandings.

Biomedicine affords technology, visualization, and measurement of some of the constituent components of craving. This has facilitated the development of medications that function to physiologically mediate craving, a solution that falls far outside of capacity of the Buddhist system. Buddhism, on the other hand, offers a deep and holistic framework and a prescription, a set of ethical precepts and practices, for modifying behavior. This is a conceptual cohesion that has not been achieved in biomedicine with regard to craving. The potential functional implication of the Buddhist framework (or prescription) is provision of a clear path with specific practices that can be cultivated over time to mediate behaviors in the face of cravings. Elements of the Buddhist prescription for overcoming craving have made their way into the addiction medicine purview in the form of secularized mindfulness-based practices, which will be discussed in depth in Chapter 6. The theoretical frameworks laid out in this chapter inform, to large degree, patient and practitioner notions of pathology (craving and attachment as a personal, internally located pathology versus an impersonal force pervading human experience), agency (how much individual agency is ascribed to and effective in addressing craving), and etiology (craving as triggered by individual behavior versus a de facto undercurrent of existence). The lived interpretations of these theoretical frameworks will be the emphasis of subsequent chapters.

Chapter 4

Mismatched expectations in the medical management of eating

As I approached patients in the clinic waiting room throughout the first afternoon at the start of fieldwork to talk about this research, I was mostly met with barely contained irritation or outright rejection. Many patients stared steadfastly at their cell phones, adding an additional layer of challenge to striking up a conversation. Others seemed skeptical when I approached, presumably dubious of a stranger coming to them with questions and paperwork during a routine visit to the clinic. After mustering the courage to approach one patient, Allison and bracing myself for a disgruntled response, her engaging smile and openness to conversing provided an unexpected reprieve. We began talking in the clinic's brightly colored waiting area, which was mostly empty at this point. When the treatment area door swung open and a medical assistant in teal scrubs called Allison's name, we hastily exchanged contact information for a later meeting.

We met again the following week at Caribou Coffee, a branch of a local chain of coffee shops, near Allison's home. She explained that she often worked remotely, and this café was one of her favorite work locations. Our conversation lasted more than two hours, meandering through a multitude of topics. She told me about her marriage to her high school sweetheart, with whom she had grown up in a small town in Minnesota and had a seven-year-old son. She spoke about her work as a book editor, and the challenges of demarcating her time at home between her professional work and parenting tasks.

Since she had stopped working in an office, she found her time to be a more fluid continuum of editing and related tasks, parenting, and housework.

We began discussing health and eating. Allison took the Yale Food Addiction Survey that I passed to her, making several comments along the way; we returned to discussing this questionnaire after she had finished marking her answers. Allison enjoys relatively good health, with no chronic medical problems. However, she and her husband had recently explicitly discussed their needs to make dietary changes because they were “spending too much money on food” and “becoming less healthy,” which she explained was part of the reason she was so excited when I approached her in the waiting room. “So serendipitous!” she exclaimed.

She and her husband had grown up eating a “standard meat-and-potatoes diet” while in Brainerd, Minnesota. When she and her husband moved to the University of Minnesota to attend college, they began to view food for the first time as a source of experience and entertainment. Allison describes a constant tension she feels between choosing an activity the family enjoys (dining out) and choosing to eat in, which she knows is healthier and saves money. She said, “But we do eat out a lot, just because it’s... kind of our hobby... then sometimes we’re eating out more than we’re eating in.” She explained,

I would say that food at home lacks excitement compared to going out. And I think part of this too might be from, growing up in Brainerd. There [were] NO options for restaurants. I mean, I think Brainerd had the basic, basic, basic, basic fast foods like your Burger King and your McDonalds, and then I think it had... Perkins [an American chain restaurant that serves breakfast all day]. **Laughs.** So, you know for us, just having a wiiiiide range of options including for ethnic foods that we were never able to have before. We really *like* a variety of foods, so, you know, eating out you can satisfy those likes and those interests and that taste for food.

For Allison's family, food serves as a regular source of pleasure because it provides a sense of experimentation from the "normal, bland" food of Allison and her husband's upbringing. Each member of her family values the relative excitement of going out to eat compared to eating at home, and it is an activity that they can enjoy doing together.

In addition to feelings of pleasure and excitement, Allison's family's decisions about where to eat depend most heavily on time and convenience. They arrive at decisions of where to eat "democratically with the three of us." When asked how each of them chooses what food to eat at each meal, she stated, "You know he [Allison's seven-year-old son] loves things like mac 'n' cheese [macaroni and cheese] but you can't have mac 'n' cheese every night so we try to guide him in those decisions. But otherwise, it's almost anything goes." Allison described this "almost anything goes" as stressful, leaving her confused about what her family should eat. She noted that the stress she feels about food selection increases during times of illness and life uncertainty.

In these moments, she has turned to doctors for guidance on what to eat. Allison described several instances of raising the issue of food with her doctor. However, she had typically left these clinical interactions deeply frustrated, feeling that she did not receive the kind of guidance she had been seeking. Most recently, she went to her physician looking for food advice when she had repeated episodes of uncomfortably warm and sweaty palms, a time when her body would feel like it was "overheating, almost like early onset menopause symptoms." Suspecting that these symptoms were related to her diet, she made some changes on her own, "eliminating and adding certain food," and when she didn't see any improvement, she made an appointment with a family physician.

The doctor performed some basic lab tests and explained to Allison that food was very unlikely to be contributing to the way she was feeling. Allison said of the interaction,

She [the physician] was very... kind of like... dismissive. I was *really* upset... actually. Just walking out of there feeling like not only did I not get any help or support of answers, I kind of felt like, like... I was just kind of dismissed. You know... it was almost like she was kind of offended that I would even try and bring these kinds of concerns [about food] to her...you know?

Meanwhile, Allison's son developed a severe and intermittent rash that the family attributed to food and chemical sensitivities. She took him to a different doctor, who responded to her inquiries about the possible dietary contribution to the rash by saying that his diet was not a concern, given that he was eating a much better diet than most children. Skeptical of this advice, Allison again left the appointment dissatisfied by her doctor's unwillingness to discuss food as a potential cause of the rash. She stated,

So... we're in this, this situation where... I'm kind of looking for a doctor to... help us move away from, you know, just... "oh, its okay! Whatever you eat..." And, you know, the family physician, she just said like, "He's just doing fine. He's eating better than most kids!"

Dissatisfied with her doctors' responses, Allison turned to the internet for more information. Despite extensive research, Allison remains unsure of which foods may be contributing to their respective ailments. She is able to make some preliminary hypotheses on how food affects her health in various ways, but continues to seek input from people she feels to be medical authorities (doctors) to alleviate the chronic uncertainty she faces with regard to food decisions.

This anxiety manifests in ambivalence each time she ingests food or makes decisions about what the family eats. She explained, "You know at this point... we're right in the thick of it. So, like, every time we eat, there's kind of like... there's this... this

huge tension. Like... I don't knowwww... let's see what happens." While Allison does have some sense of "better" versus "worse" choices, she described strongly feeling as though the outcomes of her food decisions on behalf of her family could easily have negative consequences on their immediate and long-term health. This is a source of worry for her, especially when someone in the family is experiencing symptoms that she thinks could be related to diet.

Part of her motivation for seeking the input of an external authority is to remove herself as solely responsible for each of these food decisions. She feels trapped between what she "should" do and the decision she wants to make based upon her energy level and her immediate social milieu (son and husband), as well as all of the messages she receives from the wider cultural context about the importance of eating exciting foods and using food as a way to bond with her family. The broader social systems push her to take her family to go out to eat, but this is a social pressure that does not take into account the health consequences for her family. She feels responsible for addressing physical symptoms that she thinks her family might be experiencing due to their diet.

Allison has countless resources for obtaining information about what to eat. She uses books, the internet, and advice from her friends and colleagues to gain such instruction, yet she does not feel confident in her ability to sort through this information and come to "correct" conclusions. When I ask Allison what type of guidance she is looking for in these clinic visits, she stated,

If somebody [a doctor] was writing it on the prescription pad... you know... "You MUST stop eating these foods" it would be so much more motivating. And it would be so much realer in my mind than just myself kind of saying, "maybe I should stop eating this stuff." Or, you know... "gee are we, you know, we eat [out] a lot"... you know, maybe those are just *big* portions, there's a *lot* of fat in there...

For Allison, the prescription pad is (at least theoretically) the desired culinary regulator.

When I ask her why she seeks this specific type of guidance, she stated,

Perhaps it would be... it would be a way of like... letting myself off the hook for it [being more selective about food]. Or it would perhaps be that... just that the, like the authoritative stamp on something that... maybe I wasn't *quite so sure about* myself. But then again, that I... I *know* a lot of the decisions that we're making are not good. It's not like it's a gray area. **Laughs.**

She explained that she knows that the family goes out to eat too much, and eats too much salt, sugar, fat, and other ingredients that are common in restaurant food and that she knows "aren't good." She notices that everyone in her family feels better when they go out to eat less frequently and when they cook at home more frequently. However, she has difficulty pinpointing (to herself and to her husband and son) exactly what is troublesome about what they are eating, since they do not have symptoms that overtly and consistently relate to what they are eating. She intuitively feels that she needs to be more selective about what to eat, but does not know which of her streams of information to follow. She stated, "I have a lot of ideas about what *not* to eat, like all these things that are bad for you, going out to eat all the time, but I wish someone would tell me what's good for my body."

Allison wishes that food would play a greater role in her medical encounters and that diet could be a more prominent part of the clinical discussion so she could feel less alone in considering links between her diet and the way that she and her family are feeling. She said, "I know there's a connection there but I don't have... the training or the expertise... you know, I just don't know exactly what to change or how different foods are affecting my body." Based on experience working in clinics and hospitals, I was

unsurprised to hear that Allison felt confused about the health implications of her food choices. Since becoming a medical student, and then after graduating and becoming a medical resident, I have been increasingly asked by patients to clarify the link between their diet and a medical diagnosis for which they are being treated. Examples of such questions include: “I have been feeling depressed for years and read that diet can have a lot to do with mood. What do you think I should be eating to feel better?” or, from a patient who had recently had surgery, “What do you think I can order from the hospital menu that wouldn’t upset my stomach?” These two questions demonstrate the wide span of food questions ranging from pragmatic, in-the-moment advice (the latter) to seeking longer-term big-picture advice aimed at managing particular symptoms. For reasons that will be discussed later in this chapter, I feel inadequately prepared to answer these questions, and supervising physicians are seemingly reticent to engage in this type of discussion as well. As I repeatedly observed patients struggling to discuss food with their physicians, tensions surrounding the varying expectations about the medicalization of food between patients, healthcare providers, and the medical system at large became a clearly pertinent ethnographic focus. The former two of these aspects will be the focus of this chapter, and the latter will be addressed in Chapter 7.

Through field interviews with patients, physicians, and medical students, I investigate potential points of divergence between patient expectations and physician delivery of food instruction. Patients, confused about what to eat due to the breakdown of culinary regulators, seek professional expertise in an effort to avoid navigating food decisions and the accompanying anxieties alone. However, the medical institution, in its current economic and epistemological construction, is not an ideal locus of expertise for

motivating food-related behavior change, despite the unmistakable relationships between food consumption, diseases, and the diagnostic and therapeutic roles of the biomedical institution. Doctors receive inadequate training about food to meaningfully address patient concerns, and time is a chronic constraint that limits doctors' willingness and ability to discuss food in clinical encounters. Biomedical discussions of food primarily center on fear of diffuse symptoms and future illness. Fear-based motivation exacerbates food-related anxiety, leading states of constant surveillance and risk management, which are counterproductive to the aim of easing physical suffering. The chasm between patients' expectation of food guidance from physicians and physicians' lack of time and proficiency epitomizes the problematic limitations of a (medical) system that stakes claims to expertise regarding the intimate workings of the bodies—and consequently the lives—of patients, while its technological, profit-driven mode of action remains incommensurate with such panoptic aims.

Processes of medicalization

Medicalization is a concept that was first articulated during the technological advances of the 1960s. Broadly defined, medicalization is the process by which elements of human life come to be considered and treated within the biomedical paradigm. Geographically and disciplinarily diverse thinkers, including French sociologist Foucault (1973), French medical sociology writer Zola (1977), Polish British medical sociologists Conrad and Schneider (1992), Hungarian American sociologist Szasz (2002), and Croatian Austrian philosopher Illich (1972, 1977) were among the first and most

prominent to elaborate upon the concept of medicalization, as they observed the developing power of technology in managing expanding domains of human life. According to White (1991) in *An Introduction to the Sociology of Health and Illness*, a defining feature of medicalization is that the necessity of applying the medical paradigm or medical knowledge is not self-evident. Key characteristics of the medical paradigm to which the term medicalization refers include favoring empirical data, emphasis on health as an individual issue, and the power afforded to the professional medical institution.

Examining the sociological foundations of the concept of medicalization clarifies how the medicalization of food is conceptually divergent from historical precedents. In his work *Limits to Medicine: Medical Nemesis, the Expropriation of Health*, Ivan Illich (1976) put forth an early discussion of medicalization that still holds wide relevance today, emphasizing the concept of “iatrogenic medicine,” and the medical institution as legitimizing and reifying unjust social structure. He wrote that the medical system “reinforces a morbid society in which social control of the population by the medical system turns into a principal economic activity” (Illich 1976, 43). The pressure to impose diagnoses on an ever-expanding number of life’s processes can be easily understood by considering the basics of the financial structure of US healthcare: insurance companies reimburse only procedures and therapies linked to a medical diagnosis, and biomedical research funding favors the creation of knowledge linked to diagnosable diseases. The problematic collusion of incentives highlighted by Illich is striking when the coupling of new diagnostic categories coincides with large pharmacological breakthroughs. For example, Fishman (2003), a sociologist of medicine, wrote about how the marketing of

Viagra coincided with defining erectile dysfunction (formerly impotence) as a medical condition, rather than a part of aging.

Despite his vehement opposition to the economic role of medicine, Illich (1976) did not blame doctors for intentional or malicious expansion of the realm of medical control. He stated, “it would be inaccurate to blame the inflation in medicine on the greed of the medical profession” (50). Rather, he decried the “host of well-titled paper-shufflers” administering the practice of medicine. Most importantly, he pointed out the systemic effects of functioning within an economy that favors intervention, highlighting the influence the system exerts over the individuals within. He wrote, “Even more significant is the new prejudice in favor of high-cost hospital care” (50). In his estimation, the medical bureaucracy and the ever-increasing reliance on high-tech solutions facilitate wrongful expansion of the medical realm.

In his work entitled *Medicine as an Institution of Social Control*, Irving Zola (1972) framed another explanation for the ever-expanding jurisdiction of medical authority. He argued that medicalization occurs through an expansion of the *concepts* of illness and health, rather than as a side effect of bureaucratic and technological expansion. Furthermore, the process of medicalization is not contingent on the medical professionals’ actual ability to affect change: “this is not occurring through the political power physicians hold or can influence, but is largely an insidious and often undramatic phenomenon accomplished by ‘medicalizing’ much of daily living, by making medicine and the labels ‘healthy’ and ‘ill’ relevant to an ever increasing part of human existence” (Zola 1972, 487). This explanation of the medicalization process resonated deeply with the progression described by Allison and other participants, in which the emergence of

food in clinical encounters seemed like a conceptual expansion of the purview of medicine due, in part, to the shrinking of other social mediators of eating behaviors. The process was quiet, yet insidious. Notably, it was neither physician-driven insistence nor special knowledge possessed by the physician that perpetuated these encounters. In fact, physicians and medical students expressed deep ambivalence towards involvement in conversations about food, and felt nearly universally unequipped with factual knowledge and time to have productive conversations about eating.

Like Illich, Zola (1972) was clear in not attributing the excessive expansion of biomedicine to the mal-intent of individual physicians. He wrote, “Nor is this extension into society the result of any professional ‘imperialism,’ for this leads us to think of the issue in terms of misguided human efforts or motives” (487). While the medical anthropology literature has often described medicalization in terms of an overreaching of a hegemonic biomedical system due to “bureaucratization and rationalization,” commonly for economic benefit or for the exertion of social control, my ethnographic data showed instead that patients and systemic forces (medical, pharmaceutical, and food industries, as well as food culture) mutually drove the medicalization of food. The profit-seeking influence of the aforementioned systems will be discussed at length in Chapter 7.

Clinical ethnography provided an *in situ* view of the dynamic process of medicalization as it plays out in clinical encounter. Allison’s experience highlights several salient themes in the process of medicalization of food practices. At the level of the clinical encounter, patients like Allison often approach medical conversations seeking “management” of their eating by professionals, turning to physicians for guidance on what to eat. In a divergence from the medical anthropology literature we have discussed,

I argue that patients (predominantly women) desiring a greater incorporation of food into the clinical discourse facilitate the medicalization of eating behavior in my fieldwork site.

Women advance the medicalization of food

Medical anthropology literature has often portrayed women as resistant to medicalization. The medicalization of female reproductive processes (such as menstruation and childbirth) and the creation of mental health categories argued to be “outgrowths of the sexism of psychiatry” (Pugliesi 1992) serve as oft-cited examples in which medicalization is decried by feminists as an outgrowth of patriarchy. Margaret Lock, a prominent Canadian medical anthropologist, wrote,

At the same time certain feminists, among them anthropologists, publicly characterized medicine as a patriarchal institution because, in their estimation, the female body was increasingly being made into a site for the technological intervention in connection with childbirth and the reproductive cycle in general. (Lock 2004, 118)

However, Lock argued that perceiving rejection and suspicion as the invariable feminist response to medicalization incorrectly oversimplifies the dynamic positionality of women with relation to medicalization. She stated, “in certain situations the majority of women apparently think that medicalization coincides with their best interests” (Lock 2004, 110). In a book entitled *Pragmatic Women and Body Politics*, Lock and Kauffert (2000) contended that women will often evaluate medicalized intervention for themselves and (possibly) for their family, and act accordingly. Indeed, when it came to the

medicalization of food within my field site, I observed that female patients actively brought food into the clinical fold.

During our conversation, Allison explicitly outlined her attempts to discuss food with her doctor. In my participant-observation in the clinical setting, there were many examples of conversations in which doctors and patients discussed the importance of food. In these conversations, I observed a range from subtle to overt negotiation of the relevance of food to the creation of a treatment plan. Below, I present descriptions of two clinical scenarios in which the patients, Karen and Lisa, and their respective doctors carried out these dynamics in their clinical interactions.

As Dr. Carol enters the examination room, Karen, a 55-year-old woman, interrupts Dr. Carol's greeting by leaning forward excitedly and thrusting a book into Dr. Carol's hands. "The parts that say Dr. Carol I want you to read and then I have questions on my phone." She goes on, "If we could find what's causing my chronic inflammation we could get rid of my pain."

For the rest of the appointment, Karen provides extensive analysis of her food intake and corresponding inflammation symptoms. Dr. Carol interjects, "How has taking your medication been going?" and Karen says impatiently, "No, I'm off all my meds. I haven't been taking them!"

Dennis, Karen's husband, leans forward and explains to me that Karen had been taking high daily doses of narcotic medication to ease her chronic pain, which Dr. Carol and Karen had agreed might be exacerbated by consumption of certain foods. Dr. Carol is a biomedical doctor who practices functional and integrative medicine, a system-based approach to medicine in which quality food is considered foundational to good health. Karen began seeing her specifically because of her willingness to consider food modifications alongside other treatment recommendations.

Karen clearly sets the agenda for the appointment. She animatedly brings forth discussion topics and brushes aside the questions posed by Dr. Carol that she finds cursory or irrelevant. She has clearly prepared for the meeting and has a specific set of items she wishes to review with Dr. Carol.

Karen was one of Dr. Carol's many female patients who arrived to their clinic appointments with notes and reading materials (usually printed from the internet, occasionally passages in books). Several patients also brought handwritten notes (either in a separate notebook or in binders with medical documents), comprised of lists of questions to remember to ask Dr. Carol. Many patients brought food journals in which they had recorded notes with their daily food intake and symptoms. Often, discussions in the clinic made it clear that patients had analyzed their food intake and symptoms prior to the appointment, as they put forth their own theories to Dr. Carol as to the relationship between their eating and their symptoms.

Another example of a female patient seeking medical expertise regarding food took a completely different course. During her appointment, Lisa, a patient in her 40s, repeatedly asked her doctor what she should be eating to stay in remission from the breast cancer she has been diagnosed with several years prior. These requests were continually disregarded by her doctor, who was focused on discussing the symptoms for which she should be surveilling in order to promptly detect any cancer recurrence or spread. During their conversation, Lisa heard about signs of illness including breast pain and nipple discharge, back pain from the spread of cancer cells to the bones in her back, and headaches from the growth of cancerous tumors in her brain.

I spoke with Lisa in the clinic waiting area and asked if she would be willing to meet for a more extended conversation about her experience. She agreed and later invited me to her home in Minneapolis. When I went to see her, she had set out fresh bread and butter on a wooden cutting board, alongside a French press full of fresh coffee and a pair of earthen mugs. She told me that she had baked the bread earlier in the afternoon. As I

took the chair across from her beside the living room fireplace and took out my voice recorder, she pointed to the butter and said, “Apply as much as you’d like, that’s what we say around here.” From there, we spoke for several hours as her two young sons ran around, occasionally twisting newspaper and throwing it into the fireplace, and intermittently jumping into the conversation to ask questions.

Lisa told me about growing up on a farm, which shaped her early food philosophies. When she said that her father raised beef cattle when she was a child, her younger son jumped up and down on the couch and yelled, “HE DID!?” Lisa then told me about her marriage and we eventually spoke about her cancer diagnosis, treatment, and remission. We discussed the food questions that stemmed from surviving cancer. When I asked if she had ever been guided on what to eat by any of her other doctors, she stated,

No. I mean generally, doctors **[laughs]** I mean I spend a lot of time at the cancer center and generally doctors are like, “You already have it figured out. We don’t need to talk about this.” Like my oncologist that I had during cancer treatment...I remember asking her at the end of an appointment, “What is the anticancer diet that you would recommend. Like what should I be focusing on?” And she said to me, “You read Mother Earth News. You already know... you already know what to eat.”

I asked if she, like Allison, was seeking a specific prescription of what to eat, and she responded, “No, I just wanted [to know] what comes to the top of her mind. What’s the most important thing that doctors see and read over and over again.” While Allison and Lisa both highlighted looking for specific guidelines (prescriptions) of what to eat, Lisa’s focus is on learning about dietary modifications that could aid in preventing cancer. She pointed out that although she can and does educate herself extensively on the health effects of food, she does not have specialist expertise about her body on the cellular level

at which doctors, particularly oncologists, operate. It is this perceived expertise that keeps Lisa posing questions about food to her doctors, despite the unsatisfactory answers she continues to receive. Lisa is not seeking structural guidance. She seeks specialist expertise to intervene in a specific problem (cancer and possible recurrence). Her request for information about food is unmet, *despite* fitting within the biomedical epistemology of specialized interventionism.

While Lisa is among the numerous women who made specific inquiries as to how to alter their diets in response to symptoms and disease, I did not see men seeking this type of information from their doctors. As she described her frustration at the dearth of advice relating to food, Allison noted that her father sought the exact opposite from his clinical encounters, resenting dietary advice that he was given. He had exhausted medical intervention options for a food sensitivity, and as his issue was so unambiguously food related, his doctor referred him to a dietician, who told him that he needed to modify his diet. Allison explained,

...even my dad who has [had] these issues [food-related skin symptoms] his whole life, he just kind of wanted a doctor to tell him, “Take this pill. That problem will go away.” *One* time, he went to see a dietician at Mayo [Clinic]. And they sat down and she said, “Well you’ve gotta eat better.” And they talked about it. He got very offended and so... it has to be very difficult for doctors to know who *wants* to hear that information, who’s going to take it.

In this medical interaction, Allison’s father received advice about eating because he was experiencing a health condition that was caused exclusively by his diet. Even so, he resented the opinion given, which Allison said he perceived as an “intrusion” regardless of the fact that it was the medical opinion of a doctor at one of the most highly esteemed

medical institutions in the country. I experienced men reacting to eating advice with emotions ranging from vague interest to disregard to frustration in the clinic as well.

For example, Brian, a man in his 30s, came to Dr. Carol's clinic with hypoglycemic (low blood sugar) symptoms including headaches, dizziness, and stomach pain between meals. Dr. Carol gave several recommendations, including "eating a handful of nuts" with his morning coffee. When I went to his workplace to see if this food advice had impacted his behavior, he said, "That kind of advice just goes in one ear and out the other. Food isn't on my mind like that. I just eat what's in front of me." Following his appointment, Brian continued to eat as he had been eating, and he continued to experience the symptoms that had provoked him to see his doctor. He was "not really interested" in further exploring ways to change his diet.

In Chapter 2, we examined literature on the distinct levels of concern ascribed to eating by women and men, despite the universality of food's relationship to health. I asserted that American women are socialized to see their bodies (and the bodies of those under their care) as something to be "managed" through food. The theoretical gendering of food preoccupation was plainly paralleled in the lived experiences of patients in Hennepin County. The clinic, and the possibilities of professional expertise regarding eating therein, served for female patients as a potential avenue for releasing some of the continual onus of food considerations. Unfortunately, the realities of the clinic interactions fell short of this expectation.

Individual physicians resist the medicalization of food

Both patients and physicians openly acknowledged the looming limitations of the biomedical system in providing the kind of information women are seeking. Thus, the rising prominence of the clinic as a realm of formal instruction about eating is a complicated phenomenon. Peter Conrad, an American medical sociologist, described how the medical profession claims elements of life linked with illness “irrespective of its capacity to deal with it effectively” (Conrad, as cited in Friedson 1970a, 250). Conversations between female patients and their doctors about food that locate eating squarely within the medical jurisdiction even in the absence of illness exceed even Conrad’s estimation of the bounds of medicalization. At the level of the patient–doctor conversation in the clinic or hospital, doctors resist in-depth discussions with patients about food.

Physicians are quick to list food as a contributory factor in most diseases and medical issues, including heart disease, knee pain, anorexia, diabetes, and an increasingly wide-ranging array of possible food-related sensitivities. However, beyond evoking food as a causative agent in circumstances ranging from specific symptoms to potential future ill health, physicians provide very little in the way of precise recommendation. While this is a *kind* of medicalization (bringing food into the medical jurisdiction), it is not the kind that women are looking for. Rather, patients like Allison, Karen, and Lisa are seeking process guidance to alleviate the mental load of constantly making food decisions alone. After naming food as a contributory factor in a patient’s disease, the physician most often refers the patient to specialists for the management of symptoms: gastroenterologists for gastrointestinal distress symptoms (pain, gas, bloating, blood in stools); dieticians and nutritionists for assistance in selecting better foods (such as patients who struggle to lose

weight); and cardiologists, nephrologists, and other experts with respect to the organ systems ultimately affected by poor diet.

For patients like Allison who were seeking “food prescriptions” relating to preventing the progression of medical symptoms, these referrals were readily perceived as brush-offs. There was an uncomfortable disjuncture in talking about symptoms and diseases with one healthcare provider (doctor) and talking about the contributory diet with another (nutritionist or dietician). If diet is known to play such a critical role in causing disease, Allison wondered, why were her doctors unable to engage her in a more in-depth conversation about what she should be eating? Suspecting that this disjuncture between the expectations of patients like Allison and the support they received would be multifaceted, manifested throughout various stages in the medical training system, I began exploring this disconnect through the perspectives of other patients, doctors, and medical trainees.

Standard biomedical setup does not facilitate food discussions

Conversations with physicians and medical students illuminate several key sources of resistance to in-depth engagement with food, despite the well-known role of food in many disease processes. Perceived lack of time and expertise, with 15-minute clinic appointment slots and a paucity of training about food in medical school (lack of formal food education), were cited as major barriers for discussing food during clinic visits. As medical school and residency training are notoriously stressful and time intensive, most doctors spend the majority of their formative years in environments that

preclude the formation of consistent, healthy food habits. Finally, the compensation structures in the medical system favor interventions (prescriptions, surgery, referrals) over lengthy discussions about food.

Dr. Carol is one of three doctors at Hennepin County Medical Center's Whittier Clinic who practices integrative medicine. Also called functional medicine, this is a more holistic style of practice compared to Western biomedicine, with practitioners often incorporating aspects of "alternative" medical systems (acupuncture, chiropractic, etc.). The homepage of the Institute for Functional Medicine (2017) states, "Functional medicine is a personalized, systems-oriented model that empowers patients and practitioners to achieve the highest expression of health by working in collaboration to address the underlying causes of disease." The interpretations of "personalized" and "systems-oriented" are manifold, and enacting these values depends in large part on the amount of time and resources afforded to a practitioner within a particular practice setting. In the integrative medicine frame, lifestyle and food are understood to be the major roots of chronic disease, and the standard acute care model is seen as ineffectual in the majority of cases of long-term diseases. Accounting for the complex conversations needed to discuss topics relating to the "roots of disease" (for example, diet, stress, hormones, immune function), integrative medicine appointments at Whittier clinic are scheduled for 30 minutes (with hour-long initial intake appointments), compared to the 15-minute visit typical of the biomedical primary care model.

Dr. Carol, who was in her late 50s at the time of the study, has spent most of her career working within the standard biomedical system as a family medicine doctor in the Indian Health Service and then at the Community University Health Care Center. We met

in her office during a break from an employee resiliency training session at Whittier Clinic that Hennepin County Medical Center was offering in an effort to address some of the stress and burnout that employees of the health system experience. We began our discussion by talking about how she became interested in the role of food in illness throughout her career. Dr. Carol has been curious about the effects of food since her childhood, and healthy eating was a memorable part of her early family life. She stated, “We ate whole foods [a plant-based diet consisting primarily of vegetables, fruits, and whole grains] before anyone talked about it.” In the early part of her career, she was surprised by how unwilling patients were to talk about food, and how nebulous the link between food and health seemed in their minds. When I ask about the prominence of discussions about eating in her current clinical discussions, she replied,

Pretty much at this point food is one of my primary topics as an integrative and holistic and functional medicine oriented provider. That is what I call “first medicine.” So, yes. I talk about food all the time. I try to meet the patient where they are with their understanding of food and nourishment, and then, based on why they’re coming to see me, you know their symptoms, their conditions, maintenance of good health or whatever, then I move from there.

She animatedly continued, explaining why she sees educating patients on the effects of food as one of her major responsibilities as a primary care provider. She stated,

I mean it has just been fundamental to how I believe we need to stay well as human beings. So I just realized slowly over time how crucial it is, not just for myself and my little family, but as a physician to bring this into an education realm in my practice and to continue to learn more about it.

Despite believing that food is central to health, incorporating extensive discussions about food into her clinical practice took years for Dr. Carol to accomplish, and continues to involve compromises in other areas of her life. She spent many years in clinics that did

not offer her the time needed to conduct in-depth conversations with patients about food. She thus spent the majority of her career rushing to cover too many topics in a short time period, because patients were generally unable (due to time or finances) or unwilling to schedule the number of visits required to cover such vast information in the 15-minute increments that the standard appointment schedule required. It took several iterations for her to create a work environment that would enable her to take more time with patients, but she still finds that the amount of content that she and the patient wish to cover in an appointment always exceeds the allotted time.

I asked Dr. Carol how she is able to incorporate food discussions in such short, already rushed clinic visits. She stated, “Well... so you’re going to be late. If you’re on the 15-minute model and you make this a part of your practice, to truly counsel and educate patients, you’re going to always be late. So get used to it until we change that piece of the system. Really.” Dr. Carol has come to terms with the fact that she is constantly running far behind schedule. However, despite being in a practice environment that allows more time for each patient interaction, clinic staff and patients express frustration at her frequent tardiness. One patient told me that she tries to schedule the first appointment of the day because that is the appointment that is most likely to run on time, with subsequent appointments falling later and later. I saw Dr. Carol often being met with frustration (“You’re so late!” or “I’ve been waiting such a long time!”) as she first entered a patient room. However, this irritation seemed to fade quickly as patients realized that they now had Dr. Carol’s full attention for as long as they needed.

Dr. Carol routinely stays for several hours after her last clinic patient leaves in order to do the charting and paperwork that was impossible to complete during or

between her clinic visits. She feels that these extended conversations are important enough for her to give up her personal time in order to ensure that they happen in an appropriately complete manner. However, cutting conversations about food out of the clinic visit seems like an inevitability for providers who do not attribute such a strong connection between food and disease and see it as their clinical responsibility to address eating practices with patients. Observing the degree to which nonsuperficially discussing the link between food and symptoms prolongs each appointment, and subsequently each workday, shows that time limitation is a glaring barrier to meaningful discussions about food in the primary care context.

Another major impediment for physicians in talking about food is lack of knowledge and expertise about the particularities of healthy eating—content that remains prominently and curiously absent from standard medical curricula. Despite Dr. Carol’s longstanding philosophy that food and medicine are inextricably linked, she initially found it difficult to bridge these two interests in her medical training and clinical practice, largely due to her own perceived lack of professional expertise. From her own eating practices and personal experiences of how foods made her feel physically, she had developed an intuition for what was “good to eat” (from a health perspective), but did not have the professional training she felt she needed to advise patients on specific questions. She stated, “I mean I tried to learn more [about food] in med[ical] school and it just wasn’t available.” When I asked Dr. Carol if she had learned anything about food in her undergraduate or medical education, she said,

Not so much... no. I would say no. I took a nutrition class in college that was very foundational, you know, built on the macronutrients. I don’t much remember much from that, except, you know kilocalories per gram of food or whatever. It was all calories and carbs and protein and fat. Um, I’m thinking... in medical

school... we just learned [that] food is something that goes through the digestive system.

Due to this lack of training in her formal medical education, much of her knowledge about food has come from her personal study. She reads widely about the effects of food through the functional medicine, Ayurvedic, and Tibetan medicine frameworks, and investigates biomedical studies on nutritional excesses and deficiencies. She says that a food prescription for one patient is going to differ from that for the next. “Even though parts of it are good for you and parts of it are good for me, there’s nuances in there. [Getting] to that level of specificity takes a bit more time.” Again, the onus of taking time to learn about food and nutrition falls upon Dr. Carol. She cannot bill for this time; thus, it is financially uncompensated by the medical system.

Medical schools provide insufficient training about food

Formal medical education about the effects of diet on health has remained largely unchanged since Dr. Carol’s training. During the rapidly escalating obesity epidemic in the 1980s, the National Research Council Committee on Nutrition in Medical Schools published a landmark study outlining the need for nutrition education in medical school, and a requirement for 25 hours of nutrition education in each medical school’s curriculum was subsequently established (Nutrition Education in U.S. Medical Schools 1985). According to a 2010 follow-up study by Adams et al. (2010), only 38% of U.S. medical schools met the 25-hour nutrition training requirement, demonstrating that

nutrition education in medical schools continued to be inadequate even by the minimal parameters set forth in the 1980s.

There have been countless calls in recent years for the integration of more extensive nutrition training in medical education, perhaps most impactfully by Nathan Morris, a second-year medical student at Harvard. In the *Journal of the American Medical Association*, a widely read and highly regarded medical publication, he stated that “Despite an obesity epidemic and increasing burden of chronic, diet-related disease in the United States, medical schools have continued to neglect nutrition education over the past several years” (Morris 2014, 841). He described the content of nine hours of formal nutrition education that he and his classmates received (with 45 minutes of classroom time dedicated to obesity), in comparison to 60 hours of cardiology instruction in the second year of medical school alone. He pointed out that patients look to physicians as a trusted authority on nutrition information, but the content of medical training does not afford doctors with this authority. He wrote, “Deficiencies in nutrition education help explain this disturbing mismatch between the skills of physicians and the needs of patients” (Morris 2014, 841), and pointed to lack of physician education and the ensuing “poorly trained physician workforce” as a notable structural barrier amidst the abundant structural barriers patients face in attempts to eat well.

In order to ascertain the relevance of these national trends in the lived experience within my fieldwork context, I spoke with several medical students currently in the didactic portion of their education. The perception of being exceedingly undertrained in nutrition echoed throughout these conversations. When I asked second-year medical student Bernadette what she had learned about food in medical school, she said, “I have

not gotten very much information about food at all through my medical education. Maybe [about] basic vitamins and minerals in first-year biochemistry, and a lot of... obesity causes all these illnesses. But nothing more than that.” Fourth-year medical student Emma corroborated this statement. When I asked her to describe the medical education surrounding food, she said,

Very, very, very little. Disappointingly. So, first year we learned about nutrition in terms of like, macronutrients and micronutrients and metabolism, but you don’t learn about it in terms of food as more than that... I don’t feel confident in prescribing nutritional advice, really. I feel like what I prescribe is based kind of on what I’ve learned *myself*, and through the yoga teacher training, and not through what I learned in medical school.

Emma is a former track-and-field college athlete who self-describes as someone who “enjoys eating healthy foods.” Amongst her medical school colleagues, she considers herself to be much more aware of nutrition, and eats in a manner she considers very healthy. However, her knowledge about food comes from her personal experience and she does not feel comfortable using her experience as the foundation to make prescriptions to patients. Given the deficiency of nutrition information in her medical training, she, like Dr. Carol, feels that the onus of finding scientific data on nutrition to help her make specific statements about nutrition is on her, and that this occurs outside of her already demanding formal medical education.

Maria and Bernadette are two medical students who have undergone eating disorder treatment at various points in their lives, and their perspectives on food discussions in the clinical context straddle the nexus of patient and provider. They independently described what they found to be an astonishing insufficiency of food

counseling in the biomedical system, even in the treatment of their conditions (eating disorders), which were unambiguously eating-related. Maria said,

When I think about food through [a] medical perspective it is really what I learned when I went through the eating disorder treatment. We had to have, you know, a fat and a fruit and a protein for every meal. A Pop Tart counted as a fruit and a fat. And I was like, “dude, there’s nothing that’s *actually* food in this. You know, it’s *crazy*.” So intellectually it didn’t work for me, but I thought that, okay, these are experts.

In a similar vein, Bernadette specifically recalled being told to consume bagels with bacon to regain weight. In this case, Bernadette felt a tension between an “expert recommendation” and her own intuition that this would not be a healthy choice.

Bernadette found in medical school that while many patients asked about food and eating, the responses to these requests seemed superficial. While conventional medical teaching repeatedly asserts that food creates problematic symptoms and disease states for patients, the education stops short of teaching *how* and *why* these detrimental food habits take root, and how to reverse them. As a result, students feel largely underprepared to provide guidance on the topic of eating, specifically, and behavior modification, more generally.

Maria stated, “We don’t address *why* people have high blood pressure, *why* they’re depressed. We give them antidepressants. You know? We just try and give a pill for things rather than getting to the root of it.” For Maria and Bernadette, the dubiousness of the nutritional information they had received during their respective eating disorder treatments detracted from the authority of their treatment providers. They did not feel as though they could relax, trusting the expertise of their providers. Instead, constantly being told that their eating (or lack thereof) caused poor health without coupling this with useful dietary prescription reinforced a state of vigilance and

surveillance about food. Lacking culinary regulation from culture or cuisine, patients like Maria and Bernadette turn to the medical establishment to manage their constant anxiety about what to eat. However, these interactions either provide unconvincing information, or exacerbate anxiety by magnifying the risk of eating “the wrong foods,” without clear and comprehensive guidance about alternatives.

Protocols: Patients use personalized cuisines for one to try to manage the perceived risks of eating

Patients are taught by the medical institution to regard food as potentially injurious, but are left without sufficient guidance on how to mitigate the risks presented by food. In my ethnographic study, I observed two major ramifications of the perceived ubiquity of risk: the first was a state of food surveillance and the second was the protocolization of eating. There is widespread societal perception that food is a potent transmitter of risk. Attempts made by women to gain professional support to manage this risk are often unsuccessful in the current medical climate, for the reasons discussed in this chapter. This means that the charge of managing this risk falls upon the woman herself. One important component of this risk management is self-surveillance of eating. According to Peterson, a sociologist of health and disease, “Through their deployment of the construct of ‘risk’, both medical and feminist health discourses call upon women to make themselves objects of self surveillance. One outcome of this is that ageing women’s desires are circumscribed by a responsibility to resist their own decrepitude” (Peterson

1997, 7). Indeed, within my clinical context, questions from patients seemed to stem from the perceived risk inherent in eating, and the consequent stress of self-surveillance.

A startling example of the potential extent of self-surveillance presented itself when Erica, a 38-year-old, relatively healthy veterinarian lamented her decision to eat a banana a few days prior to her doctor's appointment. She stated, "I didn't know what to eat and so I said, I really want that banana. And it's a banana, it's not *horrible*, but it is sweet." Her obvious confusion at what would be a "safe" food to eat and her clear remorse at indulging in what seemed like a perfectly innocuous and "healthy" choice attuned me to the threat she perceived in food. She did not explain a particular reason why she thought that eating a sweet food might be detrimental, but the phrase "it's not *horrible*" articulated a negative perception. Other patients conducted similar dietary surveillances, facilitated through acts such as keeping written food diaries. They described the restrictions they had imposed on their eating at clinic visits. As I began to pay closer attention to the restrictions patients described, I noticed more and more patients talking about their food "protocols."

The concept of food protocols as a specific manifestation of self-surveillance was exemplified in an interaction in which a patient named Amy, experiencing symptoms of irritable bowel syndrome (frequent diarrhea, abdominal pain, bloating, and other abdominal symptoms) came to a clinic appointment. The doctor asked, "Are you pooping every day?" to which Amy responded, "Well I am if I do follow my *protocol*. When I eat gluten or go off the protocol, it's just *classic* [diarrhea]." In this instance, Amy was referring to an elimination diet protocol, in which she had removed gluten, dairy, nightshade vegetables, and corn from her diet in order to help manage her irritable bowel

symptoms. Several other protocols, including the “paleo autoimmune protocol” (AIP), “Marshall protocol,” and “gluten-free protocol” were subsequently mentioned by patients in clinic interactions. In these instances, the word “protocol” refers to adherence to a diet that includes or excludes specific foods. While doctors in my ethnographic context did not specifically prescribe these protocols (patients I interviewed most commonly learned about protocols through the internet), protocols did provide shorthand by which doctors could get a sense of a patient’s diet. More importantly, patient pursuit of pseudo-medical food protocols when confronted with diet-related symptoms indicates an uncertainty in dietary practices. Food “protocols” were used to mitigate food-related symptoms and modulate food anxiety, functioning as one stand-in for cultural food regulations. These protocols are presented as “medical” solutions, typically endorsed online by a physician or healthcare professional. For example, Amy Meyers, MD, made the AIP famous, and many other protocols have the public endorsements of physicians. They serve as one solution to the mismatch between the concrete guidance that women seek from the medical institution and the (in)ability of physicians to provide this depth of expertise. While they help to varying degrees in managing symptoms, they are unhelpful in managing (and can even exacerbate) the chronic anxiety about eating the “right” thing, and they leave the responsibilities of eating with the individual.

Conclusions

This chapter utilized clinical ethnography to examine the dynamics of eating as they manifest in discussions between patients and doctors. I argued that women, who

typically internalize more anxiety in relation to food compared to men, actively medicalize eating processes. Women bring food into the medical jurisdiction by asking doctors to provide guidance and prescriptions about what to eat. Meanwhile, physicians resist this medicalization due to the uncompensated time needed to thoroughly discuss issues related to eating. Physicians also feel that they lack the knowledge and expertise needed to meaningfully discuss food with patients, partially due to inadequate training regarding diet in medical school. The time and financial incentive structures in the clinical context de incentivize in-depth discussion of food despite its clear implication in disease processes. Protocolization of eating is one manner in which patients attempt to control symptoms through food within a medical environment that does not offer adequate guidance on what to eat through one-on-one discussions between doctors and patients.

Chapter 5

Common Ground ethnography

Participant-observation at Common Ground Meditation Center comprised a major source of ethnographic data for this study. In this chapter, I will describe various facets of Common Ground's physical, interpersonal, and ritual spaces. First, I describe the physical meditation center, the surrounding neighborhood, and the rural retreat center. I then circumscribe the particular Buddhism(s) enacted by the center participants, contextualized within the Vipassana meditation lineage and the local cultural milieu. From here, I describe Common Ground's participants and their motivations for partaking in the center's various activities. Next, I explore the workings of a Common Ground retreat, focusing on the retreat food rituals. Finally, I analyze the mechanisms of food habit change in the Common Ground environment. I argue that behavior change paradoxically occurs when participants' attitudes towards foods "loosen." I investigate what practitioners mean when they characterize attitudes towards food as "tightening" and "loosening," and then discuss three interrelated facilitators of "loosening" attachment to food. These are (1) the suspension of judgment, which is essential for cultivating an intimate and nuanced understanding of craving through direct observation of eating experience; (2) diminished need for individual control, enabled by the socially regulated framework for eating that operates in the retreat setting; and (3) the diminishment of painful thought patterns about food. In combination, these interrelated threads alter, to varying degrees, some Common Ground participants' attitudes towards eating.

Participants consider these modifications to be productive, healthy, and less compelled by craving than their behaviors prior to beginning Buddhist practices.

Common Ground facilities

The exterior of Common Ground is nondescript, reminiscent of its former existence as The Diner, a neighborhood “greasy spoon” diner restaurant. The building exterior has been stripped bare to an earthen brown. It sits beside a perpetually closed credit union, occupying a corner opposite the partially dilapidated Hexagon bar. A few buildings down the street, a liquor store with a colorful graffiti wall stands beneath its large white-and-red painted sign. In this area, the residential bleeds into the industrial. An uneasy gloom lurks as if nearby—not quite permeating—perhaps from the deserted buildings, the solitary hooded figures inhabiting the liquor store parking lot, or the proximity to the infamous “Hub of Hell,” a gritty corner historically known for dive bars, fights, and police violence. This corner maintains its reputation despite the vibrancy of surrounding areas.

As I approach Common Ground and peer through the window, I see people sitting still in neat rows, or heads of graying hair moving in gentle unison during the yoga or qigong classes in the main meditation hall. Around the corner, the entrance to the building has a carved wooden sign that reads “Common Ground,” and another sign describing the yellow and pink wildflowers that comprise a small, lush rain garden. Once inside the main door, the interior of the building is sparse and orderly, yet warm. Statues of the Buddha and other Buddhist figures sit interspersed throughout the main rooms.

Spaces are clearly labeled and equipped for their respective functions. For example, brown cafeteria trays line the wooden shoe racks to catch the snow and ice that drip from winter boots. Labeled bins hold nametags for the center's various group activities. The kitchen cupboards have clearly marked spaces for mugs, plates, utensils, and teas.

Past the main office, common kitchen area, and unisex restroom is the expansive meditation hall. Immediately outside the meditation hall, a large bowl sits with paper cranes in muted colors hanging above it. This is the *dana* bowl, where participants can place donations. Inside the hall, Black *zafus* (round zen meditation cushions) atop *zabutans* (rectangular cushions) are neatly arranged in a semicircle, facing towards a raised wooden rectangular platform at the front of the room. The room's only adornments rest atop a wall-mounted glossed wooden installment above the platform: a Buddha statue, fresh-cut flowers, sometimes an unlit candle. The meditation hall is lined with folding chairs, occupied by people who enter the room late through one of the two doors (which are weighted, so that they close silently), or by those whose bodies make seated floor meditation uncomfortable. After a meditation session, participants fold and transport chairs to the basement (the only part of the building with clutter or excess) in preparation for the yoga, qigong, and other classes that take place in the meditation hall and require open space.

Common Ground people

Common Ground follows the Insight Meditation (Vipassana) tradition. Spirit Rock (Marin County, California) and Insight Meditation Society (Barre, Massachusetts)

centers form the large, well-known American establishments of this spiritual lineage. Insight Meditation has been practiced in the US since the late 1970s. Sharon Salzberg, Joseph Goldstein, and Jack Kornfield, the founders of Insight Meditation Society, are often credited with popularizing Insight Meditation in the US, while Vipassana meditation is arguably the most practiced and fastest growing Buddhist movement in the country. This rapid growth is often attributed to Insight Meditation's "Westernization" of Theravada Buddhism.

Explaining the prevalence of Insight Meditation in the US, Gil Fronsda of Spirit Rock Meditation Center wrote in the compilation *Faces of Buddhism in America*,

To a great extent this [rapid growth] can be attributed to the practice being offered independent of much of its traditional Theravada Buddhist religious context. This autonomy has allowed the American Vipassana teachers and students to adapt and present the meditation practice in forms and language that are much more thoroughly Westernized than most other forms of Buddhism in America. (Prebish 1999)

Early in the Vipassana tradition, a bifurcation arose between "traditional" and "Western" manifestations of Vipassana in the US. Fronsda described traditional Vipassana in the US as follows:

The most traditional is within some of the more than 1150 ethnic Theravada temples where Thai, Lao, Cambodian, Burmese, or Sri Lankan monastics may function as meditation teachers. Here Vipassana practice is usually intermixed with Theravada forms of worship, chanting, teachings, and efforts at cultural preservation. (Fronsda, as cited in Prebish 1998)

As we will discuss in the next chapter, it is secular mindfulness, in contrast to the more traditional expressions of Vipassana, that has proliferated throughout hospitals, schools, and corporations. Spirit Rock, Insight Meditation Society, and their offshoots such as Common Ground lie somewhere in the middle of the spectrum between the "traditional"

and secular mindfulness manifestations of Insight Meditation. According to the Buddhist Insight Network's *sangha* listing, there are currently over 200 Insight Meditation *sanghas* in the US, including the aforementioned meditation centers.

Common Ground Meditation Center was founded in 1993 in a storefront adjacent to the home of Mark and Wynne, the center's founders (CGMC n.d.). The center's website describes the substantial growth of center attendance over the past 23 years: "While in its early years the morning sits would only see a handful of meditators, now over 500 people pass through the doors of Common Ground each week" (CGMC n.d.). According to estimates by Common Ground's leadership, about 500–700 people per week currently attend Common Ground for various activities.

More precise quantification of the center's attendance proves difficult. Common Ground does not collect data about the demographics of participants, as there is no formal record of participation. Most of the center's activities do not utilize a sign-in process. The economic structure of Common Ground further impedes quantification of center membership. The center operates on a system of *dana* (generosity), meaning that access to the center's activities and the teaching of the *dharma* is freely given, and donations from participants are freely received. Instead of collecting a fixed payment for activities, participants are welcome to make (often anonymous) donations, either in the *dana* bowl or online, whenever they feel moved to do so. Rather than framing their giving in transactional terms, participants at Common Ground are encouraged to donate only when giving stems from joy. This is one of the distinguishing features of the Insight Meditation movement from other Buddhist traditions that teach and practice in the US. Gil Fronsdal wrote, "Within the Insight Meditation movement it is commonly said that the Dharma

has been maintained down through the centuries through *dana*. Within Theravada Buddhism the Dharma has traditionally been taught freely, with teachers supported by *dana*” (Fronsdal n.d., 4). Many of the Zen centers in the Twin Cities, in contrast, charge a fixed amount for programs or have a suggested donation amount.

For these same reasons, it is also difficult to quantify the center’s demographics. The Insight Meditation lineage historically attracted predominantly white, middle- and upper-class participation. My ethnographic participant population reflects this demographic slant at the meditation center. The centrality of racial dynamics during my time at Common Ground, which mirrors trends in Vipassana centers throughout the country, makes this ethnographic context important to discuss here.

Both Insight Meditation Society and Spirit Rock have sought to address the virtual absence of people of color from their *sanghas*². The reasons for these efforts are articulated in the Insight Meditation Society website in a section entitled “A multicultural refuge:”

When the Buddha awakened, he decided to teach out of compassion for the suffering of all beings. IMS [Insight Meditation Society] is rooted in this same aspiration—our mission states that we are “a spiritual refuge for all who seek freedom of mind and heart.”

² The term *sangha*, used frequently in this chapter and throughout the dissertation, needs further definition due to its diverse meanings in various Buddhist communities. According to Oxford Bibliography, the term translates from Sanskrit and Pali along the lines of “assemblage” or “community”. This word has been historically used in Theravada traditions as a community of monks (*bhikkus*) and nuns (*bhikkunis*), people who have “gone into homelessness”, left their homes and lives as laypeople to follow the teachings of the Buddha (Sangha, Oxford Bibliography, 2018). Some types of *sangha* (such as the fourfold sangha) included lay people, but the term largely referred to the monastic institution.

In this dissertation, *sangha* is used as it is understood in North American Vipassana tradition. According to the Insight Meditation Center website, “In modern Western terms, Sangha refers to the community of practitioners on the Buddhist path. We are an open community that is welcoming to anyone who is interested in the teachings and practice we offer” (Community, Insight Meditation Center, 2018). The definition is broad and deliberately inclusive of monastic’s, laypeople. There are no formal requirements for membership in the *sangha*, which includes anyone who self-affiliates as a member of the group.

But it became increasingly clear over the decades that, in terms of racial diversity, people of color were largely absent from our sangha of retreatants, teachers, staff, Board members and volunteers. Were people of color not interested in the Buddha's teachings? Based on the strong attendance at our annual People of Color Retreats for the last 10 years, enthusiasm for the dharma is clearly evident. So why this absence? IMS began a quest a few years ago to better understand contributing factors and to fully address them. We are clear that, if people of color feel IMS is just like many other predominantly white institutions in the country, then it cannot be a true spiritual refuge. In that case, we would be failing in our mission. (Insight Meditation Society 2016)

To address this issue, Insight Meditation Society began offering retreat scholarships to people of color, and created a three-year action plan (from 2013–2015) to examine the racial disparity in the center's attendance, to mitigate the barriers to attendance faced by people of color, to create a welcoming environment for people of all backgrounds, and to teach the *dharma* in a manner that “resonates with a racially diverse sangha by enhancing cultural sensitivity on the part of our faculty and by increasing the number of teachers of color” (Insight Meditation Society 2016). Common Ground seems to mirror Insight Meditation Society's pattern of attendance. White, middle-aged, middle-class people form the vast majority of attendees for many *sangha* activities, though the center has shown commitment to diversifying its participants.

Beginning around 2014, Common Ground formally committed to “Awakening Justice and Unraveling Oppression,” a focus that has led to increased public discourse on issues of racial justice. In response to dynamics similar to those described at Insight Meditation Center, as well as the pertinence of local racial politics underlined by reports of police brutality against young black men, and subsequent Black Lives Matter protests in Minneapolis, Common Ground hosted a 10-week intensive anti-racism course. Interest in the course was widespread, and was followed by increased offerings of talks, seminars,

and workshops pertaining to race, including a three-week course entitled “Understanding our Racial Selves” and a workshop entitled “Waking up to Whiteness.” Several participants (white and nonwhite) expressed the value of contextualizing racial issues within the Buddhist framework, particularly as the protests exposed painful longstanding racial tensions.

On the other hand, several Common Ground participants of color described the difficulty of robustly engaging with a predominantly white *sangha*. During a Practitioners of Color Community Group meeting, a black participant articulated his feelings of “otherness.” He said, “Sometimes when I come here I feel like everyone is the same and it’s hard to tell what’s *dharma* and what’s white people being white people.” He explained that practicing with other people of color alleviated the feelings of being “other” that sometimes prevented his deeper engagement with the Common Ground *sangha* at large. In one effort to address this problem, the center runs a host of small groups for people who may not affiliate with the predominant demographic. For example, a Practitioners of Color Community Group, DharmaCore Queer Meditation Group, a meditation group led in Spanish, Gay Men’s Practice Group, and Teen Meditation Group are all highly attended and demonstrate active engagement by practitioners outside the typical Insight Meditation profile.

Description of the center’s demographic is complicated by the widely differing attendance between various activities. For example, there are two weekly practice groups on Sundays, one at 10:30 am and the other at 7:00 pm. The content—approximately 30 minutes of meditation and a *dharma* talk—is exactly the same in both sessions. However, during the morning session, the meditation hall fills with many young, diverse families,

likely due in part to the children's group that coincides with the weekly group. The evening session is typically split between people in their 20s and 30s and white people in their 60s. The Wednesday morning qigong session is normally attended exclusively by white people of middle age or older. However, despite these longstanding attendance patterns, "long-timers" at Common Ground describe a discernable shift in the center's demographics. According a man who has attended Common Ground for many years, and now works in the front office, there has been a steady rise in center attendance by "young people, queer people, and brown people" in the past five to eight years.

Rather than focusing specifically on demographic sampling for my research, I concentrated on finding participants who were engaged in the Common Ground community with some depth and frequency. I wanted to speak with people who attended Common Ground on a regular basis, to differentiate them from those who attended in the spirit of a brief mindfulness intervention. For example, many exclusively participate in the perpetually popular Introduction to Mindfulness Meditation course but their participation does not extend in chronology or scope beyond the Mindfulness course. To connect with participants who attended Common Ground with some regularity, I sought people whom I saw repeatedly at Common Ground—participants who seemed widely invested in the center's activities. This degree of participation in the Common Ground activities immediately begged the question of motivation: what prompted these people in the Hennepin County context, with nearly unanimously non-Buddhist upbringings, to take significant time from their invariably busy schedules to engage in Buddhist practices at Common Ground?

Most practitioners describe various forms of psychological stress as the initial impetus for exploring Buddhism. One young woman talked about coming to Common Ground after her father died of a drug overdose. Another described intense feelings of burnout during her graduate school training. Many told me about their long-term experiences of anxiety, attending Common Ground at the recommendation of friends who had benefited from meditation practices or news articles touting the calming effects of meditation. Still others described their substance addictions and relapses (some of whom attend a dedicated Common Ground group entitled “Mindfulness in the 12 Steps”). On one retreat, I watched from the other side of the dining hall as one male participant, forearm covered in tattoos, stared at his veins as he clenched and unclenched his fist. Many participants described a desire to learn how to manage various forms of craving: for relationships, for calm, for substances, for companionship, for stability. Various forms of entangled cravings also seemed to underlie issues that are so difficult to address in the biomedical context. In the Buddhist center, these cravings are directly recognized. This makes Common Ground an intriguing ethnographic counterpart for delving into questions of craving, food attachment, and addiction that I have observed in the biomedical spaces.

One participant described the Common Ground community as follows: “I think of the community in thirds. There are the people who are the anxious, frazzled out types for whatever reason. There are the recovering addicts. Then there are the people who had really gone through something. Sometimes they stop coming once they are feeling better.” While there were practitioners who cited curiosity or academic interest as their motivation, I observed that participants who described recovery (from a traumatic life event, anxiety, depression, or addiction) as their initial motivator seemed to devote more

time and energy to immersing themselves in the Common Ground activities and community. For example, when asked about his relationship with Buddhism, Adiye, a second-year medical student and long-term Buddhist practitioner, said that he had started meditation after a serious “nervous breakdown” while “super stressed out” during college: “...so I have maintained a personal meditation practice for the last 11 years. And it’s to keep from going crazy.” Jack, a man who sporadically attended Common Ground meditation sessions for years, made attendance a priority after experiencing anxiety during a stressful time in his life. He said,

Well... I think... last year was kind of a challenging year for me. And over the summer, some things happened that were... uh... emotionally challenging and I was dealing with more anxiety than I normally do. And I know that meditation... and uh... just Dharma teachings are very stabilizing for me and very helpful.

Conversely, during the course of my research, several participants reduced their participation in Common Ground or stopped coming entirely once they “felt better.” Others maintained or accelerated their participation in Common Ground activities and their personal meditation practices as they continued to perceive their involvement as making them “feel better,” although often not always in the specific ways they anticipated. In subsequent sections, I will examine the places, rituals, and practices to which practitioners attribute their affective changes, focusing focus primarily on changes in food habits resulting from participation in Common Ground activities.

Common Ground retreats

Prairie Farm retreat property was purchased in 2013 following a decade-long search for a suitable and affordable space for Common Ground members to retreat year-round. Located approximately 1.5 hours by car from the Minneapolis Common Ground Center, the retreat property is situated in a large field bordered by woods in rural Wisconsin. Stepping into the retreat center entryway, Sarah (who typically practices meditation with a different organization that does not do residential retreats, so joins Common Ground occasionally for meditation sessions and for this retreat) remarked, “Whoa, this is totally Common Ground!” The two Common Ground spaces do indeed share an aesthetic. With broad, golden wood plank floors, large windows, and an open-plan minimalism, the “Amish Zen,” description offered by one retreatant fits. The large kitchen features open shelving stacked with ceramic dishware made by local (Minneapolis) artists, and fresh-cut flowers adorn the enormous dining table and meditation space. With five private bedrooms, the retreat property is used for small retreat groups.

Larger retreats lead by Alex, Common Ground’s guiding teacher, continue to take place at Holy Spirit, a retreat center inhabited and managed by a group of Franciscan nuns. There, a sizeable meditation hall and large kitchen and dining space accommodate the always fully attended retreats, for which participants are selected by lottery due to the enormous demand. The consistent interest demonstrates motivation and dedication to achieving what is perceived as the positive effects of retreat practice. Participants cite mental clarity, freeing the mind from negative thought patterns, ease of implementing healthier habits, commitment to “wholesome intentions,” more joy, less negatively patterned behavior, and a feeling of community and belonging as some of the reasons

they feel compelled to carve time out from their work and families to attend the silent retreat. Retreats also afford time away from the daily responsibilities of feeding oneself—a rare chance to not consider the time, money, or effort involved in eating. The food is cooked by volunteers, who plan meals according to particular guidelines designed to facilitate physical well-being and mental clarity that retreat participants need to sustain meditation practice.

At both the Prairie Farm and Holy Spirit retreats, participants are asked to structure their days according to a specific schedule (exact schedule included below). There is no formal enforcement of the schedule, which the retreatants are able to modify as needed, such as in the case of illness. Throughout the day, the bells that are rung by volunteers between activities signal the passage of time.

Typical full-day schedule

5:30	Wake-up Bell
6:00–7:00	Chanting and Sitting
7:00–7:45	Breakfast
7:45–8:30	Work Period and Break
8:30–9:30	Guided Meditation and Q&A
9:30–10:10	Walking
10:10–10:50	Sitting
10:50–11:30	Walking
11:30–12:10	Sitting
12:15–1:00	Lunch
1:00–2:00	Rest and/or Walking
2:00–2:30	Sitting Practice
2:30–3:15	Qigong or Walking Practice
3:15–4:00	Sitting
4:00–4:45	Walking
4:45–5:15	Guided Loving Kindness
5:15–5:45	Light Dinner
5:45–6:15	Break
6:15–7:00	Sitting

7:00–7:30	Walking
7:30–8:30	Dharma Talk
8:30–9:00	Walking
9:00–9:30	Evening Chanting and Sitting
9:30	Continue Practice or Sleep

Participants are asked to turn off their cell phones for the duration of the retreat and to leave other electronics and communication devices at home. The pre-retreat instructions include a landline phone number to distribute as a contact number in case of emergencies.

On the first day of the fall retreat, Alex described the retreat structure as a time to “really let go” to a roomful of retreatants who sat in “noble silence.” During retreats, participants do not verbally communicate except during meetings with the teacher. Even nonverbal communication such as making eye contact, smiling, or gesturing is discouraged. Alex described the tendency to get swept away by the momentum of culture, and the difficulty of doing “spiritual work” within the culture, schedule, and demands that constrain us on a daily basis. He explained that even nonverbal communication holds us in our habitual patterns of exchange, and that these habits should be “abandoned” for the duration of the retreat, so the retreat could serve as a “sacred space” to attune to one’s existence with minimal influence from regular cultural programming.

Retreat food rituals

Common Ground retreat meals interrupt highly conditioned patterns of everyday food consumption. Large meals are offered early in the morning and around noon. A rotating cycle of volunteers prepares these meals. Retreatants are encouraged to eat

sparingly in the afternoon and evening. During meditation sessions preceding mealtimes, the clattering of pots and the smells of curried vegetables escape the kitchen and waft into the meditation hall.

For me, the sounds and smells of cooking created sensations that initially made it difficult to continue meditating. I noticed my stomach beginning to grumble audibly partway through the pre-lunch meditation session. With certain smells, I observed myself salivating, and tried to swallow quietly so as not to disturb the other mediators. These sensory perceptions of cooking food were not neutral, but triggered familiar and frustrating thought patterns. Sometimes, the sound of vegetable chopping was an overwhelming distraction that “was ruining” the meditation. Other times, my mind surged into elaborate imaginings of the upcoming meal. I wondered what was being cooked, whether I would like it, how much I would take, whether there would be enough for everyone, whether I would have some tea with honey after the meal, and on and on. Bringing my attention back to the meditation, I felt frustration about being so profoundly “distracted” by something so routine as lunch preparations.

Other participants described similar feelings of frustration with their food preoccupations on retreats. Yael, a young woman who has retreated every season for the past two years, described “just wanting to be done with thinking about food” on retreats, feeling as though meals, one of the only retreat activities she found pleasurable on a sensory level, disproportionately occupied her thoughts. Martha, a woman in her sixties who has attended several meditation retreats through Common Ground, said, “At first the meals [on retreat] were just hell. You go all day in meditation looking forward to eating and thinking about what they might be serving up that day and then you get there and it’s

the same old black hole of thoughts as usual.” Insight Meditation teachers described meal preoccupations as normal reactions to the silence and pace of retreat, an opportunity to observe one’s conditioning around food as it rises to the fore. Gil Fronsedale wrote in the Insight Retreat Center Newsletter,

Our relationship with food and eating is seldom simple. Retreats are an effective environment in which to become better aware of this relationship. In addition to noticing the act of eating, the silence and slowness of retreat life create opportunities to notice desires, emotions and beliefs that operate at mealtime... Discovering how to be free in relationship to food, eating, and all that happens around meals is an important area of the Buddhist path. (Fronsedal 2015, 1)

Often, the silence of retreats brings forth deeply held thoughts conditioned into patterns over many years. Alex elaborated,

All of our retreats, our day-long and longer retreats involve meals. And we talk about how to use mealtimes as practice. And basically how to observe the conditioning that we have around food... my getting started [with Buddhism] and wanting to understand the mind has completely coincided with sort of waking up to all of the conditioning I have around food.

In this framing, unflinching examination of the thoughts, cravings, and conditioning that pass through his mind during meals serve as important information relating to “waking up to” various attachments.

Alex explained, “I feel like my relationship about food is very much related to my relationship with life and my mind and all the not-so-skillful and skillful forces in my mind. It’s like a microcosm of all of my conditioning. I’ve always sort of seen food as a place to learn a lot.” When asked what he meant by “all my conditioning,” he explained that he was referring to the conscious and (largely) unconscious, highly patterned mode of thought that can unwittingly drive behavior. One example of conditioning pertaining to food on retreat is the unfounded fear many participants describe that there won’t be

enough food. Even when food clearly abounds, this thought often leads to loading one's plate with more food than necessary.

At the conclusion of the meditation, when the meal is ready, a kitchen volunteer comes to the hallway where retreat participants are lined up, plates in hand. Painstakingly slowly, the volunteer collects herself, often with a dramatically deep breath, before ringing a bell. That the bell-ringing is an intentional and performative act was made apparent by the three separate whispered conversations I overheard outside the kitchen, where one kitchen volunteer instructed another about when and how to ring the bell (when the meal was completely ready, the bell should be taken outside and rung slowly, intentionally, and without hurry). The ringing of the bell signals for retreatants to approach the long tables loaded with plates of grains, salads, and fruit. The line moves slowly, as participants carefully regard the food selection and the written descriptions, unhurriedly ladling food onto plates in a public enactment of mindfulness. The room is silent except for the scraping of utensils against dishware.

On one occasion, I stood towards the back of the line and watched Yael assembling her meal. She peered into a large pot labeled "curried quinoa." Noticing the stack of earthenware bowls beside the pot, she selected the bowl on top and used a long ladle to spoon the mixture into her bowl. She set the brimming bowl down and pushed it along the table, stopping at the salad selection. She picked up a set of tongs and piled greens onto her plate, reading the labels beside each of the toppings before adding olives, sliced peppers, sunflower seeds, and "Hollyhock" dressing. She lifted her bowl of quinoa and plate of salad and carried them to one of the tables interspersed throughout the dining hall, her eyes briefly passing over the "Special Needs Food" table (featuring an

assortment of nut butters, gluten-free crackers, and fruit). Setting her food on the table, she reached for one of the green, laminated meal prayer cards collected in the center of the table. She read one side of the card, and then regarded her food silently, lips moving. Finally, she grabbed her spoon and took her first bite.

The first time I volunteered and cooked lunch on retreat, the gazes of the practitioners silently regarding the food felt unnerving. Accustomed to the overt compliments typically issued to the cook in the “outside world,” I felt self-conscious and a little distressed by the absence of commentary, which was replaced by wordless chewing. As I grew accustomed to these silent group meals, I found that the combination of physical company and silence allowed me to focus on the smells, tastes, and sounds of the food to a degree precluded by the distraction of talking with people while eating, or the loneliness of eating alone. In addition to intensifying awareness of the sensory experience of the meal, eating silently in the company of others created a distraction-free time and space for observation. The only available external distraction from the food experience is the prayer cards.

Prayer cards: A case study

Green prayer cards are a fixture at Common Ground meals. The cards are laminated so that they can easily be wiped off after being splattered with food or drinks. The cards are kept in containers at the center of the dining tables. On smaller retreats at Prairie Farm, the volunteer preparing the meal often sets a prayer card beside each place setting. At the larger tables at Holy Spirit, the cards remain stacked in a pile in the center

and retreatants can choose to reach for a card to read before or during a meal. In this section, I use the meal prayer texts as a point of entry to the food ethics cultivated through Common Ground retreat meal practices.

On one side of the card is a grace by Zoketsu Norman Fischer, co-abbot of the San Francisco Zen Center. A meal *gatha* (verse) written by Thich Nhat Hanh and the Buddha's reflections on food are printed on the other side of the card. The three texts read:

One Heart Grace

As we make ready to eat this food
We remember with gratitude
The people, animals, plants, insects,
Creatures of the sky and sea
Air and water, fire and earth
All turning in the wheel of living and dying
Whose joyful exertion
Not separate from ours
Provide our sustenance this day.
May we join with the blessing of this food
Join our hearts
To the one heart of the world
In awareness and love
And may we together with everyone
Realize the path of awakening
And never stop making effort
For the benefit of others.

Norman Fischer

Meal Gatha (The Five Contemplations)

This food is the gift of the whole universe~
The earth, the sky, and much hard work.
May we eat in mindfulness
so as to be worthy to receive it.
May we transform our unskillful states of mind,

and learn to eat with moderation.
May we take only foods
that nourish us and prevent illness.
We accept this food to realize the path of understanding and love.

Thich Nhat Hanh

Reflections on Food

Wisely reflecting on this food
I use it not to distract my mind
nor to gratify desire,
not to make my form impressive
or to make it beautiful,
simply to be sustained and nourished
and to maintain what health I have
to help fulfill the holy life;
with this attitude in mind,
so I will allay hunger without overeating
so that I may continue
to live blamelessly and at ease.

The Buddha

These texts radically position food in three major ways. First, the writing positions eating as a meta-communal act despite the apparent solitude (silence) of retreat meals. Second, each *gatha* specifies a mindset with which food is appropriately consumed. Third, the texts state (thereby clarifying) the reasons for ingesting food.

The meal *gathas* repeatedly emphasize the idea of the individual act of eating enacting an engagement with the world at large. The first two verses articulate the universal forces and processes necessary for provision of the food on the table (air, water, “creatures of the sky and sea,” and much effort) and asserts that these forces are not separate from us (“Whose joyful exertion/Not separate from ours/Provide our sustenance

this day” [Fischer]). The “One Heart Grace” constructs a parallel between blessing the meal with the “joining our hearts” to the “one heart of the world.” Along with the predominantly communal language of the *gathas* (use of “we” rather than “I,” for example), the unambiguously collective ambition of the prayers lends immediacy to interconnectivity beyond the individual and the retreat community.

Acknowledging the “joyful exertion” (Fischer) and “much hard work” (Hanh) required to produce a meal, the *gathas* describe the attitudes “worthy to receive it [food]” (Hanh). The meal is an extension of the retreat practice to “transform our unskillful states of mind” (Hanh). The *gathas* call attention to the skillfulness of the mind states of gratitude, remembrance, and mindfulness in the context of eating. These states of mind arise more easily when understanding the vast and interconnected conditions necessary to produce the meal. Unflinching mindfulness of the thoughts and emotions that pass through ones’ mind during a meal (often greed, craving, judgment, and aversion) builds embodied understanding of the vast, unnecessary suffering created by these unskillful mind states.

Finally, the *gathas* express the intended purposes of food. This element, in particular, diverges significantly from mainstream conceptions of the role of food. The *gatha* attributed to the Buddha systematically dismisses distracting the mind, fulfilling desire, and making the body “impressive” and “beautiful.” Instead, food is to be consumed for nourishment, for realizing the path of understanding and “love,” and for continuing to live “blamelessly and at ease.” In these articulations, improvement of the body (in terms of both physical form and health) is deemphasized, and maintenance of

health serves not as a primary focus, but rather one element in the context of living a “holy life.”

Effects of retreat food rituals: Tightness and loosening of thoughts about eating

For many practitioners, the structure, content, and ideology of eating on retreat diverge vastly from everyday enactments of eating. The remainder of this chapter will analyze practitioners’ shifting food dynamics facilitated by the treatment of eating in the Common Ground retreat setting. Specifically, transformation of tightness, judgment, desire for control, and caustic thinking constitute the analytic threads developed here. The prominence of these themes in Buddhist practitioners’ descriptions of behavior change make them important areas of inquiry for conceptualizing constructive modes of therapy around eating.

Many practitioners described a paradoxical “loosening” of tension around food simultaneously with their developing awareness of bodily and mental phenomena during eating. These terms—“tightening” and “loosening”—being part of neither biomedical discourse nor common parlance, I became interested in what Buddhist practitioners meant when they used these terms in relation to food. When I asked them to clarify, practitioners elaborated on “tightness” as the “stress,” “mental anguish,” “frustration,” “tension,” and “conflict” incited by eating processes. It is a state of mind that is patterned, sometimes to the point of being obsessive, without space for considering alternatives to this distressed attitude towards food.

Alex, the guiding teacher at Common Ground, described how his views of food

have changed throughout his engagement with Buddhism: “I’m *much* more relaxed, and nonjudging, and not [as] tight about food as I was. It’s not like I was that unhealthy around food, but uh... but I have a lot more space in my mind.” He explained that his previous mindset about food was controlling and judgmental, and described the “tension I had around food,” which manifested while making decisions about what to eat, and during meals. Even when he made a food decision he considered “good” or “healthy” (which occurred the majority of the time), there was a degree of “suffering” in his internal argument that preceded the decision. He attributes the changes in his attitudes towards food to the dismantling of dualistic thinking about food, wherein he has trained his mind through Buddhist practice to resist the tendency to label phenomena strictly as “good” or “bad.” This training was not specific to food, yet his relationship with food was a useful microcosm for examining this dichotomy in his mind.

Della also described “loosening up” in her thoughts about food, but she emphasized different facets of this process. She meditated for years before moving to Minneapolis, where she began attending Common Ground activities regularly as a social network. She attributes her “loosening” to learning new structures of eating while on retreat, and applying various elements of retreat meal mindset to her everyday life at home. She explained,

So, when you go on retreat, you’re obviously trying to be mindful all the time, like be really aware of everything you’re doing, and you eat in silence. Right? So you eat in a big hall where like nobody is talking. And, it’s great because you actually notice like what the food tastes like in your mouth, the feeling of chewing, you chew slower, you chew it all and then swallow as opposed to shoveling it all in.

Mealtimes on retreat enabled Della to break away from her default of continual “shoveling in,” to finish one bite before “preparing the next on my fork.” This consciousness of her eating that began in the retreat setting, with few opportunities for distraction, has trickled into her everyday life. Della described how she practiced engaging with the moment-to-moment experience of her meals on retreat, and this carried over to her meals at home: “I think another big thing that has changed with my eating that I *do* think is a direct correlation [with Buddhist practice] is just *noticing* what I’m eating and, like, noticing as I’m eating that I’m eating.” Before attending retreats, Della routinely “either sleepwalked or multitasked meals,” and frequently ate her meals while looking at the computer.

She still chooses to eat in front of her computer at times, but she describes this more as an active choice compared to what previously felt like a patterned and inescapable habit. She explained, “If I’m busy I’ll be like, ‘Okay, I’m gonna eat this while I read some emails.’ But I know I’m conscious of doing that and making a choice right now to multitask. A lot of times I’ll make the other choice of I’m just going to eat. I’m not going to check emails, read something, I’m just going to eat.” Despite increased awareness of the experience, thoughts, and sensations that occur during mealtime, Della feels much less angst surrounding meals: “But it’s funny because it’s not like I’ve gotten more tight with myself about food. If anything, I’ve gotten more relaxed about food than I used to be. Um, but... I don’t really pig out anymore.” The articulation of a less stressed relationship with food while shifting behavior in a healthier direction raises several questions: what are the mechanisms underlying the “loosening?” How does “loosening” affect behavior? Can “loosening” be actively facilitated?

In the next sections, I will examine three interrelated processes to which Common Ground practitioners attribute loosening food attachment: (1) the suspension of judgment as requisite for the cultivation of intimate familiarity with craving; (2) attenuation of “desire for control” through participation in a socially regulated eating framework with clearly defined parameters; and (3) the alleviation of toxic thought patterns about food through the depersonalization and depathologization of thought conditioning relating to food.

Judgment as an impediment to freedom from craving

As elaborated in Chapter 3, craving is understood in the Buddhist purview as a critical impediment to freedom. Dismantling craving requires practitioners to deeply examine and understand its workings. Common Ground practitioners describe self-judgment as a barrier to the examination of craving. In transforming the strength and frequency of judgmental thought patterns, practitioners convey the value of mindfulness training within the structures of the retreat setting. Common Ground *dharma* teachers frequently emphasize the importance of understanding craving, which can be viscerally examined during eating. Rebecca Bradshaw, the Guiding Teacher at Insight Meditation Center in Easthampton, Massachusetts, gave a guest lecture at Common Ground entitled “Exploring Conditioning and Craving Through Mindfulness of Eating” on a frigid evening in February. In her talk, she encouraged “befriending” craving. She said, “The energy of craving is one we really need to get to know. I’m going to suggest that we get very curious about it and explore it deeply.” Alex, too, often asserted the importance of

developing an intimate familiarity with craving. In one *dharma* talk, he said, “We are students, devotees of craving. Craving doesn’t hold up when we study it. Just to have the understanding that craving should be observed has a liberating quality on the mind.” The importance of understanding craving is reflected in the Four Noble Truths, which clearly attribute suffering to craving, and unambiguously articulate the possibility and path for transforming craving.

Long-term practitioners at Common Ground described their evolving understandings of craving, including their ability, when paying close attention, to observe the anticipatory desire for pleasure (craving), the experience of pleasure itself, and the subsiding of the pleasant sensation. By illuminating each of these stages (particularly the third), familiarity with thoughts surrounding food counterbalances the delusion of permanent satisfaction. Craving contributes to this delusion, and understanding pleasure as transitory helps to break it down. One woman described the morning when this insight fully took hold. She was at a long-awaited retreat in Burma. Prior to the retreat, she had eagerly anticipated the taste of the tea on retreat. She had enjoyed this particular tea tremendously, and had only ever had it at this particular retreat center. She described finally tasting the tea on her first morning on retreat. It was as delightful as she had expected, and yet, she said, “I cried all the way through breakfast one day because I couldn’t make the pleasantness stay.” After realizing the impermanence of pleasant tastes in this way, she more easily observed her food cravings as passing thoughts with limited authority.

Judgment precludes data collection

Despite the widely acknowledged importance of understanding craving within the Common Ground community, many practitioners are initially unable to observe their cravings closely enough to develop the depth of understanding described above. Both Buddhist practitioners and biomedical patients frequently explained experiences of relentless self-judgment in the face of eating decisions. These judgments and ensuing negative emotions precluded “staying with” the thoughts and experiences surrounding eating. Participants had a difficult time sustaining their examination of the mental phenomena that occurred around mealtimes. Instead, the tendency was to become “caught up” or “swept away” in habitual streams of temporary pleasure, internal dialogue, and negative emotions that can predominate experiences of eating. In other words, a patterned series of strong thoughts prevented the necessary “data gathering” required for developing holistic understanding of the causes and results of craving.

Della articulated how this judgmental mindset limits the ability to gather data about craving. She described how judgment triggers familiar stories that are usually very negative. These stories hinder connection with the situation as it actually unfolds in order to observe it. She said,

I mean we all have a tendency to beat ourselves up about things, and especially around food, and, I’ve seen in my sister, for example, its almost like she’s so frustrated by it and feels so bad about it that she can’t even approach it. It’s like, she’s too... its too painful and its too personal, like “I’m a fat person,” whereas maybe if she could get out of that frame and just be like, “hmmm, when I eat this, you know, I end up feeling more slothlike.” There’s no judgment in the second one so it’s not painful and you can actually learn.

Overwhelmed by the self-loathing judgments, Della’s sister is unable to investigate what is happening in real time. Rebecca Bradshaw elaborated on the conflict between

judgment and the gathering of useful data about food in her Common Ground lecture: “If you’re judging something, you can’t get interested in it. Judgment and interest don’t go together. If we’re not interested, we can’t see clearly.” Armed with clear (theoretical) understanding of the inverse relationship between self-judgment and the ability to examine a present experience, practitioners must develop skills for interrupting often highly patterned modes of judging.

Mindfulness facilitates nonjudgmental intimacy with craving

Practitioners described mindfulness as a tool for the exploration of craving and conditioning. Mindfulness facilitates understanding of craving by cutting through habitual judgments that frequently occur while eating. The repeated practice of observing thoughts, acknowledging them, then “letting them go” without fixing to their meaning or content is a skill that can be applied during meals. Della spoke at length about her own process of gradually detaching from the judgmental thoughts that mediated her experience of food through the cultivation of mindfulness during meals. She discussed her insights about the thoughts that kept her food habits in motion, and how these habits subsequently made her feel. She said,

I think that in some ways a really easy way to teach mindfulness is with food. So, um, you know, so there’s this sort of this idea in Buddhist practice that a lot of the practice is about... understanding the law of how things are, right? So when I’m feeling greedy and I eat like a huge piece of cake, I feel... I end up feeling kind of uncomfortable and icky afterwards. And rather than berating yourself—like, “I’m not supposed to eat cake” or “It’s not healthy to eat cake” or “I’m going to look fat if I eat cake”—rather being in touch with like, how do I *actually* feel. What’s the bodily connection to the cake I’ve just eaten and being able to be informed by that and the next time be like, “hmmm the last time I ate that huge piece of cake I didn’t *feel* that good, so maybe I won’t do it this time,” rather than being like,

“mom told me not to,” or, you know, “I’m not going to get a boyfriend,” or, you know, those other *ideas*.

Della distinguished between judgmental engagement with food (as in, “I’m not supposed to eat cake” and “I’m going to look fat if I eat cake”) and the neutral and open gathering and application of information related to the experience of eating (“hmmm, the last time I ate that huge piece of cake I didn’t *feel* that good, so maybe I won’t do it this time”).

Gathering this type of data requires a curious mind that is not overcome by patterned assumptions.

I commented to Della how this type of questioning seems to mirror empirical investigation. She replied, “Right, right, exactly. It’s not saying something about who you are, but rather, it’s just this behavior connects to this outcome, kind of thing. Just cause and effect.” Training in mindfulness allows Buddhist practitioners to observe thoughts during eating, and to observe the tendency to get “swept away” by these thoughts.

The frameworks within which these mealtime thoughts are observed at retreat prove essential in the sustenance of paying attention to craving. The retreat environment offers time and space to deeply explore craving in a way that cannot happen when mindfulness is employed clinically for alleviating specific symptoms (discussed in Chapter 6). First, to “stay with craving,” the participant needs training in an environment free from distractions except for clear guidance about the “qualities of mind” with which to approach the meal (relayed through the prayer cards and *dharma* talks). Second, there is an emphasis on regarding thoughts as information, rather than *truth* about a fixed, unchanging self. Finally, the participant benefits from insistence in the *dharma* teachings about the universality and salience of craving as an impediment to freedom, rather than a

personally located problem. In other words, retreat structure supports the fundamental idea that craving is a human universal requiring a system of supports to manage. This orientation contrasts from how craving is addressed in the biomedical system, as individually localizable and specific problems (diseases) that require personal management.

Importantly, experienced Common Ground practitioners articulated the function of mindfulness as a tool for gathering data for understanding reality and developing wisdom, rather than for fixing a specific problem. The two are not mutually exclusive, and the former can inform the latter, but they do form distinct orientations towards practicing mindfulness. Alex explained why effective data gathering is critical for developing wisdom, which in turn can contribute to beneficial habit change. He said,

Not engaging in [a] bad habit is really coming from a *system*... a mind-body system that has cause-and-effect data at its disposal. If I have a lot of data, a lot of evidence about what happens when I live this way versus live that way, then what's to stop me from living in a way that's more easeful and happy? The system will go that way. The system wants to be happy. But it needs a *bigger picture* with data about cause and effect. But if I'm not operating on all that data, I'm just operating on a very limited thing, like I put this in my mouth and there's sweetness, you know, that's all I know. That's the data I'm operating with. Then I'm going to put it in my mouth, because I get a little joy. And I'm not thinking about the bigger picture, the kind of stream of cause and effect, like I'm going to be sick tomorrow. I'm not going to feel good. I'm not going to want to get out of bed tomorrow.

Alex emphasized the tendency, when operating from a limited view, to repeat behaviors that are ultimately harmful “because I get a little joy” in the moment. In his estimation, behavior change comes from deep investigation of cause and effect and the wisdom of unambiguously understanding “the way things are.” Mindfulness practice is one tool for ascertaining this type of data.

Communal control of food mitigates individual anxiety

Communal ritualization of eating alleviates the anxiety of having to constantly control one's food intake. Retreats simplify the logistics of eating. For many practitioners, the structure, content, and ideology of eating on retreat diverge vastly from their everyday enactments of eating. The eater is not involved with cooking and does not need to consider what and when to eat, since the retreat structure determines these factors to a great degree. As discussed in Chapter 2, the presence of rituals and structures around eating mitigates the sense of intense personal responsibility in the face of stressful ambiguity about how to eat.

Further, practitioners expressed comfort borne of the communal locus of responsibility for food that occurs on retreat. Jane said, "The kind of food we eat on retreat isn't what I would eat at home but I feel so much better after a few days that I don't mind sticking with it even though I don't like it at first. It's like most things with the Buddhist stuff. It's not like it's much fun. But overall it works so well that I just keep going." In Jane's articulation, eating in a particular way is one example of a beneficial result of subscribing to a mutually reinforcing system of communal values that "works." When I pressed Jane on what was "working" better than before, she replied that there was no specific area of her life that she could pinpoint, but rather a generalized sense of more clarity and more ease in her life. She said that she continued to see and acknowledge her problems, but that everything felt more "workable" and that she didn't feel as "sucked

into my usual patterns” or “feel like I personally need to figure everything out,” which decreased her overall anxiety, including anxieties related to food.

Retreats reveal caustic thought patterns about food

At the same time, the removal of most distraction during mealtimes can illuminate the confusing and often painful thoughts that are present in the mind. Martha expressed her surprise at the painful judgments accompanying her at retreat meals, considering that all of the foods served on the retreat were what she would consider good, healthy options. She said, “I would just sit there and stare at my lentils and salad and go through all my usual thoughts about if I should clear my plate or not and I would feel overwhelmed and go up and get another piece of toast with nut butter and scarf it down before I could think twice and then berate myself for it.” Even more vicious thoughts were described by many other participants.

Maria, the 37-year-old medical student, also described her painful internal dialogue around mealtimes. Here, she talked about a conversation with her sister after seeing the movie *Precious* (about a young obese woman who was brutally abused by her family and oppressed by society). She said,

So I saw that, I saw it with my sister. We walked out [of the movie theater] and I said to my sister, “I cannot *imagine* treating another human being like that.” And she said, “What’s your dialogue to yourself like?” And I was like, oh my gosh, that’s what I say to myself every day. “Oh, you fat fucking piece of shit, you goddamn lazy motherfucker worthless piece of shit.” That’s what I’m telling myself.

Maria described how her mealtime thoughts came to be less painful: “So I think that

that's what the whole... diving into Buddhism and learning that I'm not defined by my thoughts, that these are just these fleeting things that I get to let go of." She described how increased awareness and detached examination of such critical thoughts was a necessary precursor to seeing them as "just thoughts," rather than a personal, permanent truth. By understanding thoughts as conditioned manifestations of universal phenomena, instead of personally located shortcomings, flaws, pathologies, or problems to solve, the corrosive hold of these thoughts becomes an area for investigative engagement, rather than an immersive painful involvement.

For Maria, the depersonalization of thoughts began for the first time when she started studying the *dharma* and heard descriptions of her personal struggles presented in far more universal terms. For example, Rebecca Bradshaw, in her Common Ground talk about eating, said, "Don't blame yourself, blame craving. It's only the strongest force in the universe. And if craving wins several rounds, it's not personal. It's conditioning. Intense conditioning. It's primal." Having struggled with her weight and a deeply internalized sense of moral failing when she would overeat, Maria described the Buddhist framing of craving as revelatory in its disruption of her thought patterns about food.

Conclusions

In this chapter, I have explored Common Ground's physical (urban and retreat center) spaces, Buddhist practitioners' motivations for initiating and sustaining practice at Common Ground, and the structure(s) of Common Ground retreats. With regard to eating, Common Ground retreats enact specific rituals. Meals that consist of specific

foods are prepared by kitchen volunteers and are served during the morning and around midday. Deliberate ringing of a bell signals mealtimes. Eating occurs silently and free of distractions with the exception of prayer cards. Retreat meal practices diverge significantly from the majority of Common Ground practitioners' meals at home. The observance of retreat rituals facilitates observation of the content and tenor of predominant thought patterns during meals. Because of the salience and tenacity of these thoughts, meals provide a critical avenue in the overarching retreat goal of training the mind in understanding craving as a limiter of freedom.

Through retreat practices, participants described a "loosening" of their attitudes towards foods, facilitated by eating within structures that ritualize the physicality of eating and clarify the purpose of both food and mealtimes. Common Ground practitioners reported a changing orientation towards meals. This occurred through examination of the nature of craving by cultivating tools (such as mindfulness) to suspend judgment. Through the repeated gathering of data, craving can come to be understood as a patterned, universally present constellation of thoughts and inclinations, rather than a personally located failure.

Chapter 6

Biomedical interpretations of Buddhism: The secularization and medicalization of mindfulness

The inadequacy of existing treatments for food attachment alongside the promise of preliminary research outcomes in mindfulness interventions relating to food (Godsey 2013; Katterman 2014) encourage the expanded use of mindfulness interventions in the realm of eating. The predominance of mindfulness interventions as a low-cost, high-utility alternative to standard biomedicine for diverse psychological and physical suffering lends a sense of its applicability to food pathologies. At first glance, mindfulness is a clear fit for treating problematic eating, with many of the logics of mindfulness coinciding with food discourse. However, the blanket application of mindfulness interventions to eating-related pathologies, while attractive, fails to address the root causes of manifested suffering.

In this chapter, I will discuss the theoretical limitations of interventions using secularized mindfulness, predicated on scientific evidence, for food attachment. I will begin by examining the extensive proliferation of mindfulness throughout the institutional spheres of society, including healthcare, the workplace, and the criminal reform system. I will argue that the adoption of mindfulness as a societal panacea subverts attempts to address social determinants of suffering. Next, I will elaborate on the current role of mindfulness-based interventions across the medical disciplines. I argue that prescribing mindfulness as a science-backed intervention divorced from Buddhist frameworks proves problematic for three reasons. First, the claims made about the evidence for mindfulness-based interventions have exaggerated the presently available

evidence. Second, biomedical evidence is predicated on empiricism, and many of the mechanisms by which Buddhist practitioners in my study describe sustained behavior change are not readily quantifiable. Third, clinical mindfulness reinforces suffering by personalizing symptoms and making patients responsible for their alleviation. Further, the therapeutic framing of mindfulness as a neatly packaged “intervention” stands at odds with the Buddhist prescription for liberation from suffering by eliminating cravings of all kinds through the holistic development of wisdom, ethical conduct, and concentration.

Although they share *vocabularies* of suffering, healing, investigation, and empiricism, the ontologies of Buddhism and biomedical therapy inherently clash. Positioning mindfulness within the latter dilutes the potential for freedom from suffering conceived in the Buddhist path. In the discussion to follow, I often refer to “Buddhist practitioners” and “mindfulness practitioners.” The former refers to participants at Common Ground Meditation Center who engage with the Buddhist framework through multiple avenues, including weekly teachings, reading, and meditation, and consider themselves members of the *sangha* (Buddhist community). For this discussion, by contrast, “mindfulness practitioners” are individuals who practice mindfulness meditation, often prescribed to them by a healthcare professional, without cultivating a broader Buddhist ethic. Importantly, Buddhist practitioners who participated in this study describe far less anxiety regarding their food decisions, and in many instances tell of profound food habit changes throughout their engagement with Buddhism, while mindfulness meditation plays a trivial role in this sustained transformation. Buddhist practitioners, however, describe this dietary shift as one outgrowth of a changing view of the role of food in one’s life, an evolving orientation of the role of one’s life in the

broader world. Ethnographic analysis leads me to the conclusion that in isolation, mindfulness-related interventions can at best symptomatically and only temporarily alleviate eating-related suffering. At worst, they recreate and propagate suffering-inducing narratives and structures.

The establishment of clinical mindfulness

American mainstream mindfulness is described as nonjudgmental awareness of the present moment (Kabat-Zinn 1994). The cultivation of mindfulness within institutional contexts occurs predominantly in the eight-week MBSR training format developed by Jon Kabat-Zinn, founder of the stress reduction clinic at the University of Massachusetts Medical School. In this form of transmission, mindfulness is presented through a scientific lens, specifically decontextualized from the Buddhist framework (Wilson 2014, 235). Thus, it is often referred to as “Buddhist meditation without the Buddhism.” Courses utilizing the MBSR structure typically meet for two hours every week for eight weeks. During the course, students/patients are taught various meditative practices, including awareness of the breath, body scan meditations, loving kindness meditations, and hatha yoga postures. Students are given a set of instructions, aimed to facilitate cultivation of a continual awareness of the present moment observed with a nonjudgmental attitude. Daily homework for the course generally consists of 30–45 minutes of meditation, along with jotting down notes from the daily experience.

At the conclusion of the course, students are encouraged to continue their mindfulness meditation practices indefinitely. They are taught that there is no limit to the

number of circumstances in which mindfulness principles can be applied. Baer (2003) commented on the idea of continual mindfulness in a meta-analysis, saying that “a mindful perspective about one’s thoughts can be applied to all thoughts” (129). However, establishing this degree of continuity of awareness requires significant practice, typically necessitating more than eight weeks to develop. In order to facilitate mindfulness practice, some students form mindfulness “meet-ups,” where they meet to meditate together at school, work, or on the weekends. Many students describe great benefits from the mindfulness practice during the duration of the course, but experience difficulty continuing with meditation without the structure of homework and a specific place to come and learn about meditation each week. Nonetheless, MBSR and other mindfulness-based interventions continue to hold great promise in the eyes of leadership of diverse institutions.

Specific to the subject matter of this dissertation, systematic review and meta-analysis have shown the efficacy of mindfulness in improving outcomes in the psychological aspects of disease. Some of these conclusions are very broad, requiring further research. According to Alsubaie et al, “There was evidence that global changes in mindfulness are linked to better outcomes. This evidence pertained more to interventions targeting psychological rather than physical health conditions” (Alsubaie 2017, 74). Other reviews find mindfulness to be effective in modifying certain types of mental experience. In a meta-analysis of 39 studies examining mindfulness in the treatment of anxiety and depression (both of which are linked to changes in eating behavior), mindfulness training is found to have positive outcomes (Hoffman 2010, 169). This was one of a body of systematic reviews that find mindfulness to be helpful overall, but

without specifically elucidated mechanisms. A systematic review of 8 small studies of mindfulness-based interventions in the treatment of various eating disorders similarly found the results to be a “promising” area for further research.

Beyond biomedicine: The proliferation of mindfulness through society

Mindfulness-based interventions first appeared in the medical realm, but have quickly extended in scope throughout major sectors of society. The corporate uptake of mindfulness is exemplified by Google’s Search Inside Yourself program (Tan 2012), an employee mindfulness training program that has led to the Search Inside Yourself Leadership Institute at Google. The US military adopted mindfulness training in order to help soldiers and veterans better cope with military stressors (Ryan 2012). “Mindful Nation UK,” a report by the Mindfulness All-Party Parliamentary Group, provides a comprehensive insight into the proposed multidisciplinary applicability of mindfulness at the governmental level in the UK. I draw on this text as a case study to track the methods and language used in the systematic dissemination of mindfulness across the health, workplace, education, and criminal justice systems. I also use the “Mindful Nation UK” document to illustrate the implementation of mindfulness by governmental institutional infrastructures, and discuss how this expansion is contingent on secularization of these mindfulness practices. Notably, the “Mindful Nation UK” document reflects bipartisan support of extensive inclusion of more mindfulness services in the aforementioned sectors. The unprecedented scope and scale of proposed mindfulness interventions across

social institutions in the form of statewide adoption of secular mindfulness illuminates the dynamic expansion of imagined uses of mindfulness.

The document begins by proclaiming the myriad potential benefits of mindfulness. The preface reads,

On a number of issues ranging from improving mental health and boosting productivity and creativity in the economy through to helping people with long-term conditions such as diabetes and obesity, mindfulness appears to have an impact. This is a reason for government to take notice and we urge serious consideration of our report. (MAPPG 2015, 4)

In the first section, entitled “The Role of Mindfulness in Health,” mindfulness is described as a promising alternative to stigmatizing mainstream mental health efforts.

The document reads, “Mindfulness is one of the most promising prevention strategies and is regarded as popular and non-stigmatizing, unlike some other mental health interventions” (MAPPG 2015, 5). Biomedical institutions position mindfulness interventions as superior to existing mental health options for many conditions, justifying the ambitious expansion of these interventions.

The document also features, in the health section, reports of the scientific evidence base for alleviating various health conditions; discussion of the efficacy and money-saving potential of mindfulness strategies; and “case studies” from citizens who have benefited from mindfulness training. In one case study, Tamsin Bishton says of her job in digital communications,

But there was a culture of overworking, pressure and burn out. I kept going by taking anti-depressants, but I stopped them because of the side effects. I hardly slept and when I closed my front door at night I was swallowed by panic attacks. One day I realised I just couldn’t make myself go back to the office without something changing radically. (MAPPG 2015, 25)

Prescribed a mindfulness-based cognitive therapy course, Bishton credits the meditation practice with changing her entire life. She states, "...instead of feeling overwhelmed I felt in control for the first time in years – and it all came from stopping, sitting and breathing" (MAPPG 2015, 25). She goes on to say,

Finding time to practice every day is still difficult, I'm married with a child, and I never take it for granted. But five years on I've taken ownership of my wellbeing and changed how I work. I respond to stress more constructively; and my ambition is to take what I've learned back into the workplace to help others like me. (MAPPG 2015, 25)

As this case study illustrates, the "Role of Mindfulness in Health" section emphasizes cultivating an individual's positive response to their stressful milieu. The section portrays the role of the healthcare system as providing infrastructure (expanding access to mindfulness courses) in order to facilitate the skills to relate to situations in a "healthier," "more mindful" way. The main problem acknowledged in the document is the difficulty of "scaling up" mindfulness programs to meet the vast needs of patients. Books and online courses are proposed as one means of extending the reach of mindfulness.

The next section of the "Mindful Nation UK" document, entitled "The Role of Mindfulness in Education," outlines mindfulness's potential in the education system for improving academic achievement and student mental health. Evidence for the efficacy of existing mindfulness in school programs is cited as an impetus for scaling up the efforts.

A side box encourages mindful parenting, stating,

Mindful parenting programmes aimed at parents in socio-economically disadvantaged families (who are at greater risk of stress) can reduce parents' destructive behaviour, increase their ability to disengage from emotionally charged stimuli, reduce parents' stress and enhance their emotional availability, and improve children's behaviour. (MAPPG 2015, 32)

There is no discussion of how a socio-economically stressed parent might find additional time for mindfulness exercises, or what support they would receive in undertaking this endeavor. Again, the therapeutic nexus is contained between a brief mindfulness course and the individual undertaking the cultivation of mindfulness practices.

In the “Mindfulness at Work” section, decreased worker anxiety and depression, along with increased productivity and focus, are the purported benefits of mindfulness training. The document outlines proposed implementation of mindfulness programs mainly through digital mindfulness training, acknowledging that research for these sorts of interventions is limited. There is a list of corporations and the types of mindfulness training offered to employees within that institution. The following balancing statement is offered: “There has been criticism that mindfulness is being used to prop up dysfunctional organisations and unsustainable workloads. The document acknowledges the critique that ‘mindfulness is offered as just the right medicine to help employees work more efficiently and calmly within toxic environments’” (MAPPG 2015, 78). It goes on to say, “While it seems that mindfulness can offer real benefits for reducing stress and absenteeism, it is important to emphasise that as an isolated intervention it cannot fix dysfunctional organisations.” However, this is a mixed message in the context of Bishton’s case study (above), in which she sums up her transformation by saying, “...and it all came from stopping, sitting and breathing” (MAPPG 2015, 25), crediting her personal mindfulness practice alone for completely altering the way she relates to her overwhelming work.

In “The Role of Mindfulness in the Criminal Justice System,” mindfulness is described as having potential positive effects in decreasing depression and anxiety,

recidivism, and substance addiction, and improving affect. Heartfelt testimonials from prisoners thank mindfulness for “affording me the luxury of peace in an environment that seems to be made of noise [prison]” (MAPPG 2015, 58) and allowing “me to re-connect with Life [sic]” (MAPPG 2015, 58). Here, too, the proposed intervention is building mindfulness infrastructure to help citizens cope with the challenges of their social structures, such as prison, with more ease. Purported to be a value-neutral “bare attention” training, the silent side effect of the institutional expansion is pacification of the need for problematic structures to be examined. Robert Falconbridge, a prisoner at HMP Dumfries, writes of his experience with mindfulness in prison, “So thank you, mindfulness, for enabling me to turn a bad situation into a good” (MAPPG 2015, 58). Such testimonials portray an individual exercising personal agency to wholly transcend social context, including extremely trying contexts such as prison, through meditation practice. Institutions are using the provision of mindfulness training as a rationale for claiming holistic transformation of suffering, and are thereby subverting responsibility for maintenance of the status quo.

In the biomedical realm, the individualization of social suffering has been widely critiqued. Nancy Scheper-Hughes (1987) provided a nuanced analysis of the “three bodies”—the individual, the social, and the body politic—by problematizing the disproportionate emphasis of the individual in biomedical sciences:

As a result, the “illness” dimensions of human distress (i.e., the social relations of sickness) are being medicalized and individualized, rather than politicized and collectivized (see Scheper-Hughes and Lock 1986). Medicalization inevitably entails a missed identification between the individual and the social bodies, and a tendency to transform the social into the biological. (9)

Mindfulness interventions fall within this troublesome dimension of medicalization by making *personal* societal symptoms or institutional structures (such as dissatisfaction with difficult work environments, or difficulty coping with the challenges of prison) and their solutions.

Further, the practice of mindfulness as it is taught in the MBSR context is ultimately an individual undertaking. Following the conclusion of the brief training course, mindfulness meditation is typically practiced alone, outside of the context of instruction or community dialectic. In my participant-observation in the clinic, many patients and practitioners expressed their dissatisfaction through sentiments such as “I need to make more time to meditate so I can address my stress,” and articulated frustration at meditation “not working.” They expressed personal responsibility through statements such as: “I don’t know if I’m doing it wrong because it [mindfulness meditation] is not making it [symptoms] better.” They learned of these mindfulness practices through hospital-based programs, hearing about mindfulness in the media, and reading articles about mindfulness. Individuals internalizing the responsibility for “relating poorly” to problematic social structures, such as work or prison environments, as illustrated in the “Mindful Nation UK” analysis above, potentially subvert efforts to modify suffering-inducing social structures. Nonetheless, patients and providers continue to regard mindfulness as an exceptional solution to a plethora of ailments.

The rise of the secular mindfulness panacea

The privileged positioning of mindfulness as a perceived panacea occurred through the secularization and medicalization of the practice. In the US, secularization is an important step in introducing practices perceived as religious into the public realms of government, schools, and public hospitals. The failure to “sufficiently” secularize practices perceived as religious has resulted in several prominent court cases. Most recently, in the 2013 court case *Sedlock et al. v. Baird et al.*, parents fought to deem the teaching of yoga in their children’s school to be unconstitutional. In this instance, Judge Meyer ultimately ruled that the yoga course at Encinita’s School District “had a secular purpose” and that it did not represent excessive conflation of religion with school. The court ruling makes explicit the requisite degree of secularization: that the purpose of the activities is secular, not an attempt at promulgating the moral frameworks with which the practices may be historically entwined.

This aim of sufficient secularization is frequently enacted in the language and teachings of therapeutic mindfulness. In his foreword to the “Mindful Nation UK” document, Kabat-Zinn acknowledges a relationship between mindfulness and Buddhism but immediately emphasizes that mindfulness is separate from Buddhism or any other ideology. He says, “While the most systematic and comprehensive articulation of mindfulness and its related attributes stems from the Buddhist tradition, mindfulness is not a catechism, an ideology, a belief system, a technique or set of techniques, a religion, or a philosophy. It is best described as ‘a way of being’” (MAPPG 2015, 9). He goes on to say, “Basically, when we are talking about mindfulness, we are talking about awareness – pure awareness” (MAPPG 2015, 9). The “Mindful Nation UK” document further emphasizes, “Using these methods, but freeing them from any religious or

dogmatic content, Jon Kabat-Zinn began teaching his MBSR course to patients at the University of Massachusetts Medical Center in the late 1970s” (MAPPG 2015, 14). In these descriptions, statements of what mindfulness is are in tandem with vehement descriptors of what it is not (namely, religion).

The fully secular nature of the practices recommended in the document is reiterated in a page of personal testimonials from various parliamentarians who have undergone mindfulness training. One of the parliamentarians comments, “I found the ethos, thinking and practice totally compelling and, additionally, free of ‘psycho-babble’, religion and spiritual allusions. A very, very enriching experience” (MAPPG 2015, 16). Here, religion is listed alongside “psycho-babble,” and the absence of both leads to an enriching experience. All in all, that the mindfulness practices are secular is made repeatedly clear throughout the document. Marx, a clinical psychologist, read this secularization as a beneficial means of bringing a much-needed technique to the masses. He asserted that Kabat-Zinn’s “disidentification from Buddhism is in the tradition of the Buddhist notion of *upaya*, or skilful means” (Marx 2015, 1153). He argued that skillful means employed by contemporary mindfulness training “enables large numbers of Westerners, who would have been put off by a traditional Buddhist format, to access its sometimes life-changing benefits” (Marx 2015, 1154). Skillful or not, the secularization of mindfulness has allowed its rapid uptake into the scientific and therapeutic realms, and its diffusion beyond these disciplinary boundaries. The secularization of mindfulness has placed it squarely in the realm of scientific inquiry, the results of which, in turn, facilitate its societal transmission.

Overstating the reach of clinical mindfulness practices proves difficult. Empirical evidence that demonstrates the utility of mindfulness for treating a range of medical and psychiatric conditions facilitates the ever-expanding realm of mindfulness practices. Initially, the clinical application of mindfulness primarily occurred in the psychiatric and psychological fields, to reduce stress and treat depression and anxiety. Now, mindfulness interventions span the medical specialties. At present, PubMed, the search engine of the US National Library of Medicine and the NIH, contains nearly 3,000 papers evaluating the utility of mindfulness in various medical contexts. Among these are papers proclaiming mindfulness interventions' superiority over the current biomedical standard of care in the treatment of major depressive disorder, improving nursing satisfaction, decreasing pain in chronic headache sufferers, and decreasing inflammatory bowel disease symptoms. Mindfulness interventions feature prominently in the biomedical treatment of various forms of pathological eating, and for addressing craving manifested as addiction. Numerous publications specifically examine "mindful eating" interventions for a wide range of eating-related illnesses, including binge eating disorder, food restriction, and overeating (Albers 2008; Nhat Hanh 2015). Mindfulness interventions are central to the mitigation of an ever-growing range of symptoms in the body and mind.

Attending Jon Kabat-Zinn's talk at the University of Minnesota provided me with a unique opportunity to observe his reach in my local field site. The talk took place on the first truly wintry Friday evening in late November. Darkness had fallen long before the 6:30 pm lecture start time, and lines of puffy-coated people snaked around the outside of the dark building. The tension and excitement resembled a concert or the imminent sighting of a famous person. In the auditorium, the crowd was composed of 2,000 mostly

white, mostly middle-aged people. Kabat-Zinn began his talk by emphasizing the noteworthiness of such an enormous crowd of Minnesotans paying to spend their Friday night learning about meditation. He asked members to raise their hands if they had previously attended MBSR training, and about one third to half of the audience members raised their hands, to which Kabat-Zinn responded, “Wow. This is new. I’ve been asking this question for a long time and this is new.” Indeed, the concept of mindfulness has been discernibly proliferating through the Hennepin County Medical Center system during the four years I have been part of the institution as a medical student and a researcher.

Over the past few years, I have observed mindfulness as a part of patient–provider discussions in psychiatry, primary care, and pediatrics. Mindfulness training featured prominently in multi-day employee resiliency training. During this research period, I was asked to work with a psychologist at the institution to develop a mindfulness training course for emergency physicians, based loosely on the MBSR model. This program was then scaled for hospital employees in other departments. In each of these instances, mindfulness is approached as “awareness training,” and it was clear that Buddhism would not feature prominently in the sessions.

Kabat-Zinn did briefly describe the Buddhist context of mindfulness in his Minneapolis talk, saying, “The most elaborate articulation of mindfulness comes from the Buddhist tradition.” He moved the discussion quickly to the scientific realm, saying, “The Buddha was a remarkable genius of a scientist, investigating the nature of suffering and the nature of the mind.” Kabat-Zinn ultimately framed mindfulness in the biomedical/therapeutic realm, emphasizing how mindfulness fills an unmet need in the

biomedical institution. He said, “The auto mechanics form of medicine has been a big failure. We need to cultivate a participatory medicine,” and then articulated how MBSR functions to improve the biomedical realm by empowering individuals to “play a role in their well-being.” Here, he positioned mindfulness squarely in the scientific/medical realm. He pointed out that the super-specialized and piecemeal approach (the “auto mechanics form of medicine”) has not worked, and framed mindfulness as a participatory alternative. Yet he immediately rendered mindfulness interventions as individuals taking responsibility for their individual health. This individualistic and scientific focus expedites the acceleration of mindfulness through the disciplines of clinical medicine.

The science of symptom reduction

Framing mindfulness practices in terms of scientific evidence proves problematic on multiple levels. On a practical/empirical level, mindfulness research has proliferated at such a rate that some of the science produced is of questionable quality. In this section, I discuss key methodological critiques of the “science of mindfulness” literature. More troublesome than the quality of evidence is the mentality of symptom reduction that is perpetuated by the evidence-based claims for mindfulness. Scientifically backing mindfulness interventions reproduces the outcome-oriented thinking about the self, which creates suffering in the Buddhist purview. Fragmenting the broad and abstract ideas of suffering and liberation into constituent ailments and the promise of their healing contributes to the tracking and monitoring of effects and progress. Scientific literature provides practitioners with a roadmap of potential results that can be expected, with

numbers and data points to monitor progress. These (successful) endeavors in quantifying the outcomes of mindfulness practices undermine their very ability to ease suffering in a holistic sense.

This is not to say that the *teaching* or the content of secular mindfulness revolves around results-oriented discourse. Rather, the systemic uptake of mindfulness into the realm of medicine as a prescription for alleviating symptomatology frames mindfulness interventions in terms of quantifiable benefits proffered. A study on a mindfulness intervention for heart disease typifies the summaries from studies of this type. The investigators concluded, “Mindfulness training showed positive effects on the physiological parameters exercise capacity and heart rate and it might therefore be a useful adjunct to current clinical therapy in patients with heart disease” (Younge et. al. 2015). Here, mindfulness’s utility is contingent upon its ability to measurably alter physiology. This particular study was a randomized controlled trial. Studies of this type are considered rigorous, and often regarded as the “gold standard” of biomedical research.

Randomized controlled trials of mindfulness-based therapies have been conducted at diverse institutions around the world. Three major institutions, however, remain the major authorities on clinical mindfulness: The University of Massachusetts Center for Mindfulness, the University of Oxford Mindfulness Centre, and the Center for Investigating Healthy Minds at University of Wisconsin—Madison. Within each is a leader (Dr. John Kabat-Zinn, Dr. Mark Williams, and Dr. Richard Davidson, respectively), each of whom has trained extensively in both the biomedical sciences and Buddhist meditation, and has studied the Buddhist sources of the mindfulness practices

they promote. Each of the three institutions is highly regarded within the biomedical community, has grown tremendously over the past two decades, and continues to publish research on the clinical efficacy of mindfulness interventions.

Many Buddhist leaders have enthusiastically engaged with this research. The Dalai Lama personally recruited monks who had practiced meditation for 10,000 hours or more to participate in Davidson's functional magnetic resonance imaging study visualizing and measuring changes in brain activity caused by meditation (Davidson and Lutz 2008; Lutz et. al. 2008). The Dalai Lama and many monks have spoken publicly about the benefits of this type of research (Davidson and Harrington 2001). Many prominent Buddhists have also highlighted the compatibilities between Buddhism and science in articulating a hypothesis and testing it in the laboratory of experience and the world. For example, in his book entitled *The Universe in a Single Atom*, the Dalai Lama wrote, "My confidence in venturing into science lies in my basic belief that as in science, so in Buddhism, understanding the nature of reality is pursued by means of critical investigation" (Bstan-'dzin-rgya-mtsho 2005, 2). Buddhism and science are both concerned with increasing understandings of our world. Science applied as medicine shares with Buddhism a core interest in understanding human suffering, albeit with emphases on different types of suffering. In translating these investigations into a set of therapeutic "results," however, a patient's attitude of investigation is often eclipsed by expectations that come from the prescriptive stamp of authority. Biomedical interventions are expected to improve or heal an individual self. The focal point of intervention is within the individual experiencing symptoms. Actions are expected to have perceptible,

preferably measureable, results. These ambitions make biomedical investigations and treatments largely incommensurate with Buddhist aims.

Problematic methodologies in mindfulness research

Positive preliminary results of these endeavors by reputable scientists to study mindfulness have led to an accelerated production of science of inconsistent calibers, yielding results of varying validity. In a large 2003 meta-analysis of the empirical literature on mindfulness, Baer pointed out many methodological problems lurking within the rapidly growing science of mindfulness. The literature has greatly expanded in quantity since then, but many of the quality issues she illuminated remain. Baer (2003) stated, “The empirical literature on the effects of mindfulness training contains many methodological weaknesses, but it suggests that mindfulness interventions may lead to reductions in a variety of problematic conditions, including pain, stress, anxiety, depressive relapse, and disordered eating” (126). Baer described the methodological foundation of many mindfulness-based interventions as flawed, and recommended “methodologically sound investigations.” These methodological problems include lack of meaningful control groups, small sample sizes, limited “evaluation of integrity of treatment,” and insufficient follow-up period for studies. Neuroscientist Catherine Kerr (2014) echoed these concerns, adding that “the studies are too cherry picked and too positive” (1).

Many of these methodological weaknesses have been acknowledged by leading mindfulness researchers. For example, in his November 2015 talk at the University of

Minnesota, Kabat-Zinn expressed trepidation at the overhyping of mindfulness, stating that the science is in its infancy and “needs more high quality rigorous science. This falls into the realm of hype and as every scientist knows, that’s the kiss of death” (Kabat-Zinn 2015). Mark Williams, another of the aforementioned global leaders on research who has investigated mindfulness using scientific methods, articulated similar trepidations in a talk at Blackwell’s bookshop on Broad Street in Oxford, as he described the current uptake of mindfulness as a trend that will inevitably dwindle. He emphasized the need for high-quality research to back vast claims that are enthusiastically made about mindfulness (Williams 2013).

The “Mindful Nation UK” publication also acknowledged the risk of overhyping existing scientific evidence, and specifically used the word “panacea” as potential perception of mindfulness efforts. The document stated, “We are aware that the current popularity of mindfulness is running ahead of the research evidence in some areas, and have tried to steer a balanced course midst the claims and counterclaims reported in the media. While it is not a panacea, it does appear to offer benefit in a wide range of contexts” (MAPPG 2015, 5). Though the leaders of mindfulness research have thus expressed self-awareness about the limitations of their research and explicitly warned against overstating the benefits of mindfulness, institutions and patients, desperate for attainable solutions to chronic problems, are often swept into the sound chamber of positive results reports.

Measuring mindfulness mechanisms: An empirical challenge

In addition to being potentially overblown in media and scientific literature representation, many of the vital elements of mindfulness's influence cannot be measured. Yet the biomedical measurement of mindfulness forms the basis for reporting the effects of mindfulness interventions, justifying their role in biomedical intervention. This measurement is undertaken through various “clinical instruments”—surveys and questionnaires asking patients to select answers that most closely correspond with their experience. The Mindfulness and Awareness Attention Scale, the Kentucky Inventory of Mindfulness Scale, and the Freiburg Mindfulness Inventory are three commonly referenced tools for quantifying the effects of mindfulness interventions. The creators of the Freiburg, a widely used mindfulness quantification instrument, explained their aims: “It thus seems useful to measure mindfulness either as a target variable of clinical interventions, as a moderating variable, and perhaps even as a personality trait, and thus we constructed a measurement instrument” (Walach et al. 2006, 1). Items on the Freiburg Mindfulness Inventory include “I am open to the experience of the present moment” and “I am able to smile when I notice how I sometimes make life difficult.” For each statement, study participants are asked to choose the number between 1 (rarely) and 4 (almost always) that most closely aligns with their frequency of experience.

The scientists who developed the Freiburg Mindfulness Inventory concluded that the 14 questions contained in the questionnaire fully encapsulate and effectively quantify mindfulness. They stated, “The [Freiburg Mindfulness Inventory] is a useful, valid and reliable questionnaire for measuring mindfulness. It is most suitable in generalized contexts, where knowledge of the Buddhist background of mindfulness cannot be expected. The 14 items cover all aspects of mindfulness” (Walach et al. 2006). Their

description of mindfulness characterizes it as mental processes that diminish psychological distress. More specifically, the instrument relates mindfulness to the development of “self-awareness” and the diminishment of “dissociation.”

Despite the authors’ claim that their questionnaire covers “all aspects of mindfulness,” I argue that this biomedical therapeutic interpretation of mindfulness fundamentally misses the critical shifts Buddhist practitioners describe as responsible for sustained and meaningful behavior change. These questionnaires cast mindfulness as a standalone concept that leads to a linear and predictable outcome in the psyche and body, without needing a system of reinforcing values and insights and a community within which to enact these values. The characteristics specifically articulated by Buddhist practitioners that are notably absent from the biomedical enunciation of mindfulness include deemphasizing the sense of an individual self with personal problems in need of “fixing,” and the cultivation of values that challenge the need to grasp and fulfill various kinds of cravings.

In her meta-analysis, Baer (2003) elaborated on the dearth of literature measuring many of critical elements of mindfulness training. In her view, these (so far) immeasurable yet important outcomes of mindfulness training are improving wisdom and insight. She argued that rigorous investigation of mindfulness is necessary, and that measuring these “other concepts” that are not encapsulated by current biomedical metrics is a valuable undertaking. She said,

As described by Kabat-Zinn (2000), the practice of mindfulness meditation is concerned with the cultivation of awareness, insight, wisdom, and compassion, concepts that may be appreciated and valued by many people yet difficult to evaluate empirically. Thus, although methodologically rigorous investigations of the effects of MBSR are both possible and necessary, perhaps researchers should consider ways to incorporate these other concepts, in addition to more readily

measured constructs such as symptom reduction. (Baer 2003, 140)

Baer highlighted how “deliverables”—those parameters of mindfulness that can be measured and reported upon—become the most frequently evaluated. The problem with this mentality is that it minimizes the importance of the “other concepts,” which likely contribute much, if not most, of the potency of mindfulness practices. This leaves a prosaic discussion framed in terms of symptom relief and therapy at best, self-help at worst. The self-help genre proves problematic in this context because of the strong emphasis on the “self” as a distinct entity in need of improvement, with clear means of attaining this improvement. I discuss the counterproductive expansion of self-view through mindfulness infrastructure at more length in the next section.

Related to the idea of “deliverables” is the notion of the “lowest therapeutic dose” of mindfulness interventions. Researchers, healthcare providers, and patients are interested in the minimum amount of mindfulness instruction and meditation that can have the desired effect in symptom reduction. In this mindset, the eight-week mindfulness course is seen as the more involved course, and other modes of delivery (usually shorter courses and less in-person instruction) are tested for efficacy. In the “Mindful Nation UK” document’s section on implementation, the framing of mindfulness interventions as a dose-dependent endeavor is made explicit:

It is important to emphasise that most of the academic research and evidence on mindfulness programmes has been conducted on the eight-week MBSR/MBCT [Mindfulness-Based Cognitive Therapy] curricula and their derivatives. There is early evidence that lower intensity/self-help interventions methods of delivering mindfulness – such as books and online courses – may be beneficial but more research is needed to answer nuanced questions regarding what approach works for whom and in what context, and the differential effects of low-dose versus traditional delivery. (MAPPG 2015, 64)

While the desire to find a low-cost/high-impact intervention makes sense in the context of governmental scalability, the language of “low-dose delivery” problematically medicalizes and circumscribes a complex system. Considering the previously discussed shortcomings of research on the eight-week mindfulness courses, it is rather alarming to see the results taken as a given, already referred to as “traditional delivery.”

Mindfulness personalizes and individuates suffering

When mindfulness practice in isolation is framed as a way to reduce symptoms, it risks reinforcing a sense of self, thereby strengthening craving. As discussed in Chapter 3, bolstering the story of a separate, fixed “self” lends weight and urgency to stories of craving, and dismantling the former helps to alleviate the hold of the latter. The fortification of the sense of a self with personal problems in need of fixing undermines the potential for liberation from suffering from the Buddhist perspective. Nonetheless, many practitioners initiate mindfulness practice as a treatment to alleviate particular bodily or psychological suffering.

Secular mindfulness rhetoric casts mindfulness as a process through which the individual should become expert in caring for his or her unique set of symptoms, reinforcing a goal-driven personalization of health. According to Kabat-Zinn (1994), “The whole point of mindfulness-based stress reduction is to challenge and encourage people to become their own authorities, to take more responsibility for their own lives, their own bodies, their own health” (191). In this instance, Kabat-Zinn’s framing

emphasizes ownership of one's body and experience in a manner counter to the Buddhist purpose of meditation. Marx elaborated,

Buddhist meditation aims to deconstruct this illusory sense of ownership of our experience by an experiencer, not to strengthen the dualistic idea of a separate experiencer/observer who manages her thoughts better (see Low 2004; Norbu 2006). Secular mindfulness practices... may miss the deeper significance of these practices in a Buddhist context in which they are used to cut through the construction of an illusory sense of a solid self as subject and experience as object, which is seen as the root cause of suffering. (Marx 2015, 1155)

Not only does secular mindfulness miss the deeper significance described by Marx, but it may facilitate a false sense of control over one's body. Practices such as food protocolization and the general anxiety about what to eat exemplify these feelings of having, and needing, to exert control over the functioning of the body to eliminate symptoms.

In mindfulness practices undertaken from a symptom-centered mindset, with the aim of overcoming shortcomings through individualized efforts, patients and practitioners inevitably focus their meditation efforts on themselves and the mitigation of unwanted states of body and mind. Winnie Nazarko, a prominent Buddhist teacher, explained the problem of symptom personalization as follows: "There is a wisdom in not wanting to suffer... the less skillful part of that is thinking you're going to directly excise things from your mind stream that are there because of causes and conditions that you don't directly control" (Nazarko 2015, 54:24). Marx (2015) characterized this endeavor as ineffective in easing suffering because "It does not touch the delusion in which I, as a perceived individual, attempt to act more effectively upon the world in order to try and control, master and shape it more to my liking—an enterprise that is laced with

unhappiness” (1158). Thus, there is delusion (in the Buddhist sense) both in the attribution of problems to the “self” and in the individual’s attempt to control symptoms in an attempt to reach a less uncomfortable state.

Mindfulness teachers routinely discourage against this results-based position on an individual level of engagement with mindfulness. However, many patients are introduced to mindfulness in a clinical context that frames healing in terms of efficiency and effectiveness, and shifting this orientation within a brief eight-week intervention proves difficult. Additionally, popular media has portrayed mindfulness practices in an overwhelmingly positive light, contributing to bolstered patient expectations.

The aforementioned leaders of therapeutic mindfulness, in each of the speaking engagements I attended, openly spoke about the limitations of undertaking mindfulness with a goal-oriented mindset. Williams provided an analogy of planting seeds into the ground and growing (cultivating) certain qualities of the mind. He explained that we do not need to dig up the seeds every day to check how they are doing or to measure them. When we do this, the seeds can’t grow. We just need to keep tending to them without constantly checking up on them (Williams 2013). This framing directly opposes an emphasis on evaluating effectiveness by parameters that can be readily ascertained at specific time points. Nonetheless, many of my discussions with practitioners of secular mindfulness (research-related and personal) made clear the relationship between undertaking mindfulness practices in a therapeutic context and a desired, often very specific, outcome.

In contrast, Buddhist practitioners, including those who were discernibly overweight or experiencing medical problems, articulated far less goal-driven orientation

towards meditation practice. Paradoxically, they were able to “achieve” many of the outcomes that elude biomedical endeavors, and articulate far less anxiety in the process. I asked Susan, a woman in her 60s who is currently experiencing a major health crisis, about how her illness affects her meditation. She said, “It’s hard not to focus in on your aches and pains while sitting and meditating. It’s hard not to. But that just makes you tight. That’s just wishing for something, grasping for a reality that isn’t there. That’s the opposite of acceptance. So of course it [pain] crosses my mind but I don’t make my meditation about getting rid of it.” Many Common Ground practitioners expressed similar sentiments, emphasizing the importance of acknowledging painful symptoms as “feelings being known,” not endeavoring to change them. In my own participation in the Common Ground context, I observed how consistently the concepts of the impersonal nature of suffering and the cultivation of nonself are reinforced in the teachings that accompany mindfulness instructions. Undertaking mindfulness practice within this ethical milieu facilitates a fundamentally different endeavor than mindfulness training contextualized within biomedical agendas of symptom eradication with the lowest therapeutic dose of practice.

Conclusions

In this chapter, I have argued that clinical mindfulness-based interventions in isolation are self-limited, replicating the reductionist interventionism of the biomedical system through which they are prescribed. Using the “Mindful Nation UK” document as a case study, I analyzed the proliferation of mindfulness through major social sectors, and

concluded that the institutional emphasis on promoting mindfulness training potentially subverts reconsideration of the stressors imposed by these systems on their constituent individuals. While the founders of mindfulness-based interventions nod to the Buddhist frameworks from which these interventions were conceptualized, the proliferation of these practices through mainstream society has been contingent on a high degree of secularization and decontextualization. Thus, patients engaging with these practices do so within the biomedical goal-oriented logics of diminishing personal symptoms. In the Buddhist purview, this desire for the obliteration of a particular part of one's experience (such as a specific symptom) is a craving that will inevitably lead to more suffering. Indeed, in my ethnographic engagement with Buddhist practitioners, profound behavior changes were not specifically attributed to mindfulness practices. Rather, in these cases, a shifting ethical view occurred through engagement with various elements of the Eightfold Path in tandem, rather than through an exclusive focus on mindfulness. Changes in eating patterns and other behavior modifications were regarded by Buddhist practitioners as "side effects" of their practice.

Chapter 7

Sickening structures: Healthcare, industrial agriculture, and Big Pharma

Now that we have investigated the theories and ethnographic contexts of the Buddhist and biomedical epistemological spaces separately, this chapter will apply Buddhist ideas as an interpretive lens for unraveling the ways in which interconnected hegemonic systems set in motion the causes and conditions that accelerate our predilection for food attachment. Patients and medical providers beholden to the healthcare system, the industrial agriculture system, and the pharmaceutical industry (also known as Big Pharma), remain enmeshed in an interdependent framework formed by these industries and their respective profit motivations. This chapter is descriptive, with the aim of understanding the issue of food attachment with an assiduousness allowed by using an interpretive analysis of lived experiences without resorting to immediate, piecemeal intervention. In other words, this work does not aim to propose a single, effective solution to issues of food attachment. Hopefully, by this juncture in the dissertation, it has become abundantly clear that such an effort would prove counterproductive to discussion of the types of interconnected issues with which we are dealing. As American journalist and cultural critic H.L. Mencken famously said, “For every complex problem there is a simple solution and it is wrong.” Besides not proposing a specific solution to the problems described herein, this dissertation also does not fully expound the number of factors contributing to food attachment. Other scholars, such as those who elaborated the Foresight map (see Appendix), have made exceptional gains in portraying this complexity.

Rather, this chapter ideally serves as a robust amplification of a middle way between the politicized agendas of ascribing unilateral agency to *either* the individual *or* problematic systems, allowing us to consider some important systemic factors generally obscured by the transmission of individualized fear that has dominated discourses of eating in this country. This chapter will first establish the normalcy of craving and attachment formation in the Buddhist view. While it is not necessary to categorize food attachment in the specific biomedical terms of addiction, I will synthesize the Buddhist and biomedical paradigms of addiction and attachment for a compassionate, expansive, and nondivisive interpretation of extreme attachment. From here, I will examine how Americans exist within systems that work synergistically to augment these attachments. In addition to literature and ethnographic data, this work will utilize autoethnography. Due to my positioning within the biomedical environment, autoethnography provides a convergence point from which to investigate several factors that detrimentally influence both patients and medical workers. This requires elucidating the ways in which major systems (the agricultural industry, the pharmaceutical industry, and biomedicine) contribute to shaping our cultural and psychological spheres. Using the framework of dependent origination provides a dispassionate elucidation of the links of causality that reinforce, or alternately could alleviate, suffering caused by craving.

Buddhism and addiction

Buddhist texts do not utilize the word “addiction,” nor do they classify addictive behavior as a category of experience distinct from attachment. However, cycles of

craving and attachment as described in Buddhist texts, and the attempted fulfillment of these desires through ultimately destructive actions, in some ways parallel the biomedical notions of addiction. According to Mingyur Rinpoche, an author and Tibetan Buddhist teacher of the Karma Kagyu lineage, “Attachment is in many ways comparable to addiction, a compulsive dependency on external objects or experiences to manufacture an illusion of wholeness. Unfortunately, like other addictions, attachment becomes more intense over time” (Yongey, Swanson, and Goleman 2007, 119). These attachments fueled by unchecked craving are frequently referenced in Buddhist texts and portrayals. In previous chapters, I have discussed the epistemological convergences and divergences of the Buddhist and biomedical notions of craving. Next, I will examine the potentials and limitations for meaningfully combining the two paradigms in the conceptualization of therapies.

Dr. Paramabandhu Groves, a clinical psychologist and consultant for the National Health Service, elaborated on the conceptual links among craving, attachment, and addiction. Groves discussed the utility of Buddhist principles in addressing the issue of craving in addiction therapy. He stated,

Taking addiction as a form of attachment normally associated with craving, Buddhist teachings then constitute a rich source of aetiological models and possible therapies for addictions, for Buddhism of whatever type proposes how craving and attachment arise, what forms they can take and provides detailed accounts of strategies to deal with them. (Groves and Farmer 1994, 183)

At the very least, considering the Buddhist philosophical insights into the nature of craving can provide direction and focus for a field of medicine that is fragmented, inconclusive, and challenged.

Groves correlated the three forms of *tanha* with corresponding addiction ideology, stating that

Kama means sense experience, for example as provided by drugs, food or sex. Bhava means a state, in the sense of craving for a particular state of mind or looking forward to a particular condition where one expects to feel happy and secure – as with craving a cocaine high. Vibhava is nothingness, narcosis or non-existence, reminiscent of alcohol or opiate use to “blot out feelings.” (Groves 1994, 185)

Beyond correlating Buddhist ideas with particular examples of specific types of addictions, the orientation towards craving in Buddhism radically departs from biomedical concepts.

This Buddhist understanding of craving as a *normal* part of being human is a subtle but important distinction from biomedical classifications, in which people are dichotomized as “normal” or “pathological,” without much acknowledgment of the permutations of these states and the possibility of transition between them. In the Buddhist model, craving is a fundamental part of human existence; thus, there is a constant effort by practitioners to prevent attachments and suffering caused by untempered craving. Indeed, craving is a socially acknowledged part of the experience of *all* beings. Additionally, even when an individual is entrenched in a strong pattern motivated by craving, it is still an extreme manifestation of a normal process that can be overcome through consistent practice.

As craving forms the foundation of suffering, endeavors in healing and easing suffering require building systems that mitigate, rather than accelerate, attachments. In the Common Ground context, ethnography demonstrated that these systems include *sangha* (community) activities, meditation, *dana* (generosity) practices and emphasis on

service to others, and everyday rituals that embody the teachings such that one's thoughts and attachments can be examined with impartial interest and need not always be the impetus for consumption or action. On an individual level, Common Ground practitioners undertook the teachings of the Eightfold Path to varying degrees, and practiced noticing the ways in which one thought, action, or condition gave rise to another.

On the other hand, in biomedicine craving is addressed *post facto*, once a patient has presented with a physical or psychological disease rooted in excessive attachment. Excessive attachment to substances such as alcohol or drugs is diagnosed as addiction, while attachment to worried thoughts bears the label of generalized anxiety disorder. Attachment to food is addressed only after the patient begins to exhibit physical complications such as obesity, anorexia, malnutrition, or specific physical symptoms despite patients expressing concern for their struggles with food in advance of these expressions. Craving is only “diagnosed,” or addressed, once it manifests as another illness (e.g., diabetes) or as an addiction. Thus, once a diagnosis of craving has been established, patients bear the label of pathology. The responsibility for developing and managing this pathology is localized within the individual. Many US systems exploit the ubiquity of these roots of attachment for profit, rather than taking collective effort to mitigate the hardship they reinforce. In the following sections, we will look at divergences between the biomedical and Buddhist approaches to mitigating problems associated with craving, examining the interdependent factors that contribute to attachment formation at the levels of training, care administration, and the systems within which healthcare is suspended.

Autoethnography

In this section I turn to autoethnography, examining my own experiences grappling with food attachment as I work within the biomedical system. Although this is not written in the literary or novelistic style described in Ellis's (2004) book on autoethnographic methodology, it does use the characteristic autoethnographic focus on self-reflexivity, and draws attention inward to my own experience as a valuable source of material for analysis (Dauphinee 2010; Ellis 2004; Holman Jones et al. 2015). This method resonated due to my positionality as a researcher who is nevertheless deeply embedded within the biomedical system, feeling with immediacy a confluence of factors that I wished to describe. McIlveen (2009) wrote, "The defining feature of autoethnography is that it entails the scientist or practitioner performing narrative analysis pertaining to himself or herself as intimately related to a particular phenomenon" (3). At a certain point during writing, I began feeling as though I was describing processes in terms of the feelings of others, abstracting them, when in fact many of the described tensions continued to rattle through my own life.

Acknowledging the detrimental systems in which I was deeply implicated, and that in turn exerted adverse effects, proved difficult at times. Ellis (2004) wrote that this is typical of the autoethnography process, which is in turn both painful and rewarding:

That does not mean that the process [of writing autoethnography] will be pain free; usually some degree of emotional turmoil accompanies the vulnerability required to scrutinize yourself and to reveal to others what you find. Almost always, the insights you gain about yourself and the world around you makes the pain bearable, even welcome at times. (Ellis 2004, xx)

Indeed, there were many days of painful self-doubt about my own professional choices, as well as a sense of defeat regarding the immenseness of complexity and seeing clearly my own role within it. The following vignette uses autoethnography to illustrate a typical clinical day:

The alarm begins ringing insistently at 5:00 am. Outside, it will be dark for hours, and by the time the sun rises, I will be ensconced in the windowless wards of the hospital. I had ambitiously set the alarm early enough for a lightning-speed breakfast, but sleep is more appealing at this hour and besides, there is nothing in the fridge except days-old leftovers. I sleep for a few more minutes, then rush around getting dressed and gathering my things for the day, literally running out the door, without having eaten anything. I arrive at the hospital one minute before the 6:00 am sign-out, where the exhausted team who have been in the hospital overnight provide a summary of everything that has happened with each of the patients overnight.

After sign-out, I hurriedly begin collecting information: reviewing vital signs, medications administered, and notes about each patient from the previous night. As the resident in the Medical Intensive Care Unit, I am preparing to present each patient to the large team during rounds, and need to see to each patient (and often exhausted family members who are dozing in hospital chairs) before the attending arrives and announces that they would like to begin making rounds. At some point during this pressurized scramble, I feel hunger pangs gnawing at my stomach and I rush to the hospital cafeteria with a portable phone in hand and a pager clipped to the neckline of my scrub top. In the cafeteria, my usual choices are individually made omelets (filling and tasty but taking far too long to prepare for the time I have), cheesy potatoes (heavy and satisfying after a night shift, but inevitably resulting in a stomachache and sleepiness), oatmeal (by far the healthiest choice that will keep me satiated for a while), and a long array of frosted donuts and other baked goods. By this time, the hunger and cravings are so overwhelming that I reach for the cheesy potatoes. After I smother them with some ketchup and hot sauce and quickly devour the cooling lump of potatoes, cheese, and butter, I have a few moments of bliss and satiety before sleepiness kicks in and rounds begin.

Rounds last for hours, as we make plans for each patient in the unit. Our team of an attending, fellow, resident, pharmacist, medical students, and dietician gloms through the hallway pushing several computers on wheels. Hunger, headache, and exhaustion are overwhelming by the time we finish rounds after 2:00 pm, by which time the cafeteria is closed. There is another small café with a very limited selection, and I order a flatbread pizza, the cheese and carbohydrates overwhelmingly appealing. I bring the pizza back to the workroom, where the pharmacist gives a lunchtime lecture on different types of anticoagulant

medications and their risks and benefits, while I sit mindlessly chewing on the familiar cardboard-like pizza.

A few minutes after the lunch lecture ends, I go to the resident room, exhausted, to prepare a coffee before beginning the hours of orders, notes, procedures, and conversations with families that occupy the afternoon into the evening. During this time, patients are admitted from the emergency room, a process that takes hours of sitting in front of the computer and writing long “admit notes,” as well as seeing the patients and performing all necessary procedures and determining which medications are required for stabilizing any emergencies. Patients are also transferred, or moved to a different unit in the hospital—a process that consists of conversations with other specialties, transfer orders, and more paperwork. The time spent documenting feels tense, as I tediously record the decisions, orders, and conversations that have occurred throughout the day. We are constantly reminded in both formal teaching sessions and in casual conversations with supervising doctors of the importance of CYA (Cover Your Ass) documentation, the prompt and thorough records that absolve responsibility when some number of “cases” inevitably ends up in court.

Partway through my first note, a nurse pushes open the workroom door and looks at me. “Are you taking care of 6017?” she asks me. I look down at my list of patients. I find the number 6017, along with a row of information about this person. I nod. “The family would like an update,” the nurse says. I groan internally, look at the note I am working on. At least a half hour of writing remains. I save and close the patient’s chart before opening the chart of the patient in room 6017. After reading the notes from consultants, I go into the room to talk. I knock on the door and find the patient’s mother sitting in a chair and crying, extremely worried about some of the medications her son is on, why he is so sleepy, and when he will wake up. We are nearly at the end of the conversation before I allow myself to fully relax and to be with her in this discussion. As I walk back into the workroom, the fellow on the team looks over at me and says, “Where have you been? We had a new admit and I had to go to the ED [emergency department] to see them.” “I was with a patient,” I respond. The fellow looks over to the senior resident. “That’s why you don’t send interns to talk to patients. Takes too long.” I feel anger and frustration bubble to the surface, but I say nothing, turning to the computer to record the details of my last conversation and order the medication adjustments we had discussed.

Despite several small interruptions and complications, I finish my work and leave by late evening and drive home. Preparing dinner, much less planning meals for the next day or two, feels like an insurmountable task. I feel exhausted even thinking about where to procure food. “Should I have a quick, convenient meal? Should I buy something healthy? I had such a long day of work. I deserve to eat a treat.” The internal monologue continues on and on. It feels difficult to make any decision at this point in the day, no matter how inconsequential. I am feeling indecisive and seeking quick satisfaction through “unhealthy” foods. Lately, a

combination of stress and hunger at times of decisions about what to eat make me gravitate towards meals comprised of carbohydrates, dairy, and sugar, despite feeling physically worse after eating them.

I have the funds and knowledge to make decisions that will not lead to abdominal pain, weight gain, and other symptoms, yet continue to choose foods that fulfill emotional, rather than physical, needs. Several days of the week, I come home from the hospital and walk to Pizza Luce, the restaurant across the street, and buy a single slice of pizza, eating that before supplementing it with some food at home. I get into bed after dinner, scrolling on my phone for some source of connection before falling asleep.

Repeating this process day after day creates a near-perpetual fatigue, taking a toll on both my body and my mental health. During medical training, I have gained weight, had chronic gastrointestinal issues that nearly completely resolve when stress subsides and I can plan for a diet that consists of less gluten, dairy, and fried food. Since beginning this research, there have been periods of time when I have meditated, kept up mindful eating, and maintained a light and fulfilling supply of food that has made me feel well. However, during phases of hospital duty, I feel near-constant stress due to the number of decisions that must be made with limited information, the emphasis on documentation and efficiency rather than fostering the relationships that I thought a career in medicine would comprise. Though there are many meaningful and fulfilling moments at work each day, there is also a general sense that helping others is not at the core of what I spend my day doing.

Bothered by these stress-induced symptoms, I sought medical care. My doctor and I had a brief conversation; she performed a few tests and recommended taking medication for anxiety, saying, “I had to start taking anxiety medication in medical school and before that I had stomach issues. They totally went away after I started taking medicine.” She performed some basic lab tests and noted that one of my thyroid levels was elevated and that I could take a medication to normalize it, despite our discussion that I did not have any hypothyroid symptoms. Finally, she said that if my gastrointestinal symptoms did not go away, she could refer me to a gastroenterologist to have a colonoscopy. We did not discuss diet, sleep, or other lifestyle changes that would (and had previously) relieved these symptoms. Having gone through medical training herself, my doctor (rightly) considered these to be immutable constraints for the time being.

In the following sections, I will dissect the assemblage of contributors to poorer health that are built into the circumstances described above. I found that the mode of operation of the biomedical system, driven by the aim of maximizing profit, aggravates attachment

to food as a response to stress. Ethnography of medical students existing at the intersection of Buddhist and biomedical ideologies highlights the ways in which the structure of the medical education system precludes having the time to discuss and tend to complex, multifaceted behavioral elements of illnesses.

Healthcare: Caring for profits over people

The medical institution is based on the commoditization of care in order to maximize profits, creating stress for providers and patients alike. According to Brown and James, authors of a book entitled *The Truth about Big Medicine*,

The health care industry has uncanny similarities to the financial industry. Both sectors have price bubbles, toxic assets and products, a too-big-to-fail attitude, and privatized gains and socialized losses whereby the system benefits financially from the harm it causes and shifts the human and financial cost to individuals and society (Brown and James 2015, ix)

Health expenditures comprise a considerable percentage of national spending, meaning that the stakes for the industries that constitute healthcare are enormous, even in comparison to other countries. Singer and Baer (2009) wrote, “The United States spends more money on health care than any other nation on Earth... about twice as much as the next most-expensive health-care systems in the world, those of Switzerland, Germany, and Canada.”

The outcomes of The US’s healthcare system do not justify its spending. Singer wrote, “For-profit health care is not only more expensive; much research has also documented that its outcomes are worse than those in nonprofit or publicly delivered care... when profits are primary, care is necessarily worse, and results in worse

outcomes” (Singer 2009, 215). Commenting specifically on the poorer outcomes achieved by the US healthcare system, the author of *U.S. Health in International Perspective: Shorter Lives, Poorer Health*, a publication by the Institute of Medicine, wrote that Americans face poorer health outcomes than people in “peer countries” (16 countries deemed comparable in income) in realms including obesity and diabetes, heart disease, chronic lung disease, adverse birth outcomes, injuries and homicides, adolescent pregnancy and sexually transmitted infections, HIV and AIDS, and drug-related mortality, and disability” (Fineberg 2014). Additionally, the high resource expenditure on healthcare in the US is not equitably distributed. Rather than considering healthcare a fundamental human right as do other developed nations, healthcare in the US functions based on corporate profit-maximization ethics, and individuals are often responsible for procuring the means to secure healthcare resources.

A great deal of the healthcare costs go into profit. According to Martha Livingston in a paper entitled “U.S. Healthcare Commodification Kills,”

Insurers refer to the amount of the health-care premium dollar that is actually spent on health care as the “medical-loss ratio,” or “medical-cost ratio.”... For-profit corporations’ primary responsibility is to make profits for their shareholders; that’s what corporations do—and in health care, they’re getting better at it all the time. (Livingston, as cited in Singer 2009, 214)

This orientation towards profit influences the way that doctors go about making their decisions. In our medical training, we have frequent “didactic” sessions including discussions about documentation for maximizing billing and ordering medications in appropriate “bundles” to ensure the largest possible insurance reimbursement. Often, during these didactic sessions, it is unclear when the teaching is based on evidence of

which medication or action is in the best interest of the patients' treatment, versus which is being recommended in order to bring in higher reimbursement to the hospital.

Receiving this information at a formative stage of training surely has implications for shaping thought processes regarding clinical decisions. Gottfried (2009) wrote,

Today, the decisions doctors make are governed by insurance reimbursement, consumer demand, liability concerns, and market share. Big business and money have come to dominate the American medical landscape. The choice of antibiotics given for infections, surgeries performed for ailing hearts, chemotherapy administered for cancer, and screening tests recommended to prevent diseases are as strongly influenced by nonmedical, economic forces as by science or common sense. (x)

Obviously, this orientation towards making decisions is a disservice to patients, whose trust in their doctor reasonably includes a sense that clinical decision making will be made with the patient's health, rather than the hospital's fiscal interest, in mind.

Additionally, the constant encroachment of systemic profit-motives exhausts clinicians, who cannot freely deploy their medical training. Relative value units (RVUs) are a standard measure of physician productivity and can be an important driver of medical decisions by attending (supervising) physicians. An RVU is the dollar amount that Medicare reimburses for a "unit" of a physician's work. A committee determines the work that comprises a unit. Extant research has estimated that about two thirds of physicians' compensation in the US is tied to some degree to RVUs. The explicitness of using RVUs to evaluate doctors varies widely between health systems. At some residency interviews, senior residents talked to me about their post-residency work contracts. In some cases, the salary was tied to the "RVUs I bring in." For example, one chief resident told me, "My salary will be around 400k, but it can get up to 700k because I'll take home a percentage of the RVUs." In other systems, physicians make a salary independent of

their productivity, but might receive, for example, a monthly email listing the RVUs of each doctor in the group, subtly pressuring those with lower “performance” to “bring more value.”

A committee called the Specialty Society Relative Value Scale Update Committee assigns RVUs to various clinical tasks. The parameters for setting clinical tasks at certain RVU levels lack transparency to the public. Generally, high-intervention activities (such as procedures and surgeries) are compensated at a higher level, creating physician incentive for prioritizing these actions, regardless of whether they are in the patients’ best interest. Reforms recognizing the value of primary care conversations and lower-intervention activities have been called for. In an article entitled “Adding Value to Relative-Value Units” in the *New England Journal of Medicine*, Stecker and Schroeder (2013) wrote, “Across the board, RVU levels for cognitive clinical work could be increased and those for procedural work could be decreased to create incentives for primary care services.” Stecker and Schroeder highlighted secrecy of the committee and tight control over RVU allocation as potential roadblocks in reconfiguring reimbursement structures that dissuade healthcare focused on conversations with patients.

Buddhist medical students: A conceptual confluence

At the level of medical education as well, students are trained to think of their patients as collections of “problems,” rather than people with whom to holistically and thoroughly engage. Experiences of medical students at the intersection of the biomedical and Buddhist epistemologies demonstrate the processes by which biomedical teaching

wears away holistic approaches to understanding. Bernadette was a second-year medical student when we first met. She studied philosophy as an undergraduate student and was a competitive and very successful college runner. She had applied to medical school aspiring to become a primary care physician, hoping to be involved with the health and wellness of patients and their families over the span of many years.

During her first year of medical school, she was taken aback by “how much the medical school curriculum leaves out.” She explained, “I think that the... the absence of... I mean in sort of blunt terms the humanistic or spiritual approach to medical education... the amount that felt missing to me was a lot bigger than I thought it was going to be. And my response to it was stronger.” Rather than building on her prior understandings of suffering and healing (amassed through study and personal experience with severe illness), Bernadette was confronted with the task of learning an enormous number of facts, often with very little understanding of how the facts linked to one another or to patient experiences. The resultant feeling of purposelessness, alongside the stress of the first year of medical school, prompted Bernadette to attend Common Ground. She said, “The first year of medical school is hard for most people and one of the ways it was hard for me was *not* feeling like there was any context for what we were learning and for health, illness, disease, how we make decisions about bodies, and how we treat bodies, it was just all these separate facts.” Without a broader framework for understanding how what she was learning had meaning for people, she felt that much of the information she learned lacked purpose.

She began cultivating a personal meditation practice because of “just hearing from so many people that it’s an important part of spiritual growth and exploration, and

um, Common Ground is really close to my house. So I had both heard really good things about it and it was really convenient.” As a medical student and regular Buddhist practitioner, Bernadette squarely occupied the spaces of both biomedicine and Common Ground Buddhism. She was in geographic proximity to both settings, interacting with people from both social spheres as she pursued her daily activities. In her neighborhood, both Common Ground practitioners and medical school students and preceptors shop at her local co-op, eat in the local cafes, and are active on campus (for example, many Common Ground practitioners are involved with the University of Minnesota Center for Spirituality and Healing). She was shaped (or “formed”) by a combination of factors from both spheres as they intersected in her daily life. During this process, she ultimately realized that these two systems of thought were completely irreconcilable and that the medical system within which she was training precluded the kind of regard for the whole person that she had hoped to have. She said, “You can’t both be in a rush all the time and be with people. You can’t care about someone and get to know their problem while rushing them out of your office all the time.” She also felt that medical school was wearing away at her health and her belief in the things that she most deeply cared about. “You can’t make yourself sick trying to make other people better,” she said. Feeling that the aims of the medical system were directly harmful to herself and her patients, she took time away from medical school; she may return after a period away.

Adieye, also a second-year medical student, entered these social worlds in the reverse order. He had maintained a long-term, consistent Buddhist practice for many years before beginning his medical education. He described his decision to go to medical school after working in other healing realms (as a certified massage therapist, certified

yoga teacher, and pursuing a master's degree in complementary and alternative medicine) before he decided to pursue a career in biomedicine. He said, "Mmm, so I've always fashioned myself a healer of some sort. Before medicine I thought I was going to take part in the healing of people's minds. Be a psychologist, therapist, or maybe even a minister." During a trip to Eritrea, he witnessed "an intense scenario" in which a baby was born by emergency C-section. He was moved to explore healing through medical school. He said, "It was a really intense, scary, dramatic thing and it was... so the baby and mom made it through. They actually both died in the process but they were resuscitated and ended up making it through, and it was because of the interventions of modern medicine. I was like woooooow this is something here." Adiye decided that a biomedical education would allow him to access a unique technical expertise absent from the other healing realms in which he had trained and participated.

Despite his enthusiasm to learn the technicalities that made the aforementioned intervention possible, Adiye is disheartened by how little of what he would consider "healing" is contained, or even allowed for, in the overwhelming number of hours he must "spend memorizing facts" in medical school. Adiye endeavors to retain and develop his knowledge of what he considers to be healing: spending time with people, being present with people, attending to them and making them feel better, through regularly attending Common Ground and by teaching yoga. He also works part-time as a massage therapist while he accrues technical knowledge as a medical student. He consciously decided when moving to Minneapolis from the East Coast for medical school that Common Ground would be his main commitment in his limited time outside of medical school, "Because I [would be able to] get pretty much everything I need in terms of

community at Common Ground were I to dig in, and so that's what I did." He believes that the medical system sorely lacks emphasis on healing, but does not think that this needs to remain the status quo. He hopes to continue to combine the technical elements of biomedicine while developing other ways of attending to "the rest of the person and spirit" through practices outside of medicine, eventually merging the two in "ways that remain to be seen."

Bernadette and Adiye's involvements illustrate the strength of biomedicine's dominance in limiting the ways in which students are able to make sense of healing. Their perspectives also demonstrate the erroneousness of strict dichotomization of the Buddhist and biomedical realms within the context of my fieldwork. Bernadette and Adiye highlighted that the profit dedication of the US biomedical system markedly contradicts the values and interests of some of its trainees. Moral distress, defined as a trainee's perception of a moral conflict, in which they are unable to enact their personal values, ranks at the top of explanatory factors for high rates of depression, anxiety, and suicides in the young physician population (Berger 2014). When reimagining the ideals of the biomedical system, it is important to note the ideological porosity of young medical trainees in this fieldwork context. Biomedical critique frequently depicts the medical institution in pre-deterministic terms that do not adequately account for the dynamism of medical institutions comprised of people capable of change, in part through their involvement in other ideological spaces. The medical students who attend Common Ground exist within at least two ontological realms, embedded within their concurrent processes of continuous formation.

Bernadette and Adiye's experiences also emphasize the divergences in the kinds

of knowledge that can be readily accessed within the Buddhist and the biomedical teachings. Medical students and Buddhist practitioners are both presumably interested in suffering and healing, but the kinds and structure of information available in the two spaces contrast significantly. Students describe medical school training as focused on extremely wide-ranging technical information, yet minimally concerned with the *experiences* of suffering. Medical students who also practice in the Buddhist context seek a meta-structure to make sense of the atomized information to which they are exposed in medical school.

The treatment of food in both contexts maps onto descriptions of the divergent questions and answers predominating in each realm. Biomedicine provides detailed, micro-level information about macronutrients and their respective effects. Even the very formative training in medicine is atomized. Students are taught to think in discrete intervenable parts, rather than in *systems* relating to suffering. Buddhism, on the other hand, provides a language, as well as an intellectual framework, for systematically investigating suffering. While Buddhist texts and Common Ground discussions of food do not address the technicalities of nutrition, they do provide a framework for the behavioral questions of *what* (in very general terms), *how*, and *when* to eat.

Industrial food production

Food production and acquisition have become large-scale, industrialized undertakings in the US. The mechanisms of food production, advertising, and consumption traverse national boundaries, and influence the ways in which the world

eats. While there is enough food produced on earth to feed adequately, or even excessively, the number of human beings in existence, chains of production and profits result in extremely unequal distribution of food. As academic and journalist Raj Patel wrote in his book *Stuffed and Starved* (2008), “Overweight and hungry people are linked through chains of production that bring food from fields to our plate. Guided by the profit motive, the corporations that sell our food shape and constrain how we eat, and how we think about food” (1). Seeking maximum profit favors production of cheap and low-nutrition food on a massive scale, and selling this food regardless of the impacts on the people eating it. In a book entitled *America’s Food*, Harvey Blatt (2008) wrote, “Corporations maximize profits for their shareholders primarily by externalizing as many of their social and environmental costs as possible. They are not financially responsible for the damage their refined sugar and saturated fat products do to people or for the higher health maintenance costs caused by the weight gain they cause” (220). Since the healthcare industry profits, as described in the previous section, from sickness, these costs are externalized through the healthcare system onto the individual him- or herself.

Technology and large-scale industries separate consumers from their food and prevent producers from confronting the human beings that their foods will affect. Thus, industrial food production and sales systems obscure personalized responsibility for the consumption of their products, allowing profit maximization to remain a principle concern. Highly processed foods, which can remain on the shelf much longer than their fresh, perishable counterparts, mitigate the urgency of immediately selling a product and prolong the period of potential profit. This food can be engineered into a compelling

combination of flavors and molecules that facilitates overeating. According to Blatt (2008),

Technology is used irresponsibly to create taste-tempting, nearly irresistible edible products that are beneficial only to the bottom lines of company balance sheets. The numbers on their bottom lines increase in tandem with the size of our bodies. Corporate responsibility seems to extend no further than ensuring that their food products are not lethal in the short run. (261)

Instead, individuals are charged with navigating the barrage of detrimental substances packed and advertised to them as food.

Farmers, beholden to the corporate bottom lines that influence food production techniques, must react to destructive trends by altering their farming practices. These production techniques portend poor outcomes in terms of human health and animal welfare. Effects include excessive dependence on fossil fuels for maintaining and transporting crops, along with other methods that are considered environmentally unsustainable. Innumerable writers have discussed the extreme cruelty towards animals inflicted by these industrial farming practices. Aside from the hardship endured by the affected animals, these specific forms of cruelty towards animals portend poorer health outcomes for the humans eating products from these animals. For example, farm animals squeezed into close proximity with other animals and force-fed a low-quality diet contract frequent infections. The resultant infection/antibiotic cycle is thought to contribute to the creation of “superbugs,” microbes that are resistant to standard antibiotics and require high-potency, often intravenous medications requiring hospitalization to administer. High concentrations of animal wastes drain into waterways, altering biology of lakes, rivers, and water supplies. As Rosenberg (2014) wrote, “The food leads us to drugs and the drugs lead us to food, in a vicious cycle” (13). The low

nutrient content of mass-produced foods also leads to deficiencies that contribute to poorer health. However, these effects (individual and cumulative) are deliberately obscured from consumers. In a book entitled *The Fight Over Food*, the authors write, “The fruits of the modernized productivist system are low-cost foods for the masses, with dysfunctional consequences hidden from the view of most consumers” (Wright and Middendorf 2008, 274). When a consumer enters a brightly lit supermarket full of colorfully packaged foods, the realities of how these foods came to be seem very distant.

Food retailers intentionally enlarge this distance, since it is essential in selling large quantities of mass-produced food. Michael Pollan wrote about the tremendous amount of corn that Americans eat due to food subsidies resulting in corn surpluses, in excess of what Americans can safely eat. The bulk of food produced must then be sold to an already overfed population in order to make a profit. Corporations receive tax breaks to advertise food. This advertising affects a population that is susceptible to marketing due to a lack of internal regulatory mechanisms for influencing food choices, and vested corporate interest pushes towards purchasing and consumption of more food than is recommended to maintain good health. School lunchrooms, hospital and other corporate cafeterias, and prisons are all parts of this foodway. The ingredients that make their way into feeding large swathes of the population on a daily basis conform to the quality limitations of mass-produced food, which is often transported long distances before reaching the eater. This type of eating on a long-term basis contributes to many diet-related diseases. However, the companies processing and supplying The US’s foods are not held responsible for cumulative health effects on consumers. Blatt (2008) wrote,

No one quarrels with the need of corporations to make a profit from their food production activities, but this does not mean that they should be free of social

obligations. It should be, and is, possible to combine the need of the corporation to seek its own best self-interest with fulfilling a social obligation that clearly is desirable. That obligation is to deliver the healthiest food possible to the public. (220)

Instead, corporations continue to produce food that is of little nutritional value at low cost in an effort to expand potential profits, while individuals are left to confront the true cost of this system of food production, which declares itself in physical and mental illness.

While the healthcare system profits in terms of RVUs generated by widespread illness, the cumulative systemic load detrimentally affects patients and care-givers working within the healthcare system. The healthcare system is, at different levels, simultaneously complicit in, profits from, and is disadvantaged by industrial food production.

Big Pharma

When individuals turn to the healthcare system for the care of eating-related issues, treatment plans often center on medications for managing symptoms. As we have previously discussed, doctors do not feel adequately equipped or compensated for the depth of engagement required to promote long-term, sustainable behavior change. The pharmaceutical industry benefits financially from societal reliance on medication to address problems. As the food industry makes people sick, the healthcare and pharmaceutical industries profit from “fixing” these problems through medications and interventions. Since each of these systems is profit driven, there is no incentive to eradicate the cause of illness at its core, but rather the impetus is to “manage” symptoms in a manner that keeps patients chronically locked in. While ethnography shows that the

motivations of individual providers favor care and healing, we also see how the day-to-day pressures of existing within the system create a level of fatigue that obviates energy for meaningful change.

The high-cost pharmaceutical industry has been blamed for increasing the cost of healthcare. Pharmaceutical companies assert that high cost is a necessary corollary of research and development expenses, yet sales tactics such as direct-to-consumer advertising account for a large portion of pharmaceutical costs. According to Rosenberg (2014), direct marketing of pharmaceuticals to patients is a relatively new phenomenon, beginning with a Claritin ad in 1997. The advertising escalated and, in 2006, Big Pharma spent 5.5 billion dollars marketing medications directly to consumers (Rosenberg 2014, 26). According to Gottfriend (2008), “drug companies spend between two and four times much on marketing as they do on research and development” (55). He also remarked that these research funds are tax subsidized. As Martha Livingston wrote,

The pharmaceutical industry (Big Pharma) is the single most profitable industry in the United States, with close to 20 percent net profit in recent years... Contrary to Big Pharma’s claim that these profits are necessary in order to support their research program, in fact this is net profit—after all expenditures, including research and development costs. (Singer 2009, 214)

Marketing directly to consumers not only proves financially beneficial, but also perpetuates a mentality favoring medication as the simple solution to problems with vast causes.

Drug advertising also contributes to the formation of new disease categories. Rosenberg (2014) wrote about the creation and overhyping of diseases when a corresponding pharmaceutical becomes available. As Joan E. Paluzzi wrote in her paper *Selling Sickness/Creating Demand*, “As long as the pharmaceutical companies maintain

control over the process of drug research and development, we will continue to see drugs created because of their potential for large profits rather than as a response to critical human need” (Paluzzi, as cited in Singer 2004, 277). Prescription medication advertisements highlight the benefits of medication while listing, but de-emphasizing, the potential harms. The opiate epidemic, which saw widespread deaths due to opiate medication overdoses, is an example of unintended consequences of prescribing. Over half of the drug overdoses in the US are caused by prescription medications, and overprescribing of opiate medications is said to have catalyzed the process in which many patients became addicted to opiate medications and later overdosed on street drugs. This is an explicit example of the medico-pharmaceutical complex having created an addiction problem; many of the dependencies that these interconnected systems create are more subtle.

Can Biomedicine be saved?

While this dissertation has comprehensively detailed many limitations to the biomedical approach to eating, it is both impractical and undesirable for the biomedical system to cease, or to spontaneously radically transform. Biomedicine’s technological orientation positions the system as the best equipped for handling acute, life-threatening illness. Despite the significant problems detailed in this thesis, the biomedical system will likely continue to manage long-term chronic illness as well. However, for the reasons detailed in this thesis, the current technocratic approach towards managing food-relating illness is failing miserably.

Changing the orientation of the deeply interrelated systems that currently shape the eating environment in the United States will require iterative modifications. Prescribing solutions for restructuring the current biomedical system is an enormous undertaking, well outside the scope of this work. However, there are a few developments that have clearly presented throughout this research as potentially impactful areas of intervention, while functioning within the existing system.

The most obvious angle from which to address the issues confining biomedicine's efficacy involve restructuring the compensation scheme in biomedicine. If health and the prevention of disease are truly a central goal of the system, then behavior modification must become one of the most intensive systematic investments. As such, the current RVU structure favoring interventionism through higher compensation should be re-imagined to reimburse at a higher rate those activities that aid in prevention: primary care discussions about eating practices and modifications, and other evidence based behavioral interventions.

Next, since food plays such a key role in the majority of health conditions facing the American healthcare system, we must equip healthcare providers with holistic education on eating and the role of food and disease. In Chapter 5, we discussed how unprepared doctors feel to have extensive food discussions with their patients. Many educational programs are attempting to fill this deficit in knowledge and comfort. For example, a well-attended course called “Healthy Kitchens, Healthy Lives”, offered through the Chan School of Public Health (Harvard), Harvard Medical School, and the Culinary Institute of America, teaches healthcare providers about nutrition research and provides a setting in which to learn hands-on skills for patient education. According to

the program webpage, “How many doctors, nurses and other healthcare professionals truly understand the latest scientific evidence to distinguish "healthy" versus less healthy or unhealthy foods? How many know how best to successfully engage their patients to improve their dietary choices and practice mindful eating and lifestyle strategies?” (Culinary Institute of America 2018). Investment in such education for primary care providers, nutritionists, and those expected to address the primacy of food in health, means fair compensation, both for the coursework, but more importantly for the time that it takes to acquire and disseminate this information to patients (again compensating for the time-intensive discussions).

Finally, recent biomedical research reinforces understandings of the deeply psychological underpinnings of many food related illnesses. Within our current healthcare structure, many people are not able to afford psychologists. Restructuring should occur such that psychologists are considered part of primary care providers for people suffering from food-related illnesses. Access to professionals who can help directly investigate and address the thought processes that hinder effective behavior change help further the therapeutic holism discovered in the Buddhist portions of the thesis.

Conclusions

When considering the totality of the influences of the systems we have discussed, recognizing the difficulty for one individual in extricating him- or herself from this collusion of profit-driven industries is clear. Each of the systems discussed above—healthcare, industrial food, and the pharmaceutical industry—profits when the individuals

utilizing them consume food to a degree that makes them physically ill. Thus, the intricate, inseparable networks among these three systems form a web that mutually reinforces consumption of sickness-producing food. Because these systems are based on *tanha*, they form a self-perpetuating system favoring greed and illness. Ethnography demonstrates that many individuals within these systems are not explicitly motivated by *tanha* and experience consternation at the barrage of tasks involved in perpetuating the suffering caused by a greed-motivated system.

However, the profit-driven logic of the system as a whole turns out to be insurmountable for some members within it, who see their options as leaving the system (Bernadette), delaying gratification and working within the system with a hope of influencing change at a later time (Adiye and I), or dedicating personal time and resources to supplement elements of treatment that are missing within the medical system (Dr. Carol). An effective medical system depends on doctors who are well enough to turn their attention to making others better. Chronic sleep deprivation, constantly shifting day and night schedules, and time constraints, which limit healthy eating and exercise, contribute to a baseline state of health for a healthcare provider that is far from the optimum. The perpetual pressures on healthcare providers to document all activities for billing purposes contribute to the degradation of the mental health of medical providers.

Biomedicine cannot adequately manage illness and suffering related to food attachment and illness unless a marked shift occurs on the level of many interdependent systems. Currently driven by profit, the medical, pharmaceutical, and food production systems are structured in a manner that favors overeating, leading to the development of cycles of *tanha* that are well articulated in Buddhist thought. Effective solutions require

acknowledgment of the interdependent structures that keep people locked into cycles of craving.

Chapter 8

Shifting motivation for behavior change from personal fear to wisdom

The moment of illness diagnosis is a uniquely potent transmitter of fear. Patients often cite specific interactions with the biomedical system in which fear created a temporary motivation for behavior change. For example, two of my participants described the diagnosis of type 2 diabetes and breast cancer, respectively, as motivational turning points. Fear of an acute threat to the body spurs an intense but temporary effort to change behavior, until the patient succumbs to old habits. Generalized fear of illness and death are well-articulated US cultural phenomena (Gawande 2014; Kleinman 1988). This necessitates an examination of the ways in which medical providers augment fear.

The prominence and positioning of fear critically contrast in the biomedical and Buddhist contexts. The employment of fear in the clinical exchange ranges from vague and difficult to pinpoint to overt, and at times violent. In a primary care clinic setting, fear is often mobilized as a motivator to change behaviors that are viewed as maladaptive or detrimental. Examples of conversations routinely dominated by fear include “patient education” about overeating saturated fats, using drugs, getting too little sleep, not wearing a seatbelt, not taking appropriate precautions to prevent illness while traveling, and the other myriad public health and safety endeavors that fall under the biomedical jurisdiction. The trajectories of these conversations are frequently framed in terms of “risk,” outlining the potentially dangerous health outcomes of continuing engagement with particular behaviors.

In many instances, especially in the acute setting, a care provider imparts a sense of fear without intending to change behavior. In one such instance during my research, an emergency room physician responded to a patient's request for more pain medication by nearly yelling, "You have rheumatoid arthritis! This is how it's going to be! This is a condition you will live with for the rest of your life!" The room fell silent, and the doctor walked out, leaving the patient with a sense of fear that she expressed repeatedly during her time in the emergency department by asking anxiously, "Do you really think I'm going to be sick for my whole life?" as her mother interjected, "No, no, no, no honey, Jesus is gonna take care of you."

Of course, the invocation of fear can be completely unintended. This example could be read as the doctor expressing frustration at powerlessness in the face of a frustrating medical challenge (which, as articulated by the medical students attending Common Ground, is a regular clinical occurrence for which many medical trainees feel inadequately prepared). In instances where doctors intentionally appeal to fear, the motivations are manifold. In conversations with several physicians, the majority recognized the likelihood of causing fear through the process of diagnosing a new illness and counseling about the disease. One physician said, "I'm just giving the facts and the patient has to decide what to do with that information." Another acknowledged a desire to galvanize behavior change, seeing fear as a useful instigator, particularly when discussing diet, alcohol consumption, and smoking cessation. "I know it's not the best way to motivate people but sometimes it feels like a shortcut," he said. He later elaborated, "People need to recognize that their behavior is going to cause them harm in the long term and then it becomes our responsibility to clean up the mess." The responses

ranged from regarding fear as a necessary or useful clinical tool, to seeing fear induction as an unavoidable corollary of difficult clinical conversations, to acknowledging a need for alternate modes of engagement without clear ideas of how this would look.

Observations of food-related conversations in particular reveal the biomedical propagation of fear as a commonly utilized behavioral motivator. This manifested most frequently in various statements such as “Your weight puts you at risk of...” and “If you don’t lose weight, you’re at continued risk of...” Medical school facilitates an early internalization of “risk/benefit” and “harm reduction” language. Risk factors are memorized and tested in conjunction with the clinical pathologies taught in medical school. For many diseases (various heart diseases, diabetes mellitus, high blood pressure, stroke, metabolic syndrome, etc.), “obesity” is learned as a key risk factor. Maria, a fourth-year medical student, described the difficulty of being obese during medical training: “the huge struggle for me has been being obese in medical school. There’s a huge judgment factor there.” Part of the difficulty Maria described is the fear that intensified through her medical school education. She said, “...I’m on the road to having diabetes and heart disease if I kept doing what I’m doing.” Later in our conversation, she vehemently added, “Like, I am *morbidly obese*. I am headed to the grave. I am going to die of diabetes and heart disease. You look up any risk factor tables at my age and my height and my weight and it’s 100% that’s where you’re going.” Rather than serving as a motivational force, the strong negative emotions associated with these thoughts stimulate Maria to consume food. Maria said she spends 70% of her waking hours hating her body and wanting to change it. I asked if perhaps this might be a high estimate and she responded that, if anything, it was a low estimate and more likely, when alone, closer to

90% of her thoughts had to do with losing weight. Despite her abundance of motivation for change, Maria's life has been punctuated by dieting attempts and cyclical weight loss and gain. Many obese patients similarly described a long list of health outcomes that they worry about developing, yet they are unable to harness their fear into energy for sustainable habit change.

Fear as self-view

In the Common Ground interpretation of Buddhism, fear is an unreliable motivator, a contracted outlook stemming from a self-based view³. Seeing the world through a self-based frame is ignorant (as in, not seeing the world as it is) and potentially harmful. At Common Ground, self-view is frequently discussed in its capacity as a dangerous motivator. In a one-on-one practice meeting, Alex explained to me, “Harming always comes, destructive behavior always comes from a self center. Because that mode... someone's afraid, someone thinks they need something.” Motivations predominated by craving and grasping are described in Buddhist texts as servicing the ego. However, the notion of fear as an unambiguously self-centered motivation challenges the prevalent status quo of fear-based motivation. Alex described the importance of understanding motivation for change: “What's their motivation for change? And a self-motivation, a very self-centered motivation, like fear is a very self-centered motivation, like fear of

³ This is true of the secularized Buddhism delineated in the “Bounding Buddhism” section of this work, is in contrast to traditional Buddhisms in which fear has been used as prominent strategy for illustrating the effects of cycles of desire and suffering. Various descriptions and visual images depicting fear-inducing imagery are seen through various Buddhist texts and imagery, but are almost uniformly absent from the *vipassana* texts and teachings.

getting sick. That's *limited*." Alex described the kind of behavior change that stems from fear-based motivation and why this kind of motivation does not work. He said,

Because sometimes it [our behavior] is like a ricochet... we refrain, we refrain, we refrain, and then we go and basically consume as much as we would have otherwise consumed because the motivations aren't what we would call wholesome. You know, they weren't based on compassion or [a] real sense of renunciation. They were based on fear, or some other kind of contracted self-state. And if we believe the self-story of fear, then we're going to believe the self-story of desire. So fear... you get temporary effects by scaring people, but you're basically training them to follow self-view. And self-view is what drives the unhealthy habits too. So that's why suppression and refraining... it's only temporarily useful, and it needs to be in the context of deepening wisdom, so that the mind isn't seduced by self view...

In a fear-driven state, the motivation could be boundless in amount, but is limited in the ability to produce positive or beneficial effects sustained over a long period of time. Alex elaborated, "So when you have a fear view, a self-view, then you may have a lot of motivation to change, but the motivation, the intention, the aspiration, the resolve, these are the ways they translate this word here. It's all limited by the view it comes out of." This pattern described by Alex resonates strongly with the patterns of dieting, bingeing, and despair described by Maria and other patients and Buddhist practitioners.

Biomedical diet literature also mirrors Alex's assertion that fear is an initially strong but short-lived motivator. Interventions (including invasive surgeries such as gastric bypass) create habit change for a short, circumscribed time period, usually less than two years. This is followed by the rebound phase, in which patients often regain weight, sometimes surpassing their pre-intervention weight.

The idea that fear strengthens self-view and self-view undermines long-term behavior change (and strengthens attachment to the stories created by craving) raises many complex questions with significant implications for the goals of food-related

conversations in the biomedical context: What are the alternatives for motivating sustainable, nonself-based habit change? What are the discursive patterns that would either strengthen or weaken a “self-view”? How can this discursive shift be facilitated in a clinical context?

“Right view” as motivation

Paradoxically, Buddhist practitioners, including those who are discernibly overweight or experiencing medical problems, are able to “achieve” many of the outcomes that elude biomedical eating interventions. Further, they articulate far less anxiety in sustaining these behavior changes. Below, I present two case studies of Buddhist practitioners who undertook substantial dietary changes, highlighting the various contributory views and commitments shaping their eating.

Brian is in his early to mid 20s. He attends meditation sessions and *dharma* talks at Common Ground at least once per week. We met at Seward Café, an organic co-op-style eatery located less than a mile away from the meditation center. He spoke spiritedly and at great length, clearly having given in-depth consideration to his eating habits prior to our conversation. The most prominent theme in his narrative of habit change is the desire to live what he calls “an ethical life,” a trajectory of motivation that stands in stark contrast from a fear/symptom-focused orientation. His impetus and sustaining motivator in his food habit change are aligning his actions in all realms with the values he cultivates through Buddhist practice, and he described how his food practices are a straightforward extension of his Buddhist practice. He said, “I guess I find that as I open more and more

to the practice of simplicity and silence, that the need to do simple changes that I can make as far as consumption, like being more ethical in the way that I eat, I see that as a very easy decision.” When asked about these notions of simplicity and silence, Brian explained that he directly developed these ideas through meditation, reading, and the *dharma* instruction at Common Ground.

Brian became interested in Buddhism as a teenager, when he came across and read some books by the Dalai Lama. Throughout his teenage and college years, he consumed what he calls a “standard diet,” featuring “an excess of meat, alcohol, and sugar.” He began attending Common Ground after graduating from college a few years ago, and has since meditated regularly. I asked Brian whether he worries about food and he said, “Am I worried? I’m not worried but I am definitely trying to make some conscientious choices right now about what I eat. That’s always a changing process.” The conscientious choices to which he referred include avoiding meat; abstaining from alcohol, sugar, and coffee; and cooking food that is high in nutrition.

Despite Brian’s elimination of certain food groups, seeming structurally similar to the “all-or-nothing” mentality described in the last section, both his motivations and his emotional valence about these changes qualitatively differ from the above-described approach. These changes occurred gradually, and Brian feels that the diet he currently consumes is sustainable for him in the long run in terms of expense, time commitment, and health effects. When asked how he had set out to change his eating habits, he said, “It’s in a more holistic sense as far as... I’m approaching my life in a way that I’m really trying to really push towards ethical values [of Buddhism]... Also from a sense that I do not want to spend the precious resources that I have on things that... that I don’t need in

my life.” Throughout this engagement with Buddhism, he began to question the way he was spending his time and resources. He reconsidered his corporate job, which he felt was not enacting the values he wished to uphold, and applied for a doctorate in renewable resources, finding the work more aligned with his developing conceptions of ethical conduct (specifically the “right action” and “right livelihood” components of the Noble Eightfold Path). He was accepted to several programs and will begin research in algae biofuels next year.

Along with these macro-level life changes, the way Brian views the role of food in his life has also gradually shifted. He no longer sees food as a legitimate means of entertainment or simple pleasure. Rather, he emphasizes the bounded role of food as providing sustenance. He said,

One thing I’m working on in Buddhism, I think specifically, is, you know, food as basically a means for practice. You try to view food as this holistic thing that supplies you sustenance and energy, right? Versus food as something that’s pleasurable as far as taste, right? And so that’s been an interesting thing I think about and try to practice a lot.

The “food practice” that Brian describes here closely resembles the manner in which the Common Ground meal prayer cards frame food.

Despite having clear guidelines motivating his eating habit changes, Brian described challenges of enacting his values through food. He said, “I felt after I would eat [my main meal], it was like ‘ok I need something to finish it off,’ you know? To top it off. Like a cookie. And there was this... this drive. I definitely have to kind of confront that... that restlessness and move on from that.” I asked him how he dealt with such experiences and he responded, “Well... just of part my practice is confronting that in almost every part of my life.” For Brian, the themes of ethical values enacted through

food decisions, clear guidelines on the role of food in one's life (sustenance rather than entertainment), and established practices for observing cravings without reflexively acting upon them form a holistic, mutually reinforcing web from which his behavior changes developed.

Mike, a former special needs teacher turned Americorps volunteer who has attended Common Ground for the past several years, explained how he, too, views his dietary decisions as an outgrowth of his Buddhist practice. He said, "it wasn't like one day I was like, 'I want a six pack,' you know or like, 'I want to...' like I never like set out for these physical goals." Rather, his dietary changes centered around, "being worried about the ethical treatment of animals and farmers and stuff like that." He explains that he eats the simplest food possible to subsist and maintain good health, and he actively works towards eliminating substances that do not provide nourishment or nutritional value. He described the reduction of various foods he has come to view as superfluous to his diet, including meat and much of his sugar consumption.

He specifically noted his calculus in leaving out processed tortillas from his vegetable enchiladas: "So, I think it was just like something extra that I didn't need, that my body didn't need, society didn't need me to consume it. Like it takes a lot of energy to make that product." This effort does not feel restrictive to him, because he feels a freedom within the loose parameters he has set for himself. He said, "...I'll have a pastry and coffee on the weekend even though I don't especially need either of those things." He feels propelled onward in his current dietary trajectory by the "positive effects" his decisions have in "not just being a mindless consumer but getting to make a conscious choice." This example aligns with his overarching calculus of food decision making,

which, like Brian's, more heavily weights an external center of motivation than the modification of his own health or appearance.

Brian and Mike are both younger, relatively healthy men. I wondered whether people experiencing food-related pathology might be more symptom or self-focused in their orientation(s) towards food. I also explicitly investigated whether the experiences of Brian and Mike aligned with experiences of women at Common Ground, since, as discussed in early chapters, women face unique pressures around food. However, there was consistency in Brian's and Mike's experience with the accounts from Common Ground practitioners experiencing specific illnesses, as well as female practitioners.

Common Ground practitioners experiencing current health challenges spoke of their eating in less personally fraught terms than might be expected to correlate with the severity of their illnesses. Yael, a woman experiencing severe chronic digestion issues, described how Buddhism has allowed her to "accept that some of what my body is going through is the result of various causes and conditions and I can do the best I can to affect these causes through regular practice and through what I eat, but it's not going to be totally in my control." Along with seeing a psychologist and a dietician, regular Buddhist practice over the last several years has significantly decreased the disruptiveness of her symptoms. She attributes the wisdom developed through systematic practice (including quarterly retreats) with making her "situation feel workable, if not always ideal."

Jane, a woman in her 60s who is currently experiencing a major health crisis, talked about the relationship between her illness and her Buddhist practice. She said,

It's hard not to focus in on your aches and pains while sitting and meditating. It's hard not to. But that just makes you tight. That's just wishing for something, grasping for a reality that isn't there. That's the opposite of acceptance. So of course it [pain] crosses my mind but I don't make my meditation about getting rid

of it. I keep trying to follow on the [Noble Eightfold] path and try not to put too much stock in painful feelings that might be known.

These perspectives cast active engagement with the holistic path as an endeavor separate from personal physical improvement. Rather, the gradual changes that occur are discussed as “side effects,” rather than primary aims. Through engagement with the ethics and practices comprising the Eightfold Path, Buddhist practitioners report the kinds of lifestyle changes pursued by medical patients.

Conclusions

Food attachment has progressively fallen under the jurisdiction of the biomedical field. Biomedicine and public health claim a vested interest in reversing the medical “catastrophic epidemics” of obesity and other food-related illness. However, the profit-based medical system benefits from prescribing medications and performing procedures. The industrial food system profits from feeding people more food, regardless of how it affects their health. The pharmaceutical industry makes more profit when more people are ill and dependent on medications. The food industry creates food under conditions that require increased reliance on pharmaceuticals to keep animals alive long enough to produce more food. The food that is produced and sold with this mindset makes people sicker. The healthcare system prescribes medications with side effects that often necessitate the use of other medication, and patients become entrapped in medication cycles. Time pressure to see more patients, produce more RVUs, and perpetually

document compel providers to prescribe medications rather than to have in-depth behavioral conversations.

The Buddhist framework provides another perspective on some questions that must be considered in order to make any significant headway on the tangle of issues that entrap so many Americans in detrimental eating patterns. First, the biomedical institution must become clear about its role in food attachment treatment. At present, many patients depend on the system to serve a role that it is not equipped to play. Bowing out of that role would mean acknowledging that the biomedical jurisdiction may not be as far-reaching as the myth that patients and doctors perpetuate. Frankness about the limitations of a fragmented system, which is not armed for biopsychosocial issues as integral to our humanity as eating, is long overdue. Nevertheless, biomedical practitioners would need a tremendous degree of humility, and the system would risk significant profit loss if these limitations were to be acknowledged. If the biomedical system continues to claim a central role in the mitigation of obesity, it must be very clear about the role of these various interconnected systems, which are designed for profit and benefit from excessive eating and related illness. Understanding the interdependent system requires investing concerted energy towards modifying several facets simultaneously.

Second, if the system genuinely endeavors to help mitigate food attachment, the role of craving, greed, and attachment within the system must be intensely considered. The Buddhist system for understanding *tanha* provides one explanatory model backing the idea that profit-driven medicine beholden to the aforementioned systems proves mutually exclusive with the facilitation of healing. The medical system forms its workers through disciplines, which demand their conformation to the system's infrastructure

while favoring efficiency and time maximization—an orientation that actively detracts from compassionate care. Listening to the patient, being generous with time and energy, and making medical decisions holistically based on the patient’s best interests are challenged by the constraints of the system, which lead to constant fatigue, time pressure, and a training epistemology that favors procedures and interventions. A sincere assessment of the aims of the biomedical system shows that it perpetrates craving, attachment, and suffering in ways that are predictable by Buddhist philosophy.

If the treatment of problematic eating is to remain within the biomedical purview, incentive structures in medicine must be flipped in order to favor the discussions, mentorship, time, space, and care required for patients to succeed in long-term behavior change. This means reestablishing incentive structures that do not prioritize interventions and procedures, do not pay more to specialists, and do not reward physicians for prescribing more medications. This would obviously require a massive overhaul of the entire biomedical system, and would impact many relationships among its players. If healing through diminishing food attachment, rather than preserving the self-interests of hegemonic structures, is to motivate care models, then some of these deeply entrenched ties must be undone. In recognition of the behavioral complexity of eating and its disorders, psychologists (who have the training and the time model for in-depth conversations), rather than medical interventionists, would be enrolled as the primary providers. The attempted motivation of behavior change with fear would be recognized as a short-term, ineffectual solution for managing craving, and would be replaced by more comprehensive therapies aimed at understanding the roots of craving. People

suffering from food attachment-related conditions would benefit from designating resources to address the underpinnings, rather than the aftereffects, of craving.

A key take-away from my ethnographic study is that people raised in a capitalist ethical system, which has favored efficiency and profit, can relearn to exist (at least in some areas of their lives) according to a different set of values. By cultivating “right view” and attending to various aspects of the Noble Eightfold Path, practitioners describe a process of loosening attachments, which eventually, in some cases, leads to profound behavior change. It entails a shift in ethical stance towards deemphasizing personal gain that led to these changes, rather than amalgamating pseudo-Buddhist practices, such as brief mindfulness interventions, into the personal realm. Biomedical patients, too, can benefit from a care system that deemphasizes illness as a personal problem in need of fixing through individual control.

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Appendix

Image from:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/296290/obesity-map-full-hi-res.pdf

Foresight Obesity System Map

