

Eat Well to Work Well:  
Oppression, Risk, Power, and the Rhetorics of Employee Wellness

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## **Abstract**

This dissertation draws on interdisciplinary scholarship, anchored in the rhetoric of health and medicine and technical communication, and employs mixed methods, archival texts, and participant stories to investigate the impact of eating-related discourse and practices in an employee wellness program (EWP) on people’s lived experience with food, health, and their bodies. Wellness as a concept is deeply complex, often fraught, slippery, pervasive, and commodified. Workplace wellness, as exemplified through EWPs, only adds to this complexity through institutional power dynamics and by tying wellness to health insurance coverage and healthcare costs. EWPs provide a good context for examining power and practices around “healthy bodies” and “healthy eating,” and what those practices mean for bodies that are excluded, marginalized, or otherwise framed as unable to participate in the pursuit of wellness. Overall, this study aims to interrogate the intersection of eating habits, institutionalized wellness, and medical ableism broadly, using one EWP as a site of study. The EWP under study here facilitates investigating how employee wellness is built on ableist foundations, how institutional wellness programs wield power in perpetuating dominant biomedical norms around eating habits, body size, and able-bodiedness, and how EWP discourse and practice impacts employees’ lived experience. This project contributes both theoretical and methodological insights to the rhetoric of health and medicine and technical communication. It centers social justice, user experience, and critical theory aimed at revealing power dynamics and systemic oppression in order to demonstrate how material-discursive practices that enact wellness operate outside medical settings.

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## ***Amuse-Bouche: What it Means to Be Well***

According to the World Health Organization, health is more than the absence of disease. Health is a state of optimal well-being. Optimal well-being is a concept of health that goes beyond the cure of illness to one of achieving wellness. Achieving wellness requires balancing the various aspects of the whole person according to the American Holistic Health Association. We can achieve high-level wellness by being aware of our healthy or unhealthy habits and changing those that are unhealthy. ... Wellness is never a static state. There are levels of wellness, just as there are degrees of illness. Our health is our responsibility. Our lifestyle choices and decisions make a big difference in our overall health. Your mind, body, and spirit need to be in balance for optimal well-being. ... Wellness can be looked at as dimensions that incorporate the mind, body, and spirit as well as how we live and our relationship in the world. The seven dimensions of wellness we are using include: occupational, environmental, spiritual, emotional, physical, social, and intellectual. (University of Minnesota, 2004a)

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I did not like [the Wellbeing Program]. What I did not like about it was the disproportionate effect a biometric screening had on your points. Everyone would go, oh, just look at your biometric screening, it's 250 points right there and then you go do the follow-up visit, that's 100 and you've got almost all your points. Like yep, and for somebody in a traditional sized body, that might be okay. But I am super uncomfortable doing that because it is already hard enough for people in larger bodies to go seek medical care, period, let alone a doctor that's *not mine* at my *place of employment*, to have them run all my stuff and say, you're fat, you need to lose weight. You know, like, there's no other information this doctor who isn't mine would have about me. But yet they're supposed to biometrically screen me, and my coworker told me that they do it like they do a blood drive. You're a huge room with other people stepping on a scale and I'm like, *OH HELL NO*. So I always had to work three times as hard to get my points because I refused to go do it. I'm like no, I would rather pay more in insurance premiums than do something that makes me uncomfortable. So it was super, super frustrating. And it felt like there was no understanding given to the like, the bias that people experience in the medical community depending on who you are. Not even just for larger people, African Americans, like there's so many other people that do not have an equal experience in the medical community. And so to be like, oh, just go do this, just was completely short-sighted. And for the U of M, surprisingly un-researched, like, we're an institution where one of the three pillars is research. Like, get it together. It's really frustrating. I also don't like that so many of the options you had to pay to do, like you can do our cooking classes that are 50 bucks. I'm like, I can also just pay my insurance premium. And, I feel bad because

it costs them money to do those things. So I understand both sides, but it felt like what looked like a large menu of options, when you really started looking at what was doable, it wasn't that many options. So I ended up doing all these [Wellbeing Program vendor] classes where I read about eating a Mediterranean diet, which I already do, and mindfulness, which I already do. Just so I could earn points because I couldn't earn points the way that everybody else did. I could, but it would have been an uncomfortable thing for me and not for them. So it felt, I don't know what the word is, I don't want to say disproportionate, but it just, it felt, it felt bad. How about that? It felt *bad*. (Kelly,<sup>1</sup> research interview participant, 2021, emphasis original)

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The two long quotes above illustrate a disconnect between the employee-facing discourse of the University of Minnesota (UMN) Employee Wellbeing Program (EWP) and the lived experience of one of my research participants. When it launched its employee wellness program (EWP) in 2003, the University of Minnesota (UMN) took up broader wellness discourse in delineating what it meant to be well. Drawing on the World Health Organization, whose definition was fundamental in the emergence of the broader wellness culture in the U.S. in the mid-20th-century, the first iteration of the UMN EWP website defined wellness as holistic and multidimensional—as a practice of being aware of and making changes to health-related lifestyle choices (e.g., diet, exercise, meditation) in order to achieve an optimal balance between mind, body, and spirit—as seen in the first long quote above.

Despite a holistic definition, in practice the UMN EWP emphasized activities closely aligned with a biomedical model of health and diet, or a focus on measurements of physical health like body mass index (BMI) and cholesterol levels for the purposes of disease prevention, treatment, and cure. In other words, the UMN EWP was talking about holism but was incentivizing and prioritizing physical health measures that aligned with

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<sup>1</sup> All interview participants are referred to throughout this dissertation by pseudonyms in order to protect their privacy.

Western biomedicine. For many of the employees I talked to as part of this research project, the focus on physical health, and especially diet and weight, felt oppressive, as Kelly described in her long quote above. In contrast to the EWP's description of wellness as holistic, Kelly described a system that privileged biomedical measurements of body size, that worked to bring her private health information under her employer's purview, and that embedded all of this in a complex system of points and finances. She went on to elaborate:

I have probably been class-three obese most of my life. Out of most people I know I invest more time into my own wellbeing than probably anybody. I only work 30 hours a week because I need that extra time to spend time caring for myself. I go to counseling once a month. I'm seeing a dietitian on my own. There's a lot of ways that I have found ways in my life to be better. And I felt like originally none of that was really seen by the [wellness] program. They had a *very specific idea* of what it *meant* to be well. (Kelly, research interview participant, 2021, emphasis original)

I begin with the juxtaposition of these quotes in order to foreground the disconnect between what the UMN EWP talked about and what employees experienced, and to help ground my work with a concrete example. That said, as we will discover throughout this dissertation, wellness as a concept is deeply complex, often fraught, and slippery. Workplace wellness, as exemplified through EWPs, only adds to this complexity through institutional power dynamics and by tying wellness to health insurance coverage and healthcare costs. In this dissertation, I work to outline the rhetoric of employee wellness through discussing findings from my research on how the idea of "eating right" manifests in the UMN EWP, how the EWP restricts and/or facilitates access to wellness, and in turn how that impacts people's lived experience with food and wellness.

## Chapter One: Rhetorically Framing Employee Wellness

Within the broader UMN EWP—which included<sup>2</sup> programming around exercise, disease management, health assessments, diet and cooking—the latter is my primary focus. Thus, while my dissertation considers the rhetoric of employee wellness broadly, it centers food and eating-related EWP programming as a key area where the EWP promoted ideas about bodies and health. Food has been deeply entangled with health and medicine since ancient times (Melonçon, 2021), a relationship shaped through discursive and material practices that have implications for daily lived experience. Additionally, food and eating are profoundly personal, with tight ties to family, social events, culture, and identity (Biltekoff, 2013; Biltekoff et al., 2014; Brown, 2015; Mudry, 2009). As Cristina Hanganu-Bresch (2021) says in the introduction to a special issue of *Rhetoric of Health and Medicine* on food as medicine:

Food *is* essential to life, and essential to our health. Food also shapes the substance and texture of our lives in countless ways: it is linked to pleasure, escape, friends and family time, cultural traditions and rituals; it is both intimate and communal; and it has accrued a great deal of symbolic, moral, and transformative meanings. (p. 114, emphasis original)

Food and eating habits are often linked to body size and health, especially in mainstream biomedicine and nutritional science (Biltekoff, 2013; Guthman, 2011; Hite & Carter,

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<sup>2</sup> I use past tense when talking about the UMN EWP for two reasons: first, I bounded my collection of EWP data in time (1981-2019), which I discuss in more depth in my methods in Chapter Two; and second, as we will see in this dissertation, the UMN EWP changes over time, sometimes from year to year, in terms of its programming options and incentives, and it has changed since I ended data collection, so past tense is appropriate for representing their past discourse and practices.

2019; Mudry, 2009). Biomedicine and epidemiology medicalize extra fat, positioning it as a disease—obesity—which is associated loosely with higher mortality. The process of medicalization, or placing something within the purview of medicine, means that classifying fatness as disease marks it as abnormal and something in need of medical intervention (Guthman, 2011). Further, in the last decade or so, medical research has connected obesity to chronic illness (e.g., type 2 diabetes) and to disability (for example, see: Chang et al., 2017; Froehlich-Grobe & Lollar, 2011; Tsiros et al., 2011). In other words, by classifying fat bodies as diseased, biomedicine delineates fatness as in need of a cure or treatment in order to return the body to a “normal” size, therefore avoiding or alleviating fatness-associated chronic illnesses, disabilities, or risk for illness/disability. By pathologizing fat bodies, biomedicine defines a normal body as being of a particular size, and links body size to able-bodiedness (Stoll & Egner, 2021). Ableism is a systemic social issue that relates both to oppression and marginalization of disabled people and to the valuing of an ideal body and forms of functioning or ability (Clare, 2017; Kafer, 2013). Ableism, racism and classism are issues of social justice that are “constituted through and by each other” (Kafer, 2013, p. 32).

Importantly, the links from food to body size to health to disease and disability to medical ableism and social justice are complex; much of the rest of this chapter and dissertation will be spent unpacking these ideas further. In what follows, I will first outline my research questions, then contextualize my study in terms of my positionality and the project’s origins. Next, I will discuss the interdisciplinary theoretical perspectives that inform my dissertation before providing some key background on EWPs and a brief overview of the UMN EWP. Overall, my aims in this chapter are: to position my project within existing scholarship both to anchor it and to demonstrate how and where it extends



current conversations; and to contextualize my research in terms of my relationship to the project, why EWP's are a salient site for research, and in the overall context of the UMN EWP.

### **Research Questions**

How does the UMN EWP affect people's lives? This was the central question I grappled with as I began developing this project. To explore this question, I developed a three-phase, sequential, mixed methods study that triangulated data from three sources in order to unpack what the EWP does and why, and how that in turn impacts employees. I broke down my overarching question into four research questions that guided my study:

RQ1: How does the EWP incorporate and discuss eating habits?

RQ2: How do people experience the EWP's eating-related discourse and programming?

RQ3: How does the EWP's eating-related programming impact people's daily lived experience?

RQ4: How does the EWP facilitate and/or restrict access to wellness?

I began initially with the first three questions above, mapping them onto the three phases of my study design. As I worked with data during the project's first phase, I found myself becoming attuned to themes of oppression in the data; I therefore added the fourth research question in order to foreground these themes. Additionally, the theoretical perspectives I present later in this chapter grew, in large part, out of my work grappling with the data as I conducted my largely grounded theory analysis. I will go into more detail about methodology and methods in Chapter Two. For the moment, the important thing to establish is that as my research project progressed and evolved, my theoretical perspectives also evolved and coalesced together.

Ultimately, I seek to build rhetorical and technical communication theory about employee wellness programs and the broader entanglements of food, technology, institutional power, and medical ableism within them by studying the UMN EWP as a site of discursive and material practice. In particular, I take up rhetorician Colleen Derkatch's (2018) call for further examination of the powerful, yet often hard to discern, ways that institutional wellness discourse shapes individual lives and beliefs. Derkatch argues that wellness has "the capacity to expand the domain of illness" and to encourage everyday health practices dependent on institutionalized programs that turn individuals into "the disempowered, medicalized patients they seek not to become" (2016, p. 196). My dissertation project aims to extend Derkatch's work on wellness rhetorics through examination of the UMN EWP and the ways it impacts peoples' lived experiences with food, health, and their bodies. My dissertation specifically contributes to the rhetoric of health and medicine (RHM) by examining extra-medical discourse and practice and how in turn that impacts people's daily lived experience. I also take up Jones et al.'s (2016) call to resist ableism historically perpetuated by technical communication widely, if not inadvertently, by centering ableism in my analysis and presenting what is, in many ways, an antenarrative of EWPs (refer to "Methodology" in Chapter Two). My dissertation also contributes to both RHM and technical and professional communication (TPC) methodologically by pairing user experience research with the rhetorical study of lived experience. Before I turn to the theoretical perspectives that informed my project, however, I ground my study in my own positionality and the origins of the project. Reflecting on my positionality in the context of my study is a way for me to consider my own privilege, potential bias, and my power to take action. Considering positionality is also a crucial practice for understanding others, like the people behind the UMN EWP

and my research participants, that “makes space for contradictions and tensions and strips away self-justification for imposing a simplified identity or agenda” (Walton et al., 2019, p. 79).

### **Grounding the Study: My Positionality and My Project’s Origins**

Some of my earliest memories are of food. When I was a small child, we had a strawberry patch in our backyard, and I was obsessed. I remember being only a few years old, sitting in the dirt, eating ripe red strawberries still warm from the sun. My mom worked as a cook for a bit when I was that age, and has always been an amazing home chef and baker, making everything from scratch. The strawberries were always ripe right around my birthday as spring turned to summer, and every year my mom would make me a cake with white frosting and sliced fresh strawberries all over the outside. Somewhere in the first few years, she started making them in the shape of the number of years old I was turning, and I distinctly remember being sad that she stopped when I turned 10, because two cakes was too many. (She does not remember it this way, and we laughed together about our different memories when I told her I was writing this in my dissertation because she had to cut and form the cake into numbers anyway, so two numbers should not have made a difference, but either way I stopped having number cakes when I turned ten.)

I remember sitting on top of the ice cream maker to hold the lid down while she hand-cranked it, the delicious flavor of plain yogurt when it came out of her yogurt machine, and the smell of baking bread. When I think of being a child, I think of happy food memories, and love, and how food brought me closer to my mom. Now, as an adult, I know that she made (and still makes) so many things from scratch for two reasons: because she can control what is in it, avoiding hidden things like corn syrup in packaged

bread or cutting the sugar in a cookie recipe in half; and because it can save a lot of money, and my family has almost always struggled to make ends meet. Income, geography, and food access are deeply connected to each other and to health inequities, especially today, but experiences vary. While I have friends whose families were similarly poor but more urban—I know someone who basically grew up on sugary breakfast cereal, McDonald's, and Hamburger Helper—because my mom was a cook and seamstress with odd hours, and because we lived in a tiny rural Idaho town with no fast food restaurants and few grocery stores but a strong culture of raising and growing food, my mom reduced our food expenses by raising chickens for their eggs, trading some of those eggs to the folks down the street for milk from their goats, and growing what vegetables and fruit she could in her garden. It is important to acknowledge the significant amount of labor that my mom put into providing food; rural versus urban differences in food availability was only one aspect of our eating habits when I was a child. My mom basically worked a second job growing and preparing food for us that she felt was healthy, something that many people do not have time to do.

Food was an important aspect of my culture growing up, as well, as my mom taught me through holiday rituals around Hanukkah, Rosh Hashanah, and Passover to appreciate latkes, matzo ball soup, challa, hamentaschen, charoset, and gefilte fish. I learned about food as a symbol for other things through the Passover Seder plate, such as charoset (a sweet paste of fruit and nuts) for the mortar and bricks made by Jews when they were slaves to the Pharaoh in ancient Egypt, or the dipping of parsley into saltwater to represent the tears and pain felt by the enslaved Jews. I don't remember any other Jewish families in our little Idaho town and my extended family was on the other side of the country in New York, so I learned through my mom and through food about my

heritage as a third-generation American and ethnic Jew whose great-grandparents emigrated to the U.S. from the Polish and Latvian regions of what were then the German and Russian empires before World War I broke out.

I love food. I have always loved food, and I have always closely associated it with care, pleasure, community, and culture. I also have struggled with both invisible disability and my weight. Like so very many people, these have been entwined, lifelong struggles. While my memories of food bring positive feelings, as I described above, my memories about my health and my body are not as positive. I hit adolescence at the same time my family moved from rural Idaho to Miami, Florida; and while body ideals expressed in popular media have been problematic for most of the past century, I was suddenly grappling with culture shock, a changing body, and bombardment with peer pressure, images, and discourse about “ideal” beach bodies, stick-thin models, and, confusingly, big butts (thank you, Sir Mix-a-Lot).

I labored to navigate healthcare systems and struggled with dismissal, being labeled a complainer, and even misdiagnoses. I was told umpteen times I needed to lose weight by doctors, family members, friends, and society while struggling with a health condition that complicated weight loss. Like so many of the participants in this study, I sought out information about my own health and weight, developing my own expertise on diet, disability, and my health conditions. I recall vividly spending hours as a young adult grappling with medical research articles in order to try to make a case to yet another doctor to order the blood test I thought would (and did) lead to the right diagnosis; and I remember crying in my car after my appointment with him because finally I found someone who had read the latest research and didn't refuse the test while condescendingly giving me the same, outdated line about how it simply *was* this other

condition. After various fad diets, Weight Watchers, and different fitness routines, I finally settled into what felt, to me, like a version of holistic wellness that balanced my physical, mental, and social health.

More recently, I remember struggling in similar ways to Kelly, whose story opened this dissertation in the preface (*Amuse-Bouche*), when I was faced with an EWP that wanted to have a role in my healthcare by collecting my private data. To Kelly, and to me, it's not just data and it's not innocuous health improvement/promotion; it's deeply personal and inherently connected to our lived experience as people with bodies different than the medical ideal, and it raises the specter of decades of moralization, of being told that thin is "good" and fat is "bad," that food can be divided into "healthy" and "unhealthy," that the size of our bodies is our fault and if we just knew about how to eat "right," we could easily solve our "problems."

My interest in studying the UMN EWP arose relatively early in my Ph.D. program. The EWP came up in a casual conversation with a UMN employee I knew outside my department. Something I said reminded her that she needed to finish getting her wellness points before the end of the year, and she made a casual joke about it feeling like a game she kept having to play over and over. She reminded me of my own experience with the EWP, and as I was starting to dig into RHM scholarship, I found it interesting from a rhetorical perspective. Prior to beginning my Ph.D., I had been an employee at UMN for a number of years, and had been exposed to the EWP, though I had never opted to participate for reasons described above. I resisted pursuing this project for a while, because I was unsure whether or not I could set aside my pre-existing biases against the EWP. Over the next few months, however, I kept returning to that faculty member's comment. Her words got stuck in my head, and I couldn't stop thinking about

her story.

Considering EWPs through an RHM lens highlighted for me the entangled influences of medical discourse, embodied practice, and lived experience. As I began to work on historical research on the UMN EWP for a History of Medicine course, well before this became my dissertation topic, I found that every employee I spoke to had a story about the EWP. These anecdotes were embedded in people's lived experience: something that happened with the EWP at a specific time and place in their lives that carried memorable and lasting meaning for them. Many stories had tendrils that connected workplace and personal life through health, such as an ongoing chronic condition or a life event like a pregnancy. Things people were *doing* also featured prominently in the stories; they often contextualized their EWP story within their broader health practices like dieting, disease management, or health maintenance with a physician.

The stories were crucial for two key reasons: first, they helped me realize that by using methodologies attuned to lived experience, I could center employee voices and experiences, which would help counter my own bias; and second, the stories impressed on me the meaningfulness of institutional EWP discourse across space and time.

Thus, I tell these stories here about food and my health for two important reasons: to help ground my research and acknowledge my positionality with and my interest in the topic of EWPs; and to illustrate the importance of stories. Stories are powerful; they give voice and agency to people who are potentially oppressed or othered, allowing them to name their experiences in the world (Jones, 2016a). Centering stories can be a move toward social justice, by centering the lived experience of participants without obscuring or generalizing them (something I will dig into more deeply when I discuss methodology

in Chapter Two). Stories will take a key role in this dissertation, though I personally will step into the background after this and work to amplify my participants' experiences and stories in order to center them.

### **Theoretical Perspectives**

As a scholar of rhetoric and technical communication, in this project I examined EWP practices (discursive and material) around food and wellness and their impact on employees' lived experience with eating, bodies, and health. I relied on four theoretical perspectives as lenses for surfacing and understanding these different practices: (1) TPC and social justice; (2) rhetorics of health and wellness; (3) critical studies of food, fatness, and risk; and (4) medical ableism and disability. In the remainder of this section, I discuss these four theoretical perspectives in more detail.

#### **Technical and Professional Communication and Social Justice**

As a field, TPC pays "close attention to texts used to get work done, particularly work that requires specialized knowledge" (Rude, 2009, p. 206). Rude suggested that TPC researchers should ask how texts "have influenced knowledge, values, and actions in a variety of contexts. What difference have they made? When they have made a difference, or failed to make a difference, do we know why?" (2009, p. 208). In the years since Rude posed these questions and proposed, in her words, "social change" as a core line of TPC inquiry, social justice has become a central focus to much TPC work (Jones, 2016a), yet social justice can mean different things to different people. In considering social justice in my own research, I draw primarily on work by political philosopher Iris Marion Young and TPC scholars Rebecca Walton, Kristen Moore, and Natasha Jones.

Like Walton et al. (2019), I believe social justice is central to TPC, and that to consider justice, we must start with oppression. Young (1990) described oppression as



systemic and structural, rooted in power dynamics that privilege certain social groups while marginalizing others. Social groups are collectives of “persons differentiated from at least one other group by cultural forms, practices, or way of life” (Young, 1990, p. 43); most people associate themselves or are associated by others with at least one social group, and association at least partially constitutes people’s identities. Because people are typically associated with more than one social group, oppression operates in intersectional ways; while one association, such as whiteness, might be associated with privilege, another, such as disability, might be associated with oppression. Further, because oppression is manifested in social systems, social justice is the act of working toward “the elimination of institutionalized domination and oppression” (Young, 1990, p. 15). Both critical consideration and action are key to social justice; it is both theory and a means to advocate for and ameliorate oppression people face who are marginalized along axes of race, gender, class, culture, sexuality, and ability (Jones, 2016b). Within TPC, Jones and Walton (2018) define social justice as:

Investigat[ing] how communication broadly defined can amplify the agency of oppressed people—those who are materially, socially, politically, and/or economically under-resourced. Key to this definition is a collaborative, respectful approach that moves past description and exploration of social justice issues to taking action to redress inequities. (p. 242)

Importantly, this definition acknowledges the agency (or the capacity to act) of the oppressed, which makes rhetorical space for negotiation and resistance (Jones, 2016b). It also recognizes that communication, including TPC, is not neutral; communication has an important role in both oppression and social justice (Walton et al., 2019). Technical communicators have a responsibility to advocate for users, and socially just TPC aims to

address power imbalances that systemically privilege some users and disenfranchise others (Agboka, 2013; Haas & Eble, 2018). Power is a critical element in understanding systems of oppression and strategies for demarginalization and empowerment. Michel Foucault is an oft-cited theorist of power (and his theory will take a significant role in my analysis in Chapter Six), but Foucault alone is inadequate (Walton et al., 2019). As Walton et al. (2019) expertly articulate:

oppression must be understood as intersectional and as constructed across a range of systems. Foucault's theory of power, much embraced in our field, helps demonstrate the ways that power functions within systems and that it need not be executed by a person. His theory of power has been fundamental to our understanding of the ways institutions and organizations maintain and enact power relations. ... We agree that Foucault has been helpful in clearing the way for some important empowerment work in the field of technical communication. But his theoretical frame has not sufficiently prepared us to grapple with the intersectional experiences of people from multiply marginalized positions. And, importantly, his theory doesn't move us to explicitly understand opportunities for redressing inequities in active ways. A theory that leads to the empowerment of those who are marginalized prioritizes activism, social action, and the demarginalization of nondominant groups. (p. 109)

By drawing on Foucault alongside Young, Walton, Moore, Jones, and others theorizing social justice in TPC, I aim to both reveal how power and oppression operate in the UMN EWP and to imagine ways to do employee wellness that aim for anti-oppression action. As TPC, broadly speaking, is concerned about crafting texts that “get work done” (Rude, 2009, p. 190), I turn to user experience (UX) scholarship within TPC to inform my

understanding of how employees experience EWP technical health discourse, technologies (e.g., website, app), and practices (e.g., programming).

User experience (UX) has its roots in usability scholarship. Usability has traditionally been concerned with the effectiveness and efficiency of human interaction with technology through design choices (Johnson et al., 2007; Norman, 2002; Nielsen 1993; Porter, 2013). Traditional usability has tended to be system-centered, meaning that even if a system is designed with users in mind, the users are incorporated at the end of the process in a way that seeks to determine if they can accommodate their actions to the system, more than if the system can be accommodated to their needs (Johnson, 1998). Within TPC, usability has focused on ensuring usability of documents and information via the use of genre, organization, and document design principles; however, TPC usability is rhetorically-informed, meaning it strives toward understanding, articulating, and improving the relationship between humans and technology (Johnson et al., 2007; Redish, 2010; Salvo & Rosinski, 2010).

Where usability tends to focus closely on interactions of users with systems in fixed contexts (i.e., employees with software in a work setting) with a focus on effectiveness and efficiency, UX aims for a more holistic understanding of the complex and subjective interactions between user, system and context (Lallemand et al., 2015). Holistic approaches in UX seek to understand users' lived experiences within their real-life contexts, employing phenomenological strategies such as in-depth interviews and narrative storytelling to elicit how meaning-making happens in complex, often social, contexts (Christiansen & Howard, 2017; Melonçon, 2017, 2018). A key aspect of UX is a focus on communicating complexity, where "complexity is audience specific" (Redish, 2010, p. 199). The rhetorical expertise that technical communicators bring to usability

adds sensitivity to specific purpose, language, context, medium, and audience (Mirel, 2013; Salvo, 2001). Further, Potts and Salvo (2017) argue it is important to think about experience within ecosystems of activity rather than single tasks and paying attention to the way that users, places, and technologies intersect, while still attending to context and advocating for users (Potts & Salvo, 2017). Context is critical in health and medical settings, as complexity arises not just from audience, but also contexts of use; for this reason, “one cannot use a rigid or universal approach to UX in health and medical situations” (St.Amant, 2017, p. 63). Drawing on these theories allows me to use UX as a theoretical perspective for my research, one that informs my methodology and analyses but does not require formal usability methods.

Social justice provides a crucial lens for UX by bringing “attention to oppression, demanding that designers not only be honest and transparent, but that they reconsider who and what contexts of use matter” (Rose et al., 2018, p. 2). Indeed, Emma Rose and Joanna Schreiber (2021) argue that advocacy and justice are key contributions from the field of TPC to UX. For health contexts, Lisa Melonçon advocates for a new model she calls patient experience design (PXD): a “participatory methodological approach centered on contextual inquiry to understand the relationship between information (or technology) and human activities in health care” (Melonçon, 2017, p. 20). Drawing on RHM and UX theory, PXD is a methodological, user-centered lens that prioritizes information and technology design aimed to both improve patient outcomes and patient lives. Melonçon argues that current usability and user experience methods are not able to sufficiently account for “the myriad complexities and nuances of ... unique health and medical contexts” (Melonçon, 2018, p. 21). Context in particular is of importance to rhetorically-informed PXD: context is in constant flux as users, especially of mobile and wearable

technologies, shift from one context to another over time; context can be vast, encompassing an entire network, but is also specific and localized to a moment and place of use (Melonçon, 2017).

The people in my dissertation study may be patients in some contexts, but it is their context as *employees* that primarily matters for my study; their interactions with health-related discourse and practice takes place not in a medical office or hospital, but at their *workplace*. Social justice-oriented TPC scholarship provides me a theoretical perspective for understanding how employees, as users, experience the EWP's material and discursive practices in context, while keeping me attuned to issues of oppression and marginalization. In order to understand material and discursive health practices, I turn to rhetorical theory.

### **Rhetorics of Health and Wellness**

In their call for naming the field, Blake Scott, Judy Segal, and Lisa Keränen (2013) argued that “scholars adopt the term *rhetorics of health and medicine* to signal a broad array of health publics, their *nomoi*, and their discursive practices, some of which only partially intersect with medical institutions” (p. 1, emphasis original). While a significant portion of RHM research to date has focused on medical settings, rhetoricians of health and medicine have more recently called for research that foregrounds broader health practices in order to shed light on how people experience health and wellness outside biomedical institutions (Derkatch, 2016; Scott & Melonçon, 2018), as well as research aligned with critical theory and focused on topics like ethics, user experience, and the impact of personal health technologies (e.g., mobile digital devices, apps, wearables) (Heifferon, 2017; Melonçon & Frost, 2015). Expanding RHM research is important because “health involves more than what happens in hospitals, clinics, doctors’

offices, laboratories, or medical schools” (Angeli & Johnson-Sheehan, 2018, p. 3).

Further, “knowledge produced through research in RHM advances critical understanding of how our values, beliefs, and behaviors as health citizens are constituted through prevalent and ideologically inflected discourses of health and well-being” (Derkatch & Spoel, 2020, p. 29).

A rhetorical approach is key to understanding how institutions and individuals navigate slippery and contested ideas and practices around eating, health, and bodies. Like Jay Dolmage, I understand “rhetoric as the strategic study of the circulation of power” through discursive and material practices (2014, p. 3). In rhetorical theory broadly, I engage scholars who define rhetoric as linguistic and material, human and non-human, embodied and affective, and contextual and co-created (Dolmage, 2014; Foss & Griffin, 1995; Fountain, 2014; Hawhee, 2009; Johnson, 2017; Kessler, 2020a, 2020b, 2022; Teston, 2017). This understanding of rhetoric as contextual embodied, linguistic, and material practices that both make and unmake meaning is an anchor for my research design and analysis. While traditional, especially Aristotelian, approaches to rhetoric focus on *persuasion*, I find that approaching rhetoric as broader than persuasive discourse is important because it facilitates attention to people and bodies in my work, which allows me to ask questions about how discourse and technology impact and are impacted by practices in daily life. Rhetoric can be a particularly useful approach to examining and problematizing discourse and practice in health and medicine (Segal, 2005).

I draw on theories that conceptualize rhetoric as ecological, emplaced, and material in order to understand wellness and eating-related discourse and practice, as they are concepts that resist traditional rhetorical examination. As Jenny Edbauer Rice argues, “*the elements of rhetorical situation simply bleed*” (2005, p. 9, emphasis original).

Edbauer proposed moving from a model of rhetoric as “conglomerated elements” toward a “framework of affective ecologies that recontextualizes rhetorics in their temporal, historical, and lived fluxes” (2005, p. 9). Pulling together ecological, material, and new materialist theories, Caroline Gottschalk Drushke and Candice Rai (2018) describe rhetoric as:

multi-dimensional, existing as and tethered to the many forces and tools, histories and consequences, ideas and discourses, things and processes, desires and hopes, public memories and cultural narratives, people and other beings, symbols and materialities, ways of knowing and relating, and all manner else, that constitute and enable the powers of persuasion in any particular place. Beyond this sense of rhetoric as a complex constellation of persuasive forces in the world, we see rhetoric as a capacity of sorts to both perceive and act within this constellation: a form of responsivity and response. Such a capacity might be individual, collective, and even ecological to include human designs and more-than-human things that assemble in this way or that to incline particular lines of sight or action. In this sense, rhetoric becomes a tool—not simply of persuasion, connection, and collective action, but also of perception and orientation within these constellations. (p. 2)

Rhetoricians of health and medicine have successfully employed ecological models of rhetoric in order to understand complex health-related discourse/practices. Katie Walkup and Peter Cannon draw on Edbauer for their examination of addiction treatment in order to theorize “health ecologies [that] distribute agency through networks of patients and providers ... where health information, provider input, and the patient’s own beliefs formed an expanding network” (2017, p. 112). For Walkup and Cannon, an

ecological model helps them to place provider and patient beliefs into a broader context that resists viewing addiction treatment in a way that reinforces patriarchal views of medicine wherein the expert provider knows better than the non-expert patient. Like Walkup and Cannon, an ecological model helps me to situate employees, employers, wellness program administrators, and health care providers in an expanding network with distributed agency and interacting beliefs that affect employee “patient” practices and lived experiences.

RHM scholars have also recently pushed for the field to attend more to bodies and embodied lived experience (Edwell, 2018; Kessler, 2020b; Melonçon, 2018). That said, what counts as lived experience varies among scholars taking it up, and frequently the term is invoked without being well defined, making “lived experience” a slippery term. I turn to theory on lived experience as it dovetails nicely with TPC scholarship around holistic and socially just UX. Importantly, traditional rhetorical theory alone may be inadequate for capturing and analyzing lived experience. Blake Scott (2003) argued that traditional rhetoric positions people as encoders and decoders of discourse, a model which overlooks the ways that disciplinary power constructs and shapes bodies via language. Here, Scott invoked Foucault’s theory of disciplinary power, or the ways that institutional power “shapes people as particular kinds of subjects and subjects them to various exercises of power” (2003, p. 7). Disciplinary power thus simultaneously measures people against cultural norms and invites people to reshape themselves in order to conform or normalize (Scott, 2003). In this way, disciplinary power manifested through discursive practices has important material impacts. In other words, rhetoric shapes our understanding of bodies and, in turn, our actual bodies. As Jay Dolmage suggests, “rhetoricians [should] also recognize the ways that rhetoric shapes not just



utterances or inscriptions, but also beliefs, values, institutions, and even bodies” (2014, p. 2). By recognizing the ways power and discourse impact bodies, rhetoricians of health and medicine can seek to understand the ways that discursive practice impacts bodies and lived experience.

Bodies are a crucial aspect of lived experience (Chávez, 2018; Garland-Thomson, 1997; Grosz, 1994; Mol, 2002; Selzer & Crowley, 1999). Embodiment can be thought of as the many ways we relate to being in our bodies in the contexts of specific times, places, and cultures, and through which we enact our being in the world (Melonçon, 2018). Embodiment is also a way to attend to “the experience of living each day with [an illness] and the role that science and technology play in those experiences” (Martins, 2008, as cited in Hartelius, 2009). Lived experience coalesces around embodied practices that involve rhetorically consequential material objects within locations/contexts (Fountain, 2014; Gries, 2016; Koerber, 2013; Melonçon, 2018). In contexts of health, in particular, attending to bodies alongside other material objects helps to illuminate the myriad ways that health and illness are practiced and how, in turn, those practices impact lived experience.

Early medical rhetoric work focusing on biomedical research and clinical medical contexts laid the groundwork for recent expansions of RHM toward studying health more broadly. Widening RHM to study health outside medical contexts foregrounds “the myriad of actors (especially flesh-and-blood people) with varying relationships to and stakes in health, illness, and wellness” (Scott & Melonçon, 2018, p. 7). It is within this relatively new expansion of RHM into extra-medical health practices that I situate my work. The modern idea of wellness grew out of public health efforts in the 1960s (Dunn, 1957, 1961), though today the term “wellness” has become a buzzword, appearing on

magazines, health centers, herbal supplements, and even a popular pet food brand (Derkatch, 2012, 2022; Kirkland, 2014b). Wellness is generally framed as holistic, referring to “the optimization of an individual’s daily life across multiple domains (physical, psychological, social, and spiritual), emphasizing function over dysfunction, agency over passivity, and overall well-being over mere bodily health” (Derkatch, 2022, p. 3<sup>3</sup>). As originally conceived in the 1960s, wellness activities are typically aimed at improving the already- or borderline-healthy person, rather than treating illness or disease (Dunn, 1961).

Many discursive and material practices included in wellness are holistic, rooted in complementary and alternative medicine (CAM<sup>4</sup>) and inhabiting spaces along the fringes of mainstream biomedicine. While the boundaries between biomedicine and CAM are always a bit in flux, those boundaries tend to be reinforced through discourse and practice, with biomedicine maintaining a position of privilege despite the large number of people using CAM (Derkatch, 2016). Preventive care is an area that does not fit exclusively into biomedicine or CAM, existing instead at the blurry boundaries between them. While biomedicine pivoted toward a focus on interventive care in the 20th century (Hoffman, 2012; Tomes, 2016), it has in recent years incorporated more preventive interventions<sup>5</sup>, driven in part by the Patient Protection and Affordable Care Act (ACA) requiring health plans to cover preventive services (Hoffman, 2012). On the other hand, many CAM practices have long prioritized preventive care (Whorton, 2002). Like

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<sup>3</sup> Page number for this Derkatch, 2022, quote taken from a pre-print version of the book and may not match final copy page number exactly.

<sup>4</sup> I use CAM to refer to various approaches to health that are not part of standard Western biomedicine, from systems like traditional Chinese medicine and chiropractic to practices such as meditation, prayer, certain specialty diets, and herbal remedies.

<sup>5</sup> I use the term preventive intervention to signal a difference between holistic preventive care, or living an overall healthy lifestyle, and biomedical preventive care that intervenes in risk factors for disease.

preventive care, *wellness* lives within this shifting overlap between biomedicine and CAM. While wellness encompasses many preventive care practices, wellness is also a moving target because of its focus on health enhancement, or seeking to improve one's body to an optimized level of health (Derkatch, 2018). People can always strive to be better than just well through optimization (Elliott, 2003).

Derkatch (2018, 2022) theorizes the ways that wellness discourse, predicated on conflicting logics of restoration and enhancement, is inscribed onto individuals through higher-level institutional and biomedical discourses. Derkatch (2022) argues:

Wellness constitutes a language that circles back on itself, appearing to empower individuals to take charge of their health outside of an illness-centric pharmaceutical model of medicine while simultaneously reinstalling them anew in that same system. In this system, what it means to be “well” is forever just out of reach: there is always more we could or should be doing for our wellness—a new book to read, a new supplement or diet to try, a new clinic to visit, or a new app to download. (p. 5-6)

In other words, wellness discourse purports to provide an alternative to the mainstream biomedical illness model, but instead reinforces the biomedical model's central tenets in new rhetorical situations.

Food is a key ingredient in wellness discourse. From the rebranding of Weight Watchers to WW or “Wellness that Works,” to probiotics and “power foods,” to EWPs, healthy eating and wellness are nearly inseparable. The majority of EWPs include some form of eating-related or weight-loss programming (Cederström & Spicer, 2015). Carl Cederström and André Spicer (2015) elaborate on the relationship between bodies, eating, and wellness:

Our body determines where we live, whom we spend time with, how we exercise, and where we go on holiday. Part of this corporeal obsession is our deep fascination with what we put in our mouth. Indeed, eating has become a paranoid activity, which is not just intended to bring momentary pleasures through taste. It puts your identity to the test. Eating correctly is thought to be a way to cook up a happy and prosperous life, free from stress and despair. To eat correctly is an achievement, which demonstrates your superior life-skills. (p. 7)

Generally speaking, everyone eats, and food is tangled up with culture, politics, sociality; food is laden with meaning, and is deeply rhetorical. As Jessica Mudry says in her examination of dietary guidelines, “I am interested in ... which specific ways of talking about food ground, legitimize, or authorize specific claims ... In other words, why are certain justifications of eating practices or descriptions of food particularly persuasive?” (2009, p. 142). In this way, food is a critical avenue of study within wellness programs, as language around “healthy” eating may also, like the language of wellness, not provide a way to opt out of a mainstream biomedical model of eating and nutrition.

### **Critical Studies of Food, Fatness, and Risk**

Rhetorical theory provides me a way to pay close attention to the meaning-making work that discursive and material practices perform in the world and in people’s daily lives, and how varied eating practices and foods can be equally valued by and valuable to different individuals across time and space. However, in order to examine food and eating as they intersect with broader public discourse, including EWPs, I turn to critical scholarship on food, fatness, and risk. Eating-related discourse is value-laden, discursively tied to morality, and often mobilizes nutritional science, public health, dietary policies, and institutional power in the delineation of “healthy eating” and

“healthy bodies.” In this section, I will first unpack scholarship from critical food studies that theorizes dominant U.S. models of nutrition as based on quantification and nutritionism. I will then touch on the idea of biomedicalization and expand on how biomedicalization frames fatness and risk. Overall, this section aims to explicate how wellness discourse that takes up mainstream models of eating may replicate reductive and harmful ideas about food, fatness, and risk.

### ***Critical Food Studies***

Scientific advances in the 19th and 20th centuries made possible a view of food as quantifiable data, in turn driving a nutritional science predicated on quality of food as determined by the numerical breakdown of its calories and nutrients (Broad & Hite, 2014; Cullather, 2007; Mudry, 2009; Scrinis, 2013). There are two key concepts at work here: quantification, or the numerical measurability of food calories and nutrients (Mudry, 2009); and nutritionism, or a reductive focus on the nutrient composition of a food and concomitant interpretation of the roles of various nutrients in health (Scrinis, 2013). Quantification and nutritionism focus on the numerical measures of the apple, such as calories, fiber, and sugars, as the only important aspect of the apple as a food item. Quantification and nutritionism do not leave space for social, cultural, environmental, or even overall dietary considerations. In other words, a quantified and nutritionist model of eating does not make a distinction about where or when the apple was eaten or with whom, the eater’s overall meal or eating habits, nor does it account for the climate where the apple was grown or its variety, how far it may have been shipped, whether it is native to the region, or if apples were in season. Quantification and nutritionism reduce food to numbers, and elide other, myriad foodways (cultural, social, environmental, and economic aspects of or traditions related to food).

Quantification and nutritionism underlie the development of sweeping nutritional standards in the U.S. via the United States Department of Agriculture's (USDA) Dietary Guidelines for Americans (DGA), which were subsequently widely adopted in biomedical models of healthy eating (Hite & Carter, 2019; Mudry, 2009; Scrinis, 2013). While the primary aim of dietary models, such as the DGA, at an institutional/national level may be to improve health, the "process of teaching people to 'eat right' inevitably involves shaping certain kinds of subjects" (Biltekoff, 2013, p. 4) through institutional and disciplinary power. Eating habits are thus moral and ethical as well, with individual choices like a "good" kale salad tied to being a good person and, likewise, avoiding the "bad" temptation of a devil's food cake (Biltekoff, 2013; Biltekoff et al., 2014). In this way, eating choices can be construed as reflective of a person's worth (Lupton, 2005). Further, the DGA is predicated on the values of upper-middle-class experts in the U.S., mostly white men, rather than being spurred by conclusive scientific discovery, and the universal, or one-size-fits-all, approach of the DGA devalues many eating habits and foods from around the globe (Biltekoff et al., 2014; Hite & Carter, 2019). Thus, numeric guidelines about what everyone *should* eat made possible the measurement of "good" foods and "good" eaters and privileged the numeric over the social and cultural.

Allison and Jessica Hayes-Conroy (2013) draw on diverse critical food studies research to advance a model they call "hegemonic nutrition," which they argue does four key things:

- Standardizes food and the food-body relationship (a calorie is a calorie is a calorie to everyone);
- Reduces food to numbers through quantification and nutritionism;
- Fundamentally decontextualizes food from culture, bodies, and the

environment, and any gestures toward cultural variation that are included are superficial at best, such as altering body mass index (BMI) norms for different ethnic/racial groups or including some limited “ethnic” foods in healthy eating guides;

- And, by bracketing itself off from broader social and cultural contexts, hegemonic nutrition creates a hierarchical system of knowledge that privileges expert knowledge advanced through nutritional science practitioners, the media, the health and diet industry, and social institutions such as schools and workplaces.

In this way, Hayes-Conroy and Hayes-Conroy (2013) demonstrate how dietary standards and ideas about “healthy eating” such as those advanced by the DGA become pervasive across social systems and structures. Hegemonic nutrition is equally present in the food pyramid, the MyPlate model that replaced it, fad diets, school lunches, and the dietary advice provided by the UMN EWP. Thus, hegemonic nutrition is central to mainstream eating-related programming; many diet programs focus on counting calories, moderating intake of particular macronutrients (e.g., a low-carb diet), or rely on a proxy (e.g., Weight Watchers Points) for calories and nutrient values. Hegemonic nutrition also manifests in the idea that food and eating habits are deeply connected to weight and fatness, a link that critical scholars have worked to problematize.

A rise in so-called weight-related health issues in the 20th century U.S. came with a concomitant rise in doctors prescribing weight-loss and even specific diets (Brown, 2015). While there may be some link between diet, weight, and disease, that link points less to a causal relationship and more to a correlation between ideas of health within nutritional science and biomedicine (Mudry, 2009). Mudry calls this a paradox, noting

that there has been a “concomitant rise in diseases related to diet *and* an increasing body of sound, scientific knowledge regarding the link between diet and health” (2009, p. 172, emphasis original). Mudry (2009) further argues that discourses of quantification have, to date, been a “massive failure” in that they cannot, and have not, achieved the goal of improving public health, nor have they demonstrated an effective link between biomedical nutritional advice and actual eating practices (p. 172). Mudry goes on to explain that:

If there is a link between diet and disease, then we all have the ability to fend off potential sickness by eating correctly. But if we follow the regimens offered by the USDA what will we be able to say about the state of our well-being? Does the evidence of diet-related disease really leave us with an adequate conception of health and well-being if that conception is devoid of pleasure, tradition, taste, and so forth? (2009, p. 18)

The questions Mudry poses are critical to my study, but as she admits, a complete answer may not be possible; however, these questions are especially salient as I am examining eating-related practices within a program meant to be about holistic wellness. Thus, it is my aim, like Mudry, to consider questions of pleasure, tradition, culture, and so forth as I analyze the eating-related discourse and practices of the UMN EWP and employees.

Experience is a crucial extension of critical food studies work. As Charlotte Biltekoff (2013) argues in the introduction to her study of dietary reform, including efforts like the DGA:

We need to find and analyze historical evidence of how the assumptions embedded in the discourses I study have been adopted, resisted, and contested by



the people who have been the targets of reform, and we need to explore how people who are not reformers have generated and acted on their own “truths” about good food. We also need ethnographic and other kinds of qualitative data that can show how people of different racial, cultural, and class backgrounds currently understand and use, or refuse, concepts such as “good diet,” “good eater,” and “eating right” in their everyday lives. (p. 11)

In incorporating critical food studies into my project, I am to address Biltekoff’s call here to examine people’s lived experience with hegemonic nutrition discourse and practices.

### ***Biomedicalization***

While diet has been linked to health for millennia, hegemonic nutrition in recent decades has led to food becoming “profoundly medicalised in its association with health, illness and disease “ (Lupton, 2000, p. 205). Today, medicalized food appears in a multitude of programs, products, and ideologies, from fad diets to manufactured ‘functional foods’ designed to address specific health concerns (Scrinis, 2013).

Medicalization refers to a process whereby the nonmedical becomes described and treated as medical (Conrad, 2007; Crawford, 1980; Rose, 2007), and is a process that has likely existed as long as medicine. For example, people with uteruses have been giving birth since the dawn of humanity, but scholars have noted that the medicalization of pregnancy in the nineteenth century rhetorically shifted understandings of and expertise about pregnant bodies away from the pregnant people themselves and practitioners like midwives and doulas, positioning pregnancy as risky and in need of medical intervention (Barker, 1998; Jensen, 2016; Schuster, 2006). In addition to extending the purview of biomedicine, medicalization also functions as a phenomenon that delineates deviance through naming what counts as health (normalcy) and what counts as disease (deviance)

(Crawford, 1980). That said, it is important to acknowledge that medicalization by itself is not necessarily inherently a negative thing (Rose, 2007). Medical intervention has certainly improved the lives of countless people, even if medical interventions may simultaneously advance harmful ideas about what is normal and what bodies should look like and be able to do (Gupta, 2020). Modern biomedicalization is biopolitical, technoscientific, and increasingly about health and the optimization of bodies (Clarke et al, 2010). Biomedicalization also “increases the power of biomedicine as an institution of social control” (Gupta, 2020, p. 2). Based on these ideas, my project specifically uses the term “biomedicalization” to refer to activity around the use of biomedical ideas about bodies, nutrition, weight, obesity, and health risks to reframe eating habits.

### ***Fatness and Risk***

Through biomedicine, BMI has become the ubiquitous measure relating body fatness to health outcomes despite also being critiqued widely as a reliable measure of adiposity (Guthman, 2011; Halse, 2008; Hite & Carter, 2019). Measures like BMI may be used to “evaluate compliance with dietary guidelines or to track prevalence of obesity, but BMI may not be meaningful or helpful to the individuals being measured nor does it indicate what factors impact the health of those individuals” (Hite & Carter, 2019, p. 153). Further, biomedicine has framed obesity as a disease, even though links between fatness and disease are generally correlative rather than causative (Jutel, 2008; Guthman, 2011). Evidence suggests that “yo-yo dieting,” or gaining and losing weight repeatedly over many years, may be equally detrimental to health as being fat in the first place (Klein, 2010). Beyond the classification of obesity as a disease, even without the presence of other specific disease or illness, overweight and obesity<sup>6</sup> are often viewed as

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<sup>6</sup> Overweight and obesity are words typically used in biomedicine to classify bodies as abnormal and

risks for chronic illnesses such as cardiovascular disease or type 2 diabetes (Halse, 2008). Further, much has been made in the medical literature and in popular media about the “obesity epidemic,” though in large part the framing of fatness as a dire health epidemic is a media effect (Berlant, 2007, 2010; Jutel, 2008), which may in fact be driving poor health outcomes through motivating people to diet obsessively or in harmful ways (Klein, 2010). Weight issues (being at risk for obesity, being at risk for other disease because of obesity) have thus become the target of medical intervention through the medicalization of risk (Armstrong, 1995; Conrad, 2007; Crawford, 1980; Derkatch, 2018; Sadler, 2014), closely tying weight to the medical establishment (Brown, 2015). These ties place diet and nutrition squarely within the purview of biomedicine, and underscore the biomedicalization of what counts as “healthy” food and efforts toward promoting modification of eating habits for weight-related reasons.

The concept of risk invoked in the previous paragraph emerges from probability calculations, as in the insurance industry, and population measures, as in epidemiology. Risk calculations make possible the quantification of the probability of becoming ill, and in turn, drive efforts aimed at potentially managing or avoiding illness and disease (Beck, 1992; Lupton, 2013). Further, many risks associated with social problems, such as overweight and obesity, become neoliberally framed as the result of individual habits (Beck, 1992; Lupton, 2000, 2013). Neoliberalism, as defined by David Harvey, is

a theory of political economic practices that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights,

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unhealthy; I will use language like fatness and body size, following the approach taken in critical obesity studies, unless I am referring to the biomedical framing, measures, or literature on body size that use overweight and obesity.

free markets, and free trade. The role of the state is to create and preserve an institutional framework appropriate to such practices. (2007, p. 22).

Julie Guthman (2011) elaborated nicely on Harvey's neoliberal theory, explaining that:

Neoliberalism, in contrast [to classic liberalism], primarily values free enterprise, really a no-holds-barred approach to profit making in the name of the public good, despite its nods to broader liberties. As a practical political philosophy, neoliberalism has guided policy efforts to privatize public resources and spaces; minimize labor costs through, for example, defanging unions; reduce public expenditures on entitlements, subsidies, and other sorts of redistributive welfare (public health services, public education); eliminate regulations seen as unfriendly to business, especially health, labor, and other environmental protections; and reduce taxes in order to spur more private-sector investment. (p. 17)

In a neoliberal system, then, epidemiologically-driven risk factors such as those associated with overweight and obesity become the individual's responsibility to address, eliding institutional or societal roles (Guthman, 2011). In doing so, scholars have argued, poor health outcomes are seen as a result of individual choice and self-management of health becomes conflated with being a good citizen (Biltekoff, 2013; Derkatch & Spoel, 2017). In other words, fatness is the result of individual choices in terms of eating habits, and eating habits are a reflection of morality (as noted above in the Critical Food Studies section), thus fatness is a result of "bad" eating habits, "poor" moral character, and lack of self-management. However, this view ignores systemic factors inherent in social determinants of health such as access to food and healthcare, living and working conditions, and education and health literacy (World Health Organization, n.d.).

Many public health campaigns related to weight rely on individual self-

identification of being at risk and then individual action to mitigate that risk (Lupton, 2013). Risk calculations also come into play in preventive medical care as well, with risk for illness needing intervention and management, a shift that biomedicalizes risk (Armstrong, 1995; Conrad, 2007; Crawford, 1980; Derkatch 2018). Further, “[r]isk and surveillance mutually construct one another: Risks are calculated and assessed in order to rationalize surveillance, and through surveillance risks are conceptualized and standardized” (Clarke et al., 2003). Surveilling risk is an aspect of the medical gaze, or the objectification of the patient as a location for disease and disease as the object of medical interest (Foucault, 1994). Through risk surveillance, people are invited to reshape themselves to match dominant norms, and through the incorporation of risk surveillance in public health campaigns and EWPs, biomedicalized ideas about risk permeate the technical and public spheres, implicating each of us through “elaborated daily life techniques of self-surveillance, and the management of complicated regimens around risk and chronic conditions” (Clarke et al., 2003, p. 172). Importantly, using risk factors to identify at-risk individuals elides the complex social, economic, and political factors that contribute to health disparities and risk factors in the first place (Guthman, 2011; Happe, 2018; Lupton, 2013; Scrinis, 2013). Additionally, the “relevant psychological, economic, social, cultural, biological, and ecological factors are inextricably coconstitutive” and issues related to risk factors and eating habits are very difficult to untangle neatly (Guthman, 2011, p. 189). These conceptions of risk are not objective and have important implications for how we think about and experience our bodies and our eating habits in daily life (Lupton, 2000). Risk is important in my study because reliance on weight-related risk factors and individual responsibility often drives eating-related programming, like that taken up in EWPs; in other words, someone who is

deemed at risk for health problems based on weight is typically advised to change their eating habits.

Overall, hegemonic nutrition (quantification and nutritionism) has an impact on people's relationships with food and eating. Through the medicalization of food and risk, weight becomes the target of medical intervention through diet-related programs. Lauren Berlant (2007) argued that obesity was only deemed an epidemic in the U.S. when it began interfering with labor costs through healthcare expenditures and the economic impacts of absenteeism at work. Berlant suggests that designating obesity as a disease made possible including it in medical records and health insurance coding, which in turn contributed to identifying obesity as a "so-called epidemic" (2007, p. 758). In other words, fatness became expensive, and healthcare systems and educational programs like EWPs, which aim to inform people about the risks of fatness, became the means for diminishing the cost impacts of fatness. Therefore, wellness discourse that takes up mainstream models of eating can replicate hegemonic nutrition rather than providing a holistic alternative. And lastly, eating habits and food are tightly tied to dietary reform movements, institutional power, culture, and morality. Food is tangled up with culture, politics, and sociality; food is laden with meaning, and is deeply rhetorical. In this way, food is a critical avenue of study within wellness programs because of their focus on weight and eating-related programming, and because of the association of fatness with risk, chronic illness, and disability.

### **Medical Ableism and Disability**

In the context of programs like EWPs and their diet programming, the biomedicalized links between food, fatness, and chronic illness position fat bodies as abnormal and in need of intervention through dietary change and weight loss. As noted

above, fatness is biomedicalized through its classification as disease (obesity) and obesity's associated risk for weight-related diseases (e.g., type 2 diabetes, cardiovascular disease). Many such chronic illnesses can be considered to be disabilities. The pathologizing of fat bodies as deviant and diseased (or at risk of disease) links fatness to disability and, in turn, to ableist ideas about able-bodiedness. To unpack these complex ideas, in this section I will first briefly describe how and why I am incorporating critical disability studies as a theoretical perspective. Then, I discuss the relationships between deviance, stigma, and disability, outline how medical ableism positions disability as deviation from ideal able-bodiedness, and discuss how ideas about disability and pain, and diagnosis, cure, and overcoming, operate in medical ableism. Next, I will touch on disability and chronic illness, and link the biomedicalization of disability and of fatness. Lastly, I'll touch on themes of individual responsibility, institutional power, and academic ableism, in order to connect medical ableism and academic ableism underlying the UMN EWP as a university wellness program.

Following Julie Minich (2016) and Sami Schalk (2017), I employ critical disability studies as a methodology or analytic lens, rather than engaging disability as an object of study. As a methodology, critical disability studies “involves scrutinizing not bodily or mental impairments but the social norms that define particular attributes as impairments, as well as the social conditions that concentrate stigmatized attributes in particular populations” (Minich, 2016, p. 3). This allows me to understand ability/disability as a “system of social norms which categorizes, ranks, and values bodyminds and *disability* as a historically and culturally variable category within this larger system [of marginalization and privilege]” (Schalk, 2017, para. 3, emphasis original). Thus, critical disability studies aims to “radically disrupt the multiple

sociopolitical ideologies that assign more value to some bodies and minds than to others” (Minich, 2016, p. 5). As a key theoretical perspective, critical disability studies facilitates my examination of how bodies are rhetorically enacted through language, policy, programming, and practice around the EWP, and supports my work toward illuminating how the EWP both arose out of an ableist medical model and reproduces ableism in its programming.

Able-bodiedness and disability operate as conceptual opposites. If able-bodiedness is socially constructed as the ideal, then disability is socially constructed as deviant (Garland-Thomson, 1997). The Americans with Disabilities Act of 1990 provides as a legal definition of disability: “a physical or mental impairment that substantially limits one or more major life activities” (Sec. 12102). Rosemarie Garland-Thomson (1997) explains that:

Essential but implicit to this definition is that both “impairment” and “limits” depend on comparing individual bodies with unstated but determining norms, a hypothetical set of guidelines for corporeal form and function arising from cultural expectations about how human beings should look and act. Although these expectations are partly founded on physiological facts about typical humans—such as having two legs with which to walk upright or having some capacity for sight or speech—their sociopolitical meanings and consequences are entirely culturally determined. ... Moreover, such culturally generated and perpetuated standards as “beauty,” “independence,” “fitness,” “competence,” and “normalcy” exclude and disable many human bodies while validating and affirming others. (p. 6-7)

Able-bodiedness, then, is the norm while disability is deviant. Further, sociologist Erving



Goffman (1963) delineated deviance, or “possessing an attribute that makes [one] different from others,” as stigma, or “an attribute that is deeply discrediting” (p. 3). Goffman defines the normal individual so narrowly that he eventually concluded that “in an important sense there is only one complete unblushing male in America: a young, married, white, urban, northern, heterosexual Protestant father of college education, fully employed, of good complexion, weight, and height, and a recent record in sports” (1963, p. 128). While this sketch of a normal human might seem dated and laden with oppressive ideas, I think our contemporary context of a resurgence of white supremacist and civil rights movements in the early 21st century indicates its lasting power in terms of being normative. What Garland-Thomson argued in 1997 about Goffman’s “unblushing male” conclusion in many ways holds true today:

This image’s ubiquity, power, and value resonate clearly. One testimony to the power of the normate subject position is that people often try to fit its description in the same way that Cinderella’s stepsisters attempted to squeeze their feet into her glass slipper. (p. 8)

In essence, disability is socially constructed as deviance from the normative idea of able-bodiedness, and this deviance is further socially constructed as deeply discrediting, which in turn reinforces the normative power of striving for ideal able-bodiedness.

The idea of able-bodiedness and its normative power is central to this dissertation, as the idea of striving toward ideal able-bodiedness is at the core of wellness discourse and EWPs. The medical model of disability frames “atypical bodies and minds as deviant, pathological, and defective, best understood and addressed in medical terms” (Kafer, 2013, p. 5). In this medical model framework, then, disability is understood as an individual deficit, as something to be diagnosed, treated, cured, and/or overcome (Clare,

2017; Dolmage, 2017, 2018; Kafer, 2013; Shakespeare, 2017; Wendell, 2001). Able-bodiedness is then what we all should aim for; it is a compulsory aspiration (McRuer, 2017). In this way, the medical model of disability is ableist and, additionally, it positions disability as an exclusively medical problem centered on fixing individual deviance. This neoliberal view of disability as individual responsibility is central to the medical model, and ignores systemic, structural factors in our understanding of what bodies can and should be. One function of oppressive ableist ideas is, as Ibram Kendi argues about racism, to “manipulate us into seeing [individual] people as the problem, instead of the policies that ensnare them” (2019, p. 8).

In recent decades, disability rights advocates have pushed back against the medical model, arguing that disability should not be framed around individual deficit, but rather thought of as a social phenomenon manifested in discourse, systemic oppression, and built environments (Kafer, 2013; Shakespeare, 2017). This social model of disability rests on differentiating between impairment (a physical reality) and disability (a social construction), and is closely tied to the idea of civil rights (Shakespeare, 2017). In many ways, the social model of disability manifests most clearly in ways the ADA is operationalized: adding wheelchair ramps, signs in Braille, etc. However, the social model of disability risks implying a narrow definition of impairment that may exclude chronic illnesses and/or suggest that impairment is not a problem (only the environment and society are problems); ultimately, the social model is inadequate for understanding the complexity of lived experience with a broad range of disability. Alison Kafer critiques the social model as having too sharp a distinction between disability and impairment, noting that

social and structural changes will do little to make one’s joints stop aching or to

alleviate back pain. Nor will changes in architecture and attitude heal diabetes or cancer or fatigue. Focusing exclusively on disabling barriers, as a strict social model seems to do, renders pain and fatigue irrelevant (p. 7)

Further, Kafer argues, “drawing a hard line between disability and impairment ... makes it difficult to explore the ways in which notions of disability and able-bodiedness affect everyone, not just people with impairments” (p. 8). All of us are affected by cultural and social norms and ideals about able-bodiedness, especially as ableist discourse about ideal able-bodiedness is pervasive and ubiquitous, echoing through medical settings, popular media, and non-medical institutional discourse like that in EWPs. In other words, the pervasiveness of the view of disability as an individual defect to be cured or overcome by medicine is the manifestation of systemic medical ableism.

Ableism is an oppressive systemic social issue that relates both to the marginalization of disabled people and to the valuing of an ideal body and forms of functioning or ability (Clare, 2017; Kafer, 2013). In other words, ableism both marginalizes disability and inherently promotes compulsory able-bodiedness. Medical ableism is the systemic valuing of an ideally able body and framing of disability as deviance/deficit within mainstream biomedicine; biomedicine, then, is a structure responsible for systemic oppression (Cherney, 2019; Clare, 2017). Framing disability as defectiveness or disorder and making it a potential subject of medical diagnosis is an ableist invention that helps generate systemic ableism; it often frames disability as suffering that requires a cure (Clare, 2017).

Through diagnosis, disability and disease become categorized, and those categories are mobilized in different spaces in order to enact different ideas about bodies and ability. Diagnosis wields immense power “because it projects the concept and

practice of *disorder* onto us ... meaning not only *dis-ordered* but also wrong, broken, in need of repair” (Clare, 2017, p. 43, emphasis original). Diagnosis and categorization can thus frame bodies as in need of cure. Cure is a medical intervention aimed at returning a body deemed abnormal or defective to an “ideal” or “natural” state of being. As Clare argues, “Defectiveness justifies cure and makes it essential ... [it] wields incredible power because ableism builds and maintains the notion that defective body-minds are undesirable, worthless, disposable, or in need of cure” (2017, p. 23). Further, cure works through and relies on a network of overlapping medical processes, including prevention, which together work to define and redefine normal and abnormal. While prevention is not cure itself, it aims to stop disability from happening in the first place (Clare, 2017), and prevention is at the heart of EWPs.

Inherent in medical ableism is the assumption that disability intrinsically involves pain and suffering. Even though not all disability involves pain or suffering, people frequently assume or assign pain onto disability (Siebers, 2010). Siebers (2010) gives the example of a blind man, who feels no pain in his eyes or elsewhere, yet is admired by others for his bravery in the face of suffering and adversity. The fear of pain justifies the fear and avoidance of disability and the need for cure (Reynolds, 2017; Wendell, 2001). Importantly, combating stigma around pain and disability means “learning how to interpret ableism and the ableist conflation at work in stories of disability, in stories about fear or resilience in the face of illness, and in all storytelling and communication about the myriad experiences of bodily variation” (Reynolds, 2017, p. 159). Thus, the ableist conflation of pain and disability is at the heart of medical ideas of cure and is tightly bound to rhetorics of risk; the ableist conflation is a justification for medical interventions based on the risk of future disease or disability.

EWPs in particular tend to focus on the prevention of chronic illnesses, especially biomedically-defined weight-related diseases such as type 2 diabetes. However, the relationship between disability and chronic illness is problematic. While many people are disabled by chronic illness, and many people with disabilities not caused by illness have chronic health problems caused by their disabilities, others have disabilities without any chronic illness (Wendell, 2001). The disabilities rights movement has pushed back against identifying illness with disability because it contributes to the medicalization of disability, or the positioning of disability as in need of medical intervention/treatment/cure (Wendell, 2001). Yet, despite the problems presented by the potential medicalization of disability through association with chronic illness, chronic illness<sup>7</sup> must be included under the umbrella of disability (Kafer, 2013).

Much disability is precarious, especially chronic illness, which is not necessarily clearly defined, predictable across time and space, or even noticeable in many contexts. The social model of disability centers the idea of accommodations or physical modifications to the built environment; however, accommodation is closely tied to neoliberal discourses of productivity that are especially pernicious for those with chronic illness or pain (Price, 2018), because structural changes such as accommodation can do little to relieve actual pain or fatigue (Kafer, 2013). Many people with chronic illness are thus unaccommodatable (Price, 2018). Therefore, chronic illness must be included in disability studies in order to better nuance impairment and to embrace the phenomenological side of being disabled (Wendell, 2001).

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<sup>7</sup> While I use the umbrella term “chronic illness” here as a catch-all, it is important to clarify that chronic illness does not always equal disability. Many people with chronic illnesses do not consider themselves disabled or impaired (whether that is a result of pervasive ableist ideas or not is very interesting to me, but beyond the scope of this dissertation). Additionally, many people with chronic illness may move in and out of phases where they would consider themselves healthy, ill, disabled, or impaired.

Pushing back against the medical model of individual deficit and the social model of disability, which resists connecting disability with pain and illness, Susan Wendell advances a framework of healthy and unhealthy disabled. In Wendell's (2001) model, the healthy disabled may be

people who were born with disabilities or people who were disabled by accidents or illnesses later in life, but they regard themselves as healthy, not sick, they do not expect to die any sooner than any other healthy person their age, and they do not need or seek much more medical attention than other healthy people.” (p. 19)

The unhealthy disabled, then, are generally people with chronic illnesses. Wendell acknowledges that the boundaries between these groups and their membership are always in flux; healthy disabled people may become unhealthy disabled in the future, and some unhealthy disabled people have recurring acute conditions (e.g., infectious Lyme disease) where they have periods of ability and disability. While Wendell makes a definitive case for including chronic illness in disability, she sidesteps defining the term health, despite using “healthy” and “unhealthy” as categories. One of my goals in this dissertation is to grapple with how the EWP and employees define health and wellness, which I will address more later in this chapter and in Chapters Four and Five. I will note here that, as a rhetorician, language matters and I resist the idea of using the term “unhealthy” in relation to people with chronic illness. Despite the problematic terminology, however, Wendell makes an important contribution in placing chronic illnesses under the umbrella of disability and for nuancing how disability and chronic illness can be always in flux.

Chronic illness as disability in flux is especially important when considering obesity and weight-related disease (e.g., heart disease, type 2 diabetes). Non-communicable diseases (NCDs), including diabetes, have been surging in the U.S.; NCDs

accounted for less than 20 percent of deaths in 1900 but now account for about 80 percent (Bennett, 2013). Type 2 diabetes accounts for about 90 percent of all diabetes cases and can lead to additional disability such as kidney failure, blindness, or amputation of extremities (Bennett, 2013). Fatness connects to disability through obesity as a biomedically defined disease and the related links between obesity and risk for weight-related disease. When an individual is deemed obese or at risk for weight-related disease, they are often told to change their eating habits or, in some cases, to seek weight-loss surgery. These interventions can be seen as “cures” for fatness. In discussing the medical-industrial complex’s unrelenting focus on cure, Clare elaborates that

in practice there is a routine acceptance of potential cures, partial cures, and failed cures. I think of fat people and all the technology designed to make them slender: fad diets, prescription weight loss drugs, gastric bypass and lap band surgeries. In a fatphobic culture, it doesn’t seem to matter that dieting, more often than not, results in weight cycling rather than long-term weight loss. Nor does it matter that surgery outcomes range widely—from death to permanent difficulty with eating, nutrition, and digestion; from significant long-term weight loss to weight loss followed by weight gain. The quest for slenderness, for an eradication of fatness, is seemingly worth all the failures, dangers, dubious medical procedures, and direct harm. ... And when cure plainly fails, we—the consumers, clients, or patients—are often blamed, either subtly or blatantly, for these failures. We didn’t try hard enough. We were lazy. We were drug resistant. We were noncompliant. (p. 77)

Medical interventions (or cures) around disability, including those for weight-loss, are fraught; on one hand, they are normalizing and perpetuate ableist ideas about bodies, but

on the other hand, they can be ameliorative for people who choose them (Gupta, 2020). Regardless, the medical model's focus on disability as an individual defect or failure means, in the case of fatness, stigmatization and being marked by others as having poor eating habits and thus poor moral character, as noted in the Critical Studies of Food, Fatness, and Risk section.

Fatness, obesity, and weight-related chronic illnesses like type 2 diabetes are stigmatized through associated ideas of morality and individual choice (or failure), such as “bad” eating choices or lack of self-control through overconsumption. Additionally, studies highlight the perceived economic burden of fatness, with “medical spending estimated to be 42% higher for someone who is obese and ... although smoking is the leading preventable cause of U.S. mortality, some speculate that deaths due to poor diet and inactivity may exceed those from smoking” (Froehlich-Grobe & Lollar, 2011, p. 541). Further, studies in the 2000s “suggested that obesity-related medical and absenteeism costs range from more than \$400 to more than \$2,000 per obese employee per year ... [and] that obese working-age individuals have medical costs more than 35% higher than those of normal weight individuals” (Madison et al, 2011, p. 455). Around 60 percent of American adults and 30 percent of children are obese and “one out of every three children born during or after the year 2000 will be afflicted with an obesity-related disorder such as diabetes mellitus, or type 2 diabetes” (Berlant, 2007, p. 771). While it is possible to read these economic arguments generously, as aimed at saving individuals money on their healthcare expenditures, such arguments are typically embroiled in problematic neoliberal discourse about individual responsibility and choice. This neoliberal focus on the economic impact of fatness underscores individual failure; fatness not only indicates poor moral character, it represents a burden on society for which the fat



person should be blamed, a problem only the fat person can fix.

A focus on individual responsibility is widespread in both popular discourse and the medical model, and it is replicated in research supporting the idea that if people simply knew about their risk factors and behaved differently, they could avoid disease and disability (for example, refer to Anderson et al., 2011; Froehlich-Grobe & Lollar, 2011; Nyman et al., 2009). Again, it is worth noting that the focus on individual responsibility elides the systemic inequities around access to food and healthcare that disproportionately affect people marginalized along axes of race and class and, further, reinforces ideas that health and body size are mutually interdependent. Like my concern above about chronically ill people and Wendell's term "unhealthy disabled," people in larger bodies might simultaneously experience disability but consider themselves healthy, especially within their individual cultural and social contexts.

Lastly, it is important to acknowledge institutional power as a prevalent force for disciplining bodies; according to Foucault (1979), disciplinary power measures bodies against cultural norms and invites them to reshape themselves to conform to these norms. Disciplinary power works insidiously by shaping people into willing participants in their own normalization. Ableism in the medical model does this through the constant reinforcing of the ideal body as able-bodied, and by extension, employers may do the same through reproduction of ableist medical models through EWPs and other health promotion programs. Academia, in particular, is built on ableism, and we can draw a straight line from the hygiene programs of study in the 1920s to wellness programs on campuses today (Dolmage, 2017). Bureaucracy is a prevalent force in academia, defining normal procedures, processes, and participants, including what it means to be a good worker (Titchkosky, 2011). Institutions thus use disciplinary power and the

distinguishing of disability to tie together ideas about able-bodiedness, capability for work, and productivity (McRuer, 2017; Price, 2018; Puar, 2017).

Medical ableism and disability complements my other theoretical perspectives. Jay Dolmage describes the intersection between rhetoric and disability studies, noting that rhetoricians should attend to and be critical of how “disability is often used rhetorically as a flexible form of stigma to be freely applied to any unknown, threatening, or devalued group. In these ways, the ‘abnormal’ or extraordinary body is highly rhetorical” (2014, p. 4). Through a rhetorical lens, disability studies gives me an important theoretical perspective for understanding and foregrounding ableism. Further, as the EWP communicates complex health information in the workplace, TPC and social justice helps me examine how the EWP both facilitates and forecloses access to wellness. In particular, I aim to respond to Jones et al.’s (2016) call to resist ableism historically perpetuated by TPC widely, if not inadvertently, through the incorporation of disability rhetoric and disability studies. Technical communicators have an ethical obligation to consider user experience, both intended and unintended, and the ways that technical medical information can reproduce ableist narratives of normalcy (Moeller, 2015).

### **Rhetorical Questions (Part One)**

Some questions are rhetorical in the sense that they do not have stable, global answers that hold fast across even small amounts of time and space. The Oxford English Dictionary describes rhetorical questions as those “asked only to produce an effect or make a statement, rather than to elicit an answer or information” (Oxford English Dictionary, n.d.b). In this section, I address three such questions: What is health? What is wellness? What is healthy eating? While these questions are *not* my research questions (refer to Research Questions earlier in this chapter), they underlie my research questions.

I think of them as “prior questions.” The concept of prior questions comes from rhetorician Judy Segal, who explained that prior questions take a step back and ask questions that are conceptually prior to those often asked in health and medicine (Derkatch, 2022; Scott & Melonçon, 2018; Segal, 2005). Here, I ask prior questions in order to take a step back from my research questions and ask what makes certain meanings around health, wellness, and eating possible. While I draw on dictionary definitions and literature in this section, I will return to these rhetorical questions in Chapters Four and Five, drawing there on my archival and participant datasets. Most importantly, I position these rhetorical questions as prior questions for two key reasons: first, for transparency around how these slippery terms *mean* more broadly in order to support my analysis and arguments around how health, wellness, and healthy eating are enacted in various spaces; and second, to demonstrate how ideas about and enactments of health, wellness, and healthy eating shift in different contexts when different entities are involved. In other words, before and alongside my discussions of how the UMN EWP impacts people’s lived experience with food and wellness, I must address what it means to talk about “health,” “wellness,” and “healthy eating” in the first place.

These rhetorical questions are rhetorically contingent and contextual, and I ask them in order to surface the rhetoricity and variance of the possible answers. Every individual person might answer these questions differently, and not just differently from other individuals, but potentially on different days of their own lives or in different contexts or in response to different questioners. These are questions that this dissertation will not aim to concretely or definitively answer, despite their centrality to my project. Instead of working to provide universal definitions, I instead work to explore how health, wellness, and healthy eating are practiced materially and linguistically in various

rhetorical contexts and for various stakeholders, and how those various practices may align, differ, and/or conflict. The terms “health,” “wellness,” and “healthy eating” are at the heart of my project and require discussion throughout the dissertation.

Importantly, my methodology draws largely from Annemarie Mol’s (2002) multiple ontologies theory and praxiography method, and from rhetoricians of health and medicine who have taken up and extended Mol’s work (Graham, 2015; Kessler, 2020a, 2020b, 2022; Molloy, 2015; Pender, 2018; Teston et al., 2014). Praxiography, or the ethnographic tracing of practices, helps me understand how experiences with health, illness, and bodies are enacted through practice (refer to Methodology in Chapter Two for deeper discussion of praxiography). Thus, multiple ontologies theory and praxiography allow me to consider health, wellness, and healthy eating as multiple entities enacted through practice, the meanings that those enactments set in motion, and the impact of those meanings on how people experience their bodies and health in their daily lives.

In the remainder of this section, I will draw on existing literature to sketch out some of the meanings attributed to “health,” “wellness,” and “healthy eating.” In my analysis later, I will return to these questions and provide some analysis of how answers to these questions appeared in my datasets: in Chapter Four I will discuss EWP practices based on my archival analysis, and in Chapter Five I will detail employee practices based on my survey and interviews. Because the term “health” is deeply entangled in definitions of “wellness” and “healthy eating,” I will begin my definitional work there by grounding the idea of health in popular definitions and critical scholarship.

### **What is Health?**

The Oxford English Dictionary (n.d.a) defines health as “soundness of body; that condition in which its functions are duly and efficiently discharged,” a definition that

implies health means full and efficient functioning, which I interpret as pointing toward ideal able-bodiedness. Merriam-Webster, a dictionary that tends toward more U.S.-specific English usage than the OED, defines health as “the condition of being sound in mind, body, or spirit, *especially*: freedom from physical pain or disease” (n.d.), directly positioning health as the opposite of disease. When establishing its constitution in 1946, the World Health Organization (WHO) defined health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (2006, p. 1), a definition that suggests it is possible to attain a state of ideal health that is beyond simply not being ill.

Notably, these definitions predominantly skew toward a biomedical understanding of health by contrasting it with pain, disease, and infirmity. Even the WHO’s definition gestures at a biomedical model by invoking the terms “disease” and “infirmity.” A biomedical understanding of health has been cemented in U.S. public discourse by pharmaceutical companies, governmental agencies, health insurance providers, our for-profit healthcare system, and media interests (Klein, 2010). In turn, healthcare in the U.S. has become a commodity, an industry, and a representation of wealth (Klein, 2010). The U.S. has the highest global per-capita spending on healthcare (Organisation for Economic Co-operation and Development, 2020) and its healthcare system is often ranked last among wealthy countries (Schneider et al., 2021). One major issue is the large number of people without health insurance. While the ACA drastically reduced the number of uninsured Americans during its first few years in effect, that number has risen since then and, as of 2020, 30 million people were uninsured and nearly another 40 million were underinsured (Finegold et al., 2021; Schneider et al., 2021).

The ongoing COVID-19 pandemic has both highlighted and exacerbated this

issue; while job losses have led to a small rise in the uninsured, most of the people who faced unemployment early in the pandemic were people whose jobs did not provide health insurance coverage in the first place (McDermott et al., 2020). Further, marginalized populations make up a large percentage of U.S. uninsured—including those who work in frontline jobs that do not provide insurance coverage—and the uninsured and underinsured are more likely to be in a financial situation where they cannot take sick time at work, have limited access to medical care, have higher rates of chronic illness due to systemic issues, and receive poorer care from a racist medical system (Van Beusekom, 2020; Vickers, 2020). What all of this means is that, more than ever in the U.S., health is directly correlated with oppression through systems, institutions, and policies. Health really *is* wealth. In 2010, literary studies scholar Richard Klein argued “We may be nearing a point where the institutions of public health, the media, and commercial interests that surround it, and the ideological wisdom it dispenses, do more harm to the nation’s health than good” (p. 16). In April 2022 we are just over 24 months into the pandemic in the U.S. with the official COVID-19 death toll (based on deaths attributed to COVID-19 on death certificates, which is likely significantly undercounted) at just shy of 1,000,000 and climbing (National Center for Health Statistics, n.d.), a pandemic of health and vaccine mis- and disinformation, coming out of a huge surge of the Omicron BA.1 variant and bracing for a potential swell due to Omicron BA.2, and a deeply divided political landscape. In the face of all that, I would argue that we might have already reached the point Klein described. While all of this is well beyond the scope of my dissertation, the ongoing public health crisis has deeply influenced the moment in which I am thinking about and talking to people about health and wellness. Further, the pandemic is highly relevant to this section as it has both brought conversations about health,

healthcare, and insurance to the forefront in public discourse and is impacting how we think about what health *is* in ways we do not fully understand yet.

In definitions of health as the absence of disease, even when those definitions nod to multiple dimensions as Merriam-Webster's "mind, body, and spirit" (n.d.), no room is meaningfully made for other understandings. For example, drawing on Epicurean philosophy, Klein suggests definitions of health ought to acknowledge things like love and indulging in pleasure, which definitions of health typically do not include. Klein argues that a life in the best physical health but "without love, it is no life at all, only a long illness. ... conversely, there is no illness that love cannot cure or make tolerable" (Klein, 2010, p. 18). In addition, Klein says that not only is health essential to pleasure, "(that without which there is none), but pleasure improves your health. Put another way, if you inhibit the body's pleasure, you provoke disease" (2010, p. 19). However, continues Klein, due to its Puritanical roots, it is "un-American to be Epicurean," as dominant morality in the U.S. views pleasure, and indulgence in pleasure, as dangerous (2010, p. 19). Ultimately, health is complex and contextual, and is "socially, culturally, historically, and environmentally constructed" (Guthman, 2014, p. 1). Culture, in particular, has a defining role in delineating what health practices are valued and promoted (Dutta, 2008). In the U.S., this means that dominant definitions of health typically follow and fall from a biomedical model that privileges Western values by embedding them in scientific claims of fact or causality (Hite & Carter, 2019).

Modern U.S. understandings of health are deeply connected to biomedicalization, as "health becomes an individual goal, a social and moral responsibility, and a site for routine biomedical intervention" (Clarke et al., 2003, p. 171). In a neoliberal medical model, health status results from personal choices and is thus one's personal

responsibility (Derkatch & Spoel, 2017; Minich, 2016; Spoel et al., 2012).

Biomedicalization generally increases the power of biomedicine as a structure for social control, placing increasing responsibility on the individual to not only maintain but maximize their own health through the use of medical interventions (Gupta, 2020).

Biomedicine therefore positions health as a “moral obligation, a commodity, and a mark of status and self-worth” (Metzl, 2010, p. 6). In the era of biomedicalization, then, the “focus is no longer on illness, disability, and disease as matters of fate, but on health as a matter of ongoing moral self-transformation” (Clarke et al., 2003, p. 172). The pervasiveness and centrality of a biomedical model—one that is defined by the opposition of health and disease, in which maintaining and improving health is a moral obligation—in U.S. health discourse bleeds beyond the borders of the medical establishment, as demonstrated by dictionary definitions of health and, as I will demonstrate in Chapters Three and Four, the ways extra-medical institutions like the UMN EWP talk about and enact health.

Further, biopower operates in the institutional mobilization of ideas about health. Foucault (1990) described biopower as a technique used by institutions, especially medicine and workplaces in capitalist societies, to subjugate bodies and control populations. Biopower can be seen in the ways hegemonic institutions delineate health, how specific bodies maintain their health, and other conditions of social belonging (Berlant, 2007). Institutions wield disciplinary power in the shaping of subjects and the subjecting of them to cultural norms, inviting them to reshape themselves in order to conform or normalize (Foucault, 1979; Scott, 2003). The disciplined body is the docile body, malleable and usable by the institutional apparatus, and after being shaped by a near-invisible “multiplicity of minor processes,” one that makes the unconscious choice



to participate willingly in conforming to dominant capitalist norms (Foucault, 1979, p. 138). Health can be understood, then, as not only a moral imperative, but an expression of successful normativity “and people’s desires and fantasies are solicited to line up with that pleasant condition” (Berlant, 2007, p. 765).

While “what is health?” remains a rhetorical question, as it varies from person to person and culture to culture across time and space, it can be understood in mainstream dominant biomedical discourse in the U.S. to be the absence of disease, the act of striving toward an ideal state of perfection, and a mechanism through which institutional power seeks to shape bodies and workers. It is for these reasons that, earlier in this chapter in the Medical Ableism and Disability section, I pushed back against Wendell’s (2001) delineation of “healthy” and “unhealthy” disabled. If healthy means free from disease, then by implication unhealthy means diseased. Further, if health means working toward an ideal state of perfect health in the biomedical model, then anything less than perfect health is a defect to be corrected, which is an expression of medical ableism’s preference for ideal able-bodiedness.

### **What is Wellness?**

In order to address this question, the term wellness must first be placed in temporal (post-1950s) and geographic (U.S.) contexts, as they directly spawned the current institutionalized, commercialized, buzzword-ized ideas around wellness at the heart of my dissertation. While wellness is not a new term—the Oxford English Dictionary (n.d.c) traces it back to 1654—the modern idea of wellness arose in the 1950s through the work of Dr. Halbert Dunn, considered the founder of modern wellness.

In the wake of World War II, employment-based health plans became widespread through major expansions of the hospital system, the rise of private hospital insurance

plans like Blue Cross, and federal tax laws encouraging employers to offer health plans as part of their fringe benefits (Hoffman, 2012). It was in this context that, in the 1950s and early 1960s, Dr. Halbert L. Dunn,<sup>8</sup> chief of the U.S. National Office of Vital Statistics, noticed troubling statistical trends in the data his office compiled. In Dunn's view, the majority of people in the U.S. in the 1950s who were not "'sick' in the conventional sense [were] actually existing on a very low level of wellness." (Dunn, 1957, p. 226). Inspired by the WHO's 1948 constitution's definition of health as complete well-being and not merely the absence of disease, Dunn argued that a "definition of health as absence of illness is negative in character and scarcely suitable for a dynamic program to improve the levels of wellness" (Dunn, 1957, p. 225). Of particular interest to Dunn were low rates of wellness among the growing elderly population, the poor, and Black people. In essence, Dunn had identified health disparities,<sup>9</sup> though he did not call them that, and argued for an extensive, ongoing program of research into ways to improve people's wellness; in other words, modern wellness has its roots in attempts to address health disparities.

Unsurprisingly, as a trained physician, Dunn proposed a medical model of wellness, even though he suggested it should be multi-dimensional. In 1957, Dunn argued that "The great challenge at the older ages is how to keep a person fit until he dies, functioning as a dynamic unit in the population and contributing to society so that he can maintain his sense of value and dignity" (p. 229-230). Here, Dunn conflates

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<sup>8</sup> The story of wellness in many ways originates in Minnesota, as we will see. Halbert Dunn earned his B.A. in 1917, M.D. in 1922, and Ph.D. in anatomy in 1923 at the University of Minnesota. He began teaching in the Department of Anatomy as early as 1923 and by 1935 he served as Director University of Minnesota Hospitals and Professor of Medical Statistics. He then served as the Chief of the U.S. National Office of Vital Statistics from 1935-1960.

<sup>9</sup> Interestingly, this included some identification of social determinants of health and racism in the medical system, though it also included racist ideas about supposed biological health differences inherent in Black people that were more commonly accepted (though, of course, still wrong) during segregation.

wellness with both productivity and morality, something also seen in neoliberal definitions of health. By 1961, he was pushing back against the idea of illness and wellness as a binary, arguing that “well-being must consist of more than a simple state of ‘unsickness,’ as it were. There must be degrees in well-being” (p. 2). Dunn laid out a definition of high-level wellness:

High-Level wellness for the individual is defined as an integrated method of functioning which is oriented toward maximizing the potential of which the individual is capable. It requires that the individual maintain a continuum of balance and purposeful direction within the environment where he is functioning. (1961, p. 4-5)

He went on to ask why the medical establishment focused so tightly on disease and disability, pondering whether medical training oriented practitioners toward disease rather than positive wellness, noting that “it’s easier to fight *against* sickness than to fight *for* a condition of greater wellness” (Dunn, 1961, p. 3).

Dunn’s work went seemingly unnoticed by the medical profession and the government agencies he considered his audience. About a decade later, Dr. John W. Travis picked up a copy of Dunn’s book, *High-level Wellness*, from a bookstore clearance table at Johns Hopkins Medical School, where he was completing a residency in preventive medicine (Zimmer, 2010). By 1975, Travis had developed the Wellness Inventory (Travis, 1975), now in its fourth edition and still used in research studies (e.g., refer to Lothes & Nanney, 2020; Mayol et al., 2017). Notably, in the Wellness Inventory, Travis laid out a continuum with premature death on one end, and high-level wellness on the other, arguing that while medicine typically focused on returning an individual to the neutral point in the middle, a focus on wellness requires a dynamic process of moving

along the continuum toward an optimal state. Travis opened the Wellness Resource Center in Mill Valley, California, in 1975, which gained national attention through Donald Ardell's<sup>10</sup> 1976 profile of the center in *Prevention* magazine (Zimmer, 2010). By 1977, Travis and Ardell had started the National Wellness Conference at Stevens Point, Wisconsin, in collaboration with physicians at University of Wisconsin-Stevens Point, an annual meeting that continues today under the auspices of the National Wellness Institute (National Wellness Institute, 2018).

As I discuss in more depth in the next section (Background and Importance of EWP), EWPs became widespread in the early 1980s, growing directly out of the ideas of Dunn, Travis, and Ardell. Similarly, the field of health promotion found its roots in wellness, with the inaugural issue of the *American Journal of Health Promotion* opening with a definitional article drawing directly on Travis' wellness continuum (O'Donnell, 1986). The modern wellness (and health promotion) movement proliferated. Today, the National Wellness Institute promotes a holistic model that includes six dimensions of wellness—emotional, occupational, physical, social, intellectual, and spiritual—and argues that:

- Wellness is a conscious, self-directed and evolving process of achieving full potential
- Wellness is multidimensional and holistic, encompassing lifestyle, mental and spiritual well-being, and the environment
- Wellness is positive and affirming (National Wellness Institute, n.d.b)

While wellness and illness were described as a continuum by Travis (1975) and

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<sup>10</sup> Ardell was the first director of the Metropolitan Health Board in St. Paul, Minnesota, from 1970-1972. Ardell also published a popular book about wellness titled *High Level Wellness* in 1977, expanding on Dunn's ideas, and forever confusing people searching for books titled *High Level Wellness*.

Ardell (1977), the idea of a continuum still often gets operationalized by many people as a dichotomy (illness/wellness) or at best, a three-point scale (illness, borderline, and wellness). Either wellness and illness are polar opposites, replicating the medical definition of health as contrasted with disease, or wellness is a scale focused on quantification of health where ill is at ‘0’ and well is at ‘100.’ Colleen Derkatch argues that “in this impulse to quantify wellness, there are traces of biomedical emphases on numeracy and measurement that sit at odds with the principles of holism and balance central to most understandings of wellness” (2018, p. 144). The continuum/scale model relies on cycling between two logics: that of restoration, or remedying illness and risk for illness, and that of enhancement, or striving to optimize our bodies and health (Derkatch, 2018). The idea of constant striving is central to the continuum/scale model of wellness; wellness is a moving target as the means of enhancement are constantly evolving in a capitalist society where health and medicine are heavily commercialized and commodified through the supplement and natural remedy industry (Derkatch, 2018), evolving technologies (Elliott, 2003), and, I argue, the proliferation of EWPs. In other words, we can always keep working on being “better than well” because there is always something more or something new we could be doing for our health (Elliott, 2003).

Further, the pervasiveness of wellness discourse reinforces the neoliberal biomedical model that positions people as responsible for their health status, their health status as reflective of their values and moral worth, and working toward an ideal healthy and able body as compulsory. The positioning of wellness as opposed to illness reinforces ableist ideas about bodies because it positions the ideal able body as opposed to any body less-than-well, including not just those with acute, passing disease but those with chronic illness and disability. In this way, the term wellness does rhetorical work in the world by

definitionally foreclosing the possibility that people with chronic illness or disease can ever achieve wellness.

### **What is Healthy Eating?**

To consider this question, I will begin by considering who gets to decide how healthy eating is delineated. While there may be as many answers to the question “What is healthy eating?” as there are people in the world, critical food studies scholars have demonstrated the pervasiveness of a hegemonic nutrition model (Hayes-Conroy & Hayes-Conroy, 2013). Hegemonic nutrition relies on the idea that the food-body relationship can be standardized and quantified (a calorie is a calorie to everyone) (Mudry, 2009), reductively views food as a conglomeration of nutrients and their specific roles in the body (Scrinis, 2013), decontextualizes food from culture, bodies, and the environment, and privileges expert knowledge which is disseminated through biomedicine, the media, the diet industry, and social institutions (Hayes-Conroy & Hayes-Conroy, 2013). The last point is key here: hegemonic nutrition permeates what Goodnight (2012) calls the technical, public, and personal spheres fully. The primary answer to who gets to decide how healthy eating is delineated is: the organizations behind hegemonic nutrition ideals. Because hegemonic nutrition models have such extensive reach in discourse about food (Biltekoff, 2013; Biltekoff et al., 2014; Mudry, 2009; Scrinis, 2013), I begin with definitions of healthy eating advanced by the WHO and the U.S. government via the USDA DGA.

The WHO (2020) fact sheet on a healthy diet starts with “Key Facts,” including:

- A healthy diet helps to protect against malnutrition in all its forms, as well as noncommunicable diseases (NCDs), including such as diabetes, heart disease, stroke and cancer.

- Unhealthy diet and lack of physical activity are leading global risks to health.
- Energy intake (calories) should be in balance with energy expenditure. (para. 1)

The WHO (2020) goes on to delineate a healthy diet as “Fruit, vegetables, legumes (e.g., lentils and beans), nuts and whole grains (e.g., unprocessed maize, millet, oats, wheat and brown rice)” including “at least 400 g of fruit and vegetables per day, excluding ... starchy roots” and provides limits for added sugars, fats (especially trans-fats), and salt (para. 4). The focus on specific nutrients and quantified portions is an expression of hegemonic nutrition, though the WHO’s version is less specific than the USDA’s, possibly due to its global audience.

The USDA’s *Dietary Guidelines for Americans, 2020-2025*, published in December of 2020, opens with a new call to action—“Make Every Bite Count with the *Dietary Guidelines*”—that charges Americans with focusing on “meeting food group needs with nutrient-dense foods and beverages, staying within calorie limits” (p. ix). The guidelines begin with the argument that:

The foods and beverages that people consume have a profound impact on their health. The scientific connection between food and health has been well documented for many decades, with substantial and increasingly robust evidence showing that a healthy lifestyle—including following a healthy dietary pattern—can help people achieve and maintain good health and reduce the risk of chronic diseases throughout all stages of the lifespan (2020, p. 3)

The first section of the report, called “Setting the Stage,” presents a litany of facts: how the DGA is grounded in scientific studies, how adherence to the DGA has remained low over the last 15 years while “concurrently, it has become increasingly clear that diet-

related chronic diseases, such as cardiovascular disease, type 2 diabetes, obesity, liver disease, some types of cancer, and dental caries, pose a major public health problem for Americans” (U.S. Department of Agriculture and U.S. Department of Health and Human Services, 2020, p. 4). The claim about links to diet-related chronic diseases is accompanied by an extensive chart listing statistics for overweight and obesity alongside many of the listed diseases, all before finally getting to the MyPlate model and specific nutritional guidance.

Overall, the DGA retains the same hegemonic nutrition model it has promoted for years, embedded within a “science-based” biomedical argument about health risks and disease that has been critiqued as biased toward White, western ideas about food and health (Biltekoff et al., 2014; Hite & Carter, 2019) and rooted more in social and political pressure than scientific evidence (Hite & Carter, 2019). The DGA argues that a “fundamental premise of the [DGA] is that everyone, no matter their age, race, or ethnicity, economic circumstances, or health status, can benefit from shifting food and beverage choices to better support healthy dietary patterns” (U.S. Department of Agriculture and U.S. Department of Health and Human Services, 2020, p. 3). In this way, the DGA sets healthy eating up not only as a quantified, nutritionist way of viewing food, it mirrors ideas about enhancement and optimization in wellness discourse. I interpret the DGA’s statement above that “everyone ... can benefit from shifting their food and beverage choices” as arguing that, no matter how you eat now, you could be eating *better*. While in this most recent edition, the DGA has increased acknowledgement that food choices should reflect “personal preferences, cultural traditions, and budgetary considerations” (U.S. Department of Agriculture and U.S. Department of Health and Human Services, 2020, p. ix), it goes on to prescribe things like limiting refined grains,



including white rice which is a staple of many global food cultures, though it notes that shifting from white to brown rice “where culturally appropriate” (p. 32) can increase whole-grain intakes. It is not clear if these small hedges within the 149-page report are taken up in the implementation of the DGA, or if they are lost when translated to more bite-sized public guidance through things like infographics and the DGA’s own “Top 10 Things You Need To Know” webpage (though it is certainly missing in the latter) (U.S. Department of Agriculture and U.S. Department of Health and Human Services, n.d.).

Additionally, the DGA not only makes strong claims about science-based links between eating and chronic disease, it promotes the dietary guidelines as part of treatment plans, stating that while it “is not intended to contain clinical guidelines” it is “essential that Federal agencies, medical organizations, and health professionals adapt the Dietary Guidelines to meet the specific needs of their patients as part of an individual, multifaceted treatment plan for the specific chronic disease” (U.S. Department of Agriculture and U.S. Department of Health and Human Services, 2020, p. viii). Medical interventions are fraught as they are both normative but also possibly ameliorative (Gupta, 2020), and the idea of food as part of medical treatment is similar. Food has been viewed as a key element in health and wellness since ancient times, and certainly nutrition has links to diseases like scurvy, yet the links between food and diseases framed by biomedicine as weight-related (e.g., type 2 diabetes, cardiovascular disease) are not as straightforward, and are certainly not strong enough to be considered directly causal (Brown, 2015; Biltekoff, 2013; Guthman, 2011; Mudry, 2009). Yet, the idea of diet as the driver of weight and deeply connected to disease positions diet as a key part of medical care, an idea which is taken up in UMN EWP discourse as I will discuss in my analysis.

Ultimately, not only is healthy eating something that raises questions about access

and disparities, it is also mobilized in neoliberal ideas of individual responsibility. If people simply understood what healthy eating meant (according to the DGA), they would improve their eating habits and be healthier; the reverse of this is that people who are fat or have health issues linked to weight are seen as having a lack of control, making poor choices, or having poor morals (Biltekoff, 2013; Derkatch & Spoel, 2017; Guthman, 2011; Hite & Carter, 2019). The idea of self-improvement through hegemonic ideas of healthy eating is one that has been used to devalue, other, and “regulate disabled, immigrant, gendered and nonwhite bodies throughout U.S. history” (Gerber, 2020, p. 3). In this way, even something that might seem innocuous like ‘healthy eating’ can be mobilized through medical ableism to mark and judge bodies deemed to be non-ideal, which in diet culture and through biomedical assessments like BMI means fat bodies. The ideal body is both thin and able-bodied, and fat bodies are seen as non-ideal due to risky behavior like ‘unhealthy’ eating and association with obesity and, by extension, chronic illness and disability.

### **Health, Wellness, Healthy Eating, and Medical Ableism**

In this section, I tackled questions around health, wellness, and healthy eating that I framed as rhetorical, or questions I raise in order to surface their rhetoricity. Drawing on various definitions and literature, I tried to sketch some foundational ideas around the various meanings of these terms within the scope of this dissertation. One thing I aim to foreground is how threads of ableism weave throughout: a medical deficit model positions the ideal body as able-bodied; wellness discourse builds on this through discourse around constant striving toward ideal able-bodiedness; and healthy eating discourse replicates medical ableism through promotion of the thin body as ideal and the fat body as deviant or deficient. In the next section, I present more details on the

background and importance of employee wellness programs and provide a brief overview of the origins of the UMN EWP.

### **Background and Importance of Employee Wellness Programs**

EWPs are a rich site for studying the intersection of food, technology, institutional power, and medical ableism for three reasons: EWPs are widespread, potentially reaching vast numbers of American adults; EWPs commonly include eating-related programming options; and EWPs are closely linked to the medical industry through their promotion in the 2010 ACA (Kirkland, 2014a). Lastly, as institutional programs tied tightly to financial incentives and health insurance coverage, EWPs provide a good context for examining institutional power and the construction of “healthy bodies” and “healthy eating,” and what those constructions mean for bodies that are excluded, marginalized, or otherwise made unable to participate in the pursuit of wellness.

The wellness movement emerged out of U.S. public health efforts in the late 1950s aimed at holistically improving the borderline-healthy individual rather than medically healing the unhealthy one (Dunn, 1961). While these efforts failed to gain traction within governmental agencies, they were taken up in the private sector and rapidly spread across the U.S., spawning Wellness Centers, the National Wellness Institute, wellness conferences, and EWPs (Zimmer, 2010). Newspapers reported workplace fitness programs springing up nationwide at major corporations like Pepsico and Xerox, and in Minnesota’s Twin Cities, at General Mills, Pillsbury, and 3M (Budd, 1979; Kern, 1978). By the early 1980s, wellness was firmly established in American culture, particularly via EWPs, with news reports counting the number of programs in the thousands and growing (Chase, 1981). Early EWPs regularly focused on promoting healthy eating, exercise, and smoking cessation (Cohn, 1980; “New Health Plans,” 1981;

Reardon, 1998). In addition to the benefits noted for employees, news reports and research in the early 1980s pointed to the economic benefits of reduced medical service needs associated with healthier lifestyles (Chase, 1981; “Hospitals,” 1980; “New Health Plans,” 1981; Sperry, 1984). Nearly four decades later, EWP have become omnipresent, typically include eating-related programming, and are tightly tied to the healthcare and health insurance industries through the ACA.

In the U.S., by the late 2010s over 50% of small employers, over 80% of large employers, and at least a dozen universities offered some kind of EWP (Cederström & Spicer, 2015; Song & Baicker, 2019). More than half of employers offer incentives for employees to participate, as incentives have been shown to effectively increase participation to some extent (Anderson et al., 2011; Hudson & Pollitz, 2017; Madison et al., 2011). In its annual survey of employer health benefits, the Kaiser Family Foundation (KFF) (2019) found that 57% of employers offer health benefits to at least some employees, including virtually all employers with more than 1,000 employees. While most employers are smaller, 90% of workers in 2019 were employed by a company that offered health benefits to at least some workers, and overall about 61% of all workers receive employer-offered health benefits (Kaiser Family Foundation, 2019). Of employers who offer health benefits, 84% offer EWPs, 65% include a health risk assessment, and 52% offer biometric screenings. Most employers offer incentives of varying types to employees for participating in their EWP and completing health risk assessments and biometric screenings; some also incentivize meeting specific biometric measures, for example BMI or cholesterol level (Kaiser Family Foundation, 2019). In terms of technology incorporation, the Kaiser Family Foundation survey (2019) found that 30% of employers with 5,000 or more employees collect data from employees’

mobile apps and/or wearable devices like smartwatches as part of the EWP. This proliferation of EWPs means millions of U.S. adults are exposed to employer-driven health and wellness programming, and many of them experience employers collecting health data like BMI, exercise, and diet. In essence, “workplace wellness is the currently dominant variation of wellness in the United States, simultaneously more narrow and more powerful than its more holistic predecessors because of its tightened connection to economic interests” (Kirkland, 2014b, p. 958).

Most EWPs include components aimed at changing individual exercise and diet habits, tobacco use, and disease management behaviors (Cederström & Spicer, 2015; Kirkland, 2014b; Nyman et al., 2009; Reardon, 1998; Song & Baicker, 2019). In its 2019 survey of employers, the Kaiser Family Foundation found that 60% of employers with 200 or more employees offered some form of weight-loss programming. In a review I conducted of the public websites of all Big Ten universities other than UMN, I found that 11 of the 13 provide formal EWPs. Of those, all 11 included some eating-related programming, and four included the use of mobile digital tracking technologies. Three included WW (formerly Weight Watchers) as a specific eating-related programming option.

Behaviors around exercise, eating, tobacco use, and disease management are often framed by societies and institutions as individual lifestyle habits (Biltekoff, 2013; Brown, 2015; Lupton, 2013; Mol, 2013). In turn, public health and epidemiology research frame these “modifiable lifestyle risks” as directly connected to risk for certain diseases, and thus rising health care costs (Nyman et al., 2009, p. 54). Because EWPs are typically tied to employee health insurance costs, EWPs utilize this risk-based framework as part of reducing employee medical expenses by reducing health risks and improving disease

management (Reardon, 1998; Sperry, 1984). For example, the inclusion of programming aimed at changing individual eating habits is built on the idea of weight as a health risk (Cederström & Spicer, 2015). While EWPs had been utilizing this framework prior to its passage, the 2010 ACA helped cement this relationship by explicitly tying EWPs to employer-provided health insurance coverage.

The ACA established grants and programs for technical assistance to help employers set up EWPs, increased the incentives employers were allowed to provide for participation, and in essence circumvented nondiscrimination provisions in the Health Insurance Portability and Accountability Act (HIPAA) and the Americans with Disabilities Act (ADA) (Basas, 2014; Hudson & Pollitz, 2017; Kirkland, 2014a, 2014b). HIPAA prohibits employers from discriminating in their employee health insurance plans on the basis of health status and ADA prevents discrimination based on disability or perceived disability, but the ACA allows incentivized, health-contingent EWPs; in other words, while employees cannot be fired or denied health benefits based on their health status, under the ACA, employers can offer health insurance premium reductions based on meeting specific biometric markers. Further, ACA does not set standards for EWPs nor require that an EWP collect, analyze, or report data on its efficacy in improving employee health (Hudson & Pollitz, 2017); this means that essentially, through EWPs, employers are allowed to offer health-contingent healthcare coverage to employees without external oversight (Hudson & Pollitz, 2017). Yet, participation in EWPs can be difficult for disabled and chronically ill people who might not be able to meet one-size-fits-all benchmarks for physical fitness. Thus, these plans privilege a certain type of body, allowing EWPs to perpetuate discriminatory ideas about disability and disabled people (Basas, 2014).

Despite their proliferation, evidence of EWP program effects on health and economic outcomes is limited. Studies of EWP efficacy typically focus on financial outcomes for employers, with more limited examination of efforts to promote participation or on actual employee health impacts. Financial outcomes generally focus on return-on-investment (ROI) measures for EWP expenditures and cost reductions related to reduced absenteeism and increased employee productivity; ROI is seen as the “gold standard for evaluating [EWP] outcomes” (Mukhopadhyay & Wendel, 2013, p. 174). While some studies have demonstrated positive ROI (Baicker et al., 2010; or notably Nyman et al.’s 2009 evaluation of the UMN EWP’s ROI), others have found no reliable impact on financial outcomes (Pereira et al., 2015; Song & Baicker, 2019). In terms of health outcomes, while some studies have found positive health improvements (Merrill et al., 2011), others have found no reliable impact on health outcomes (Song & Baicker, 2019). One empirical study found that individuals who already had lower medical spending and healthier behaviors, and who were in the upper quartiles of the income distribution, tended to self-select into EWPs, suggesting a possible inherent bias in much EWP research relying on existing programs and employee groups who have chosen to participate (Jones et al., 2019). The inconclusiveness of research on EWP efficacy helps drive some critical examination of EWPs. As Anna Kirkland, editor of a special issue of the *Journal of Health Politics, Policy, and Law* on wellness, argues, EWPs “may well be worth criticizing even if they reduce health care costs” (2014a, p. 974). EWPs may place too much emphasis on individual responsibility and on mainstream contemporary Western health practices; they may contribute to discrimination in the workplace, especially in the case of fatness; and they may counter efforts to increase and embrace diversity (Basas, 2014; Kirkland, 2014a). Notably, EWPs

utilizing outcomes-based financial incentives may unfairly discriminate against employees in marginalized groups with higher prevalence of certain medical conditions (Henke et al., 2015).

The story of the UMN EWP begins with the emerging wellness movement and the concomitant spread of EWPs at corporations nationwide. By fall of 1981, campus news stories reported that employees were clamoring for an EWP (Sawchyn, 1981), yet it would not be until 2003 that a wellness program would be formally established at the UMN. The nascent UMN EWP only included a single organized Health Walk—a two-mile route that ended at a wellness fair with information from campus health organizations and a free flu shot (Moore, 2003). In 2012, the EWP shifted to a points-based system wherein employees could accumulate points by completing activities in order to earn a reduction in their health insurance premium for the following year (Benefits Advisory Committee, 2011b<sup>11</sup>). By 2018, the UMN EWP offered about thirty options for earning points from a menu that included: Wellness Assessment (100 points); biometric health screening (150 points); health coaching (4 individual or 7-8 group sessions for 250 points); medication therapy management (3 sessions for 150 points); bike commuting (2 points per ride, minimum 25 rides); mindfulness/meditation classes (13 sessions for 150 points); yoga or Pilates (13 sessions for 150 points); financial literacy classes (4 sessions for 150 points); pledges (to remain tobacco-free, to get a flu shot, to complete an advanced care directive - 25 points each); healthy cooking classes (6 sessions for 150 points); gym membership reimbursement (at least eight visits per month for six months - 150 points); and participation in Weight Watchers at Work (14 sessions in 4 months - 200 points) (University of Minnesota, 2018b).

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<sup>11</sup> Hereafter cited as (BAC, year).



As noted earlier, of particular focus in this study is the evolution of eating-related programming in the UMN EWP. The EWP began an on-campus farmers market centered on healthy local foods in 2005, incorporated telephone-based dietary health coaching in 2006, and began including reimbursement for employee-paid weight management programs (e.g., Weight Watchers at Work) in 2010 (BAC, 2005; 2006c; 2009). In late 2019, after eight years of inclusion, the EWP decided to drop Weight Watchers as a part of the wellness program, stating on its website that it would be researching different programs for the future that are “more nutrition-focused rather than centered on weight loss” (University of Minnesota, 2019a).

While my investigation of one site (UMN) is not generalizable to other EWPs broadly, that is not my goal. I aim to interrogate the intersection of eating habits, institutionalized wellness, and medical ableism broadly, using the UMN EWP as a site of study. The UMN EWP allows me to investigate how employee wellness is built on ableist foundations, how institutional wellness programs wield power in perpetuating dominant biomedical norms around eating habits, body size, and able-bodiedness, and how EWP discourse and practice impacts employees’ lived experience with food and wellness. Thus, in this dissertation, I employ an interdisciplinary lens, anchored in rhetoric and drawing from disability studies and TPC, to examine wellness programs as part of the social and economic fabric of the workplace. In other words, my research does not examine the efficacy of the UMN EWP, but rather the ways it deploys discourse and implements programming and the driving forces behind these choices.

### **Conclusion: Chapter Overview**

My overarching argument throughout this dissertation is that while the UMN EWP talks about holistic wellness, it both arose out of an ableist, racist, classist medical

model and replicates those systemic oppressions through its programming. Further, while employees generally enact wellness in ways that fit their bodies, values, cultures, and desires, they find a dissatisfying mismatch between their version of wellness and EWP's medical model; the medical model interpellates employees as already always patients (or pre/patients) through the rhetorical enactment of bodies as in need of surveillance and intervention as a way to avoid disease and disability. I build these arguments on the theoretical perspectives explicated in this chapter, using methodology and methods described in Chapter Two, and drawing from my three datasets (archival materials, survey, interviews) across four analysis chapters (Three through Six). The rest of the chapters are laid out as follows:

Chapter Two provides a detailed explanation of my methodology, including discussion of the importance of stories and how I use UX, praxiography, and modified grounded theory as method/ologies for data collection and analysis. It details my three-phase study design—textual analysis of archival documents, a large-scale survey of employees, and follow-up in-depth narrative inquiry interviews—and includes details about my data collection and analysis.

Chapter Three presents my kairology (or rhetorical history) of the UMN EWP, tracing the history of the EWP in the context of the larger wellness movement in the U.S.

Chapter Four presents my thematic analysis of archival materials. It begins by returning to the Rhetorical Questions I posed earlier in this chapter, drawing in findings from my textual analyses to elucidate how the UMN EWP frames health, wellness, and healthy eating. Chapter Four then delineates how the UMN EWP enacts practices around food and wellness, advancing the argument that the UMN EWP both arose out of overarching ableist, racist, classist systems and replicates those systemic oppressions in

its programming.

Chapter Five presents thematic analysis of participant data from my survey and interviews. It begins by returning again to the Rhetorical Questions, presenting findings from my participant data analysis to demonstrate how employees frame what health, wellness, and healthy eating mean. Chapter Five then discusses employees' enactments of health and wellness and explores how people are enacting wellness in ways that may not necessarily fit with the EWP, but that fit their bodies, values, desires, cultures, communities, and ideas about wellness.

Chapter Six presents the argument that the EWP links neoliberal health citizenship to the idea of being a good employee and interpellates people as always-already pre/patients through surveillance and intervention. Then, based on analysis of EWP and employee practices in Chapters Four and Five, Chapter Six presents what I call Irreconcilable Differences, or key fundamental mismatches between how the EWP and employees enact food and wellness. Lastly, Chapter Six discusses employee resistance to the EWP as an opposing strategy or form of power, rather than just an issue of EWP non-use or poor UX.

Lastly, in Chapter Seven, I conclude by considering my research questions and presenting a summary of findings and conclusions. I also suggest some implications of and future considerations for research on EWPs, and briefly consider what a better model of employee wellness might be like.

## **Chapter Two:**

### **Methodology, Study Design, and Research Methods**

In this chapter, I detail my overarching methodology and my three-phase mixed methods design for data collection and analysis. My project embraces what Scott and Melonçon call “‘methodological mutability’ ... [or] new forms of mixed methodologies” (2018, p. 5) in order to examine EWPs at “multiple scales of context (e.g., historical, cultural, institutional, local, interpersonal)” (2018, p. 6) by including historical research, qualitative textual analysis, a large-scale survey, and in-depth interviews. Context is crucial, as outlined in Chapter One, in UX as well as in rhetoric. As Jenell Johnson says, rhetoric “can be observed in the material effects and virtual traces of images, symbols, tropes, and narratives, which are best understood within the social, cultural, ideological, and political environments in which they develop meaning and in which those meanings are received, interpreted, and contested” (2017, p. 13). Following this, for the whole of my dissertation study, wellness can best be understood and observed within the social, political, and cultural contexts of the UMN EWP where it has been invoked and enacted across time and space.

#### **Methodology: Stories and Experiences**

In Chapter One, I noted that RHM scholars have recently pushed for the field to attend more to embodied lived experience, but that rhetorical theory alone may be inadequate for capturing and analyzing lived experience. Additionally, what counts as lived experience varies among scholars taking it up, and frequently the term is invoked without being well defined, making “lived experience” a slippery term. To situate lived experience at the center of this project, in this section I outline: why stories are an

important part of my work; how UX methodology helps me to center users and their stories; how I used praxiography as a methodology for attuning myself to practices within those stories; and how, together, UX and praxiography facilitated my focus on the impacts of EWP discourse and practice on employees' lived experience.

## **Stories**

Stories are everywhere. While many disciplines engage stories and have taken different approaches to stories in research, I draw primarily on the work of technical communicators and rhetoricians in framing why stories are an important part of my work, and in defining stories very broadly. In their introduction to a special issue of *Technical Communication* on storytelling, Kyle Vealey and Jeffrey Gerding (2021) argue that:

Stories bring cause and effect together into a cohesive event, thus helping us make sense of and impose—even just temporarily—a sense of stability to an uncertain world. Through stories, we are also able to articulate the complexity of firsthand experience into knowledge that is social, shareable, and lasting. That is, storytelling helps us communicate complex ideas to one another, particularly in ways that increase not only comprehension but also engagement, curiosity, and even excitement. ... stories are arguably one of the most effective ways of communicating complex technical and scientific information. (p. 1)

Additionally, Nancy Small (2017) explained that “stories and storytelling are a rich means of understanding the workplace and its communication products and processes. Story can allow us to analyze organizational identity, organizational discourse, and the persuasive role of shared narratives” (p. 235). In other words, stories can be a powerful entry into understanding material-discursive workplace practices.

Centering stories is also a way of amplifying the voices and lived experience of

research participants, especially those who are marginalized or oppressed (Jones, 2016a). Drawing on narrative inquiry scholarship from other disciplines alongside feminist and technical communication theory, Natasha Jones (2016a) argues that stories as a methodological tool can be used to locate lived experience, “providing researchers with rich data that has the ability to call into question existing knowledge, voices, silence, and perceptions” (p. 479-480). Further, Jones and Walton (2018) contend that “stories are relational, taking into account a number of actors, perspectives, time periods, and ethical views ... [and this makes] them well suited to not only conveying complex contexts but to understanding those contexts” (p. 255). Stories can reproduce and reify dominant aspects of identity and normative ideologies, or can resist or disrupt them (Jones & Walton, 2018). Storytelling and social justice are closely connected in TPC (Jones & Walton, 2018). Moore et al. (2021) draw on Black Feminist Theory and its focus on stories, activism, and lived experience, explaining that “Black Feminist Theory ... encourages an epistemological shift away from the empirical and imperial logics that dominate TPC and towards an embrace of lived experience and stories as legitimate and valuable sources of knowledge” (p. 11). Centering stories is a move toward socially just research.

In addition to being excellent vehicles for communicating and understanding complex information and contexts, stories can be understood as sites of and entities participating in meaning-making. Like Kessler (2022), I am “interested in what stories do in the world,” and thus work to “approach stories as rhetorical objects or entities that participate in meaning-making and are entangled with contexts, practices, time, space, culture, matter, and power” (p. 30). In Kessler’s (2022) work, stories are “defined less by features” (e.g., genre, stylistic categories, characters, plot) “and more by the work they

do” (p. 34). Kessler (2022) explains that

treating stories as rhetorical objects allows flexibility in the boundaries and features that define a story, and in turn, orients me toward the events and experiences shared by storytellers through their stories. Experiences and meaning-making drive the boundaries of a given story, and depending on the experience(s) shared, and the meaning made from that experience, stories can take many shapes, include diverse elements, and vary in length and scope. (p. 34)

Following Kessler, I focus on stories as a site for capturing and understanding lived experience and how that lived experience makes meaning. Despite not defining stories by their features, they must still be defined in some way for the context of my research.

Early in what Small (2017) calls the “narrative turn” in TPC, stories were defined as natural narratives and required “these primary traits: The telling of a series of events happening over time, the inclusion of characters or agents, and the use of either direct or implied commentary to reveal a central message or point” (p. 236). More recently, however, TPC scholars have complicated what counts as a story. Drawing on the work of David Boje (2001, 2008), Small (2017) suggests that differentiating between story and narrative is productive in terms of answering what counts as a story. As Boje (2001) describes: “Story is an account of incidents or events, but narrative comes after and adds ‘plot’ and ‘coherence’ to the story line ... Story is an ‘ante’ state of affairs existing previously to narrative” (p. 1). Importantly, “Antenarrative is the fragmented, non-linear, incoherent, collective, unplotted and pre-narrative speculation ... [and] non-linear, almost living storytelling ... is fragmented, polyphonic (many voiced) and collectively produced” (Boje, 2001, p. 1). Antenarrative “foregrounds the messiness of lived experience” (Small, 2017, p. 239) and resists the ways that narrative constrains what

counts as story. Further, “the dialectic positioning in antenarrative methodology—tacking in to story and tacking out to narrative—is a form of *praxis*” for questioning or resisting the dominant narrative (Small, 2017; for example refer to Jones et al., 2016). In Small’s (2017) proposed antenarrative methodology, then, stories can take many forms because specific features (like telling a series of events over time or the inclusion of characters or plot) are not required for *stories*, though they would apply to *narratives*. Antenarrative analysis can therefore be structured in order to allow for breaking data into chunks (or not), using various coding structures and number of coding passes, and incorporating multimodality such as “ethnographic observations, personal photographs and videos, online news texts and images, interview audio clips, blog entries, discussion forums, ... [and ]snippets from interview transcripts” (Small, 2017, p. 243).

Therefore, pulling together the work of TPC scholars and rhetoricians, I define stories broadly, varying in length and scope, and including both narratives and antenarratives. The central defining feature for me is meaning-making and some aspect of material-discursive practice (which I will discuss in more depth in the next subsection). In this dissertation, then, stories appear in the form of meeting minutes, survey responses, and interviews. Some take place in a discrete moment, while others flow back and forth through time as participants work to connect events and practices in ways that are meaningful to them. In all cases, I work to identify aspects of meaning-making and lived experience, and to center stories throughout my data collection and the practices within those stories in my analyses. In her ethnographic research, Mol argued that “we can listen to [a participant] as if he were *his own ethnographer*. Not an ethnographer of feelings, meanings, or perspectives. But someone who tells how living with an impaired body is done in practice” (p. 15, emphasis original). Therefore, “the stories people tell do not just



present grids of meaning. They also convey a lot about legs, shopping trolleys, or staircases. ... [A story] tells about events they have lived through.” (Mol, 2002, p. 15). For me, stories are vehicles for communicating and understanding complex information, making meaning, and recounting practices and lived experience. And, importantly, as seen in the preface (*Amuse-Bouche*) to this dissertation and in the upcoming interludes (*Entremets*) between chapters, I work to honor my participants as Kessler does: “as present and active agents throughout my research and write-up, rather than as passive data points made invisible in the name of objectivity or rigor” (Kessler, 2022, p. 14). Thus, stories are my means of getting at lived experience.

Additionally, I see stories as both a critical aspect of my data collection and analysis as well as my presentation of results and discussion of findings. As noted in Chapter One, my project takes up Jones et al.’s (2016) call to resist ableism historically perpetuated by technical communication widely, if not inadvertently. In their 2016 article, Jones et al. present an antenarrative of technical communication, arguing that “the [dominant] narrative should be reframed to make visible competing (i.e., a collection of nondominant) narratives ... an antenarrative” (p. 212). Antenarrative can therefore be used as a methodology for embracing social justice. In many ways, the UMN EWP reproduces dominant biomedical narratives about what it is to be healthy and eat healthy, which I discuss in depth in my upcoming analysis chapters. By centering people’s lived experience, I aim to make visible diverse and nondominant narratives about health, wellness, and food. In this way, my dissertation takes up antenarrative as a methodology for presenting my results and discussion of findings. Approaching data collection, analysis, and discussion here as antenarrative helps me to “open up a space that invites reinterpretation of the past so as to suggest—and enable—different possibilities for the

future” (Jones et al., 2016, p. 212). Approaching my work as an *antenarrative*, therefore, helps me think about how the UMN EWP facilitates and restricts access to wellness and how we might do employee wellness better, something I will return to in my conclusion in Chapter Seven. Next, however, in order to methodologically frame *experience* and develop methods for capturing participant stories, I turn to user experience (UX).

### **User Experience**

As discussed in Chapter One, UX scholarship in technical communication provides a lens for holistically understanding the complex and subjective interactions between user, system, and context. UX has long been tied to storytelling through methods for capturing user stories (Barnum, 2020; Quesenbery & Brooks, 2010). Recent approaches in UX provide methodological frameworks through the use of phenomenological strategies such as in-depth interviews and storytelling to elicit how meaning-making happens in complex ecosystems of activity (Christiansen & Howard, 2017; Melonçon, 2017; Potts & Salvo, 2017; Vealey & Gerding, 2021). UX in technical communication is particularly well situated as a methodology for capturing stories while working toward social justice due to its focus on centering marginalized users and user stories (Rose, 2016; Rose et al., 2018). UX researchers have located and captured user stories in a variety of places, from online product reviews (Welhausen & Bivens, 2021) to surveys (Brumberger & Lauer, 2020) to interviews (Jones, 2016a). In this project, I draw from UX scholarship in order to inform my methods for capturing my participants’ stories through a large-scale survey and in-depth narrative inquiry interviews, while staying attuned to issues of marginalization and oppression. In particular, I aim to center user voices through their own words—like the long quotes seen in my preface (*Amuse-Bouche*)—in order to avoid generalizing experience and losing sight of the individual

voices and lived experiences. Overall, UX in TPC scholarship provides me with methods for capturing user experience. In order to analyze the experiences I captured, I turned to praxiography and modified grounded theory.

### **Praxiography**

In this project, I studied lived experience by foregrounding practices, or the ways in which meaning is *enacted* in contexts and situations (Mol, 2002), following other rhetoricians of health and medicine who have employed anthropologist Annemarie Mol's multiple ontologies theory and praxiography method (ethnography of practices) (Graham, 2015; Kessler, 2020b, 2022; Molloy, 2015; Pender, 2018; Teston et al., 2014). Some scholars argue that lived experience should be observed phenomenologically via ethnographic methods (Melonçon, 2018; Mol, 2002), but others demonstrate that it is possible to capture lived experience through textual analyses and interview methods (Johnson, 2017; Jones, 2016a; Kessler, 2022; Koerber, 2013; Pender, 2018). My stance is in line with the latter scholarship; I believe lived experience can be captured through textual analyses and interview methods if they are framed methodologically around lived experience. Kessler (2022) explains in her study of stigma and gastrointestinal conditions that through "a praxiography of stories" we are "able to discern many rhetorical processes and practices that enact ... conditions in meaningful and complex ways" and further, "through the experiences shared in these stories that we can begin to understand how stigma"—and, I would add, rhetorical phenomena more broadly—are "done within rhetorical practices [and] this understanding, then, can inspire meaningful intervention" (p. 104). In other words, a praxiography of stories is well suited to locating rhetorical practices that enact meaning in myriad contexts and can point toward avenues for amelioration.

In advancing multiple ontologies theory, Mol argued for understanding reality as enacted through practice; importantly, different practices enacted different realities, and thus reality multiplies. Mol carried out a praxiography of atherosclerosis and found that while atherosclerosis was done differently in different contexts within a hospital setting, therefore enacting different realities, atherosclerosis still hung together as an object of study. Specifically, Mol (2002) explained how multiple ontologies theory helps us understand reality as multiple:

It is possible to refrain from understanding objects as the central point of focus of different people's perspectives. It is possible to understand them instead as things manipulated in practices. If we do this—if instead of bracketing the practices in which objects are handled we foreground them—this has far-reaching effects. Reality multiplies. If practices are foregrounded there is no longer a single passive object in the middle, waiting to be seen from the point of view of seemingly endless series of perspectives. Instead, objects come into being—and disappear—with the practices in which they are manipulated. And since the object of manipulation tends to differ from one practice to another, reality multiplies. The body, the patient, the disease, the doctor, the technician, the technology: all of these are more than one. More than singular. This begs the question of how they are related. For even if objects differ from one practice to another, there are relations between these practices. Thus, far from necessarily falling into fragments, multiple objects tend to hang together somehow. Attending to the multiplicity of reality opens up the possibility of studying this remarkable achievement. (p. 4-5)

Importantly, Mol's (2002) study was limited to a specific disease in a specific part of the

body—atherosclerosis in the legs—in a specific hospital in the Netherlands, where Mol primarily used observational methods for gathering data. Adapting praxiography for my research meant drawing on the work of RHM scholars who have extended Mol’s work into less well-defined objects (Pender, 2018) and argued for studying a “constellation of diverse practices” (Teston et al., 2014, p. 162), including discursive practices (Kessler, 2020b, 2022).

While, as noted above, a growing number of rhetoricians of health and medicine have adopted and adapted Mol, I build most directly on praxiography as taken up by Kelly Pender (2018) and Molly Kessler (2022). While Mol examined an arguably concrete object, atherosclerosis, Kelly Pender’s (2018) examination of the BRCA gene and breast cancer risk demonstrates methods for grappling with messy objects. Pender notes that “BRCA risk is not an object like atherosclerosis, which is to say that it is not a disease with its own symptoms, treatments, specialists, and clinics. Highly distributed and poorly defined, BRCA risk is what John Law and Vicky Singleton would call a ‘messy object’” (Pender, 2018, p. 73). Messy objects have “porous borders” that resist clean narration, but they are enacted through practice nonetheless, and “these enactments – as multiple and incongruous as they might be – make them real” (Pender, 2018, p. 73). Pender forwards controversy as an entry to praxiography, pulling together a variety of objects (language, bodies, genes, technologies) as she engages multiple research methods to trace the BRCA gene across time and space. Pender’s praxiography provides me with a model for my own praxiography of EWP eating-related practices. As noted earlier, wellness is a slippery term, not without its own controversy simply by being pervasive, commercialized, and ill-defined. Thus, as an overarching methodology, praxiography helps me illuminate the varied practices enacted in the messy object “wellness.”

Building on Mol and Pender, Kessler (2022) argues that “the praxiographic approach guides scholars to investigate the range of entities (language, bodies, technologies, germs, cells, etc.) that come into being and become meaningful within health and medical situations” (p. 88). Building on the work of Mol (2002) and Graham (2015), Kessler blends rhetorical theory and multiple ontologies by placing discursive practices among the constellation of practices in daily life that engage health and medicine, arguing that this model “attunes us to how entities ... are enacted in space and time through practice and *how such enactments are made meaningful*” (2020b, p. 298, emphasis added). In other words, Kessler explicitly layers rhetoric, or meaning-making, onto multiple ontologies theory and praxiography. Where Mol’s work centers around a specific disease, atherosclerosis, and its varied material enactments, Kessler’s inclusion of discursive practices facilitates my examination of EWP discourse and its impact on lived experience.

I find the rhetorical-ontological blend of Kessler’s (2020b, 2022) work particularly valuable as I work to understand the entwined impacts of intangible ideas, like “wellness” and “healthy eating,” on people’s eating-related practices and daily lived experience with food and health. Thus, praxiography helps me illuminate how rhetorical objects like “wellness,” enacted through both material and discursive practices, can be experienced differently by different people across space, and time. Because the EWP works to habituate users into behavior change in their everyday lives and eating choices, attending to their lived experience is a crucial aspect of understanding how material-discursive practices work to materialize bodies and wellness. As Kessler (2020a) argues, an focus on enactment “shifts the work of rhetoricians of health and medicine away from examining how language *represents* patients’ bodily and identity boundaries toward how

*representational practices* participate along with other practices (physiological, symptomatic, technological, etc.) and influence wide-ranging patient lived experiences” (2020a, p. 85, emphasis original). In other words, I studied the enactments of wellness, the meanings those enactments set in motion, and their relationship to how people experience their bodies and their health in their daily lives.

Embracing multiple ontologies and praxiography facilitates my examination of the deeply contextual, contingent, and shifting ways that practices enact “wellness.” Focusing on practices allows me to understand wellness as something that is enacted through practice in different ways for different people across time and space. Mol’s multiple ontologies theory situates enactments by different people as equally important, which helps bypass hierarchical problems that can arise from a perspectival approach that focuses on different interpretations or perspectives of a single, stable reality. In a perspectival model, different people from different backgrounds will inevitably perceive objects in different ways, yet at the center of these perspectives is a single, stable entity or object (Pender, 2018; Kessler, 2020b, 2022). In health and medical settings, this might manifest in the idea that healthcare providers and patients have different perspectives on a health condition, though that health condition is somehow a stable object at the center of those perspectives (Mol, 2002). Importantly, in health and medicine perspectivalism may lead to the privileging of some perspectives over others based on perceived expertise, such as the privileging of a physician’s perspective as more valid or more important than a patient’s perspective (Mol, 2002).

Perspectivalism shows up in patient representation efforts in health policy deliberations, such as in FDA patient and consumer representation programs and public hearings (Graham et al., 2018; Teston et al., 2014). Rhetoricians of health and medicine

have used perspectivalism to critique these FDA programs, highlighting how the FDA's belief that incorporating patient perspectives would ensure inclusion instead "may actually serve to replicate the inequitable power structures patient inclusion efforts are designed to correct" (Graham et al., 2018, p. 65). Further, Mol (2002) explains that in perspectivalism, "the words 'disease' and 'illness' are no longer used to contrast physical facts with personal meaning. Instead, they differentiate between the perspectives of doctors on one hand and those of patients on the other" (p. 10-11). However, perspectivalism is fraught in health and medical contexts because not all perspectives are treated equally (Kessler, 2020b). Behind perspectives is a single, stable truth, and doctors and patients "cast their views from different angles" (Mol, 2002, p. 20). If perspectives differ in medical contexts, or if measurements or tests diverge, one may be given more weight than the other, "one of them wins. The other is discarded" (Mol, 2002, p. 66).

The need for one perspective to 'win' highlights another problem with perspectivalism: it is entangled with a number of Cartesian binaries, including perspective/reality, mind/body, language/matter, and nature/culture. S. Scott Graham (2015) calls this the "two-world problem," arguing that when 'perspective' becomes separated from and privileged over 'reality,' likewise mind is privileged over body, language over matter, and nature over culture. In other words, "perspectivalism encourages us to focus on the perspectives, interpretations, even descriptions of some other entity—but never the entity itself, as that remains beyond our epistemological and ontological reach" (Kessler, 2020, p. 296). In health and medicine, another binary is seen: disease/illness. *Disease* is seen as the object of biomedicine, and a patient's subjective interpretation of and feelings about their disease can be understood as their experience with *illness*. However, the disease/illness binary "reinforces the line of demarcation



between patient and physician, further enfranchising the singular ‘reality’ of the disease over the manifold ‘perceptions’ of the illness” (Graham, 2015, p. 217). Thus, the hierarchization in perspectivalism privileges the biomedical model (Graham et al., 2018). Therefore, adopting a multiple ontologies approach helps avoid privileging one perspective over another, thus flattening the hierarchy between the employer providing wellness ‘expertise’ and an employee’s personal wellness practices. In my research, then, multiple ontologies theory and praxiography help me demonstrate how the UMN EWP’s version of wellness is not the only or ‘correct’ version of wellness, rather, it is one version that co-exists with a potentially endless series of wellnesses enacted across time and space. In other words, I use praxiography as a method for focusing on how practices stage different realities.

Overall, I employed praxiography as both a methodology and a method throughout my data collection and analysis. As a methodology, praxiography kept me attuned to the importance of practices throughout the project: it provided a lens or approach for the project as well as a specific method for analysis. Praxiography allowed me to “[follow] an artifact across time or space in order to investigate the practices through which it emerged, as well as those that are ‘inscribed’ within it” (Pender, 2018, p. 79). Food and wellness are both politicized, distributed, and messy, and also enacted through practices. Rather than examine how different people perceive or discuss food and wellness, praxiography allows me to investigate the multiple ways that food and wellness are enacted, or come into being through practice, and how those practices are made meaningful.

Lastly, and importantly, my approach to praxiography extends previous scholarship (Graham, 2015; Kessler, 2022; Pender, 2018) by positioning power and

issues of systemic oppression as a central concern. Systemic oppression is structural, rooted in power dynamics that privilege certain groups while marginalizing others (Young, 1990); it shapes the very nature of practice by facilitating and foreclosing what is possible in a given place/time. In other words, I sought to examine how wellness was enacted while also considering the larger socio-political forces that shape who gets to practice wellness and what practices are valued or devalued. In turn, this allows me to foreground how the UMN EWP facilitates and restricts access to wellness (my fourth research question) within the broader landscape of systemic oppression in the U.S. These moves were critical in order for me to point toward avenues for amelioration, or for doing wellness *well* (discussed in my conclusion in Chapter Seven). For data analysis, I turned to modified grounded theory, which I go into greater detail about, including codes and coding cycles, in the Data Collection and Data Analysis sections later in this chapter.

### **Attunement to Practice and Lived Experience**

Overall, the combination of UX, praxiography, and modified grounded theory helped keep me attuned to practices and lived experience throughout my data collection, analysis, and dissertation drafting. Stories are my entry into capturing lived experience. UX provides me with social justice-oriented methods for capturing stories, and then praxiography and modified grounded theory methods helped me to trace practices in people's stories and to look for themes around those practices.

### **Study Design**

The four research questions that guided my study were:

RQ1: How does the EWP incorporate and discuss eating habits?

RQ2: How do people experience the EWP's eating-related discourse and programming?

RQ3: How does the EWP's eating-related programming impact people's daily lived experience?

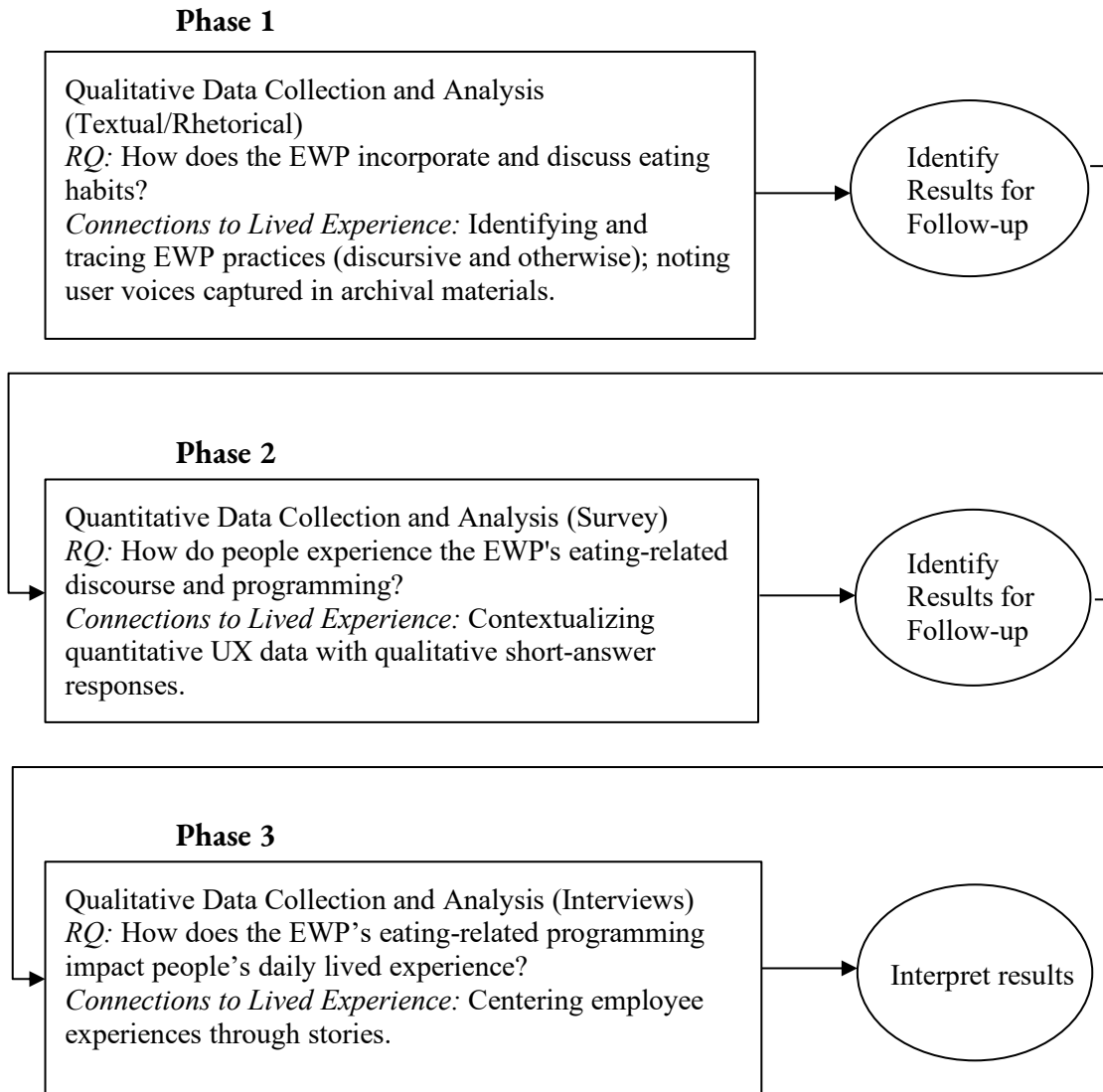
RQ4: How does the EWP facilitate and/or restrict access to wellness?

To answer my research questions, my study used a three-phase mixed methods design. An initial qualitative phase informed a quantitative phase, which was then expanded upon with in-depth qualitative data (see Figure 1 on the next page). Thus, in this project, I triangulated data from three sources: 1) archival UMN meeting minutes and reports dating 1987 through 2019, public-facing EWP promotional materials and web pages dating 2003 (when the EWP began) through 2019, and news coverage of the EWP; 2) a survey of EWP-eligible UMN employees focused on user experience with EWP discourse and digital technologies; and 3) in-depth narrative inquiry interviews aimed at understanding the ways that the EWP impacts daily lived experience. Specifically, my project began with textual analyses in order to bring forward relevant themes that then informed my survey of EWP-eligible employees and their spouses, which in turn was followed by narrative inquiry conversations with participants.

During study design, I mapped each phase of the project onto one of my initial three research questions. Thus, the design of phase one, textual analyses, was driven by question one: *How does the EWP incorporate and discuss eating habits?* Phase two, the survey, was driven by question two: *How do people experience the EWP's eating-related discourse and programming?* Lastly, phase three, the narrative inquiry conversations, was driven by question three: *How does the EWP's eating-related programming impact people's daily lived experience?*

**Figure 1**

*Mixed Methods Data Map*



As noted in the Key Questions section of Chapter One, while conducting the research, I became attuned to issues of marginalization and, as a result, added a fourth research question: *How does the EWP facilitate and/or restrict access to wellness?* Because this question was added during the study, it is not mapped onto a specific phase; it permeates all of my data analysis.

## Site of Study

My site, the Employee Wellbeing Program (EWP) at the University of Minnesota, is located in the United States; as such I am investigating the ways in which U.S. discourse shapes and is shaped by how wellness is enacted over time and in different contexts. Ideas about health and medicine can vary significantly globally, and my project is bound to the U.S. in order to examine wellness as it is enacted in a cultural context that deeply values individualism and capitalism. Further, while my project needs to incorporate both the institution and the employees as stakeholders in order to account for both the discourse and technologies of the EWP and the way it shapes how people experience their eating habits, as a move toward social justice it seeks to center the voices of those who are impacted by the EWP. That said, early in the project, I met with folks in the UMN EWP to let them know I was working on the project, chat informally about their work on the EWP and how it has evolved over time, and to let them know that I would be collecting participant data.

The UMN EWP is a salient site for study because of its size, its history, and the wealth of publicly available information about it. UMN is a large land-grant institution, with five campus locations, over 62,000 undergraduate and graduate students, and hundreds of research and outreach centers across the state. It is one of the largest employers in Minnesota, employing over 20,000 people, of which approximately 19,000 are eligible to participate in the UMN EWP based on their employment appointment type (Institutional Data and Research, n.d.).

It is important to note here that my survey was conducted in April and May 2020, early in the COVID-19 pandemic, and my interviews were conducted in December 2020 and January 2021. Originally, the survey was scheduled to be deployed in March 2020

and the interviews during summer 2020, however, mid-March UMN pivoted to online learning and working from home for nearly all employees. The sudden shift caused a lot of upheaval and affected everyone in the university community. By mid-April 2020, the university community and the pandemic-related work adjustments had stabilized enough that it became more feasible to go ahead with the survey under the circumstances than to delay my study for an indeterminate period of time. Despite some stabilization in the workplace situation in spring 2020, summer 2020 remained a time of upheaval with initial pandemic lockdowns plus large-scale protests in the Twin Cities following the murder of George Floyd by Minneapolis police on May 25. Therefore, interviews were postponed until Fall 2020 when things felt more stable (not necessarily better, I think, to most people, but at least the twin pandemics of COVID-19 and racism started to feel more like a new normal). The global health crisis certainly affected my survey and interview results; sometimes in known ways, such as survey respondents who reported canceled EWP biometric screenings or interview participants who described how working from home affected their daily eating patterns, and certainly in unknown ways, such as the possible impact of working from home on employees who may only have computer/internet access (to complete the online survey or participate in an online interview) while on campus. Many aspects of EWP programming have been impacted or curtailed by the inability to meet in person (classes, training), the lack of commuting to campus (bicycle commuter program), and the temporary unavailability during early 2020 of most healthcare providers for routine assessments (biometric screenings). Ultimately, I decided to move forward with the study design during COVID-19 shutdowns after balancing impacts on the data against possible timelines for study completion.

## **Protection of Human Participants**

This study involved human participants; however, the IRB determined that it was exempt research (STUDY00007939). Human subjects data collected included participant sentiment, reflection, and narratives about experience with the EWP. No protected health information was gathered. Minimal individually identifiable information was gathered. The survey was anonymous, and participants interested in being contacted for a follow-up narrative inquiry interview were invited to volunteer contact information to me. Data are reported pseudonymously and aggregated when possible. The primary risk to participants in this study was breach of confidentiality, so by collecting as little identifying information as needed and pseudonymizing transcripts and results, I was able to minimize risk.

## **Data Collection**

### **Phase One: Textual**

Phase one data was textual: archival materials, news articles, and marketing materials for the EWP dated 1981-2019 (see Appendix A for a full listing of documents).<sup>12</sup> I collected textual data for Phase One from the University Archives—both the physical archives in Andersen Library and digital collections housed in the university’s Digital Conservancy (<https://conservancy.umn.edu/>)—as well as the Internet Archive’s Wayback Machine (<https://archive.org/web/>). I collected archival data in two stages. The first stage involved reviewing all benefits-related archival meeting minutes and reports (about 2,000 documents) in order to identify meetings where work related to

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<sup>12</sup> The UMN EWP has changed notably since 2019, both due to the pandemic and changing EWP vendors. In many ways, the changes they have made are positive and address some of the employee concerns and complaints present in this dissertation. That said, it is still grappling with or unable to resolve many of those underlying issues because of its tie to health insurance coverage; this is something I will return to in my conclusion in Chapter Seven.

the EWP took place (103 documents at this stage). Identification of relevant texts was based on various keyword searches in the archive (e.g., “wellness,” “wellbeing program”), followed by reading for content and initially coding for “wellness” at the document subsection level (i.e., a full section of one set of meeting minutes, varying in length from a sentence to multiple pages). Materials were predominantly from the Benefits Advisory Committee (BAC), which included representation from all employee groups and multiple university campuses, though I also selected texts from the Civil Service Benefits Advisory Committee (an early, job class-specific group), the Senate Committee on Faculty Affairs, and the Board of Regents. The BAC is particularly interesting because its composition means that it falls outside the normal governance structure at the university, which is employee group-based (e.g., faculty-only, administrative staff-only, bargaining unit staff-only).

At this point, context became crucial. While my ultimate goal was to analyze the ways the EWP shaped ideas and promoted practices around wellness, I was working with historical texts that needed to be strung together in order to tell the *story* of how the EWP was developed and how it evolved over time. This was a critical step because of my focus on stories as rhetorical entities, as it facilitated my understanding of the emergent contexts in which the various archival texts were created. Thus, from the data foregrounded in my first round of coding (for “wellness”), I constructed a rhetorical history, or *kairology* (Segal, 2005), of the UMN EWP, identifying kairotic moments of tension and important change, or “historical moments as rhetorical opportunities” (Segal, 2005, p. 23). Importantly, the kairology foregrounded four key kairotic moments: the late 1980s, the early 2000s, the late 2000s, and the early- to mid-2010s. The kairology I constructed is included in my analysis in Chapter Three.



The four kairotic moments I identified facilitated my second stage of data collection, where I selected promotional and marketing materials using those key date ranges (namely the early 2000s when the EWP was established, and the early-to-mid-2010s, and the “current” program as of the end of data collection in 2019-2020) and looked for discourse and practices captured in the texts, including lived experience via employee voices captured in meeting minutes. This allowed me to pair internal and external discourse from the same periods of change in order to understand how motivations and rhetorics were entwined. Marketing and promotional materials (79 documents) were selected from the university archives as well as via the Internet Archive. My modified praxiography + grounded theory study design then emerged as a strategy for doing qualitative research aimed at elucidating key themes around *practices* in a large textual data set (see more in the Data Analysis section).

### **Phase Two: Survey**

Participants for Phase Two (survey) and Phase Three (interviews) data collection were recruited from EWP-eligible individuals over the age of 18 across the UMN broadly, including all campuses. In order to be eligible to participate in the EWP, individuals had to be enrolled in UPlan employee health insurance, which required appointment to an eligible job category at greater than 75% time for three months or longer (University of Minnesota, n.d.). Spouses of UPlan-enrolled employees were also eligible for the EWP. Employment records are public data, and I was able to develop a list of eligible employees based on job classification and percentages of time appointed (hours per week). There were 18,954 benefits-eligible employees in the UMN system at the time of my data collection per Office of Institutional Data and Research headcount; that number does not include spouses. This was a sufficiently large enough population to

support modest participant recruitment goals, though this study is not meant to lead to data generalization or representativeness.

Eligibility did not necessarily mean individuals engage in the EWP; for this reason, recruiting a mix of people who did and did not participate in the EWP facilitated my examination of the ways that people felt the program fit, or did not, into their lives. In turn, this helped me get at their lived experience with food and wellness. Thus, the population eligible for inclusion in my study was EWP-eligible employees and their spouses, who are over 18 years of age.

Phase two involved an Internet-based 49-question survey administered via Qualtrics. Email invitations to participate were sent to all 18,954 benefits-eligible employees. I received 1,717 survey responses (a 9.1% response rate). While inviting the total population was a good strategy for obtaining a random sample, my recruitment strategy was not a truly randomized sample, nor can it be assumed that it is representative of the employee population. As my goal is not to have a project that is generalizable to all EWPs, this sampling strategy was a good balance of randomization in recruitment and manageability.

Survey respondents self-identified as EWP-eligible employees or spouses; I did not verify this information with the university nor did I collect individually identifiable information. Survey questions included a mix of quantitative questions (e.g., yes/no “Do you use apps on your smartphone to track your eating (for example, through a diet app)?”), and qualitative questions (e.g., short answer “What does ‘healthy eating’ mean to you?”). The survey also had a mix of UX-informed questions aimed at understanding whether use of the EWP was enjoyable (e.g., Likert scale agree-disagree with “Using the Wellness Program website and/or app is easy”) and whether users felt the EWP made a

meaningful difference in their lives (e.g., Likert scale agree-disagree with “I feel like I have a better relationship with food and eating because of the Wellness Program”). In addition, short-answer qualitative questions (e.g., “Please say a little bit about why you no longer participate in the EWP”) were designed to capture data about lived experience. Questions were piped such that certain questions only displayed to survey respondents if they gave certain answers to other questions; for example, if a respondent said they had not ever participated in the EWP, they were not given questions about their experience with EWP programming. See Appendix B for a full list of my survey questions. Overall, my goal was to gather user sentiment data and stories about experiences with the EWP to contribute to study results, identify individuals interested in follow-up interviews, and to inform my Phase Three narrative inquiry interviews.

### **Phase Three: Narrative Inquiry Interviews**

Phase three aimed to elicit stories through narrative inquiry interviews designed to understand how eating habits, technology, and wellness fit into the context of participants’ lived experience, and how shifting discourse about eating habits impacts people’s relationships with food. Narrative inquiry is an interview method specifically designed to elicit lived experience while attending to issues around social justice (Jones, 2016a). Specifically, human-centered design (HCD), as taken up in technical communication scholarship, advocates for a turn to social justice through a focus on human dignity and research that works to amplify the agency of marginalized and oppressed people (Jones, 2016a; Walton, 2016). Narrative inquiry methodology is a way to combine HCD and technical communication research.

Importantly, narrative inquiry is an interview method that relies on researcher-participant co-creation of meaning via personal stories grounded in four commonplaces:

temporality, place, inward conditions (feelings, hopes, reactions), and external sociality (existential conditions, environment) (Jones, 2016a). Because of this, narrative inquiry interviews do not follow a semi-structured script of questions, though they may begin from questions based on the four commonplaces and then evolve into more unstructured narrative building. See Appendix C for a list of my starting interview questions. This fluidity and focus on affect and context made narrative inquiry an excellent fit with the way I wished to investigate embodied, emplaced, lived experience. Narrative inquiry does not aim to make data generalizable, as generalizing one person's personal experience takes away from that experience; rather, narrative inquiry makes space for individual voices and experiences, especially those of marginalized people (Jones, 2016a).

Interviewees were recruited from survey participants who indicated interest in a follow-up interview; 553 participants indicated interest in being interviewed. Interviewees were selected from that pool based on indicating participation in eating-related programming, campus location, job classification and demographics in order to recruit participants that represented different areas of the university. Because the focus of my research questions is on lived experience with wellness and food, the first step in narrowing my list of participants was to choose individuals who volunteered for an interview and also indicated participation in eating-related programming, including cooking classes, dieting programs, nutritional counseling, and attending the farmers market. Phase One textual analyses and the Phase Two survey highlighted employee feedback about the lack of EWP offerings at coordinate campuses across the state; thus recruiting interviewees from a mix of campus locations was a valuable step in triangulating that data. Likewise, because results in Phase One and Phase Two indicated

issues around EWP participation based on income level, care was taken to recruit from a mix of the four major job categories (faculty, professional and administrative, civil service, and labor represented). Lastly, I paid attention to recruiting individuals with varied demographics in terms of age, gender, race, ethnicity, and educational attainment.

Because narrative inquiry interviews are in-depth and the goal is to present people’s personal stories via vignettes, rather than aggregating experiences, I created a list of 26 individuals to invite for interviews; 16 of these accepted and completed interviews. Each interview lasted approximately an hour, and each participant was interviewed once. See Table 1 for detail on interview participant demographics.

**Table 1**

*Interview Participant Demographics*

Participant #	Campus Location	Job Category	Age Category	Gender	Race/Ethnicity	Highest Level of Education
1	Rochester	Faculty	35-44 years old	Male	Hispanic	Advanced graduate work or Ph.D.
2	Extension	Civil Service	45-54 years old	Female	White	Some college (no degree)
3	Greater MN	Civil Service	25-34 years old	Male	White	Advanced graduate work or Ph.D.
5	Crookston	Faculty	65-74 years old	Female	White	Advanced graduate work or Ph.D.
9	Duluth	Professional & Administrative (P&A)	25-34 years old	Female	Asian	Master's degree

Participant #	Campus Location	Job Category	Age Category	Gender	Race/Ethnicity	Highest Level of Education
10	Duluth	Faculty	65-74 years old	Male	White	Advanced graduate work or Ph.D.
12	Twin Cities	Civil Service	45-54 years old	Male	White	Master's degree
13	Twin Cities	Civil Service	45-54 years old	Female	Black	Bachelor's degree
14	Twin Cities	Professional & Administrative (P&A)	45-54 years old	Female	Asian	Master's degree
15	Twin Cities	Civil Service	55-64 years old	Female	Hispanic or Latino	Bachelor's degree
18	Twin Cities	Faculty	45-54 years old	Genderqueer/ Nonbinary	White	Advanced graduate work or Ph.D.
20	Twin Cities	Bargaining Unit	55-64 years old	Male	White	Advanced graduate work or Ph.D.
21	Twin Cities	Civil Service	45-54 years old	Female	Black	Some college (no degree)
22	Twin Cities	Professional & Administrative (P&A)	25-34 years old	Female	White	Master's degree
25	Twin Cities	Civil Service	35-44 years old	Female	White	Master's degree
26	Twin Cities	Professional & Administrative (P&A)	45-54 years old	Female	White	JD (Juris Doctorate)

*Note.* Demographic information was self-reported and collected via my survey questions, as interview participants were recruited from survey respondents.

After each interview, I completed a debriefing memo for myself where I answered the following questions:

- How did the interview go? What went well? What went not well?
- What was important? Do you have any immediate insights into the content of the interview? Did it reinforce previous findings/themes?
- Was there anything surprising? Do you see new themes or key ideas emerging?
- Was there any phenomenological stuff that you noticed (and when? what time stamp or part of the conversation?) that would be interesting from a lived experience perspective?
- How did you as the researcher shape the interview?

The interviews were a method of gathering rich narrative data centering people's lived experience to complement the large datasets from Phase One (textual) and Phase Two (survey).

### **Data Analysis**

In this section, I will detail my data analysis methods for each of my three research phases. Throughout all of my data analysis, I stayed attuned to employee lived experience. As described in the Methodology section, I used praxiography to examine how food and wellness are *done* in practice and how those practices are made meaningful. In order to conduct qualitative analyses, I turned to grounded theory informed by praxiography; in other words, while grounded theory was my analytic method, praxiography kept me attuned to *practices* during my analysis. My approach to qualitative analysis can best be described as a kind of modified grounded theory (Breuch, 2019; Charmaz, 2006; Corbin & Strauss, 2008; Heath & Cowley, 2004). Classical

grounded theory as described by Glaser and Strauss (1967) relies on the emergence of theory from iterative inductive cycles of data analysis without incorporating an existing theoretical framework (Heath & Cowley, 2004). Modified grounded theory, on the other hand, leaves room for the presence of a theoretical framework to guide the research design and the use of existing analytic techniques (Breuch, 2019; Charmaz, 2006; Corbin & Strauss, 2008; Heath & Cowley, 2004). Kathy Charmaz, in particular, advocates for a view of grounded theory as “systematic, yet flexible guidelines for collecting and analyzing qualitative data to construct theories 'grounded' in the data themselves” (2006, p. 2). In my case, modifications to grounded theory included my background as an RHM scholar, which informs my overall understanding of medical discourse, and my status as a novice with textual analysis, which led me to rely on existing coding techniques from Kathy Charmaz (2006) and Johnny Saldaña (2016).

Table 2 provides an overview of my types of data, the study phase during which they were collected and analyzed, my unit of analysis, and the type of analysis I used. Overall, each phase’s data analysis informed the next phase of my project, as well. The remainder of this section provides additional details about the analysis of each type of data.

**Table 2**

*Data Types, Units of Analysis, and Types of Analysis*

Study Phase	Type of Data ( <i>n</i> )	Unit of Analysis	Type of Analysis
One	Internal UMN meeting minutes and reports (n=78)	Cycle One: Set of meeting minutes Cycle Two: Lumps of one to a few sentences	Praxiography and modified grounded theory
One	Promotional materials (brochures and websites) for the UMN EWP	Cycles One and Two: Lumps of one to a few sentences; a whole image; or an image	Praxiography and modified grounded theory



	(n=64)	juxtaposed with a few words	
Two	Likert-scale survey responses ( <i>n</i> varies by question)	Single question	Response distribution and median response rates
Two	Short-answer survey responses ( <i>n</i> varies by question)	Single question	Thematic analysis building on Phase One
Three	Narrative inquiry interview transcripts (n=16)	Lumps of a few sentences to a single full answer	Praxiography, modified grounded theory, and narrative inquiry commonplaces

### **Phase One: Textual**

In this section, I detail how I coded my selected texts and worked iteratively to identify thematic categories and to theorize the relationships between them. Because modified grounded theory is a qualitative data analysis strategy, this section aims to elucidate the process of arriving at the theory that I discuss in my analysis chapters and that informed my subsequent research in Phases Two and Three. Thus, this section focuses more on how my data moved from “a ‘raw’ state to ‘cooked’” (Smagorinsky, 2008, p. 393), rather than on quantifiable measures of how many times certain codes appeared as might be found in a content analysis. Thus, below, I walk through each of my three coding cycles, providing tables with details about codes and sample coded text, and sample analytic memos, as applicable.

#### ***Cycle One Coding and Analysis***

I began with the texts I selected from the UMN archives (103 sets of meetings minutes, reports, and proposals spanning 1987 to 2019) based on the presence of discussions about wellness and EWPs. As noted above in the Data Collection—Phase One: Textual section, I read each text and coded broadly for “wellness” at the document subsection level in order to find and isolate all the discussions about the EWP (i.e., a

section of meeting minutes, or a portion of a report or proposal). At this point, the raw data was difficult to parse; because my coding was in such large chunks, wellness often appeared as a brief mention in a bigger conversation about health insurance costs and budgetary issues. Additionally, I had moments captured that were separated by time, and it was often tricky to make connections from one moment to another because of gaps. I had found a report of the Civil Service Benefits Committee from May 1987 with a recommendation that the university begin a wellness program, but then nothing until the early 2000s. This prompted me to return to the data and ask what made arguments for wellness at UMN fail in the 1980s (when EWP's were proliferating nationwide) but then succeed in the 2000s? I was in the beginning stages of putting together the *story* of the UMN EWP.

I pulled in news coverage to provide more context about broader issues. Alongside a handful of internal news items (bulletins from the University of Minnesota *Brief*, a weekly news digest) and external news items (articles from the *Star Tribune*, a Twin Cities newspaper), it became clear in my reading of the trajectory of wellness discourse in archival materials that the UMN EWP was intrinsically connected to the evolution of UMN's UPlan health insurance coverage for employees. This discovery reinforced for me the importance of the broader rhetorical ecology to understanding EWP discourse. While my ultimate goal was to analyze the ways the EWP and employees' practices enacted eating and wellness, I needed to understand the evolution of the EWP and its discourse within the emergent contexts in which the various archival texts were created. At this point, as noted in the Data Collection section, I constructed a kairology, or rhetorical history, of the UMN EWP (see Chapter Three for the kairology). Once I had an understanding of the history of the UMN EWP, I was able to move forward with

Cycle Two coding and analysis of the textual data.

### ***Cycle Two Coding and Analysis***

The kairotic moments identified in my rhetorical history, based on cycle one coding for the presence of discourse about the UMN EWP (as part of constructing the kairology), drove my second cycle of coding. Certain concepts emerged as places of tension worth further examination, including: ongoing economic challenges driving EWP programming, employee voices coming through in questions and criticisms of the EWP, and regular discussion of obesity and eating-related programming. In Cycle Two, I narrowed my archival dataset slightly by eliminating some meeting minutes from Cycle One that ended up not being salient (EWP updates with no relevant content). In Cycle One, I had 103 internal archival documents (e.g., meeting minutes, reports), but that was narrowed down to 84 for Cycle Two. Therefore, in Cycle Two I worked with a total of 163 documents: 84 sets of meeting minutes, reports, and proposals from the university archives dated 1987 to 2019; and 79 marketing and promotional materials from the University Archives and the Internet Archive dated 1981 to 2019. See Appendix A for a full listing of archival documents used in this phase. Coding in Cycle Two was done in large lumps of text, that is, a few sentences to a few paragraphs, and used a combination of in vivo (actual wording) and open-ended eclectic (categorization-on-the-fly) coding strategies (Saldaña, 2016) congruent with initial grounded theory coding practices outlined by Kathy Charmaz (2006).

Because the concepts that drove Cycle Two coding arose from my rhetorical history, many codes in this cycle reflected events and or programming, such as: budget crisis; Weight Watchers; diet/nutrition (non-Weight Watchers); technology use; university data practices; and user sentiment. Both events and programming are reflective

of practices, thus salient in a praxiographic study. During Cycles Two and Three, I employed a simultaneous coding strategy, meaning multiple codes could be applied to or overlap in the same lump of text (Saldaña, 2016); this allowed me to keep codes focused on a single concept but accommodate the multifaceted nature of the source material. Cycle Two codes and sample coded text are detailed in Table 3.

**Table 3**

*Phase One Cycle Two Codes and Sample Coded Text*

Code	Sample Coded Text
<i>In Vivo</i> <sup>a</sup>	A member commended the University on offering these weight loss programs. Weight control is such an important aspect of healthy living. (BAC, 2011a)
Budget Crisis	The University cannot sustain 14 – 15% increases in health care costs without some cost sharing with its employee pool. The alternative to no cost sharing is laying off fellow University colleagues. The BAC and the University of Minnesota administration are faced with the formidable task of finding the best, balanced solution to the current budget crisis. [The university president] is requesting the BAC look at creative options for saving money in the health care arena because for every \$1 million not saved in benefits, approximately 17 - 20 University employees will need to be laid off. (BAC, 2003b)
Diet/Nutrition (non-Weight Watchers) <sup>b</sup>	[The EWP vendor representative] provided information about the Healthy Living Program (HLP). Salient highlights included: <ul style="list-style-type: none"> <li>● Over 5,800 people participated in the program, and 96% of those who participated rated the program as good or excellent.</li> <li>● The weight loss program is the most popular HLP and the Meal Planner is the most popular site tool.</li> <li>● Ninety-two percent of HLP participants achieved their goals. (BAC, 2011d)</li> </ul>

Code	Sample Coded Text
Technology Use	[A committee member] said the [EWP] app was very poorly built. Some people only use their phone and don't have access to a desktop. [Another committee member] said every time you use the app, you have to login or re-login with your U of M ID. The app can't or won't save that data. [An EWP vendor representative] said that the committee's feedback is helpful. [A committee member] said it is not ideal that [the vendor] was awarded the contract before these bugs and issues were resolved. [The vendor representative] responded that one of the reasons the [the vendor] was selected was because they were bringing new technologies to the table and part of the process of developing with a new client is making improvements and adjustments based on the client's feedback. (BAC, 2018a)
University Data Practices	Some employees are reluctant to complete the assessment because they are suspicious about what the data will be used for. [The director of Employee Benefits] is well aware of this and stated that the University has been very up front about what the information would be used for. The University will continue to build employees [sic] trust and remind them that University personnel responsible for hiring and firing decisions do not have access to this information. (BAC, 2006d)
User Sentiment <sup>c</sup>	[A committee member] stated that she has heard concerns from members of the University community who are hesitant to take the wellness assessment, for example, because they believe the University will use this information to target less healthy employees. [The director of Employee Benefits] stated that the University is not allowed to use any of the information collected in the wellness assessment to target groups of employees or individuals. Along with federal legislation that protects privacy (HIPAA), the University has a Board of Regents' policy that specifically deals with this issue. Legally, the UPlan, as a self-insured entity, owns UPlan claims data information. However, by policy, the University has made a conscious decision to not collect this information. The University instructs its vendors and data warehouse to protect and blind this information from the University. The University only gets aggregate, de-identified information, and avoids to the full extent possible knowing any individual employee's data. (BAC, 2011c)
Weight Watchers	Offer two new weight management programs to address the overall population weight management issue, which continues to represent a high lifestyle risk for UPlan members – Weight Watchers at Work, and Create Your Weight offered through Fairview. (BAC, 2009)

<sup>a</sup> This *in vivo* text eventually contributed to the creation of the “Weight/diet as healthy lifestyle” code in Cycle Three (see Table 4 below).

<sup>b</sup> In the early stages of this project, I was differentiating between Weight Watchers and other diet programs in the EWP, though as the project progressed this distinction became unneeded.

<sup>c</sup> This text is an example of simultaneous coding, as it was also coded for “University Data Practices.”

During this round of coding, I began writing myself analytic memos (see Figure 2 below) to document my coding choices while noting emergent patterns and themes in the data (Saldaña, 2016). I followed some of Kathy Charmaz’s questions for early memo writing, particularly her suggestion to focus on processes by asking questions like “What process is at issue here? Under which conditions does this process develop? How do(es) the research participant(s) think, feel, and act while involved in this process? When, why, and how does the process change? What are the consequences of the process?” (2006, p. 81.) These questions fit well with my Cycle Two coding which focused on events and aspects of EWP programming, and helped me highlight pertinent connections between the data, especially in terms of practices. Figure 2 contains an example of an early memo with my thoughts on how connections between codes were beginning to look like patterns or themes in the data.

## **Figure 2**

### *Early Memo Example*

February 16, 2020 - Reflections on Cycle Two Coding

In the initial phase of coding, everything was only coded for presence or absence of relevant information - the only code was "wellness" and everything related to the EWP was coded in broad chunks. In terms of method, all possible relevant documents (over 100 docs) were added to Nvivo to facilitate text searching and broad swath coding of anything wellness-related. This phase led to the construction of the history (chronology/kaiology). In a postscript to the initial phase of coding, two additional codes were added:

- WW -- to flag any discussion of Weight Watchers at all
- Diet-nutrition-nonWW -- to flag any discussion of diet/nutrition programming that was not Weight Watchers

For the second round of coding, codes were added for “budget crisis,” “technology use,” “university data practices,” and “user sentiment.” This seems to have helped me hone in on interesting themes. Some thoughts on things to think about for Cycle Three, re: broad themes to consider when recoding the data:

- Biomedicine privileged -- anything where clearly biomedical measures/standards are being privileged over individual needs or holistic/alternative medicine
- Individual responsibility-choice -- anything placing responsibility onto the individual

- Inequity-Penalization -- any discussions of how different groups of people may be penalized by the programs
  - Surveillance-University data usage -- about how the university is surveilling or using employee data (a modification to university data usage in Cycle One? Instead of just data being collected, how it's being used to monitor employees?)
  - Weight as risk factor -- biomedical/pubhealth models of weight as risk factor for disease\*
  - Weight-diet as healthy lifestyle -- this is different than weight as risk factor because it focuses on the social/cultural idea of "healthy eating" and lifestyle choices\*\*
  - Biomedical nutrition standards -- anything where biomed models are promoted
  - Self-tracking -- pairs with surveillance, about data tracking and usage
  - Financial incentives for employees
  - Financial incentives for UMN
  - Preventive-Interventive blurring
  - Morality of diet
  - Cultural beliefs about diet
  - Power
  - Public health -- not sure, but maybe to differentiate from biomedicine privileged to pubhealth standards?
- \* Does this get at 'bodies already unwell' and pre-patients?
- \*\* Does this get at good eater=good employee? The entanglement of diet and health.

The memo in Figure 2 reflects some of my thinking through how Cycle Two codes might be elevated from descriptive nouns to abstract concepts (Saldaña, 2016). Saldaña describes the "touch test" as "a strategy for progressing from topic to concept, from the real to the abstract, and from the particular to general" (2013, p. 187). Moving from the concrete to the abstract means finding the phenomenological, representative forms of abstraction, the higher-level concepts that drive the descriptive nouns. As Saldaña notes, "You can touch an old house in poor disrepair, but you cannot touch the phenomenon of 'poverty.'" (2016, p. 276). Thus, I began thinking through the abstractions of things like user sentiment and university data usage; text that highlighted user concerns about privacy and practices like being targeted by supervisors based on EWP health data, in my estimation, pointed to larger ideas about institutional power, individual responsibility, and penalization.

Following Cycle Two, analytic memos were reviewed, and codes were brought

together thematically into conceptual categories. Throughout all cycles, praxiography kept me attuned to locating and tracing practices in the data while modified grounded theory helped me allow theory to emerge from the data. The most salient emergent categories were then used as codes to test against the data in Cycle Three.

### ***Cycle Three Coding and Analysis***

Cycle Three coding took a focused coding approach, which is a streamlined adaptation of classical grounded theory's axial coding strategy (Charmaz, 2006; Saldaña, 2016). Using categories emerging from the first cycle, I worked to break larger coded sections of text into smaller and more nuanced "lumps" of one-to-a-few sentences (Saldaña, 2016, p. 23). In Cycle Three coding, then, the most salient emergent categories from Cycle Two were used as codes to test against the data, while I worked to synthesize the data theoretically via analytic memoing. Because I am focusing on EWP material-discursive practices about wellness and eating habits, this unit of analysis (of one to a few sentences in a lump) allowed me to capture ideas rather than linguistic features that might call for smaller units of analysis. Notably, while Cycle Two coding trended heavily toward capturing events ("budget crisis") and programming types ("Weight Watchers"), with only a little focus on broader theoretical themes ("university data practices"), Cycle Three coding began to coalesce more around theory as themes like "individual responsibility/choice" and "weight as a risk factor" emerged in the data; again, throughout my coding and analysis, praxiography kept me attuned to the practices within themes/categories. For example, the theme "weight as a risk factor" might include an EWP *practice* like assessing BMI during a biometric screening which *enacts* weight as a risk factor. During Cycle Three analysis, I began to note key concepts in the data; some of these came directly from the codes (e.g., "individual responsibility/choice"), while



others emerged from combinations of or tensions between codes (e.g., racism and classism came from “access/barriers” and “cultural beliefs about diet,” among others).

Table 4 illustrates the key concepts, codes that informed those key concepts, code definitions, and representative examples of coded text.

**Table 4**

*Phase One Cycle Three Key Concepts, Codes, Definitions, and Representative Examples*

Key Concept	Code	Definition	Example
Nutritionism/ quantification of food versus holism	Holism	References to holistic models of wellness, food, diet, or eating habits.	Seven Dimensions of Wellness Wellness is both the balance of the mind, body, and spirit, and also how we relate and live in the world. For our wellness model we have chosen seven dimensions: intellectual, physical, spiritual, emotional, social, occupational, and environmental. (University of Minnesota, 2003)
	Biomedical nutrition standards	References to nutritionist/quantified models of food, diet, or eating habits.	[Wellness Resources for] <u>Nutrition 2005 Government Dietary Guidelines</u> [URL] Dietary Guidelines for Americans is published jointly every 5 years by the Department of Health and Human Services (HHS) and the Department of Agriculture (USDA). The Guidelines provide authoritative advices for people two years and older about how good dietary habits can promote health and reduce risk for major chronic disease. (University of Minnesota, 2005)
	Biomedicine privileged	Instances where biomedicine has more priority in planning/programming than holism.	What approach should the University pursue in establishing a wellness program? <ul style="list-style-type: none"> <li>● Disease Management</li> <li>● Wellness/Health Promotion (pre-disease)</li> <li>● Health Education/Demand Management (BAC, 2003a, p. 4)</li> </ul>

Key Concept	Code	Definition	Example
	Public health/epidemiology privileged	Instances where public health and/or epidemiological models have priority in planning/programming.	The top five health risk opportunities for the University are: 1. Stress 59% 2. Weight 55% 3. Cholesterol 46% 4. Eating 45% 5. Exams/immunizations 40% Stress and weight are two of the highest cost drivers so there will be an emphasis on reducing these health risks. (BAC, 2011d, p. 2)
	Weight/diet as healthy lifestyle	References to weight, diet, or eating habits as part of a healthy lifestyle	Sponsored by the Wellness Program, Office of Human Resources, the [farmers] market brings fresh fruits and veggies to the Twin Cities campus to promote a healthy workplace and a healthy lifestyle for employees, students, and people from the surrounding neighborhoods. (University of Minnesota, 2011)
Risk factors and economics driving EWP programming	Weight as risk factor	References to weight, obesity, or BMI as a risk factor for health-related issues	Numbers count. Body measurements matter. The numbers that indicate if your cholesterol is high or tell you what you weigh figure into your chances for developing illnesses such as heart disease or diabetes. (University of Minnesota, 2010a)
	Budget crisis	References to budgetary concerns or crises at the university driving decisions about health insurance and employee wellness program planning	Major UPlan challenges include: <ul style="list-style-type: none"> <li>● Rising costs of health care. The Centers for Medicaid and Medicare Services recently released a report projecting double-digit trend increases in health care costs for at least the next decade.</li> <li>● Tailoring health benefits, with input from the Benefits Advisory Committee, to better meet the needs of University employees. The University offers a very broad choice of medical plan offerings.</li> <li>● Promoting wellness and improvements in the health status of University employees.</li> <li>● Providing quality, cost-effective health benefits during a major budget challenge. (BAC, 2003d, p. 4)</li> </ul>

Key Concept	Code	Definition	Example
	Financial incentives - employee	Discussion of monetarily incenting employees to participate in the EWP.	[P]art of the reason the \$400 reduction [in health insurance premium] is being proposed is because the Wellness Program had plateaued when it comes to the current incentive structure. The University, therefore, is looking to shift to an incentive that has evidence in the marketplace for providing a greater incentive for participation in the program. (BAC, 2011e, p. 8)
	Financial incentives - UMN	Discussion of financial reasons incenting the university to promote the EWP.	A member stated that once enough data has been collected to evaluate individual wellness programs, each program should be expected to demonstrate a positive ROI in order to be considered a good investment. If some programs demonstrate they have no demonstrable impact on participants' health, they should be further scrutinized as to their value to the program. ... [The director of benefits in Human Resources] added that currently there is nothing in this ROI analysis that measures health outcomes. (BAC, 2009, p. 5-6)
Individual versus institutional responsibility/power	Health behavior change	Direct references to efforts aimed at changing the behavior of employees regarding their health, such as changing their exercise, eating, smoking, or disease management habits	Next, there was a discussion on health management, which focused on improving overall employee productivity and health. The goal behind health management is to move from an acute medical treatment model to a health plan model where consumers take an active role in thinking about, managing and improving their health. (BAC, 2004b, p. 2)

Key Concept	Code	Definition	Example
	Individual responsibility / choice	Direct statements or strong implications that health-related issues are based on individual choice or are an individual's personal responsibility	[The director of benefits in Human Resources] commented that conventional wisdom is that about 42-43% of health-care costs are driven by conditions over which people have at least partial control. Some people are healthy and some are not, through no fault of their own. The common thread for the healthy and the unhealthy person alike is "I must take responsibility for my health and my health care, it's no one else's responsibility." The employer may provide tools but ultimately it is up to the individual. (Senate Committee on Faculty Affairs, 2011, p. 6)
	Institutional power	Direct statements or implications that the university has or can wield power over employees.	In closing, [the committee chair] shared immediate next steps [including]: <ul style="list-style-type: none"> <li>● Aggressively promote wellness initiatives. This topic will be addressed this fall and a discussion will take place on how aggressively should the University enforce wellness.</li> </ul> (BAC, 2010c, p. 4)
Self-tracking, surveillance, and data practices	Employee productivity	References to wellness' or illness' impact on productivity at work (absenteeism and/or presenteeism)	<ul style="list-style-type: none"> <li>● Employees completing the assessment averaged missing 3.6 days of work in the last 12 months due to illness or injury compared to the norm group, which missed, on average, 2.8 days.</li> <li>● Wellness assessment participants reported their productivity at work was reduced on average 9.7% due to health problems. This statistic is often referred to as "presenteeism", how present people are at work when they are there.</li> </ul> (BAC, 2006d, p. 2)
	Self-tracking	References to using tools (paper logs, apps, wearable fitness devices) to self-track health data such as exercise or eating.	Points chart: NEW 75 [points] maximum (This item on the points chart requires website or mobile app use and daily tracking of fitness and/or diet; notably, it is possible to track "Live Well" activities like stress level, but Live Well does not earn points.) University of Minnesota, 2017b, p. 5)

Key Concept	Code	Definition	Example
	Surveillance/ University data usage	References to why and how UMN collects and uses employee health data from the EWP and the health insurance plan(s).	[A committee member] stated that hopefully weight loss by [health plan] members who participate in these weight reduction programs will be reflected in fewer medical claims. [An employee from benefits in Human Resources] stated that this data is being collected by [the EWP vendor] and will be used by Dr. John Nyman in calculating the return on investment (RIO) of the University's Wellness Program. (BAC, 2010d, p. 6)
	Technology use	References to encouraging or requiring technology use as part of the EWP.	An employee can earn double the points from last year by syncing their personal movement monitor (like a FitBit or Apple Watch). (BAC, 2018b, p. 3)
Marginalization	Access/ Barriers	References to perceived or reported issues with access to the EWP or barriers for participation	Concern about language availability of Wellness materials (Somali) was voiced. (BAC, 2015b, p. 2)
	Inequity/ Penalization	References to perceived or reported issues with the EWP causing or seeming to cause inequity or penalization for employees, especially based on their health or employee classification (i.e., salary and rank).	A member voiced utter disapproval of stratifying people based on their biometrics. It simply is not acceptable to penalize people based on their health conditions. To illustrate, obesity is not as simple as eating too much. According to [the director of benefits in Human Resources], the intent is not to penalize people, but to reward and incent people for taking an active role in improving their health. The objective is not to exclude people that cannot meet certain goals. However, just because people are unable to meet certain goals does not absolve them from having to work on improving their health outcomes. (BAC, 2010e, p. 5)

Key Concept	Code	Definition	Example
	User sentiment	Instances of user sentiment such as committee members speaking as users of the EWP rather than part of the group administering the program, or discussions of user surveys and feedback	Employee Comments – [Vendor] & Overall Wellbeing Program <ul style="list-style-type: none"> <li>● Bring back the ability to add outside activities (such as a marathon, 10K, organized bike ride) for credit! And, let us get more points for them! Also, please make it easy to enter so we don't have to go to [vendor] Track every single day. – 14% of responses</li> <li>● The Wellness Program has little for healthy people. In fact, it feels like it punishes people who are healthy by making them do seat in chair tasks that take time away from healthier pursuits. People would rather DO something than spend hours in a chair clicking through steps to earn points. – 13% of responses</li> <li>● This is a huge waste of time. We are wasting work time and taxpayer dollars clicking around to get a premium reduction. --- 12% of responses</li> </ul> (BAC, 2018a, p. 6)

In Cycle Three, I also continued writing memos to myself to help draw theoretical connections between the codes and flesh out the key concepts. Following Kathy Charmaz's (2006) model for advanced memos, in my Cycle Three memos I worked to address points like:

Describe how your category emerges and changes. Identify the beliefs and assumptions that support it. Place it within an argument. Compare categories in the data with other categories—which categories should become major sections? Compare the entire analysis with existing literature or the ruling ideas in a field.

(p. 81)

Figure 3 shows an example of an advanced memo with my thoughts on how theoretical connections were developing between different categories and coalesce into theory.

### Figure 3

#### *Advanced Memo Example*

March 6, 2020 - Cycle Three Coding and Food as Medicine

The EWP has a narrative of wellness embedded in it - holistic health, happiness. Images on public-facing materials are positive, generating warm feelings and optimism about wellness. Language features talk about things like mental and financial well-being, not just physical health.

On the other hand, internal documents reveal a near-total focus on the bottom line, the money. Rising insurance costs drove the adoption of the EWP, and ROI [return-on-investment] calculations drove the development of it. They tell people they want them to be healthier, but the main focus is on saving money. These are not necessarily opposed or mutually exclusive goals, but there's something uncomfortable about the difference between the internal and external narrative of the EWP. Is it really a holistic program if the parts of it that are incentivized are the biometric measures? Is it really about improving employee well-being if a major activity is gathering data to measure risk over time? Is it really holistic if the thing that matters most is the incidence of risk factors at a population level? And what does it mean that it's all about the employees having to do individual work, when feedback in minutes says that people want the university to do more re: ergonomics in offices and healthy food choices from campus dining vendors? What does it mean that there's a farmers market but it's really limited, and the main eating-related programming for most of the EWP history is diet-based like WW? Lastly, there's a lot of discussion (relatively speaking) about inequity and penalization coming up in the user feedback captured in minutes - what does this mean in relation to marginalized groups within the U employee population? Who has access to wellness, and who doesn't?

The tension between holism/CAM and biomedical models/measures is really important. The financial aspects drive this tension, but in the end, it's a *wellness* program, not a *medical* program, right?

I WONDER: What is the link from food and wellness to medicine? How does the idea of food as medicine manifest in this context? Does that come out in juxtaposing things like weight as risk factor with preventive/interventive blurring?

Look at risk literature, EWP lit from public health/medical journals, and read more in critical nutrition/food studies. Look for theoretical connections to help explain how the EWP is doing food and wellness and medicine, and economics?

Memos like the one in Figure 3 helped me think through the important connections between the categories and key concepts that emerged in my coding cycles. In their original delineation of grounded theory, Glaser and Strauss advocated for the

researcher identifying a core category, or a central phenomenon in the data within which all other categories are integrated; Kathy Charmaz (2006) offers a different view, arguing that there may be multiple key categories and the researcher should focus on making the connections or relationships between them apparent. In my research, praxiography helped me to foreground practices as one central phenomenon, while modified grounded theory gave me space to include issues of power and oppression. In working to understand the UMN EWP, I found that the important and salient meaning was found in the tensions and relationships between categories. Thus, while thinking about a single key category like “individual responsibility/choice” provided interesting fodder, the relationship between that category and “institutional power” provided a much more meaningful avenue to understanding the impact of institutional material-discursive practice on individual lived experience. My work toward understanding the relationships between categories began with questions of what the EWP is talking about and doing. During my work to elevate key concepts into the abstract and examine relationships between them, I began to ask questions about how and why. The answers to these questions contributed to the development of theory included in my analysis chapters. All key categories end up operating within and informing my development of theory.

### **Phase Two: Survey**

Quantitative survey data was analyzed primarily by looking at the distribution of responses about user experience. Because this was not an experimental study and there were no variables or groups being compared, most statistical analyses were not appropriate. Likewise, because there was not a predetermined sample, analysis of nonrespondents was not needed (Fowler, 2009). Median response rates on attitude scales such as the Likert enable helpful aggregation of survey respondent sentiment, though



direct frequency of response to particular categories and clustering of “agree” and “disagree” categories can also provide a helpful picture of user attitudes (Sullivan & Artino, 2013). It is important to note that when working with Likert scales, mean or average responses are not helpful measures, for example an average of “neutral” might mask strong responses in the categories of “strongly agree” or “strongly disagree” (Sullivan & Artino, 2013). See the *Entremet* “Data Stories” between Chapters Four and Five for a breakdown of salient quantitative results.

Phase Two qualitative data (short-answer survey questions) coding built off of codes and categories used in Cycle Three during Phase One. Essentially, I took themes that emerged during Phase One, along with salient codes, tested it against Phase Two qualitative data, and added codes for new themes as needed, in order to demonstrate how users experienced the EWP. These codes were applied to all of the open-ended questions in my survey (see Appendix B), however, the bulk of the data was from three questions that were presented to all survey respondents: “What does healthy eating mean to you?”; “What does wellness mean to you?”; and, “Is there anything else you would like to share about the Wellbeing Program, Create Your Weight, WW at Work (Weight Watchers), or other eating-related programming in the Wellbeing Program?” A significant amount of data also came from a pair of questions about non-participation in the EWP: “Please say a little bit about why you do not/are no longer participating in the EWP.” Table 5 includes my codebook for Phase Two, including codes, definitions, and sample coded text. Sample coded text excerpts were selected to be generally representative of the type of data included in each code; frequency of codes is not included because “mere numeric frequency of a code or category from data analysis and memos is not necessarily a reliable and valid indicator of a central/core category” (Saldaña, 2016, p. 253).

**Table 5***Phase Two Survey Analysis Codebook*

Category	Code	Definition	Sample Coded Text
Barriers	Culture barriers	References to aspects of the EWP that do not fit with a respondent's cultural background, demographics.	Bland food. Eurocentric vision/emphasis.
	Disability barriers	Ableism, barriers for people with disabilities	As somebody that struggles with bipolar disorder, I did not feel supported or understood by the program.
	Financial barriers	References to costs or expenses that prohibit participation (e.g., class fees)	all these fairly stupid "opportunities" either cost money or are intended for people with no sophistication or knowledge. it's a boondoggle
	Game/Joke/Con	References to the EWP being a game, a joke, a con, or describing it as manipulative.	The wellness point system is a joke. I can go to two financial classes and earn as many points that half a year of biking 10 miles a day.
	Geographic barriers	References to programs not in a given geographic/ campus location or only in a specified geographic/campus location	There are a lot of options for people in the Twin Cities, but not enough options for those of us who work/live in rural areas.
	Insurance barriers	Not able to participate because not covered by the UPlan health insurance	There are no monetary incentives for me to participate. I have VA healthcare.
	Poor individual fit	People specifically referring to the EWP being a poor individual fit with their idea of wellness, their values, or what they are looking for (but not culture/ demographics, being too healthy to participate, or not being useful)	I have looked at this program in the past and felt they really did not had anything valuable to offer. I found them lacking imagination and innovation. They are not versatile and don't meet where individuals are, need I say more!

Category	Code	Definition	Sample Coded Text
	Privacy/trust barriers	References to data usage concerns or sharing private health data as a barrier to participating in the EWP	too intrusive and orwellian
	Science barriers	Not participating in the EWP because of the lack of scientific backing or evidence demonstrating that EWPs make a difference.	Diets, like WW, are proven to be ineffective 95-98% of the time and to actually worsen health in the long run, as well as lead to an *increase* in weight. There is substantial research (here at UMN) showing that such programs are detrimental to overall health and lead to a higher risk of eating disorders
	Time barriers	References to not having time to participate in the EWP	don't need yet another worthless time-sucking thing to do
	Too healthy barriers	References to barriers for people who are already healthy and struggle to participate because there's not enough activities or ways to get points	I have always found these programs to disadvantage those who are already healthy. I am not overweight, never smoked and enjoy doing my exercise at home so many of the "points" to be earned are not applicable to me. One of the only ways I felt I could get to the point needed was to have a personal coach. I don't feel that is a route I want to go. This program has an all or nothing model so I don't participate.
	Usability barriers	References to difficulties in using the EWP program overall and/or included digital technologies; including not understanding the program (complexity) and not having any information about it (this is included because it indicates the EWP's communication plans aren't working, despite the EWP sending regular emails, printed mail, and promotional materials)	The website is byzantine. The surveys are judgmental, there is a high turnover in the health coaches so you never develop a relationship with anyone.

Category	Code	Definition	Sample Coded Text
	Usefulness barriers	References to the EWP not providing anything new, not being useful	I don't think that any of the programs have very much to add as far as benefit for the majority of people. Most people I know already know all of the information. Lack of information is not the problem.
Healthy eating-as-	Buzzword/ meaningless/ problematic term	Direct references to it not meaning anything, being a buzzword, being a problematic term (e.g., privileged term)	Not much. Used to be thinking about fruits and vegetables but I guess now I hear it as "code" for dieting, which makes me reject the term.
	Cultural	Food as part of one's specific culture	It is also important for me to eat traditional indigenous foods that my ancestors would have eaten.
	Economics	References to the economic aspects of eating, including food as a way to reduce healthcare costs, food access, food cost, larger economies/sustainability concerns	I feel that sometimes the term "healthy eating" is used to shame people for their food choices, choices that are often restricted by a variety of socioeconomic factors. I suppose it means having the access and ability to make food choices that are better for one's body, but those are not always easy or affordable. At the end of the day, I'd say that "healthy eating" is more systemically enabled (or not, as the case may be), rather than an individual choice.
	Harmful Idea/Trigger	Specific references to the term "healthy eating" being a harmful idea, loaded term, or a trigger for people with disordered eating	I have found participation to be largely wasteful of my time and to sometimes trigger self-destructive or otherwise negatively reactive eating patterns over time.
	Medicine	Food as a way to avoid/cure disease/illness or manage a chronic condition	When disease comes up, looking at what you're eating or not eating that could bring you back into good health.
	Pleasurable	Food as something enjoyable or pleasurable	For me, healthy eating is both joyful and balanced. It means eating in line with my own needs and wants. It usually involves a wide variety of food groups. Importantly, it is determined by each individual based on their own intuition - rather than dictated by an external set of rules or values or limitations.

Category	Code	Definition	Sample Coded Text
	Quantification / Nutritionism	References to calories, nutrients, food as fuel, and/or medical models of nutrition (e.g., pyramid or plate food groups, etc.); references to moralized views on food	A balanced diet of all food groups, properly portioned. It would not based on fad diets, but rather guidance from the FDA or peer-reviewed research.
	Social/ Community	Food as something social or part of a community (but not specifically culture)	In that sense, healthy eating is a social activity, building relationships, sharing a meal with other people, building relationships with the food, knowing where it came from, knowing what you are eating, ideally having prepared it yourself.
	Vague balance	References to balance, balanced diet, well-rounded, all things in moderation, without anything more specific	Well-balanced diet <sup>a</sup>
	Wellness	Food as improving health (rather than curing/ preventing illness); food as a part of holistic wellness	Healthy eating means to grow, chop, cook, and consume foods that nourish a person - mentally, physically, emotionally, spiritually.
Wellness-as-	Buzzword	References to wellness as part of the consumer health industry, wellness as a buzzword, wellness as meaningless term	Kind of a buzzword, which I suppose is intended to mean general well-being, but it feels like it has come to stand in for a range of upper-middle-class practices with dubious health benefits.
	Community	References to wellness being community-wide, and/or wellness as being part of a community (beyond close personal relationships AKA relationship health)	Also, wellness means not only the individual is healthy but also the community, environment and globe.

Category	Code	Definition	Sample Coded Text
	Economics	References to wellness as providing a positive or negative economic effect; the EWP as a waste of money, only participating for the economic benefit (premium reduction)	The content is something most adults already know. It is just another stressor in my life to have to earn the points so I don't lose \$750 on my health insurance costs. I resent having to participate, but that's too much money to leave behind.
	Holistic	Wellness as having multiple dimensions, or as holistic	The ability to be present and play with my children, the ability to feel good in my body and maintain a physical condition that will carry me into my elder years well. The ability to care for my emotional, spiritual and physical well being.
	Medical Ableism	Ideas and language expressing, even inadvertently medical ableism (e.g., wellness as avoiding disease/pain)	[Wellness is being] disease and condition free, healthy without aches and pains or health conditions
	Medicine	Language about weight, biomedical health markers/measures	[Wellness is] having good underlying biometrics (bp, pulse, weight etc.) as markers of health.
	Vague healthfulness	Equating wellness with a vague idea of being generally healthy without touching on holism (multiple dimensions of health) or specific biomedical measures	Overall Health <sup>b</sup>

<sup>a</sup>This is a complete answer to the question “What does healthy eating mean to you?”; many people answered with just a few words in a similar way to this answer, which led to me adding this code.

<sup>b</sup>This is a complete answer to the question “What does wellness mean to you?”; like the note above, many people answered this question similarly, which led to me adding this code.

Qualitative survey data are reported in upcoming analysis chapters based on these thematic codes in ways that align with broader themes emerging across all three of my datasets; in other words, as I build theory throughout the remainder of my dissertation, relevant qualitative data will be incorporated as evidence supporting specific claims and arguments. In general, I will present qualitative answers as fully as possible and in

participants’ own words in order to center employee voices and lived experience with the EWP, food, health, and their bodies.

**Phase Three: Narrative Inquiry Interviews**

Phase Three coding of narrative inquiry interview transcripts was driven by the four commonplaces—temporality, place, inward conditions, and external sociality—to tilt the coding toward understanding experience (Natasha Jones, personal communication, March 12, 2019). Phase Three coding also utilized the same codes as in Phase Two, included above in Table 4. I broke the four commonplaces into five codes specifically to differentiate forward and backward temporality as seen in Table 6, which includes these additional codes, their definitions (Clandinin & Connelly, 2000, as cited in Jones, 2016a), and brief, key excerpts of coded data.

**Table 6**

*Phase Three Commonplace Codes*

Code	Definition	Sample coded text
Backward	Temporality, the past.	I've never been a picky eater and so with, I'm told that as a child, I was, my mom said I was unusual because I enjoyed eating lettuce salads, and cooked vegetables. So I don't know, maybe I just always enjoyed healthy foods.
Forward	Temporality, present and future.	I ordered the kit for the biometro [sic] thing for home, but haven't really moved forward with that. So I'm hoping that I can be successful this year. I know. I just have to kind of get more engaged with the new program.

Code	Definition	Sample coded text
Inward	Toward the internal conditions, such as feelings, hopes, aesthetic reactions, and moral dispositions.	And I'm a very emotional relationship with food. I'm, I have pretty much for, I don't know, pretty much as long as I can remember. So yeah, eating for me is really driven by emotions or kind of avoiding emotions. And and maybe this is kind of related but, but also, also serves as a reward for experiencing negative emotions or difficult situations.
Outward	Toward the existential conditions, that is the environment.	But I think it's a common immigrant experience, I thought that's why I would share it with you because um, adjusting to food can be very hard.
Place	Attends to the specific concrete physical and topological boundaries of inquiry landscapes.	Unless I'm with friends and then obviously I'm eating wherever they're eating, but for eating out. But if I'm at home, that's where I'm usually at, in front of the TV.

My analysis focused on testing the Phase Two codes against interview data, along with the new codes for commonplaces. Themes between the qualitative survey data from Phase Two and the interview data from Phase Three were similar; the main difference was that in Phase Three interviews people embedded ideas that fit many individual codes into larger narratives about their lived experience. While survey questions were open-ended, they were more tightly focused than my interview questions, which were designed in accordance with narrative inquiry to elicit storytelling and which served only as a starting point for a more organic discussion between me and participants as we worked to co-create meaning (see Appendix C for starting interview questions). Ultimately, analysis and reporting of narrative inquiry aims to preserve individual stories rather than focus on theme-based coding, so longer direct quotes, like the one that opened my preface (*Amuse-Bouche*), will be utilized in discussion of results. This is important, as noted above, in order to not obscure individual experiences or try to generalize people's lived experience.



## **Conclusion**

Overall, my use of a three-phase study with three datasets was designed to provide triangulated data as I worked to build theory around what it means for different people and institutions to enact wellness across space and time. While modified grounded theory was only an explicit method used in Phase One of my research, my whole dissertation takes a modified grounded theory approach in spirit, in that I conducted iterative inductive cycles of data analysis with minimal starting theoretical frameworks in order to build theory “grounded” in the data (Charmaz, 2006). My data analysis led to the theory I advance in this dissertation, and my goal with Chapters One and Two was to ground my theory-building in existing literature prior to presenting my analysis.

As described in my chapter overview at the conclusion of Chapter One, my overarching argument throughout this dissertation is that while the UMN EWP talks about holistic wellness, it both arose out of an ableist, racist, classist medical model and replicates those systemic oppressions through its programming. In the upcoming analysis chapters (Three through Six) I will begin to build this argument in detail, connect it to the theoretical frameworks presented in Chapter One, and support it with triangulated data analyzed as described here, in Chapter Two.

### ***Entremet: Blueberries***

*During my research, people told me a multitude of beautiful and powerful stories about food, their lives, and their wellness. These stories did not necessarily break down nicely to fit in my analyses, but still carried important meaning in relation to my project. In these Entremets, I highlight a few of these stories as interludes between my analyses. My goal is two-fold: to continue my work centering the voices and experiences of those impacted by the UMN EWP, and to add texture and nuance to some of the ways that theory and lived experience connect.*

*In my narrative inquiry interviews, conversation often started off a bit stiff and slow; perhaps a product of chatting over video conferencing software rather than being able to meet up in a coffee shop or a green space on campus, perhaps an artifact of talking to people for research purposes, or perhaps just a product of people meeting for the first time and getting to know each other a bit. I used a couple of strategies to move the interviews from interviews to conversations, one of which was, fairly early on in the interview, to ask people to tell me a story about food. I completed my interviews during December 2020 and January 2021, a holiday season for many folks, and I was touched by many stories of how food was a part of family traditions. Sam told me a different story.*

[DANIELLE] Can you tell me a story about food that feels meaningful to you?

[SAM] Oh, wow. Hm. ... Oh, okay. Yeah, I can actually so. I volunteer with [a local organization]. And what we do is we bring in a truck of food from a warehouse where it's basically food they can't sell. And so we distribute that to the community and we often have a *lot* of something. And so last week we had an unbelievable amount of blueberries. Like it was *unbelievable*. We were giving people—you know those little containers of blueberries you'd get?—we're giving people like six of them. So they were going home with six or more because we have, I mean, an entire pallet of

blueberries. And I went home with like, I don't know, probably three dozen of those little things of blueberries. And then I gave them, and I have to tell you, it's really fun to give people such a decadent but healthful, but like, just like *amazing* food like that, I gave them to my friend Miri and my friend Geoff and you know what I mean? And, and to just like *eat something*, that's so ... it's like part of this entire sort of social justice, you know, giving food to people who need it. But then also, like we had so many blueberries, every single one of the volunteers went home with a ridiculous number of blueberries. And like, seeing the kids excited about the blueberries. You know what I mean? And so, yeah, it was ridiculous how many blueberries we had. It was unbelievable. A related story is, I often do bike delivery for vulnerable households. And this summer I delivered to a house where on top of their bag of groceries was a container of strawberries. And the one of the kids, four or five years old, saw the strawberries and said I'm gonna do the strawberry dance and she did the strawberry dance and it was like the *greatest thing ever*. It was super cute. So I look at, yeah, that volunteering is very fulfilling, you know, and it feels like a really good thing to do. And there are a lot of people who really need it. So.

[DANIELLE] Cool, thank you very much. Yeah, I wouldn't have expected you to start a sentence with we had a whole pallet of, in January in Minnesota, and end with blueberries, at all. That's, that's a very, very special treat in the middle of winter.

[SAM] Yeah. And what's wild is, you know, sometimes we get fruit, like strawberries or blueberries or blackberries or like whatever. And they're starting to go moldy. And these were not. They were *delicious*. They were like, I mean, they were as good as I literally walked into the co-op and bought some and ate them right then. And so I don't understand why they had such an abundance of blueberries to give to us. But so many people were so grateful. And by the way, the word for blueberries in Spanish is very satisfying to say, *arándanos*. And so when you ask somebody, would you like more *arándanos*? Oh, it's, you know, it's like rhythm and this kind of *joyful* word. And you see them smile because we had so many blueberries everybody got some in their bags, but then also we offered them more.

*One of the things that really struck me in this story was how much Sam's*

*demeanor changed when they started talking about the pleasure of sharing something as an abundance of fresh, perfect blueberries with people in the middle of January in Minnesota. When Sam described people's joy at receiving blueberries, I could see joy spread over their face as well with a big smile. In general, Sam was animated when we chatted, using their hands and body as part of the act of communicating, but when they were telling me about blueberries, or the child doing the strawberry dance, the happiness of those memories came through so clearly it was tangible even over a video call with spotty WiFi lag. It was impossible for me to not smile, too, to not vicariously feel the joy that Sam felt. "It's like part of this entire sort of social justice, you know, giving food to people who need it," Sam said. But I think it's not just giving food, as Sam showed, it's giving pleasure, it's giving a moment of pure joy. I thought to myself, this is why I am doing this research: because food is so deeply connected to life. It brings people together and helps us create meaning. Sam's blueberry story is an excellent example of how food is more than just a source of calories and nutrients to be used in certain ways as fuel for the body, just as the body is more than a machine that needs fuel.*

## **Chapter Three:**

### **“Lost output due to disability from cardio-vascular diseases”—**

#### **A Kairology of the UMN EWP**

The quote in the title of this chapter is from a 1987 proposal about flexible benefits in which the Civil Service Benefits Advisory Committee made 13 separate benefits program recommendations, one of which was to adopt a university-wide wellness program. As part of the justification, the wellness subcommittee included 44 pages of supporting documentation, making up almost a third of the overall report, including a telephone survey of offerings at other Big 10 universities, news reports about wellness, materials from the 11th annual National Wellness Conference in 1986, results of a survey of employees conducted by the wellness subcommittee, and some pointed queries about what happened in regards to similar recommendations they made in 1983 (Civil Service Benefits Advisory Committee, 1987). Front and center in the report was a list of eight points titled “The Cost” which included:

1. Health care costs to private industry in 1982 were \$77 billion. Alcohol and Drug Abuse annually cost \$143 billion (Dept. of Health and Human Services 1986).
2. The American Health Association (1978) estimates lost output due to disability from cardio-vascular diseases at \$8.1 billion yearly.
3. Twenty-nine million work days are lost each year due to coronary heart disease, hypertension disease and stroke. (National Heart, Lung and Blood Demonstration Projects in the Workplace: High Blood Pressure Control, Draft paper prepared May 1983).
4. A typical recreational alcohol/drug user is late three times more often than the average employee, uses three times the normal level of sick leave benefits, is five times more likely to file work compensation claims, and 3.6 times more likely to be involved in an accident. (U.S. Department of Health and Human Services, 1983).
5. Thirty percent of the work force is overweight, sixteen percent is obese and

over one-third smoke cigarettes, these conditions increase the risk of coronary heart disease, hypertension, lung cancer and stroke.

6. One smoking employee is estimated to cost employers between \$624 and \$4,611 more annually than a non-smoking employee in employee medical costs, absenteeism, replacement costs, maintenance, property damage, other insurance increases and lowered productivity. (Kristein, 1980).
7. Control Data states that poor health habits are 86 percent more likely to miss work and 100 percent more likely to limit the amount of work they do. (1982 Health Claims Data and 1982 Corporate Wide Employee Health Survey).
8. Firestone Tire and Rubber Company Study 1985 found that drug users have cost the company four times as many accidents, 2.5 times as many absences, three times as many sick benefits used, five times as many worker's compensation claims, and sixty-six percent as productive as other workers. (Civil Service Benefits Committee, 1987, p. 34)

I see a few key connections appearing in these bullet points that are also echoed throughout the 1987 proposal:

- The connection of obesity to disease
- The connection of disease to disability
- The connection of disease, disability, and lifestyle (smoking, drug, alcohol use) to productivity at work
- And, the connection of all of these to employer finances

While this proposal did not result in the implementation of an EWP at the university, it reflects conceptions of wellness rooted in an ableist medical model. In this chapter and Chapter Four, I argue that the UMN EWP both grew out of overarching ableist, racist, classist systems and replicates these systemic oppressions through its material-discursive practices. In order to build those arguments, I first trace the “rhetorically tilted” (Segal, 2005, p. 23) history, or *kairology*, of the UMN EWP in this chapter in order to tell the story of the EWP. A *kairology* considers history as a series of “shifts understood as rhetorical responses to changes in situation” (Segal, 2005, p. 17) or “historical moments as rhetorical opportunities” (Segal, 2005, p. 23). Importantly, my *kairology* foregrounded

four key kairotic moments: the late 1980s, the early 2000s, the late 2000s, and the early-to mid-2010s. It is important to note that this is *one* story of the UMN EWP; the EWP might tell a different story about its history than I do here. In this way, my story of the UMN EWP can be seen as an antenarrative, or a history “reframed to make visible competing ... narratives” to “open up a space that invites reinterpretation of the past so as to suggest—and enable—different possibilities for the future” (Jones et al., 2016, p. 212).

In an effort to trace the rhetorical work that practices around health, wellness, and healthy eating are doing in the EWP, and to provide an important contextual foundation for my analyses, I present here a brief history of the UMN EWP. Resisting a traditional chronology of events, a kairological approach pays particular attention to the “conditions of time, place, and audience” and how “arguments have a quality of truth in those situations” (Segal, 2005, p. 22). Thus, rather than examining the UMN EWP implementation as a series of events moving inevitably in one direction, employing kairology allows me to highlight how rhetorical appeals about wellness facilitated and foreclosed arguments about the EWP at different key moments. A kairology of the UMN EWP, then, is a tracing of competing discourse and goals at the moments where change becomes possible. Identifying those kairotic moments reveals the intertwined identities, priorities, institutions, technologies, and bodies that make wellness a persuasive concept within a given moment.

A key component of this kairology will be attention to threads of medical ableism, racism, and classism that underlie moments of change. For example, in the title and introduction to this chapter, I highlighted a key page from a proposal for an EWP at UMN that ultimately failed; the purpose of that page of the proposal was to highlight the cost of poor employee health to employers. Four of the eight points read together link

fatness to chronic illness to employer finances through phrases like “lost output due to disability from cardio-vascular diseases,” “Twenty-nine million work days are lost each year due to coronary heart disease, hypertension disease and stroke,” “Thirty percent of the workforce is overweight, sixteen percent is obese ... these conditions increase the risk of coronary heart disease,” and “poor health habits are 86 percent more likely to miss work and 100 percent more likely to limit the amount of work they do” (Civil Service Benefits Advisory Committee, 1987, p. 34). This page on “The Cost” demonstrates how, at that time, the employees proposing the EWP were already tying wellness programming to preventing chronic illness and disability and reducing absenteeism (missing work) and presenteeism (reduced productivity while working due to health problems or illness) in order to improve the university’s bottom line.

Race, class, and disability are always tangled and connected, particularly in relation to the ideal body (Kafer, 2013; also refer to Goffman, 1963). The eugenics movement in the U.S. in the early 20th century helped tie together race, class, and disability and give them rhetorical substance in national conversations (Dolmage, 2018). While often the first thing that comes to mind when talking about eugenics are genocides like the Holocaust, eugenics worked in insidious ways throughout the U.S. in the early 20th century, from the way immigration took place at Ellis island to forced sterilization programs to higher education (Dolmage, 2017, 2018).

Academia was the place where “eugenic ‘science’ gained its funding and legitimization ... [and] the university was also itself a laboratory for ‘positive’ eugenics, a place where the ‘right’ combinations of genes could be brought together (‘the better families’) and where eugenic ideals and values could be conveyed to the future teachers, lawyers, doctors, and other professionals on campus (Dolmage, 2017, p. 13). Eugenic



ideas were taken up at universities and perpetuated through curriculum (i.e., courses on eugenics) and programs like hygiene departments, which often promoted “positive” eugenics through ideas about how the American population could be improved through preventive health measures like nutrition and lifestyle changes (Dolmage, 2017). At the University of Minnesota, for example, Dr. Ancel Keys<sup>13</sup>, a professor of physiology, created the Lab of Physiological Hygiene in 1938 (now the Division of Epidemiology in School of Public Health), and the School of Public Health offered a mental hygiene training program for nurses in the 1940s (University of Minnesota Libraries, n.d.). Eugenics reshaped the U.S. population through immigration, reshaped bodies through medical intervention, and even “reshaped how North Americans thought about bodies and minds” (Dolmage, 2017, p. 13). Further, “we can draw a (sort of straight) line from eugenic mental hygiene and physical fitness tests, to their existence as promotional programs, to family life education programs, to wellness initiatives ... [that] offload the responsibility for “wellness” onto individual students (and teachers). Eat better. Exercise more. Sleep well.” (Dolmage, 2017, p. 56). “Wellness” as a term does rhetorical work throughout all aspects of university life, from disability service centers to student wellness campaigns to employee wellness programs.

EWPs enact wellness in ways that replicate medical ableism’s preference for an ideal able body, and through the entanglement of ableism, racism, and classism, EWPs also enact wellness in racist and classist ways. In this section, I will demonstrate how ableism, racism, and classism underpin the EWP from its inception. I will highlight four key moments where arguments for and about wellness programming were either made

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<sup>13</sup> Coincidentally, Dr. Keys was the first to link high cholesterol, heart disease, and diet. He ran this research from the late 1930s through the 1970s when he retired. (University of Minnesota Libraries, n.d.)

possible or foreclosed: initial failed efforts at establishing an EWP in the 1980s; circumstances that made the case for an EWP successful in the early 2000s; arguments in the mid- to late-2000s, during the establishment and evaluation of the EWP, that made possible discourse about what the EWP should be; and the impact of the Affordable Care Act on the EWP in the 2010s. While a kairosology might typically focus primarily on how certain arguments became persuasive in specific historical moments, in the story of the UMN EWP, beginning with a moment where arguments failed is crucial to framing the moment when it finally succeeded.

### **Failure in the 1980s**

By 1981 interested staff at the UMN had organized a Wellness Subcommittee of the Civil Service Committee, a group responsible for representing the interests of civil service employees to university administration (Sawchyn, 1981). The chair of the Wellness Subcommittee was a driving force behind its efforts, going to the National Wellness Conference at Stevens Point, WI, twice, in 1982 and 1986, attending talks by Donald Ardell and other wellness advocates. Under the chair's direction, the Wellness Subcommittee made two concentrated efforts to get an EWP established at the UMN, first between 1981 and 1983, and again in 1986 to 1987. (Civil Service Benefits Advisory Committee, 1987).

The 1981-83 efforts produced a final report and recommendation that the UMN establish an EWP. Included is a definition of wellness as

An active process through which the individual becomes aware of, and make [sic] choices toward, a more satisfying existence. These choices are greatly influenced by one's own self-concept and the parameters of one's culture and environment. Each individual develops a unique lifestyle which changes daily in their intellectual, emotional, physical, social, occupational, spiritual dimensions. (Civil Service Benefits Committee, 1987, p. 61).

This definition elides the institution and places neoliberal responsibility for wellness in the workplace on the individual and their choices, assuming that wellness choices are equally possible for all individuals.

Apparently, however, nothing came of the 1983 recommendations. University archival holdings do not contain direct documentation of the outcome of the 1983 recommendations, other than as it was taken up when efforts for an EWP resumed three years later. In 1987, in the second proposal for a wellness program, the chair of the Wellness Subcommittee included a strong accusation that the 1983 recommendations were allowed to “‘die’ or ‘fade away’ somewhere in central administration” (Civil Service Benefits Advisory Committee, 1987, p. 62). The chair argued:

The wellness subcommittee definitely needs support from central administration. If the committee does not have acknowledgement, support, and assistance ... our recommendations and diligent work will never be implemented. The final reports, the wellness questionnaire results, the U of M lifestyle program directory will merely be filed away in vice president’s offices, dean’s offices, and department files — never to be retrieved or utilized. (Civil Service Benefits Advisory Committee, 1987, p. 62).

The final recommendations in the 1987 report contended that implementation of a wellness program would go beyond increasing job productivity and would “reduce the University’s annual health care cost” (Civil Service Benefits Committee, 1987, p. 32). This claim was supported with two pages of cited and summarized health care costs in the billions of dollars due to illness and disability, including “The Cost” page quoted above, and benefits in the millions of dollars seen in specific wellness programs in other organizations. Yet, despite this extensive reporting and nearly six years of work, the chair’s predictions were accurate: central administration did not support the proposal and the documents ended up filed away in the archives.

Arguments for wellness and an EWP failed in the 1980s, though the time, place,

and audience should have made arguments about wellness persuasive because the wellness movement was in full swing in the early 1980s and EWPs were being implemented across the Twin Cities, which garnered coverage in the local news (for example: Kern, 1978; Slovut, 1979; Thornton, 1980). According to the 1987 report, UMN employee support for a program was high, and the UMN newspaper was covering the wellness efforts on campus (Diaz & Lutz, 1982; Sawchyn, 1981). Beyond health benefits, the potential financial benefits could have been suasive to university administration. Yet, at that time, the university did not have direct control over its own health insurance costs, and it is likely that administration did not see the benefit of reduced health care costs as worth the investment of university funds for programming. In order to understand the kairological moment within which arguments for an EWP later become persuasive, it is important to understand the context around health insurance that caused the argument to fail for over a decade.

### **Success in the Early 2000s**

As a state institution, the UMN was a part of the State Employees Group Insurance Plan (SEGIP) beginning in 1967, a program through the State of Minnesota that pooled insurance risk for all statewide employees (Smetanka, 2001). Risk pooling in health insurance involves insuring as large a group of people as possible, charging them each the same premium, and assuming that healthy members will subsidize costs for the sick (Hoffman, 2012). By pooling employees across the whole state, Minnesota was able to keep insurance costs reasonable for its various constituencies, and by participating in the SEGIP, UMN was able to keep costs reasonable for its employees as well. Facing budget shortfalls and increasing health costs, the State of Minnesota undertook a major study in 1997 to determine benefits to be offered in 2000. Particularly distressing to

university officials were estimated changes in the state plan in 1998 that would cause approximately 4,300 UMN employees a 76-85% increase in premium costs (Board of Regents, 1997). The university began discussing separating from the SEGIP, though it took nearly four years to fully investigate and make the decision.

In June, 2001, the Board of Regents voted to leave the state health insurance plan and move to a self-insurance plan, wherein the university would pool risk across its approximately 32,500 employees and their dependents (BAC, 2001a; Smetanka, 2001). June 7th news coverage (Smetanka, 2001) on the decision to separate notes that

Although the review of health benefits was spurred by forecasts that costs in the state plan would increase 20 percent a year over the next biennium, officials said Wednesday that cost was not the deciding factor. The ability to tailor coverage to the differing needs of employees from clerks to gardeners to professors who travel the world was a factor. (p. 01B)

Meeting minutes of the committees working on the issue, including the Health Plan Task Force (a precursor to the BAC), do show that flexibility in tailoring coverage was discussed, but that “cost containment efforts” were a top priority (Health Plan Task Force, 2000, p. 2). These conflicting messages demonstrate different levels of acknowledgement of the budgetary exigence in public-facing and internal discourse around separating from SEGIP.

The Board of Regents set forth four goals as part of the official establishment of the new UPlan health insurance program: gaining control of the university’s benefits plans; making a positive impact for both the university and its employees; tailoring benefits to meet the unique needs of the population; and establishing a wellness program (BAC, 2003a). What this shows is that, for the UMN, the establishment of an EWP was deeply connected to fiscal issues. Arguments about health cost savings were not persuasive enough in 1983 or 1987, however, by 1997 forecasted budgetary shortfalls

created the exigence necessary for the UMN to separate from SEGIP after forty years. Separation from SEGIP meant taking on full responsibility for managing employee health care costs, and with the evidence of EWP cost savings taken into consideration, implementation of an EWP became part and parcel of the overall separation plan. Because the EWP's benefit to the UMN hinged on the potential savings possible through reduction of employee healthcare costs (e.g., doctor's visits, medications, absenteeism, and presenteeism), it was tied from inception to UPlan health insurance coverage. Importantly, binding together wellness and health insurance through economics also tied the promotion of wellness to neoliberal discourses of work productivity and ableist notions of the ideal body as able-bodied, thus positioning illness/disability as both undesirable and a financial burden to employers.

### **Budgetary Issues, Health Insurance, and the Establishment of the EWP**

The budget woes that began in the late 1990s would be a continuous theme around the UPlan and, in particular, in discussions about the EWP. The decision by the Board of Regents making a wellness program a top goal in the new UPlan created rhetorical opportunities for discussions of what that program might look like. In other words, once the UMN faced a situation where fiscal matters made viable the argument for a wellness program, the resulting situation made possible arguments about what wellness meant and how it should be promoted, measured, and evaluated.

By March 2002, it was noted that the development of an EWP was highly anticipated by UMN employees and was a "very high profile issue" with the Board of Regents (BAC, 2002c, p. 4). The complexity and visibility of EWP development led BAC members to decide to contract with an outside vendor for wellness programming; this process took nearly a year, so as an interim measure, BAC members and the Board of

Regents supported providing flu shots in the fall of 2002, the first year of the UPlan (BAC, 2002d; Board of Regents, 2002). In February 2003, the BAC noted that providing flu shots on campus doubled the number of employees receiving shots and was cheaper than having employees receive them at their normal health clinic. In the same meeting, cost change projections indicated a 14% per year increase in health insurance costs each year from 2002 through 2005. BAC members concluded that the most important factor in establishing an EWP was making the employee population healthier in order to help control costs (BAC, 2003a).

Dealing with rising costs became the number one challenge for the BAC and its number one priority, and conversations routinely pointed to potential savings through wellness and health promotion programming. The four original objectives of the Wellness Program were articulated in 2003 as: “Improve morale. Improve productivity. Improve culture and image of the university. Help manage health care costs.” (BAC, 2003f). The minutes went on to describe that the EWP should:

- Support low risk individuals to keep their risks low through health promotion and programs.
- Support high risk individuals by reducing these risks.
- Support individuals with chronic conditions by helping them manage these diseases. (BAC, 2003f, p. 6)

Noting that “medical costs increase with age and risk” (BAC, 2003f, p. 6) the minutes went on to list as examples of preventable high-risk conditions: stress, tobacco use, weight, lack of exercise, high glucose levels, depression, and high blood pressure.

Notable on this list is weight, but also two conditions often associated with weight in biomedicine: high glucose levels (risk for type 2 diabetes) and high blood pressure (risk for cardiovascular disease). Importantly, two of the original goals of the EWP were financial—increase productivity and reduce health care costs—and from the beginning

the model of wellness adopted by the EWP was rooted in the idea of risk intervention, especially risks around weight and chronic conditions like high glucose and blood pressure often associated with fatness. I interpret the EWP's focus from the beginning on productivity, weight, and weight-related risks/diseases as targeting fat bodies, reinforcing biomedicine's classification of fatness as obesity (abnormal body size, disease), which is a manifestation of ableist conceptions of the ideal body as thin, able-bodied, free from illness/disease, and productive through work. These objectives continued to inform the EWP as it expanded from a single Gopher Health Walk and free flu shots in 2003 to a complex, points-based system with the possibility of earning substantial reduction in health insurance premiums in 2018.

Budgetary and fiscal issues created moments throughout the history of the UMN EWP where arguments about specific programming became persuasive, namely, through evaluating health issues that were deemed to cost the UMN the most money and identifying ways to reduce the incidence/severity of health issues and thus related expenses. The enactment of wellness here positions health issues as in need of cure, replicating ideas around cure central to medical ableism. Budgetary concerns drove post-implementation decisions about programming and incentivization of employees, and the evolution of the EWP overall. Moments of budgetary shortfall provided rhetorical opportunity for arguments about wellness programming to become persuasive to university administration, and in turn, because of the ties between the EWP and the UPlan insurance, moments of budgetary shortfall also provided rhetorical opportunity for the university administration to continually demand the EWP do better at reducing healthcare costs.

Thus, evaluation was crucial for the UMN EWP from the start. If the goal was to



save money on health care costs through investment in an EWP, work had to be undertaken to engage employees and drive participation in the program, and then to measure return-on-investment (ROI). Because the UMN was operating under a self-insurance model, it now “owned” all the data on employee insurance claims, including costs, diagnoses, procedures, and type and place of service. This data allowed the UMN to identify focus areas for wellness programming where change would make the biggest monetary impact (BAC, 2001b). With data in hand, efforts turned toward measuring ROI and incentivizing employee participation.

Beginning in 2005-2006, employees were offered a \$65 payment as an incentive for completing a Wellness Assessment, and a second \$65 payment as incentive for participating after the assessment in a 6-12 month lifestyle coaching program. Participation in the EWP was always limited to employees (and their spouses) enrolled in UPlan health insurance because this allowed the UMN to use both insurance data and EWP data (from Wellness Assessments and, later, through web- and app-based activities) to calculate ROI. Early discussions in the BAC focused on implementing practices like identifying risk factors based on insurance data—including stress, tobacco use, weight, exercise, diabetes, and blood pressure—and the viability of awareness programming for reducing those risks by influencing employee practices (BAC, 2002c). For example, in a discussion in 2002, it was suggested that “the University could assist its population in understanding lifestyle risks ... related to obesity, exercise, smoking, etc. If an employee doesn’t understand the risk there probably is no motivation to change their behavior” (BAC, 2002c, p. 3). This demonstrates how, from the beginning, the EWP linked body size to risk and health status and relied on a deficit model of communication that assumed if people simply had information about their health risks, behavior change would follow.

In the deficit model, scientific information flows unidirectionally from experts to information-deficient non-expert audiences, resulting in a change of behavior; the deficit model has been critiqued as ineffective for decades (Gross, 1994; Miller, 2001).

Because the UMN contracted with external vendors to administer the EWP, initial ROI calculations were done externally and reported back at BAC meetings. The first ROI reports were positive, with the vendor at the time presenting data compiled from 2005-2008 indicating reduction in risk factors among EWP participants and an ROI of 4.49 (\$4.49 reduction in medical costs for each \$1.00 spent on wellness programming). BAC members were skeptical, though, because all the data the vendor used was self-reported by participants; some BAC members directly queried vendor representatives about how they knew whether it was their programming that caused the risk reduction or if other variables might have caused the change (BAC, 2008a). Overall, the BAC concluded that the vendor's ROI calculations seemed to be "an industry product to prove that the industry is doing its job" (BAC, 2010b, p. 7).

The BAC opted to do its own ROI research, contracting with Dr. John Nyman and collaborators in the UMN School of Public Health (BAC, 2008b). Initial results from their research were published in the *Journal of Occupational and Environmental Medicine* in 2009, based on three years of EWP data (refer to Nyman et al., 2009). Overall, Nyman et al. found that only the disease management program had a measurable ROI effect, whereas the health risk assessments and other efforts had no effect, and the total ROI did not generate a positive income (they found about \$0.67 ROI for each \$1.00 spent). Nyman et al. (2009) hedged these results by noting the possibility that disease management may have had positive financial impact in other areas than direct health care costs (such as reduced absenteeism or increased productivity), that insufficient time may

have passed to see significant results, and that as a baseline, UMN employees often rank at or near the top on state comparisons of measures of health. Nyman's research was reported on at the BAC without the hedges present in the scholarly article, with BAC minutes noting that

Based on the claims data from 2006 and 2007, the UPlan saved \$3.9 million in health care claims and roughly \$230,000 in absenteeism costs, which equates to about a 4 hour per year decrease in the amount of sick leave used by participants who participated in the Disease Management program. (BAC, 2009, p. 5).

The removal of hedging language as the ROI results moved from the scholarly article to the BAC are an example of how accommodations of scientific information become more certain when they move from the technical (scientific) sphere to the public sphere (Fahnestock, 1998). While the Nyman et al. scholarly article worked to establish baseline facts about the EWPs ROI, the removal of hedging language when present in the BAC minutes shifted the discussion away from whether or not there was an effect and toward justification for doing something about the effect.

Reports of chronic illness incidence at the BAC helped reinforce the focus on the disease management program; in 2006, it was reported that 68% of people who completed the Wellness Assessment reported one or more chronic conditions (BAC, 2006d) and in 2009, the BAC chose to focus on core conditions identified through Nyman's research as having the highest ROI, including heart failure, coronary artery disease, and diabetes (BAC, 2009). By 2011, university research showed the disease management program ROI alone was up to 1.09, meaning that this component more than covered the costs of the entire EWP (BAC, 2011a). The high ROI of the disease management program continued to reinforce a focus on reducing the effects of chronic illness and risk for chronic illness. Understood through a model of disability that includes

some chronic illness, as discussed in “Theoretical Perspectives” in Chapter One, I interpret the strong focus of the EWP on reducing chronic illness as reifying ableist ideas of the chronically ill body as defective.

Weight and weight-related health risks/diseases were continually a central concern. Weight was listed as the number two risk in the university population for over a decade (BAC, 2006c, 2010b, 2011a, 2013b, 2015a, 2015b) and together with stress, exercise, and cholesterol levels accounted for “83.5% of the University’s avoidable healthcare costs” (BAC, 2006d, p. 2). This was a key factor in the expansion of eating-related programming, and the EWP began including reimbursement for employee-paid weight management programs (e.g., Weight Watchers at Work) in 2010 (BAC, 2005; 2006c; 2009). Weight-loss programs were incentivized and promotional materials urged employees to get “money back for weight loss” (University of Minnesota, 2010a, p. 1). Weight loss was doubly incentivized for a number of years; employees could both earn wellness points and receive partial reimbursement of up-front costs (BAC, 2011b). Yet in 2010 it was noted that “weight is a health risk that the Wellness Program has not made any progress on in terms of decreasing its prevalence” (BAC, 2010a, p. 7). And in 2011, despite having over 1,550 employees enrolled in an EWP weight-loss program, “there was a slight up tick [sic] in this biometric risk” (BAC, 2011d, p. 2). The internal emphasis on weight as a risk factor was a primary driver behind promotion of weight-loss programs, and as discussed in Chapter One and above, weight-loss programs are connected to the privileging of ideally thin bodies.

The Office of Human Resources, which administers the EWP in partnership with an external vendor, still tracks risk factors. Despite some earlier pushback at the BAC about the difficulty of determining whether the EWP has a causal relationship with risk

reduction among the employee population, in 2017 Human Resources compiled ten years of Wellness Assessments to estimate reduction of nine risk factors: alcohol use; depression; driving/safety; physical activity; nutrition/eating; stress; weight; tobacco usage; and back care (University of Minnesota, 2017a). For employees who completed the Wellness Assessment more than once, responses were compared in order to assess change in level of risk (low, moderate, and high). Calculations show overall about a 16% population risk reduction over ten years of data, based on 10,551 EWP participants who took the Wellness Assessment more than once (University of Minnesota, 2017a). While these internal data show an overall reduction in risk rates, there are too many potential variables involved for this to be completely reliable data. In addition to any number of other reasons people might realize risk reduction, the data are self-reported, and any number of factors other than the EWP could have contributed to reduction of risk. Further, as an employer with over 30,000 eligible employees and their dependents, the UMN certainly has turnover in its employee pool, and it is possible that over a ten year period less healthy people stopped being employed by UMN and were replaced with more healthy people. Regardless of methodological concerns, what the risk evaluation underscores is the continuing prevalence of diet and weight in the EWP's own delineation of health risks.

Because of the ROI research and the indication of reduced risk factors, the BAC and Human Resources argue that the EWP is making a difference both financially and in employee health. Yet, the percentage of eligible employees fully participating in the EWP remains less than half. While circumstances were finally realized that made arguments for and about a wellness program rhetorically salient, somehow employee-facing arguments to participate in the EWP remain only moderately successful despite

increasing incentivization and expansion of program offerings in response to employee surveys.

### **The Affordable Care Act and the UMN EWP**

Continued budgetary challenges, rising health costs, and the implementation of the 2010 ACA led to increasing incentives for participation in the EWP. The ACA in particular caused a lot of concern at the BAC due to the UMN's potential to be assessed significant taxes based on high base plan costs as compared to income levels of many employees (the so-called "Cadillac Tax" which penalized employers whose health plans exceeded a certain percentage of employee income) (BAC, 2010c). While HIPAA had traditionally limited the amount of incentivization employers could provide for participation in EWPs, the ACA greatly increased the potential rewards for participation while adding the potential for penalizing nonparticipation, as long as employers did not discriminate against participants with respect to eligibility or benefits based on a health factor (Kirkland, 2014a). Research generally shows that incentives can, under some circumstances, improve participation rates (e.g., see Anderson et al., 2011; Herman et al., 2006; Madison et al., 2011; Volpp et al., 2008). Incentives had been introduced in 2006 with a \$65 reward for completing the Wellness Assessment; however, the UMN's own research (from Nyman and colleagues) showed that incentives were more likely to incentivize people who were already doing incentivized activities like exercising (Abraham et al., 2011). Despite this, because of the impending implementation of the ACA as well as yet another unrelated budget crisis, BAC discussions turned toward implementing a reduction in health insurance premiums as a major incentive.

Of particular interest in revealing underlying the EWP's rhetorical framing of health and wellness was a thread of discourse at BAC meetings in 2010 related to

employees feeling penalized by the Wellness Program. Discussion revolved around implementing plans with reduced insurance premiums for employees with “satisfactory biometrics” or whose biometrics demonstrated “real progress in improving biometric results through health improvement activities” (BAC, 2010e, p. 4). A heated debate ensued, with one member arguing that “simply because UPlan participants do not participate in one of the wellness programming opportunities does not mean they do not live a healthy lifestyle” (BAC, 2010e, p. 5). Another argued that “deciding who can enroll in a particular health plan based on their biometrics is making a moral judgment about that person and that is simply wrong” (BAC, 2010e, p. 5). The director of Employee Benefits responded that “some people take the position that it is morally inexcusable to penalize people who take a vested interest in their health by exercising, eating right, not smoking, etc., and then must subsidize people who take little or no responsibility for their health whatsoever” (BAC, 2010e, p. 5). A BAC member noted that the UPlan is a risk pool, intended to spread risk across a population, to which the director of Employee Benefits responded that the idea of an insurance pool is outdated and needs to be curtailed. The member’s response was then that in looking at the issue from an economic perspective, it would make more sense to incent the unhealthy to enroll in a lower-cost plan rather than the healthy. “What does ‘healthy’ really mean?” asked another member, saying, “A significant number of people’s health problems are hereditary. Is the University going to base its hiring decisions, at least in part, on what diseases run in applicants’ families and their lifestyle behaviors? What about people who are in a car accident, or pregnant women who give birth to babies with birth defects – how is it possible to justify penalizing these people? Penalizing these people would be outrageous. Why is it necessary to have this discussion now?” (BAC, 2010e, p. 5). The

director of Employee Benefits responded that in the face of healthcare reform legislation (the impending ACA), it was “no longer possible to patiently wait for incremental change to occur in the health care system because waiting will bankrupt the U.S. economy” (BAC, 2010e, p. 5). In these discussions, health and wellness are framed by the EWP as part of an individual’s responsibility, with important moral and economic implications, despite some members’ pushback against such ideas. The meeting concluded with the issues unresolved (BAC, 2010e), and to date the UMN EWP has not implemented a program requiring specific biometric benchmarks, but the conversation reveals other interesting rhetorical tensions. Members of the BAC (who are also potential users of the EWP) raised concerns, even if not in these words, about whether such a program could perpetuate systemic oppression. In response, the director of Employee Benefits (the representative of institutional authority at the meeting) invoked the threat of financial crises as justification for potentially discriminatory practices.

Ultimately, the result of debates related to budget woes and the impending ACA provided a kairotic moment for development of a plan under which employees could earn insurance premium reductions through EWP participation. The “Wellness Points Bank” system was implemented in 2012. Rather than the flat \$65 for completing the Wellness Assessment annually, employees could complete various activities to earn points toward a reduction in health insurance premiums of \$300 for individual coverage and \$400 for family coverage (University of Minnesota, 2012a). All activity options required participating in some formal program or using a tracking mechanism; in the 2012 program there was no way to earn points for simply living a healthy lifestyle, so outdoor runners and dieters who managed their weight loss on their own received no compensation.



The points program grew, and under the 2018-19 Wellbeing Program, employees had over 30 options for earning points toward the health insurance premium reduction (University of Minnesota, 2018b). However, participation rates remained low despite increasing incentives and options for participation. Tensions in BAC minutes around programming options and changes hint at underlying issues of ableism, racism, and classism. BAC discussions highlighted barriers for lower-paid employees. In 2004, a BAC committee member noted that they were “anecdotally aware of employees that are unable to earn the wellness points because they are at an income level that requires them to have a second job [and do not have time]” (BAC, 2014, p. 3). At another meeting, employee survey feedback was shared stating that pre-paid options like Weight Watchers and fitness classes were “way too expensive for lower paid workers to pay for, and not reimbursed enough to make them within reach. ... It has become a system of paying for points and lower paid people can’t afford to pay to get an important premium reduction” (BAC, 2018a, p. 6). However, despite raising issues around “a system of paying for points” that not everyone could afford, no changes were made to class fees, and instead, due to issues with taxable income rules, many reimbursements were eventually removed (BAC, 2019). In this way, the UMN EWP restricts access to wellness to those who are able to pay up-front fees for EWP programming, which is in tension with the idea that financial incentives would be suasive to employees and increase participation, because people with disposable income for up-front fees may not be the same people who really need the insurance premium reduction for financial reasons.

Further, while race and ethnicity were rarely addressed directly as issues at the BAC, they can be inferred in certain places. In an October 8, 2015 BAC meeting, it was noted that the EWP was working to respond to “concern about language availability of

Wellness materials (Somali),” (p. 2) and a March 12, 2018 BAC meeting mentioned employee feedback that the EWP vendor “should hire coaches of other races and backgrounds, not just white coaches” (p. 5). Disability was almost never directly addressed, except in one BAC meeting during the first year of the EWP, when “It was noted that the trek [a walk across campus] can be modified for employees with physical disabilities” (BAC, 2004a). While this mention acknowledges ways that the EWP could be modified to accommodate people with disabilities, it also expresses a reductive view of disability as a physical limitation; not all disability is physical in a way that would interfere with walking, nor does accommodation address all disability. As discussed in Chapter One, chronic illness is often unaccommodatable (Wendell, 2001), and accommodation is closely tied to neoliberal discourses of productivity that are especially pernicious for those with chronic illness or pain (Price, 2018). Despite minimal mentions of ability, race, or class in BAC minutes, the issue of barriers for lower-paid employees is an issue of people marginalized along axes of ability, race, and class, as they are more likely to be in lower-paid jobs. Ableism, racism, and classism are deeply entangled forms of systemic oppression.

As the points program grew, so did incentives. During the 2018-2019 EWP program, eligible employees could earn a \$500 reduction toward their 2019-20 health insurance premiums for an individual plan, or \$750 for a family plan (University of Minnesota, 2018b). Individual plan premiums assessed to the employee ranged from \$38-69 per biweekly pay period, and family plans ranged from about \$100-228 per biweekly pay period (University of Minnesota, 2018c<sup>14</sup>). An employee with individual coverage in

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<sup>14</sup> Plan costs vary significantly from one region of the state to another, which accounts for the large range of potential costs. Costs are highest in the Twin Cities and Duluth, which are also the larger metropolitan areas of the state with higher costs of living. Wellness premium reductions do not vary from region to region.

the Twin Cities would pay about \$38 per pay period, for an annual total of around \$992. Likewise, an employee in the Twin Cities with coverage for a spouse and/or children would pay an average of about \$125 per pay period, for an annual total of around \$3,263. Given this, \$500-750 is not a small amount of money, yet only around 40% of eligible employees earned enough points to reach the target for insurance premium reductions, a participation rate that has held steady since inception of the points system (BAC, 2016c, 2017).

The EWP was touted at its launch as a program designed to “provide opportunities for employees to improve their health and feel better about themselves” (Moore, 2003, para. 3). Language included on the employee-facing UMN wellness webpage and in printed promotional materials centered on wording like “feel better,” “stay well,” and “promote health and prevent disease” (University of Minnesota, 2008, 2010a). Once financial incentives were added, appeals to employees included language like “get paid for better health” and, with the advent of the points system, “pointing the way to better health” (University of Minnesota, 2010a, 2012a). Marketing messages like these argue to employees that they should feel good about themselves for taking personal responsibility for their health while also reaping financial rewards. In addition, cobbling together the right combination of activities to earn points is presented as easy, fun, and individually customizable.

### **Conclusion**

On one hand, my kairology of the UMN EWP demonstrates the power of budgetary issues to create kairotic moments where wellness programming’s health insurance cost savings were persuasive to administrators. Yet, on the other hand, participation rates plateaued below 50% of eligible employees. The BAC and Wellness

Program staff worked to counteract this stagnancy through increasing monetary incentives, expanding EWP offerings, and continued marketing efforts. Yet, the employee-facing arguments about health, monetary benefits, and more ways to earn points have not increased participation. Rhetorically speaking, something about the overall situation has not made employee-facing arguments widely persuasive. The reduction in premium of \$500 or \$750 was not insignificant, and the EWP is marketed as easy and beneficial, yet only about 40% of eligible employees earned enough points for the insurance premium reduction each year. This is an issue I will tackle in more depth in later chapters when I dig into employee enactments of wellness and eating, and how they align with and depart from EWP enactments of wellness and eating.

As my analysis in this chapter demonstrated, the history of the UMN EWP is deeply entangled with its history regarding employee health insurance, and both of those are predicated on systemic ableism, racism, and classism. The EWP's connection to the UPlan health insurance is a tie that binds the EWP and its model of wellness to an ableist medical model of the diseased/disabled/at-risk body as deficient and in need of cure. Participation in the Minnesota state health insurance program for decades precluded the development of an EWP, and it was not until UMN moved to a self-insurance model that an EWP became a priority and even then, its core purpose was to reduce the university's health insurance expenditures. The bottom line for the institution is economics, a concern that continually prioritizes monitoring, regulating, and working to norm employee bodies toward a medical model of health. Further, through employee-facing materials, the UMN EWP advances ableist definitions of wellness and healthy eating that position the ideal body as thin, able-bodied, and free from disease or chronic illness.

Importantly, the kairology presented in this chapter provided a foundation for

analysis of the UMN EWP's enactments of food and wellness. Building on my kairology in this chapter, in Chapter Four I return to my Rhetorical Questions from Chapter One in order to discuss further how the UMN EWP rhetorically frames and enacts wellness and eating.

### ***Entremet: Food Stamps***

*In the Entremet after Chapter Two, I shared Sam’s story about giving away food as a volunteer and the joy that fresh blueberries brought to both Sam and the people receiving the blueberries. Sam also talked about doing bike delivery of food to vulnerable households, and the little girl who did the “strawberry dance” to express her happiness at the strawberries in her family’s bag of groceries. While Sam’s story highlighted their pleasure in sharing and giving food to others, it also reflected their experience as a privileged, white faculty member. One of my other interview participants, Roberta (a Black, lower-paid staff person), told me different stories about food as a young girl growing up in a poor family. (Unfortunately, I had technical issues during Roberta’s interview that resulted in a failed recording, even with backup devices, so I do not have a transcript. I immediately took extensive and detailed notes on our conversation, and so will do my best here to reconstruct Roberta’s story from those notes.)*

When Roberta was growing up in the 1970s, her family was poor and on welfare. She recalled how much she didn’t like going to the grocery store with her mother because they would get to the checkout and—she didn’t have an EBT card like folks do now—so Roberta’s mother would have to pull the papers out of the food stamp coupon book. She always pulled them out one by one, and she never did it ahead of time, always at the check-out. Young Roberta found this deeply embarrassing, saying it was the only way as a child she really knew she was poor. Roberta’s family lived outside the Twin Cities in a smaller town, and Roberta’s mother would drive in and get food from the food banks in these huge quantities.

When asked to tell a story about food that felt meaningful to her, Roberta told me about a close friend from high school. She and her friend from high school still get

together a few times a year, and when they do, they always tell the story about how, one time, Roberta's mother drove into the Twin Cities and brought home a 100lb bag of potatoes and a gigantic canister of cocoa powder. Every day Roberta and her friend would come home after school and cut up potatoes and make french fries and fudge. Roberta said, laughing: "We would fry the potatoes, put them in the deep fryer, and we would make the fudge and it was like a stick of butter, and the cocoa, and a cup of sugar, and I have no idea how I didn't grow up weighing like 400 pounds because of that." Despite being poor, Roberta fondly remembered coming home every day and making french fries and fudge, and how her and her friend would sit and watch watch *Days of our Lives*—because it came on at 3:00 and they got out of school at 2:30—and eat french fries and fudge. While french fries and fudge was a happy memory, and food was always plentiful, Roberta also remembered vividly a two-week period where her family had "nothing but beans, just beans" and she finally decided she didn't care about being embarrassed by her family's food situation, so she knocked on the neighbor's door and asked if she could eat with them because she just couldn't take one more day of beans.

*One of the things that really stood out to me when talking to Roberta was how different people's experiences with food can be depending on where and how they grew up. I conducted my interviews during December 2020-January 2021, and while most of my other interview participants recounted stories to me about holidays and food, both Sam and Roberta did not talk about the holidays. Sam talked about the meaningfulness to them of being able to volunteer with organizations that provide food to people in need—something shaped by the experience of giving food in the moment, when experiencing people's joy at receiving the food. Roberta talked about the other side of it, of being embarrassed by her mother pulling food stamp coupons out of the book one by one, of*

*eating the same thing for weeks on end because her mother got food bank items in bulk. Food was no less meaningful to Roberta, however, as she talked about how connected it is for her to Black culture, how it is important to her to both provide food for her large household (including her adult and adolescent children and at least one of her grandchildren) and to teach her children to cook traditional dishes. I share Roberta's story in this Entremet to underscore some of the ways that people's experiences with food vary along axes of race and class.*



## **Chapter Four:**

**“The long-term control of health inflation is to be found in a wellness initiative”—**

### **How the UMN EWP Enacts Food and Wellness**

The quote in the title of this chapter is from Benefits Advisory Committee meeting minutes in April 2003, as development of the UMN EWP reached its peak prior to implementation in fall 2003. The full quote was one bullet point under a “Wellness Update” and read, in full:

The long-term control of health inflation is to be found in a wellness initiative. Ultimately, through information stored in the data warehouse, the University will be able to establish a disease management program that will help the University control its inflation in premiums. (BAC, 2003b, p. 5)

In this quoted excerpt, the senior vice president of the university was referring to the university’s data warehouse, which was the place where the university stored health insurance claims data after it separated from SEGIP and became self-insured. In essence, his suggestion was to use claims data to identify individual employees with chronic conditions like type 2 diabetes, and in turn to use that data to establish a disease management program within the EWP as a way of reducing healthcare costs. As demonstrated in my kairology in Chapter Three, financial concerns related to skyrocketing healthcare costs were the key motivating factor behind the UMN implementing an EWP. In this chapter, I move from the story of the EWP (as in my kairology) and toward thematic analysis of how the UMN EWP enacts food and wellness.

First, though, I return to the Rhetorical Questions I started unpacking in Chapter One and spend a little time examining how the UMN EWP frames answers to what health, wellness, and healthy eating mean. Then, I draw on my praxiographic modified

grounded theory analysis of my archival dataset (meeting minutes, reports, promotional materials dated 1981-2019) to demonstrate how ableism, racism, and classism underpin how the UMN EWP enacted food and wellness.

### **Rhetorical Questions (Part Two)**

In Chapter One, I posed rhetorical questions that I framed as not having stable, global answers that hold fast across even small amounts of time and space. These prior questions (Segal, 2005) are meant to take a step back from my research questions and ask what makes certain meanings around health, wellness, and eating possible in the first place. These questions are rhetorically contingent and contextual; they are questions that this dissertation does not aim to concretely or definitively answer. Instead of working to provide universal definitions, I instead work to explore how health, wellness, and healthy eating are practiced in various rhetorical contexts and for various stakeholders, and how those various practices may align, differ, and/or conflict. Here, as part of my analysis of the UMN EWP archival data, I return to these questions in order to discuss how UMN EWP practices enact health, wellness, and healthy eating. Later, in Chapter Five, I will circle back to these questions one more time to detail employee practices based on my survey and interviews. It is important to ask these rhetorical questions and repeatedly work on answering them because enactments shift across different contexts when different entities are involved (e.g., the UMN EWP, employees, etc.).

#### **What is Health?**

In Chapter One's discussion of "what is health?" I concluded that this remains a rhetorical question, as ideas of health vary from person to person and culture to culture across time and space. However, a theme that arose from the literature is that health can be understood in mainstream dominant biomedical discourse in the U.S. to be the absence

of disease, the striving toward an ideal state of perfection, and a mechanism through which institutional power seeks to shape bodies and workers. It is for these reasons that, in the Medical Ableism and Disability section of my Theoretical Perspectives, I pushed back against Wendell's (2001) delineation of "healthy" and "unhealthy" disabled. If healthy means free from disease, then by implication unhealthy means diseased. Further, if health means working toward an ideal state of perfect health in the biomedical model, then anything less than perfect health is a deficit to be corrected, which is an expression of medical ableism's preference for ideal able-bodiedness. The pervasiveness and centrality of a biomedical model in U.S. health discourse bleeds beyond the borders of the medical establishment, as demonstrated by dictionary definitions of health and the ways extra-medical institutions like the UMN EWP enact health through material-discursive practices.

When the UMN EWP was established in 2003, its first website defined health by drawing on the same WHO definition of health that inspired Dr. Halbert Dunn to develop his model of wellness in the 1960s. The EWP website said

According to the World Health Organization, health is more than the absence of disease. Health is a state of optimal well-being. Optimal well-being is a concept of health that goes beyond the cure of illness to one of achieving wellness. ... We can achieve high-level wellness by being aware of our healthy or unhealthy habits and changing those that are unhealthy. We can continue to educate ourselves about information available to support our health and well-being. We can then take action to create opportunities and a reality that keeps us healthy. Wellness is never a static state. There are levels of wellness, just as there are degrees of illness. Our health is our responsibility. Our lifestyle choices and decisions make a big difference in our overall health. (University of Minnesota, 2004)

Here, the EWP directly defines health as "a state of optimal well-being" and connects health to neoliberal ideas of individual choice and responsibility, promoting the idea that it is up to individuals to enact wellness through personal practice. One of the EWP's first

programming activities involved implementing a “10,000 Steps” program whereby the university mailed pedometers to all staff and faculty to encourage them to be physically active. Throughout its history, the UMN EWP has centered biometric monitoring, diet, and exercise as key wellness practices, which I interpret as the mobilization of a biomedical model of health. For example, in the EWP’s 2010 *Discover Wellness* newsletter, the main headline on the front page read “Two steps to get paid for better health,” which included practices like taking a wellness assessment (requiring measures of height and weight and recommending that employees also provide information about blood pressure and cholesterol levels) and participating in health coaching (centered on lifestyle habit changes like quitting tobacco use, improving physical fitness, and eating “better”) (University of Minnesota, 2010a, p. 1). Similarly, in the 2018-2019 *Wellbeing Program Guide*, the UMN EWP opened with the claim that the EWP “wants to support your overall health and wellbeing. Whether that means helping you achieve personal health goals, reduce stress, maintain a healthy habit, or manage a chronic condition, the [EWP] offers a variety of options to help you achieve your personal best” (University of Minnesota, 2018b, p. 1). Overall, the UMN EWP mobilized a model of wellness anchored in a biomedical model of health that focused on diet and exercise habits, disease management, and biometric measures of health. Importantly, the EWP’s biomedicalized model also adopted ideas at the core of the wellness movement, namely that wellness is constant striving toward ideal health and able-bodiedness.

### **What is Wellness?**

In Chapter One’s discussion of the rhetorical question “what is wellness?” I outlined the roots of the modern wellness movement in Dr. Halbert Dunn’s work on public health in the 1950’s and discussed how the modern wellness movement led to the

proliferation of EWP's nationwide as well as the field of health promotion. The modern wellness movement typically describes wellness as a continuum or scale, with ill at one end and well at the other (Ardell, 1977; Derkatch, 2018; Travis, 1975), although this scale is often operationalized as a dichotomy (illness/wellness) or at best, a three-point scale (illness, borderline, and wellness). The idea of constant striving is central to the continuum/scale model of wellness; wellness is a moving target as the means of enhancement are constantly evolving in a capitalist society where health and medicine are heavily commercialized and commodified (Derkatch, 2018). Further, the pervasiveness of wellness discourse reinforces the neoliberal biomedical model that positions people as responsible for their health status, their health status as reflective of their values and moral worth, and working toward an ideal healthy and able body as compulsory. I concluded in Chapter One that the positioning of wellness as opposed to illness reinforces ableist ideas about bodies because it positions the ideal able body as opposed to any body less-than-well, including not just those with acute, passing disease but those with chronic illness and disability. In this way, the term wellness does rhetorical work in the world by definitionally foreclosing the possibility that people with chronic illness or disease can ever achieve wellness. In the rest of this subsection, I will draw on evidence from my archival textual analyses to demonstrate how the UMN EWP describes wellness.

At its inception, the UMN EWP drew on the National Wellness Institute's definition, which the EWP built on (adding environmental) in offering their initial holistic definition of wellness:

Wellness is both the balance of the mind, body, and spirit and also how we relate and live in the world. For our wellness model we have chosen seven dimensions: intellectual, physical, spiritual, emotional, social, occupational, and environmental. (University of Minnesota, 2003).

As noted in the “What is health?” section above, in addition to highlighting wellness as holistic and multidimensional, the EWP also positioned it as an individual responsibility, arguing that “We can achieve high-level wellness by being aware of our healthy or unhealthy habits and changing those that are unhealthy” (University of Minnesota, 2004a, para. 2). Of note in this definition is the juxtaposition of healthy and unhealthy, which echoes a biomedical model of health focused on deficit, or the positioning of illness as a deficit in need of intervention and cure.

By 2006, when incentives for participation were first introduced, definitional language around wellness disappeared from the website. The new Wellness Assessment, a form for reporting biometrics which could earn an employee a \$65 reward, was promoted with a “Know Your Numbers” page that proclaimed:

The wellness assessment is a confidential online tool to provide immediate feedback to help you improve or maintain your health. When you take the assessment you will be asked not only about your health habits and lifestyle, but, you will be asked to provide specific information regarding your body measurements.

To complete the wellness assessment **you will be required to know your height and your weight.**

While it is not necessary to provide other key indicators of your health, your assessment results will be more thorough and more beneficial to you if you can also provide the optional biometric measurements listed below.

Blood Pressure

Total Cholesterol

HDL Cholesterol

LDL Cholesterol (fasting)

Triglycerides (fasting)

Glucose (non-fasting)

BMI (Body Mass Index)

Body Fat

(University of Minnesota, 2006b, para. 1-4, emphasis original)

This shift demonstrates the move away from language around holistic wellness and

toward a quantified, surveilled, biomedical version of health maintenance. From this point on, biometrics and risk prevention remained prominent in Wellness Program promotional materials, though a brief nod to holism reappeared in 2017 when the program was renamed the Wellbeing Program and a tagline was added at the top of the EWP home page stating: “The University of Minnesota is dedicated to supporting all aspects of your wellbeing, including your physical, emotional, financial, and social health” (University of Minnesota, 2017c, para. 1). I will discuss the implications of this shifting discourse further, but for the time being the important thing to note is how the UMN EWP’s definitions of wellness shifted further toward biomedical models of health and biometric health measurements as time progressed. Ultimately, the UMN EWP framed wellness as holistic, but mobilized a biomedical model of health (disease intervention and cure) through its material-discursive practices, something I will discuss in more depth later in this chapter.

### **What is Healthy Eating?**

In my discussion of “What is healthy eating?” in Chapter One, I detailed how the dominant model of nutrition in the U.S. is hegemonic (Hayes-Conroy & Hayes-Conroy, 2013). Hegemonic nutrition relies on the idea that the food-body relationship can be standardized and quantified (a calorie is a calorie to everyone) (Mudry, 2009), reductively views food as a conglomeration of nutrients and their specific roles in the body (Scrinis, 2013), and decontextualizes food from culture, bodies, and the environment, and privileges expert knowledge which is disseminated through biomedicine, the media, the diet industry, and social institutions (Hayes-Conroy & Hayes-Conroy, 2013). Further, hegemonic nutrition models link eating practices with neoliberal discourses of individual responsibility and morality, positioning fatness as the

result of lack of self-control, making poor choices, or having poor morals (Biltekoff, 2013; Derkatch & Spoel, 2017; Guthman, 2011; Hite & Carter, 2019). The idea of self-improvement through hegemonic ideas of “healthy eating” has been used to mark, other, and devalue fat bodies, especially those that are disabled, gendered, and racialized (Gerber, 2020). In the remainder of this subsection, I will discuss how the UMN EWP framed healthy eating.

When the UMN EWP launched in 2003, it presented healthy eating and nutrition as a key element of physical wellness (University of Minnesota, 2003). Resources were a major element of the 2003-2004 EWP website, and one of the largest categories was “What you’re eating,” which linked to the U.S. Food and Drug Administration’s Center for Food Safety and Applied Nutrition website, the U.S. Department of Agriculture’s Center for Nutrition Policy and Promotion website and its Interactive Healthy Eating Index, the USDA DGA, and the UMN Department of Food Science and Nutrition’s *Nutrition Initiative* (University of Minnesota, 2005). The *Nutrition Initiative* listed five goals including better defining the role of nutrition in human health, developing diets for chronic disease treatment and prevention, increasing the understanding of food as medicine, and transforming nutrition research to improve population health (Department of Food Science & Nutrition, 2004). In this way, at inception, the UMN EWP defined healthy eating through nutrition policy and research and broader government programs like the DGA.

Specific nutritional guidance through the resources list disappeared from the UMN EWP around 2006, when the Wellness Assessment and its \$65 incentive launched as the new core component of the EWP, though the banner on the EWP homepage featured three call-to-action phrases overlaid on images: “Be active” on a photo of two



older people exercising, “Eat right” next to a picture of a young woman biting into an apple, and “Healthy lifestyle” overlaid on top of a woman and child doing yoga (University of Minnesota, 2006c). In 2010, when the UMN EWP added weight management programming, it also launched a new page called “Manage Your Weight” promoting the addition of Weight Watchers at Work and a program called Create Your Weight through a local medical center (University of Minnesota, 2010e). The main discussion on this new page was the out-of-pocket costs and the amount of reimbursement employees could receive. In 2016, this was replaced with a page titled “Nutrition and Healthy Eating” which provided information about Weight Watchers at Work, health coaching, a weight management program specific to the Morris campus, and the new Cooking for Wellness class, which centered nutrition, offered through the UMN’s Healthy Foods, Healthy Lives institute (University of Minnesota, 2016). Other than promoting its weight-loss programs, the EWP website had little to say about nutrition (likely because it contracted the actual EWP out to a series of external vendors that placed wellness information behind a login system) until it dropped Weight Watchers as an option in 2019, when it noted on its website it would be seeking replacement programming that was more focused on nutrition than weight-loss (University of Minnesota, 2019a).

While the employee-facing materials did not directly define healthy eating, the focus on the DGA, weight loss, and nutrition science advanced a model of healthy eating that reified broader hegemonic nutrition discourse. And, ultimately, the reliance on a hegemonic nutrition model meant the UMN EWP was materially-discursively practicing “healthy eating” in ways that reify moralistic judgments about eating and systemic medical ableism, or the marking of fat bodies as non-ideal. The ideal body is both thin

and able-bodied, or, as Goffman (1963) posited, a college-educated, heterosexual, white male of good complexion, weight, and height who is physically fit. The fat body, on the other hand, is risky due to behavior like “unhealthy” eating and fatness’s association with obesity and, by extension, chronic illness and disability.

### **Health, Wellness, Healthy Eating, and Medical Ableism**

In this section, I returned to the prior or rhetorical questions around health, wellness, and healthy eating that I outlined in Chapter One. There, I drew on various dictionary definitions and scholarly literature to outline some possible answers. Here, I tried to surface how the UMN EWP’s material-discursive practices provide insight into their definitions of health, wellness, and healthy eating and the practices they suggest employees adopt by drawing on data in my archival dataset. In Chapter Five, I will return to these rhetorical questions once more in order to demonstrate how employees’ material-discursive practices might provide some answers. Before that, though, in the next section of this chapter, I discuss my analysis of how the UMN EWP enacted food and wellness *as/for*.

### **Enacting Food and Wellness**

My overarching methodology, as described in Chapter Two, centers people’s lived experience. I used a model centering lived experience through praxiography and multiple ontologies theory (Graham, 2015; Kessler, 2020b, 2022; Mol, 2002; Molloy, 2015; Pender, 2018; Teston et al., 2014) that foregrounds practice, or the ways in which meaning is *enacted* in contexts and situations. Praxiography and modified grounded theory methods helped me to trace practices in people’s stories and to look for themes around those practices. Further, praxiography helped me to understand the different *meanings* that enactments of food and wellness set in motion and their relationship to

how people experience their bodies and their health in their daily lives. As this chapter presents analysis from my archival data, my goal in this section is to trace in more depth the UMN EWP's enactments of food and wellness.

I use the term *enact*, following Mol (2002), who adopted it over terms like 'perform,' 'construct,' and 'stage' because enact "doesn't suggest too much [or have] too much of an academic history" (p. 32). As a scholar with a background in sociology, terms like "perform," "construct," and "stage" bring with them a lot of baggage for me from social constructionism and sociological theory. While other rhetoricians of health and medicine have used terms like 'stage' alongside 'enact' (e.g., Kessler, 2022), I lean heavily on the term 'enact' in this dissertation because, like Mol, it feels like a theoretically distinct term to use to describe *doing*.

In this section, I use the distinction "as/for" to frame the two ways I see enactments taking place. *As* indicates "in the same way" or a comparison of equivalence, and aims to get at how some things are enacted *as* other things, in essence becoming them. For example, chicken soup has been touted as a treatment for a common cold for centuries. Eating soup in order to cure or alleviate a cold enacts food *as* medicine, making it equivalent in practice to taking something like pseudoephedrine (aka Sudafed) for congestion. *For* indicates "in order to," adding the nuance of purpose or outcome, and aiming to get at how some things are enacted *for*, or in order to achieve, other things. Eating soup in order to cure or alleviate a cold is also an enactment of food *for* health, or in order to achieve health. However, not all chicken soup consumption is related to health status, because chicken soup can be many other things, including a good use for leftover bones from a roasted chicken, a delicious meal for a cold winter day, or for following a family tradition (as in "my grandma's chicken soup recipe").

In my Methodology section in Chapter Two, I noted that Mol (2002) strongly emphasizes the aim of praxiography as going inside medicine to “look *at* the practices that enact disease and bodies, but not *behind* them for hidden forces or agendas” (Pender, 2018, p. 78). Mol focuses tightly on “locality” or the idea of understanding the value of enactments in their specific local contexts rather than aiming for universality or generalizability (1998, 2002). While I appreciate Mol’s aim, in order to foreground issues of power and oppression, I must look both at the practices that enact wellness *and* behind them for implicit/invisible hidden forces and goals. Systemic oppression is structural, rooted in power dynamics that privilege certain groups while marginalizing others (Young, 1990); it shapes the very nature of practice by facilitating and foreclosing what is possible in a given place/time. In other words, in this section I aim to describe how food and wellness were enacted by the UMN EWP while also considering the larger socio-political forces that shape who gets to practice wellness and what practices are valued or devalued. In turn, this allows me to foreground how the UMN EWP facilitates and restricts access to wellness.

Therefore, I use *as/for* with a slash to indicate that, while each is important on its own, the two ways of enacting are entangled and often inseparable, especially in health and medical contexts. In what follows, I discuss the ways that the UMN EWP enacted food and wellness *as/for* through its material-discursive practices. I present analysis of enactments of food and wellness across two major subsections in order to get at the ways *food* is enacted as a component of wellness, and ways *wellness* is enacted more broadly, but also to tease apart some of the entangled and circular ways that food, eating, and wellness are enacted *as/for* each other. Throughout my analysis, I aimed to foreground the ways that the EWP, perhaps inadvertently, perpetuated systemic ableism, racism, and

classism through its programming. In Chapter Five, I will return to this framework of food and wellness *as/for* in order to center people's lived experience with EWP programming; here, I analyze EWP practices in order to understand how it is enacting food and wellness as a foundation for Chapter Five's analysis of employee lived experience. In other words, before I could address people's lived experience with the EWP, I needed to establish what the EWP is doing. However, despite employee lived experience not taking a central role in this chapter's analysis, *story* is still central, because stories can manifest in many ways, as I touched on in Chapter Two's Methodology section. I interpret the EWP's material-discursive practices as telling a story about its enactments of food and wellness and how they *mean*.

### **Enacting Food**

While enactments of food and eating varied significantly, depending on a multitude of factors including culture, health, and economics, three broader themes arose out of my praxiographic modified grounded theory analysis of archival data: food *as/for* wellness; food *as/for* medicine; and food *as/for* economics. In the context of food, an enactment of food *as* medicine would mean food becomes or is equivalent to medicine, but also that food is being enacted *for* the same purpose one takes medicine—the prevention or curing of disease. In this section, therefore, I will discuss what it means to enact food *as/for* something else, meaning both “in the same way” and “in order to.” I will use the three main themes of food *as/for* wellness, *as/for* medicine, and *as/for* economics to delineate how the UMN EWP enacted food.

### ***Food as/for Wellness***

Food has a long history of entanglement with health and wellness (Melonçon, 2021), dating back to ancient times when Hippocratic medicine viewed food, drink, and

air as the source of the substances of the body; food was assimilated into and became the body, and was thus tightly connected to one's health in a positive sense (Cardenas, 2013). The connection of eating to health manifests in Western adages such as "An apple a day keeps the doctor away," and famous quotations like Jean Anthelme Brillat-Savarin's (1949), "*Dis-moi ce que tu manges, je te dirai ce que tu es*" ("Tell me what you eat, and I will tell you what you are") from which derives the modern adage "you are what you eat." Because of the history of food-health connections in theories of health and medicine, popular culture, and more recently, biomedical and popular discourse about an 'obesity epidemic' and its linking of fatness and disease or risk for disease, eating-related programming takes a core role in UMN EWP programming as seen in the kairology earlier in this chapter. Building on the theoretical frameworks detailed in Chapter One and on findings from my analysis of archival data, I define *food as/for wellness* as the idea that eating the right foods can lead to complete individual holistic well-being by improving the already-healthy person. In the remainder of this section, I demonstrate how the UMN EWP enacted food as/for wellness.

The UMN EWP connected food and holism in its ideas about wellness from the beginning of the program. As noted previously, the first iteration of the EWP website in 2003 described a holistic model of wellness including seven dimensions: intellectual, physical, spiritual, emotional, social, occupational, and environmental (University of Minnesota, 2003). Each dimension had its own page on the website, and the page for physical wellness included resources for "sound nutritional practices, stress management, and physical fitness" (University of Minnesota, 2004b). In this way, the UMN EWP enacted food as a key component of wellness.

Food has long been a strong visual theme in EWP promotional materials: a young

white-appearing woman biting into an apple in the banner of the 2006 wellness homepage (University of Minnesota, 2006); an Asian-appearing woman eating a small bowl of cut fruit with chopsticks (University of Minnesota, 2008); a basket of squash, melons, tomatoes, corn, and strawberries overflowing onto a table in the 2012 wellness website banner and the 2012 *Wellness Points Bank* brochure (University of Minnesota, 2012b); a white-appearing woman's hands chopping carrots, radishes, potatoes, and peppers on a rustic wood counter in the 2017 *Wellbeing Program Guide* (University of Minnesota, 2017b); and a white-appearing woman's hands holding a bowl of granola cereal with bright red currants on top and a bunch of bananas in the background (University of Minnesota, 2019b). In each case, food was one of only a few key images in the promotional materials, and each photo showcased brightly colored fruits and vegetables. If bodies were included with the food they were overwhelmingly white-appearing women's bodies, or more often, parts of bodies. This visual messaging communicates three key points: wellness is for white women, wellness is tightly linked to food, and food as/for wellness means fruits and vegetables. While non-white people are included more frequently in other types of images in EWP promotional materials (something I discuss further in the "Enacting Wellness" section below), there was only one non-white person depicted in the same image as food (the Asian woman stereotypically using chopsticks), and there were not any prepared dishes (other than granola). These depictions of food in a wellness context within the EWP's promotional materials presents an image of food and wellness that replicates a white, upper-middle class model of eating. Further, the predominance of images of white women enacts a racist model of wellness as whiteness, something noted as predominant in other wellness practices (Derkatch, 2022).

In terms of eating-related programming, holism (or multidimensional health) was a key element in programming decisions from the beginning. The EWP helped start a farmers market in 2005, aimed at bringing fresh, local fruits and vegetables to campus. An internal news story touted that “the farmers market goes hand-in-hand with the overall [EWP] philosophy of eating right and knowing what’s healthy” by offering employees “the chance to buy fresh, ripe, and high-quality produce grown locally ... in other words, you’ll know where your produce comes from” (Oo & Marty, 2005). In addition to this characterization of fresh produce as healthy, I interpret the farmers market as an EWP practice that connects wellness to ideas about good citizenship through discourse about local foods contributing to environmental and community well-being (Derkatch & Spoel, 2017). UMN EWP practices like the farmers market are both ways the EWP enacts food as/for wellness, and means for suggesting what employee practices *ought* to be by promoting shopping at the farmers market as a healthy practice on multiple levels. Lastly, the farmers market embraces holism by offering more than food; its web page highlights market partners, touting that “in addition to buying locally grown produce, berries, and fresh flowers, you can ... ride your bike to the market ... pick up fitness tips ... [and] apply sunscreen provided by the Masonic Cancer Center” (University of Minnesota, 2018a).

Notably, while the farmers market demonstrates holism, it is not a points-eligible activity under the EWP. Further, the farmers market is only accessible in specific locations during brief time-frames. On the Twin Cities campus, it only takes place once per week over lunch in a single location on the Twin Cities campus from about mid-July through about the end of September (University of Minnesota, 2018b). A large number of employees work a prohibitive distance from the market, may be unable to leave their jobs



to visit, or may be on nine-month academic year contracts and away from campus in July and August. Other system campuses either never have had a farmers market on campus, or in the case of the Duluth campus, it stopped taking place years ago.

The other key example of holistic eating-related programming was the cooking for wellness course series added in 2016 in partnership with the university's Healthy Foods, Healthy Lives Institute (BAC, 2016b). Promoted as teaching “foundational techniques to adapt your cooking for a healthier lifestyle and greater well-being” the classes promised to teach participants “how to include fresh produce, whole grains, and healthful proteins to make delicious and nourishing meals” (Healthy Foods, Healthy Lives Institute, 2016, para. 3-4). I view the cooking courses as holistic because they offer sessions and recipes from a variety of cuisines and foodways, and aim to embrace a view of healthy eating focused more on pleasure and enjoyment of food than on central aspects of a hegemonic nutrition model, such as quantification (the reduction of food to numbers of calories and nutrients) and nutritionism (the privileging of certain nutrients over others).

Overall, the EWP enacted food as/for wellness—or the idea that eating the right foods can lead to complete individual holistic well-being by improving the already-healthy person—through centering it discursively in promotional materials, through language around the links between eating and wellness, and through programming such as the farmers market and cooking for wellness classes.

### ***Food as/for Medicine***

As with wellness, the connection of food to medicine dates back at least to ancient times (Melonçon, 2021). In Hippocratic medicine one of the first priorities in treating illness was dietary intervention (Cardenas, 2013). In modern Western societies like the

U.S., biomedicine and hegemonic nutrition models drive the determination of “healthy” or “good” foods and “unhealthy” or “bad” foods, which reduces food from a social, cultural, contextual, and embodied experience into a remarkably biomedicalized tool (Biltekoff, 2013; Biltekoff et al., 2014; Broad & Hite, 2014; Hayes-Conroy & Hayes-Conroy, 2013; Mudry, 2009; Scrinis, 2013). The tight ties between hegemonic nutrition—or the reductive focus on calories and nutrients and their role in bodily health—and obesity discourse position (or biomedicalize) fatness as indicative of disease (i.e., obesity) or risk for disease (e.g., heart disease, type 2 diabetes). The positioning of fatness as indicative of disease or disease risk frames fat bodies as in need of medical intervention, treatment, or cure. Bringing these concepts together, I define *food as/for medicine* as the idea that eating food, as enacted in dominant Western hegemonic nutrition models, can help cure current individual disease or illness, or intervene as a treatment for a disease risk factor such as overweight or obesity. My definitions of food as/for wellness and food as/for medicine are similar, because both focus on the use of food to improve health. However, food as/for wellness is focused on improving and enhancing the already-healthy person, while food as/for medicine aligns with the biomedical model of intervention aimed at healing illness or disease.

Food as/for medicine begins with the idea that food, in an expansive sense, can help cure illness or disease. This fits with the medical deficit model of treating disease, rather than prioritizing preventive care, that emerged in the late 19th and early 20th centuries (Foucault, 1994; Hoffman, 2012; Tomes, 2016). With a rise in preventive care in the late 20th century, early intervention to prevent disease became more prevalent (Hoffman, 2012; Tomes, 2016). Alongside this was the rise of the ‘obesity epidemic,’ a biomedicalization of fatness as disease/risk taken up in medical research and popular

discourse as a crisis narrative (Guthman, 2011; Jutel, 2009; Klein, 2010).

However, “several degrees of separation exist between obesity as an indicator of a medical problem and the manifestation of a pathological condition” (Guthman, 2011, p. 39). The use of risk factors as a weak proxy for disease is primarily predicated on measurements like BMI meant to identify non-normative or non-ideal body size. Like reductionism of food in hegemonic nutrition, this focus on a single biomarker as a definitive representation of or determination of health is a reductionist quantification of bodily health (Scrinis, 2013). BMI is a notoriously crude measure of adiposity, or body fat percentage, as it is calculated solely on weight and height and allows no differentiation based on bone density or muscle mass (Guthman, 2011). Further, BMI was popularized through its use in life insurance actuarial tables charting BMI and death rates, derived from statistical averaging used to define “normal” rather than medical assessments of body size and health (Guthman, 2011).

Biomedical links between obesity and chronic disease are taken up widely in medical and popular discourse, though “interventions that target obesity to prevent chronic disease assume cause-effect relationships between these interventions (such as dietary changes or exercise programs), obesity, and chronic disease outcomes that are highly contested; some of these interventions may even be considered harmful” (Hite & Carter, 2018, p. 154). Yet, BMI as a measurement of health and health risk has become nearly ubiquitous across technical, public, and personal spheres. In turn, fatness, as measured by BMI, becomes the target of medical intervention even without the presence of illness (Berlant, 2007; Brown, 2015; Jutel, 2009; Sadler, 2014). Importantly, as discussed in Chapter One, the conflation of body size and health is an ableist delineation of what ideal bodies should look like. Because of the ties between hegemonic nutrition,

biomedicine, and the biomedicalization of fatness and risk, food as/for medicine includes institutional efforts to delineate what counts as “healthy” food and to drive modification of eating habits for weight-related reasons. In other words, the UMN EWP enacted food as/for medicine through material-discursive practices around what healthy eating and a healthy weight are and programming (e.g., Weight Watchers) aimed at weight loss.

Further, risk is an important component of my definition of food as/for medicine because models relying on weight-related risk factors and individual responsibility often advise individuals to change their eating habits and follow a hegemonic nutrition model (Biltekoff, 2013; Broad & Hite, 2014; Guthman, 2011). The most prevalent hegemonic nutrition model is the USDA DGA, which informs nutritional labeling in the US as well as many diet programs. Together, the key concepts of biomedicalization, risk, and hegemonic nutrition support the idea that food, as enacted in hegemonic nutrition models, can help cure current individual disease or illness, or intervene as a treatment for a disease risk factor such as overweight or obesity. Further, risk and surveillance are deeply connected (Clarke et al., 2003), and surveillance of risk is a key factor in the UMN EWP.

Despite its public-facing emphasis on holism outlined in the previous section, the UMN EWP’s reliance on a risk-based framework drove the inclusion of eating-related programming based on a hegemonic model. Because it was tied to health insurance costs from inception, EWP programming was always tightly connected to measures of population health risk. Both internal meeting minutes and employee-facing promotional materials since inception (BAC, 2002c, 2006d, 2008a, 2009, 2010a, 2010b, 2011d, 2013b, 2015a; University of Minnesota, 2010a, 2017b, 2019b) have advocated for the value of a healthy lifestyle, while simultaneously invoking the importance of preventing or avoiding illness or disease, primarily through assessing and monitoring risk factors.

For example, in 2001-2002, the Benefits Advisory Committee established a Wellness Subcommittee tasked with exploring how to implement an EWP. In 2002, an extensive discussion of potential EWP goals included the suggestions that the EWP focus on “prevalence of problems” among the university community and “assist[ing] its population in understanding lifestyle risks ... related to obesity, exercise, smoking, etc.” (BAC, 2002c, p. 3). The internal prioritization of addressing lifestyle risk factors bled into employee-facing promotional materials, such as the 2010 *Discover Wellness* newsletter that argued on its front page that “When you and your spouse/SSDP<sup>15</sup> complete the assessment every year you can gauge how your health habits are affecting your risk for developing illness and disease” (University of Minnesota, 2010a, p. 1, emphasis original). The perennial discussion of population risk assessment and reduction in internal texts along with the continued focus on individual health risk management in employee-facing promotional materials demonstrates how risk was a key focus in the EWP.

Weight as a risk factor was a central concern, with BAC meeting minutes noting that weight was the second-highest risk factor among the employee population, and that stress, weight, exercise and cholesterol levels together accounted for “83.5% of the University’s avoidable health care costs” (BAC, 2006d, p. 2). This foregrounding of weight as a risk drove EWP eating-related programming based on dietary change and weight loss. In 2006, a lifestyle coaching program was added; diet coaching delivered by trained dietitians was a key element (BAC, 2006a, 2006c). In fall 2009, two weight management programs—Weight Watchers at Work, and a program run by a local medical clinic system—were added specifically in order to address the “overall population weight

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<sup>15</sup> Same-sex domestic partner — this newsletter was produced prior to the passage of same-sex marriage laws in Minnesota in 2013, but during a time when UMN allowed employees to declare a same-sex domestic partner for the purposes of benefits coverage.

management issue” (BAC, 2009, p. 7). Importantly, the dietary coaching and weight-loss programs included in the UMN EWP were based on hegemonic nutrition models and, further, relied on surveillance through the use of BMI and measures like blood glucose and cholesterol. In other words, the UMN EWP’s enactment of food through its nutrition and weight-loss programming promoted the quantification of both food and bodies.

While the university has removed Weight Watchers at Work from the UMN EWP as of 2018, their statement that they are researching replacements that are nutrition-focused instead of weight-loss-focused strongly implies they will replace one program based on hegemonic nutrition with another. The EWP’s adoption of programming based on or utilizing hegemonic nutrition, which was built on models that privileged upper-middle-class white American values (Biltekoff et al., 2014), excluded any nuanced consideration of race, class, or culturally diverse eating habits.

Another key aspect of hegemonic nutrition is the linking of diet, obesity, and disease, which is best evidenced by the introduction to the 2020-2025 DGA that situates their dietary guidance as based on science demonstrating that “healthy eating across the lifespan can promote health and reduce risk of chronic disease” (U.S. Department of Agriculture and U.S. Department of Health and Human Services, 2020). In this way, hegemonic nutrition promotes food as/for medicine through the claim that food and individual food choices are at the root of fatness, health status, and that, in turn, food can be used to prevent or cure weight-related health risks or disease. In early iterations of the UMN EWP, the dietary advice provided adhered closely to the DGA (University of Minnesota, 2004b); in more recent versions of the EWP, the dietary advice provided by external vendors, including formal dieting programs like Weight Watchers, also promotes a hegemonic—quantified and nutritionist—model. In the UMN EWP, the prioritization of

weight as a risk factor to be avoided/treated and the concomitant incentivization of nutritional coaching and weight-loss programming replicated an ableist medical model of the ideal body as thin by suggesting that employees deemed to be overweight or obese change their eating practices. Overall, these are key ways the UMN EWP enacted food as/for medicine. In other words, much of the eating-related programming in the UMN EWP takes up the idea that food can help cure current individual disease or illness, or intervene as a treatment for a disease risk factor such as overweight or obesity.

Ultimately, there is nothing wrong with food as/for medicine, generally speaking. People have been enacting food as/for medicine for millennia with good reason: the overwhelming evidence is that food is an important part of health. That said, it is important to recognize that food as/for medicine is predominantly enacted in the U.S. in ways that are based on and reinforce white, upper-middle-class ideas about food and biomedicalized norms about body size based on statistical correlations (Biltekoff, 2013; Biltekoff et al., 2014; Hite & Carter, 2019). In other words, the dominant U.S. model for food as/for medicine is rooted in racist, classist, and ableist ideas about eating and bodies. The UMN EWP then centered these ideas through its eating-related programming. Thus, the UMN EWP's enactment of food as/for medicine also inherently, even if inadvertently, enacted racism, classism, and ableism.

### ***Food as/for Economics***

In the UMN EWP, the enactment of food as/for medicine is driven by measures of population health risks and return-on-investment (ROI) evaluations, which incent the university to monitor and evaluate employee health data, both self-reported through the EWP and gathered via the administration of the employee health insurance plan. In this subsection, I demonstrate how food as/for economics drives the UMN EWP; in other

words, I show how budgetary concerns incent the EWP to prioritize the inclusion and incentivization of eating-related programming.

The use of BMI to evaluate risk for health issues in the context of health insurance programs is a practice that drives the construction of fatness as not just a health risk, but a financial risk. Individuals with chronic diseases like type 2 diabetes necessitating ongoing treatment and/or medication may lead to higher health insurance usage and costs for employers (Nyman et al., 2009); by extension, those deemed at risk due to fatness are also at risk for higher health insurance costs. Population-level correlations about weight and risk are then deployed as an individual-level intervention via diagnosis and treatment (e.g., dietary changes). Food becomes a biomedicalized *economic* tool when weight and risk are entangled with health insurance and healthcare costs, contingent on the idea that hegemonic nutrition practices can reduce/eliminate risks, which may ultimately reduce incidence of disease and thus costs. Following these ideas, I define *food as/for economics* as the idea that collectively eating the right food can help solve (cure) the population-level issues of rising health insurance and healthcare costs. In this section, I will demonstrate how the UMN EWP enacted food as/for economics in order to address its own budgetary issues.

As noted in my kairology in Chapter Three, the EWP was only developed and implemented because of a budget crisis that led to the UMN separating from SEGIP, the state health insurance plan. One of the four original goals of establishing the new UPlan self-insurance program was establishing a wellness program (BAC, 2003a). Further, the original four objectives of the UMN EWP were: “improve morale; improve productivity; improve culture and image of the university; [and] help manage health care costs” (BAC, 2003f, p. 6). Importantly, two of these were financial: improving productivity and



managing healthcare costs.

Based on these goals and objectives, three key decisions were made in 2001 and 2002 during program development: first, the EWP would be permanently housed in Human Resources, which would also administer the UPlan; second, specific EWP programming would be determined based on existing employee health risk data; and third, program evaluation would be needed, primarily focused on ROI measures and reduction of population health risks (BAC, 2001a, 2002c). While EWPs in general are closely tied to health insurance, as noted in Chapter One, these specific decisions underscore UMN's binding together of health insurance, a risk-based framework, and the primacy of financial outcomes.

Notably, every time the university faced significant budget shortfalls, one of the targets was rising insurance costs, and discussion at the BAC turned to ways to increase participation in the EWP (BAC, 2003b, 2003c, 2010e, 2011b, 2012, 2013a). For example, the April 3, 2003, Benefits Advisory Committee meeting included the university president, a senior vice president, and a vice president as guests, a rare occurrence in the nearly two decades of BAC meeting minutes I analyzed. The inclusion of high-level administrators at this meeting was due to the historic budget shortfalls that were instrumental in creating the kairotic moment when arguments for an EWP became successful (see "Success in the early 2000s" in Chapter Three's kairology). The university president opened the meeting by stating that "there will need to be shared sacrifices on the part of all faculty, students and staff in terms of pay freezes, tuition increases, programmatic cuts as well as extraordinary reductions in certain areas" in order to resolve the budget issues (BAC, 2003b, p. 1). When the time came in that meeting to discuss health benefit changes, the senior vice president outlined justification for a

wellness program, claiming that “the long-term control of health inflation is to be found in a wellness initiative ... that will help the University control its inflation in premiums” (BAC, 2003, p. 5). This quote opened this chapter, and underscores how ROI was a key measure of success for the EWP from the beginning (BAC, 2004b), and in addition to EWP vendor measurements of ROI, as noted in Chapter Three, the university contracted Dr. John Nyman in the UMN School of Public Health to investigate ROI (BAC, 2008b). Nyman and colleagues’ work resulted in a scholarly publication that demonstrated positive ROI, noting that the disease management program, in particular, generated enough ROI to more than pay for the cost of delivering the entire EWP (BAC, 2011c; Nyman et al., 2009), thus also realizing a savings on health insurance costs through preventive interventions for those with chronic illness.

At the same time, the focus on weight-related risk and disease led to increasing incentivization practices around nutritional coaching and weight-loss programming. In 2006, health coaching was added that included diet, exercise, and tobacco use as three key areas of coaching. In 2009, BAC minutes show that year’s changes to the EWP as including adjustments to coaching to focus on “core conditions identified as having the highest ROI through Professor Nyman’s research” and that the EWP would begin to offer “two new weight management programs to address the overall population weight management issue, which continues to represent a high lifestyle risk for UPlan members” (BAC, 2009, p. 7). Thus, the economic value to the university of employees participating in the EWP drove program evaluation practices, and therefore programming choices, and justified incenting employee participation. In this way, the EWP was enacting food as/for economics.

Monetary incentives quickly became key on the employee engagement side, with

the annual Wellness Assessment as the first program element incentivized for employees starting in 2006 (BAC, 1997-2019, January 19, 2006). Weight management programs were incentivized when added, with promotional materials urging employees to get “money back for weight loss” (University of Minnesota, 2010a, p. 1). Importantly, the incentivized points system privileges the biomedical, as it is difficult (if not impossible for some employees) to earn the required 500/750 points without completing one of the biomedicine- or biometric-based activities. The farmers market, one of the key eating-related holistic activities, does not count toward the points system, but participation in Weight Watchers at Work or dietary coaching could earn 200 to 250 points (University of Minnesota, 2018a). Lastly, until 2018, it was not possible to earn credit for personal everyday practices such as cooking healthy meals or jogging outdoors; in 2018 it became possible to get credit for custom pledges via “Wellness My Way” that would award points for personal activities, though that was limited to 25 points each for up to 5 pledges for a maximum of 125 points. Therefore, the points system is skewed toward highly incentivizing programming aimed at biomedical measures and fostering behavior change designed to reshape individuals’ bodies to better align with ableist medical ideals.

Despite clear concern about population-level health risk factors, the BAC and the EWP framed these risks as individual lifestyle risks both in internal discussions and in employee-facing materials, and thus placed responsibility for them on individuals. In terms of internal discussions, risk reduction and ROI were key concepts from the earliest BAC discussions (BAC, 2002b; Nyman et al., 2009). In internal archival texts, lifestyle risks were described as something over which individuals have “at least partial control” and thus, while the “employer may provide tools [it is] ultimately up to the individual,” and not only did individuals need to take responsibility, they needed to change their

overall attitude about who was responsible for their health (Senate Committee on Faculty Affairs, 2011, p. 6). Similarly, in employee-facing promotional materials, the Wellness Assessment was touted as a key practice for providing “immediate, personalized feedback about your risks for developing a serious medical condition or disease and recommend[ing] lifestyle changes that are necessary to help you stay well” (University of Minnesota, 2010d). The EWP strongly promoted the benefits of biometrics (namely BMI) for employees as part of its push for Wellness Assessments and biometric screenings, though ultimately, the Wellness Assessment and biometric screenings were tools for collecting and monitoring university population health risk data—predominantly data like BMI, cholesterol levels, and body composition—to be paired with health insurance claims data for the calculation of ROI (refer to Nyman et al., 2009). Data is also the reason that employees were not eligible to participate in the EWP unless they are covered by the UPlan, as the data collected is used to measure program efficacy. The privileging of data underscored how the UMN EWP was enacting food as/for economics: data simultaneously gives people information aimed at driving lifestyle behavior change in areas deemed expensive for healthcare, and gives the university a means to evaluate ROI, a measurement they made central to evaluation of EWP efficacy.

The neoliberal focus on individual responsibility is another key element of food as/for economics: the idea that *collectively* eating the right foods can help solve (cure) the population-level issues of rising health insurance and healthcare costs. Making individuals responsible for collectively fixing healthcare costs elides the underlying role of the U.S. healthcare system in skyrocketing costs and the contributions of an unjust medical and insurance system to those costs. As I have argued throughout this dissertation, in the U.S. health is a reflection of oppression through systems, institutions,

and policies. Social determinants of health—the way that systemic factors influence health outcomes—contribute to disproportionate incidence of things like medically-defined obesity and certain diseases that inequitably affect lower-income populations. Rather than food as/for economics revolving around *institutional* responsibility for access to and costs of food and healthcare, the UMN EWP promotes a neoliberal model of food as/for economics that places responsibility on the *individual*. In other words, the UMN EWP positions individuals as responsible for collectively solving systemic issues, which makes invisible the systemic origins of those issues. Healthcare costs are rising in the U.S. not solely because of individual health or healthcare usage, but in large part due to a capitalistic, profit-driven system of private insurance and healthcare providers (Tomes, 2016). Yet, neoliberal ideas of health citizenship frame the “good” health citizen as individually responsible for participating in collective action to serve the greater good (e.g., to reduce healthcare costs for all) (I unpack citizenship further in Chapter Six). While reduction of healthcare costs may trickle down to and benefit individuals, it is the focus on individual responsibility to participate in collective action in order to solve systemic issues that I critique here. This is why I use the word “collectively” in my definition of food as/for economics: enactments of food as/for economics rely on individual responsibility for participating in collective action.

The neoliberal focus on individual responsibility elides institutional roles. For example, as discussed above, while the university brings healthy fruits and vegetables to campus via the farmers market, it only does so at very limited times and places. In contrast, the university provides a variety of dining services (e.g., cafeterias, coffee shops, convenience stores, fast food retailers) across all campus locations which could serve as a source of healthy foods for employees, but while BAC members suggested

improving the food options during dining services contract negotiations over the years, it is not clear that the university has taken up these suggestions (BAC, 2002a, 2012, 2016a). When confronted during a BAC meeting with the lack of healthy food choices available through dining services, the university president responded that while he "appreciated the comments, he reminded members that there is an element of personal responsibility when it comes to a healthy lifestyle...the University can help provide the structure, [but] it ultimately comes down to personal responsibility" (BAC, 2012, p. 2). I interpret this BAC exchange as evidence of how the university sidesteps its role in food practices in the workplace while reifying a neoliberal model of individual responsibility. While no motivation for the university president's comments are attributed in the 2012 BAC minutes, the broader context of the conversation at that meeting was the upcoming state economic forecast and its impacts on university benefits. In this context, I read the university president's comments as not only avoiding institutional responsibility for providing healthy food, but also the potential financial impacts to the university that providing healthier food via dining vendors might cost. In this way, the university enacted food as/for economics by placing responsibility on individuals, labeling critiques of food availability as outside the EWP's scope, and reifying the reductive idea that individual choices are wholly responsible for weight and related health risks.

Ultimately, ever-shrinking university budgets have placed continuous pressure on the EWP to reduce health insurance costs in measurable ways, incenting the university to promote the EWP to its employees. In turn, these economic considerations drove the prioritization of practices to reduce biomedicalized health risks such as obesity and obesity-related disease in order to reduce health insurance claim costs among the employee population. Importantly, the EWP's material-discursive practices (through

promotional materials and programming options) typically focused on driving individual behavior change to improve eating habits, rather than looking to possible institutional changes. This focus fails to account for the complex nature of weight-related health problems, access to food, and any eating choices that fall outside the DGA- and weight-loss-program-based recommendations and norms. Overall, the EWP is deploying hegemonic nutrition-based eating-related programming because of budgetary concerns and rising health insurance costs. In other words, through institutional priorities, neoliberalism, and incentivizing weight-loss, the UMN EWP is enacting food as/for economics.

### ***Promoting Wellness but Enacting Medicine Because of Economics***

In this section, I defined and discussed the idea of food as/for wellness, medicine, and economics. As I worked through my analyses, another question became salient: How does the UMN EWP *entwine* enactments of food as/for wellness *with* enactments of food as/for medicine? I found that though the EWP purported to bring holistic health improvement to employees, as an institutional program tied to financial incentives and health insurance coverage the EWP had a vested interest in shaping efficient, productive, and compliant subjects who participated willingly. Here, I pull together enactments of food as/for wellness, medicine, and economics in order to argue that the UMN EWP is discursively promoting food as/for wellness while enacting food as/for medicine because of food as/for economics.

Wellness has a particular meaning related to holism and health improvement, which the UMN EWP circumscribes by enforcing an ableist biomedical model of health and body size. Ultimately, while the EWP overtly claimed to promote holistic wellness, or the improvement of the already healthy, its reliance on biomedical measures and

biometric data drove an imbalanced points system that privileged the biomedical over the holistic. The incenting of weight-management programs and nutritional coaching invites employees to change their eating-related practices, even if they may otherwise be or consider themselves to be healthy. The superficial discursive focus on holism belies a system of self-tracking and surveillance based on the biomedicalization of risk, encouraging employees to construct themselves and their health (or potential for ill health) through numerical measures like BMI, cholesterol, and blood pressure. In this way, the EWP is an example of how wellness's pervasiveness and commercialization has shifted wellness practices away from the idea of health improvement and at least partially toward a medical illness model of surveillance and intervention (Derkatch, 2012).

Overall, in tangling and differently incenting holistic and biomedical practices, the EWP mobilized ideas about food, being well, and eating well that were driven by a risk-based framework privileging the quantification of food and health while advancing the idea of weight as a serious health risk in need of intervention. In other words, while the EWP *talked about* food as/for wellness, it was *doing* food as/for medicine *because of* food as/for economics. While these are all enactments, teasing apart the discursive from the material helps illuminate how the EWP *says* one thing and *does* another. In the next section, I will present my analysis of the EWP's enactments of *wellness*.

### **Enacting Wellness**

In this section, I turn from enactments of food as/for to enactments of wellness as/for. Like food, enactments of wellness in my archival data varied significantly, depending on a multitude of factors including culture, health, values, and economics. Three broader themes arose out of the data: wellness as/for holistic health, wellness as/for medicine, and wellness as/for economics. While these are similar in nature to enactments



of food described in the section above, there are subtle but important differences, which is why I discuss them here separately. I use the as/for distinction here in the same way as in the “Enacting Food” section. Thus, in the context of wellness, an enactment of wellness *as* medicine would mean wellness becomes or is equivalent to medicine, but also that wellness is being enacted *for* the same purpose one takes medicine—the prevention or curing of disease. In this section, therefore, I will discuss what it means to enact wellness *as/for* something else, meaning both “in the same way” and “in order to.” I will use the three main themes of wellness as/for holistic health, as/for medicine, and as/for economics to delineate how the UMN EWP enacted *wellness*.

### ***Wellness as/for Holistic Health***

Modern wellness is holistic in definition. As discussed previously, Dr. Halbert Dunn built on the WHO’s definition of health as “a state of complete physical, mental and social well-being” (World Health Organization, 2006, p. 1) in developing his model of high-level wellness. Elaborating, Dunn (1961) said:

This implies well-being both in body and mind. It includes well-being within the family and within the community life. And, it certainly includes a compatible work interest. Complete well-being calls for all of these states to happen together—wellness of the body, of the mind, and of the environment. Your body should be eager for activity. Your mind should sparkle with interest. For maximum wellness, the environment should be such as to encourage you to live life to the very full. (p. 2-3)

Building on Dunn’s work, the National Wellness Institute developed and popularized a model of wellness based on six dimensions: intellectual, emotional, physical, social, occupational, and spiritual (National Wellness Institute, n.d.b). The first proposals for a

UMN EWP in 1983 and 1986 adopted a definition of wellness that mirrored this model (Civil Service Benefits Advisory Committee, 1987). When the EWP was launched in 2003, their website built on the National Wellness Institute's multidimensional model of wellness, though it added a seventh dimension—environmental—arguing that “our health is dependent on keeping the earth healthy” (University of Minnesota, 2004c). The National Wellness Institute website suggests that “addressing *all* six dimensions of wellness in our lives builds a holistic sense of wellness and fulfillment” (n.d.b, para. 1, emphasis added), which implies that to ignore any one dimension in practice might mean not achieving wellness.

Importantly, popular models of wellness that arose during the 1970s and 1980s envisioned wellness as a continuum with a perfect state of multi-dimensional health (high-level wellness) at one end and premature death at the other (Ardell, 1977; Travis, 1975). As I demonstrated in Chapter One, while conceptualized as a continuum, wellness is often operationalized as a dichotomy (illness/wellness) or at best, a three-point scale (illness, borderline, and wellness). The continuum model of wellness is neoliberal through positioning people as responsible for their health status and is ableist through its logic of constant individual striving toward an ideal healthy and able body as compulsory. The dichotomization of wellness and illness rhetorically forecloses the possibility that people with chronic illness or disease can ever achieve wellness.

Drawing on this foundational definitional work on modern wellness, I define *wellness as/for holistic health* as the neoliberal, ableist premise that ideal health means being individually responsible for and continually striving toward perfection across broad physical, mental, and social dimensions. I did not delineate as many dimensions in this definition as the National Wellness Institute (which has six) or the UMN EWP (which

has seven) for three reasons. First, the National Wellness Institute and the EWP definitions of wellness frame all dimensions as required areas in order to achieve wellness, as I described above. Second, key elements of other dimensions delineated by them fit within my three broader dimensions; for example, occupational health can involve developing skills and knowledge (physical and mental), feeling passion for and deriving satisfaction from work (mental), and belonging and contributing to a community (social). Third, specifying and differentiating between intellectual, emotional, and spiritual is problematic; it presents opportunities for faith-based oppression (how can atheists or people who do not believe in spirituality achieve spiritual wellness?), may invoke ableist ideas about what it means to be intellectually well, and raises philosophical questions about what the mind and spirit are/are not that are well beyond the scope of this dissertation. Grounding my definition in three dimensions underscores the importance of multi-dimensionality and the whole person to definitions of wellness as/for holistic health, while necessarily avoiding complexities introduced by some additional dimensions (intellectual and spiritual).

Holism was a prominent theme in the UMN EWP's employee-facing promotional materials through inclusion of images of a variety of people engaged in a variety of activities. In the banner for the 2006 EWP website, alongside the young woman biting into an apple discussed in the Food as/for Wellness section above, there is an image of an older white woman and a Black man stretching with the words "Be active" superimposed on it, and an image of a woman and young girl, both white, in a yoga pose (University of Minnesota, 2006). On the 2008 EWP website, the Asian woman eating a bowl of cut fruit with chopsticks also discussed above is centered between two images of white men: a father and young son smiling, and an older man in a swimming pool with goggles on

(University of Minnesota, 2008). In 2012, alongside the cornucopia of fruit and vegetables is a silhouetted family walking on a beach, and a photo of white-appearing men's calves and running shoes (University of Minnesota, 2012b). Brochures followed similar patterns. In the 2018-2019 Program Guide, about one third of the front page is taken up by a large banner with two images: on the left is a photo of a woman in a lotus yoga pose, cropped to show just her crossed legs and wrists resting on her knees; on the right is a photo of a family, cropped to focus on the shoulders and faces of the woman and young girl, who are hugging, smiling and laughing. The all-caps block text overlying the photos says "DO THIS" on the left and "FEEL THIS" on the right (University of Minnesota, 2018a). I interpret this as the EWP claiming that if one engages in holistic health practices like yoga, one will be happy. The only other image in this brochure is a waist-down crop of someone walking a golden retriever. In all the images, the people are white-appearing. Further, in all promotional materials, messaging urges employees to know about and take charge of their wellness efforts across multiple dimensions (University of Minnesota, 2004, 2006, 2008, 2010, 2012, 2017, 2018, 2019).

Three main themes arise from all images of bodies in promotional materials: people engaging in wellness activities were predominantly white; wellness activities included eating produce, exercising, and smiling/laughing a lot, with minimal allusion to holism (beyond happiness which could be interpreted as mental wellness); and that well people are both average in body size (no pictures include fat people) and able-bodied (no pictures include visibly disabled people). More importantly, none of the EWP's promotional materials ever mention disability (nor, as noted earlier in this chapter, did internal conversations ever meaningfully engage disability), though they strongly promote managing chronic illness through EWP programming. I interpret these pieces of

evidence as the UMN EWP enacting wellness as holistic while also reifying, perhaps unintentionally, ableist and racist ideas about who gets to *do* wellness or be well. Overall, these examples from promotional materials demonstrate how the UMN EWP is enacting wellness as/for holistic health through the neoliberal, ableist premise that ideal health means being individually responsible for and continually striving toward a state of ideal wellness across broad physical, mental, and social dimensions.

### ***Wellness as/for Medicine***

Wellness discourse is often mobilized in ways that replicate biomedical preventive care. Prevention has long been a part of medicine, however, the medical deficit model that emerged in the late 19th and early 20th centuries prioritized physicians intervening in existing illness/disease, and preventive medicine fell by the wayside (Hoffman, 2012). While the deficit model remains central to much of biomedicine, prevention returned to biomedicine primarily as identification of and intervention in health risks, driven in part by the ACA requiring insurance plans to cover preventive services (Hoffman, 2012). In preventive medicine, risk is often constructed as the result of lifestyle habits—exercise, eating, tobacco use—and thus the intervention is typically around encouraging individual behavior change (Biltekoff, 2013; Brown, 2015; Lupton, 2013; Mol, 2013; Nyman et al., 2009). As discussed throughout this dissertation, these risk factors are derived from population-level statistics and epidemiological research, and are a poor proxy for or indicator of individual health risk. Further, using risk factors to identify and intervene in individual behavior or “lifestyle choices” elides the complex, co-constitutive social, economic, and political factors that contribute to health disparities and risk factors in the first place (Guthman, 2011; Happe, 2018; Lupton, 2013; Scrinis, 2013).

The turn to risk-based preventive intervention in biomedicine is replicated in wellness models, like the UMN EWP, that rely on identifying individuals considered at risk based on lifestyle factors. Further, reliance on a biomedical model entangles medical ableism with wellness through reinforcing the wellness/illness dichotomy and privileging the able body as the ideal body. Thus, I define *wellness as/for medicine* as the reductive idea that intervening in and modifying individual behavior can treat or cure a preventable disease risk factor. Notably, the main differentiation between wellness as/for holistic health, as defined in the section immediately above this one, and wellness as/for medicine is the focus in the former definition on striving toward ideal health and in the latter definition on treatment or curing of biomedicalized risk factors.

Much like in the earlier section on food as/for medicine, my analysis demonstrates that the UMN EWP is largely predicated on a model of *wellness as/for medicine*. Risk factors operate as a driving force behind EWP programming choices and ROI evaluations, and the idea of risk is invoked in employee-facing materials as well, especially in relation to the Wellness Assessment and screenings, which rely on measures of BMI, blood pressure, cholesterol levels, and blood glucose readings. A page specifically about health screenings on the EWP website for many years argued: “Numbers count. Body measurements matter. The numbers that indicate if your cholesterol is high or tell you what you weigh figure into your chances for developing illnesses such as heart disease or diabetes” (University of Minnesota, 2009). In this quote, the UMN EWP is enacting wellness as/for medicine by discursively framing wellness practices as risk intervention.

Likewise, the way the points system is set up privileges risk-based assessments. In 2018-2019 the program included two assessments: the vendor’s health assessment worth

100 points (which replaced the Wellness Assessment when the EWP moved to being entirely vendor-delivered in 2017); and the biometric health screening worth 150 points. At that time, the number of points needed for the insurance premium reduction was 500 for individual coverage, so one could earn half of those points through assessments, or 750 for family coverage, wherein if both employee and spouse completed the assessments they could earn two thirds of their points. Here, the UMN EWP is enacting wellness as/for medicine through its material practices in terms of how it incentivizes different programming options.

Overall, my research shows that the UMN EWP consistently enacted wellness as/for medicine, even in the same promotional materials where it discusses wellness as/for holistic health. In the “Enacting Food” section above, I concluded that the EWP was talking about food as/for wellness but doing food as/for medicine. Similarly, in this section of analysis, I argue that the EWP is *talking about* wellness as/for holistic health but *doing* wellness as/for medicine. In large part, this is due to a primary focus on physical health prevalent in the UMN EWP since inception, as acknowledged during a 2019 BAC meeting:

Currently the Wellbeing Program focuses heavily on the physical wellbeing of the employee but in the future will aim to address other areas such as social, emotional, and environmental health. [The wellbeing program coordinator] said that many of the changes to the program are intended to make it more inclusive and accessible and increase engagement over the course of the entire year. (BAC, 2019, p. 3)

Despite the similarity in the EWP in terms of talking about food and wellness as key holistic practices while enacting food and wellness as/for medicine, it is important to tease apart the enactments of food and wellness in order to nuance the EWP’s practices. Eating is only one practice within holistic wellness, and thus necessitates the untangling

of food and wellness practices in order to differentiate between and compare them. Overall, my analysis shows that the EWP is primarily talking about wellness as/for holistic health but doing wellness as/for medicine.

### ***Wellness as/for Economics***

Money drives the UMN EWP. While in the “Enacting Food” section above I argued that the EWP is primarily doing food as/for economics, here in the “Enacting Wellness” section I explicate how the EWP is doing wellness as/for economics more broadly. As in my discussion of food as/for economics, a neoliberal emphasis on individual responsibility is core to the idea of wellness as/for economics. A neoliberal model of health assumes that if healthcare costs are rising it is due to increasing healthcare needs based on individual health outcomes related to people’s lifestyle choices and habits, and not instead due to systemic issues in the U.S. related to privatization, commercialization, and deregulation in the pharmaceutical, insurance, and healthcare industries. Ableism is also at the core of wellness as/for economics, in that ableist ideas of productivity are tied up with ideas about what health and wellness mean. Building on this, I define *wellness as/for economics* as the neoliberal, ableist premise that collectively engaging in health risk reduction can help solve (cure) population-level issues of rising healthcare-related expenses and related budgetary issues.

In my kairology in Chapter Three, I discussed in depth how the UMN EWP both grew out of and was shaped by rising health insurance and healthcare costs and university budget crises. The EWP’s connection to UPlan health insurance creates an intractable financial tie, and is the underlying motivation behind prioritizing the monitoring, regulating, and norming of employee bodies toward a medical model of health through EWP programming. While I argued above in “Enacting Food” that weight-related risk



factors drove the prioritization of eating-related programming, economic motivations underlie the entirety of the EWP. In other words, the EWP is wholly predicated on wellness as/for economics, as demonstrated by the EWP's internal discussions of and emphasis on healthcare cost savings. Ultimately, in the UMN EWP both food and wellness are facades for economics, because money is the bottom line. In this way, wellness really *is* money, and discourses and practices around wellness and food are mobilized to facilitate wellness as/for economics, in order to try to solve population-level issues of rising health insurance and healthcare costs.

### ***Promoting Wellness but Enacting Medicine because of Economics***

At the conclusion of the “Enacting Food” section above, I argued that the UMN EWP is talking about food as/for wellness but doing food as/for medicine because of food as/for economics. In this section, I defined and discussed the ideas of wellness as/for holistic health, medicine, and economics. Like the “Enacting Food” section, I found in enactments of wellness that the UMN EWP is talking about wellness as/for holistic health but doing wellness as/for medicine because of wellness as/for economics. In other words, while the UMN EWP specifically enacted practices around food in order to address perceived weight-related impacts on healthcare costs, it also more broadly enacted practices around wellness in order to address institutional budget issues and rising healthcare costs.

### **Conclusion**

In this chapter, I presented findings from my praxiographic modified grounded theory analysis of archival data. I demonstrated that while the UMN EWP talks about *food* as/for wellness, it predominantly enacts food as/for medicine because of food as/for economics. Further, while the UMN EWP frames *wellness* as/for holistic health, it

overwhelmingly enacts wellness as/for medicine because of wellness as/for economics. In other words, the UMN EWP talks about holism and multidimensionality, but its material-discursive practices reveal a wellness program tightly focused on promoting individual behavior change in order to reduce healthcare costs. While the food as/for and wellness as/for discussions may seem quite similar, it is important to do some untangling in order to elucidate how the UMN EWP enacts wellness broadly and why eating-related programming is so heavily incented for employees: risk and risk reduction are at the core of wellness as/for economics, and the UMN EWP has identified weight as one of the primary risks among the university population. Thus, within enactments of wellness as/for economics lurk enactments of food as/for economics, and it is within food as/for economics that pernicious ableist ideals about body size and health appear most clearly.

Building on my analyses of archival data in this chapter, in Chapter Five I turn to in-depth analysis of my participant datasets (survey and interviews). In Chapter Five, I will once again return to my Rhetorical Questions, addressing them through employee practices, then discuss how employees enact food and wellness using my *as/for* framework from this chapter, teasing out similarities and differences in how the UMN EWP and employees enact food and wellness.

### ***Entremet: Data Stories***

*In the Entremets between Chapters Two and Three and Chapters Three and Four, I shared Sam's story about giving away blueberries in Minnesota in January and Roberta's story about food stamps. In the first interlude, I framed the Entremets as stories that did not necessarily break down nicely to fit in my analyses, but that still carried important meaning in relation to my project. While that Entremet and the others I share between chapters are participant stories from my interviews, this Entremet is a bit of a departure.*

Data plays a key role in research and, as discussed in Chapters Three and Four, data plays a key role in the UMN EWP as well. The EWP encourages people to track their data through mobile digital devices (e.g., step counters, GPS tracking of bicycle commuting) and the EWP website and app, and gathers biometric data which it promoted in early years with the tagline “Know your numbers!” Tracking biometrics, the EWP argued, would help you “gauge how your health habits are affecting your risk for developing illness and disease” (University of Minnesota, 2010a). In other words, the UMN EWP argued that your own data could tell you a story about yourself.

While data is often presented as objective or neutral, rhetoricians understand data as deeply rhetorical (Lanius & Hubbell, 2018). The data that our devices capture about our health and activities, like step counts, has been fundamentally shaped by people in terms of what gets collected, how it is presented back to the very people whose bodies generate the data, and what meaning is attributed to the data in different contexts across time and space. In other words, people use data to make arguments, to make meaning, both in shaping the data itself, the questions asked of the data, and the significance of the answers. For example, the UMN EWP implemented a “10,000 Steps” program in its early

years, distributing pedometers and encouraging people to aim for the gold standard of 10,000 steps a day to improve health. But where did 10,000 steps come from?

Epidemiological research on the efficacy of programs like “10,000 steps” found that the origins of the number 10,000 go back to 1965 and the branding/marketing strategy for a pedometer created by a clockmaker to capitalize on a surge in fitness popularity in the wake of the 1964 Tokyo Olympic Games (Lee et al., 2019). While 10,000 steps became entrenched in global material-discursive practices in recent decades, it did not originate from health research or medical expertise, and critiques of the 10,000 number have grown in recent years (Reynolds, 2021).

In my project, I conducted a large-scale survey (refer to methods in Chapter Two) that included closed-ended and open-ended questions which generated quantitative and qualitative data, respectively. In my analysis and in writing this dissertation, I began to see resonance between the qualitative survey data and my narrative inquiry interviews, and began to feel like the quantitative data did not have a good “home” in any one chapter. My original plan to present my analysis in three chapters, each focused on one dataset (archival texts, survey, interviews), started to fall apart as I found I wanted to combine my qualitative participant data (open-ended survey questions and interview analysis). In my qualitative analysis, I resisted quantifying the frequency of codes because “mere numeric frequency of a code or category from data analysis and memos is not necessarily a reliable and valid indicator of a central/core category” (Saldaña, 2016, p. 253). Additionally, I found that practices fell away a bit in analyzing the quantitative data: while it provides a snapshot of how many of my survey respondents engage with the EWP, which I see as a practice, the rich detail about lived experience that praxiography kept me attuned to in the qualitative data was not present in the quantitative

data. However, the quantitative data was still important, as it told an important piece of the story about the experiences of people in my study, but like the stories from interviews I have included in the other *Entremets*, it did not fit neatly into my analysis structure. Rather than relegate it to an appendix, as an afterthought or supplemental part of my dissertation, I present quantitative results in this *Entremet* in order to underscore how *data tells stories*, and to share the story my quantitative data told before digging into my analyses of qualitative participant data in Chapters Five and Six.

### **Demographic Data**

As noted in Chapter Two, in the Survey portion of the Data Collection section, my survey was set up with piping such that certain questions only displayed to survey respondents if they gave certain answers to other questions; for example, if a respondent said they had not ever participated in the EWP, they were not given questions about their experience with EWP programming. See Appendix B for the full set of survey questions. Because not all survey respondents answered all questions; I include total *n* for each question or question set. I also compared my responses to publicly available university headcount data to frame my sample in context of the university population; however, I did not aim for nor do I claim statistical representativeness.

Respondents (n=1,659) were well distributed across age categories:

- 2.9% were 18-24 years old
- 25.5% were 25-34 years old
- 26.3% were 35-44 years old
- 21.7% were 45-54 years old
- 19.5% were 55-64 years old
- 3.6% were 65-74 years old
- 0.1% were 75-84 years old
- 0.4% preferred not to answer

While the university does publish some employee headcount data, it does not break that

data down by age and I am unable to compare this to the overall employee population.

Gender (n=1,659) was skewed toward female: 76.8% identified as female; 21.6% identified as male; 0.3% identified as transgender male; 0.6% identified as genderqueer/nonbinary; and 0.7% preferred not to answer. The university does report employee headcount data by gender, but only breaks it into two categories: male and female. Overall, about 55% of university employees are categorized as female and 45% as male (University of Minnesota, n.d.).

Highest level of education among survey respondents (n=1,659) was generally skewed toward advanced degrees, as might be expected in a university setting where the survey population included faculty members and higher-level administrators:

- 0.6% reported having completed high school or earning a GED
- 5.0% completed some college but did not earn a degree
- 3.9% earned an associate's degree
- 1.1% completed vocational/trade school
- 31.2% completed a bachelor's degree
- 0.4% were in the process of pursuing a master's degree
- 32.2% completed a master's degree
- 25.1% completed a doctorate or other advanced terminal degree
- 0.5% preferred not to answer.

The university does not publish employee headcount data broken down by education level.

In terms of race and ethnicity, university headcount data are broken down into three categories: employees of color (which it defines as “Asian/Pacific Islander, American Indian/Alaska Native, Black, non-Hispanic, and Hispanic employees”); White or Unknown; and International (which it defines as “Nonresident alien employees”).

Overall, the university reports that in 2019 (the data for the year I conducted my survey), 79.4% of employees were White or Unknown, 17.7% were Employees of Color, and

2.9% were International (University of Minnesota, n.d.). Race and ethnicity results from my survey are shown in Table 7.

**Table 7**

*Race and Ethnicity as Reported by Survey Respondents*

Race	Hispanic or Latino/a	Not Hispanic or Latino/a	Prefer Not to Answer (Hispanic or Latino/a)
American Indian or Alaska Native	3	14	0
Asian	1	79	0
Black or African-American	5	24	0
Native Hawaiian or Other Pacific Islander	0	2	0
White	37	1449	24
Prefer Not to Answer	11	7	29

*Note.* Total n=1,661. Respondents were able to choose all racial categories that applied; one respondent may be represented in more than one racial category.

Mimicking the university’s aggregation of categories, 89.2% of my survey respondents were White or Unknown, and 10.7% were Employees of Color. I did not ask a question about citizenship. While white individuals are over-represented in my sample compared to the university’s published statistics, it is worth noting that employees of color are more likely to have limited access to technology, including internet access (Stambler, 2021). It is likely that the COVID-19 pandemic and the pivot to remote work that happened right before I distributed my survey affected my ability to recruit employees of color to participate, and/or their ability to participate due to limited technology access outside the workplace.

**Job Categories**

The university employs EWP-eligible people in four broad categories: Faculty; Professional and Administrative (P&A); Civil Service; and Labor Represented. The Faculty category includes tenure-track and non-tenure-track positions, and is perhaps the most straightforward. P&A includes academic administrators (e.g., deans, department chairs, program directors), sports coaches, and higher-ranking staff in areas like student services, research, IT, and central administration, along with lecturers and teaching specialists. Civil Service includes staff across a broad range of jobs as well, including student services, research, IT, clerical staff, and financial staff. Labor Represented also includes some staff in these categories, plus police, food services, facilities, maintenance, and groundskeeping staff; the main difference between Civil Service and Labor Represented staff is that the latter are in unions. Each of the four job categories has individuals in a wide range of salaries; however, Civil Service and Labor Represented overall have the lowest mean and median average salary among EWP-eligible employees. According to university headcount data, 49.9% of all employees of color are in the Civil Service and Labor Represented categories (21.1% and 28.8% respectively), but overall those two categories only contain 44% of total employees (23.6% and 20.4% respectively). Table 8 shows my survey respondents by job category and aggregate race/ethnicity, as self-reported.

**Table 8**

*Survey Respondents by Job Category and Aggregate Race/Ethnicity*

Job Category	White	Employee of Color	Prefer not to Answer
Faculty	231	47	2
Professional &	583	59	16



Administrative			
Civil Service	483	53	13
Labor Represented	148	19	5

Civil Service and Labor Represented employees make up 44.5% of my sample, but Civil Service (33.1%) is overrepresented compared to Labor Represented (10.4%). Together, 40.5% of employees of color in my sample are in the Civil Service (29.8%) and Labor Represented (10.7%) categories. I believe the lower response rate among employees of color in my survey is likely due to a number of factors, including pre-existing barriers to participation in EWP and in university research, which were complicated by the disproportionate impacts of COVID-19 on lower-income and marginalized populations.

### **Technology Use**

In addition to demographic data, my survey asked a series of questions about technology use, both generally and for health-related reasons (n=1,717). 98.9% of survey respondents reported that they used a computer daily, and 98.0% reported that they had been using a computer for 10+ years. 94.7% reported feeling very comfortable with using the internet, and 98% reported being an internet user for 10+ years. The majority of survey respondents typically used portable devices to access the internet: 48.9% used a laptop most; 29.9% a mobile phone; 1.9% a tablet computer; and only 19.3% a desktop computer. Most survey respondents reported using online health resources to get information and/or treatment for a health condition at some point in the last year: 13.1% said at least once per week on average; 34.2% said at least once per month; 47.9% said less than once per month; and only 4.8% said never. Of those who look for online health

information (n=1,634), most reported using a laptop (40.9%) or mobile phone (38.4%), with only a few using a tablet computer (4.2%) or a desktop computer (16.5%). Overall, these numbers demonstrate that people in my sample are regular users of computers and the internet, which fits with their choosing to respond to an internet-based survey.

On mobile digital technology usage, 97.9% of survey respondents said they owned a smartphone (mobile phone with internet capabilities). Of those (n=1,674), 82.4% said they visited websites on their smartphones daily, and only 1.8% said they rarely or never did. 90.3% said they used apps on a daily basis, and only 2.2% said they rarely or never did. 59.9% said they use apps to monitor non-eating health data, such as step counting, exercise, glucose monitor, etc., of which 56% track on a daily basis. Further, 28.6% said they used an app on their smartphone specifically for tracking eating (i.e., through a diet app), and of those (n=477), 41.1% said they track their eating daily. Lastly, 57.3% of survey respondents said they use a wearable smart device (e.g., a FitBit, Apple Watch, or other smartwatch) to help track their own health data, and of those, 85.9% use the wearable daily. These results demonstrate that people in my sample are regular users of mobile digital technologies, and that a small majority use mobile digital technologies for health-related reasons. Again, this makes sense for individuals who chose to respond to an internet-based survey about wellness and food.

### **EWP Participation**

The survey included a few questions gauging people's participation in the EWP overall, and with specific aspects of programming within the EWP. Of those who answered regarding whether or not they had participated in the EWP (n=1,678), 74.1% said they were currently participating, 12.5% said they had previously participated but were not currently, and 13.4% said they had never participated. Table 9 breaks these

participation numbers down by job category and race/ethnicity.

**Table 9**

*EWP Participation by Job Category and Race/Ethnicity*

	Currently Participating	Previously Participated but Not Currently	Never Participated
Faculty (White)	131	45	55
Faculty (Employees of Color)	23	7	17
Faculty (Prefer Not to Answer)	1	0	1
Professional & Administrative (White)	453	77	53
Professional & Administrative (Employees of Color)	43	6	10
Professional & Administrative (Prefer Not to Answer)	13	3	0
Civil Service (White)	380	43	60
Civil Service (Employees of Color)	41	5	7
Civil Service (Prefer Not to Answer)	8	2	3
Labor Represented (White)	117	15	16
Labor Represented (Employees of Color)	13	4	2
Labor Represented (Prefer Not to Answer)	4	1	0

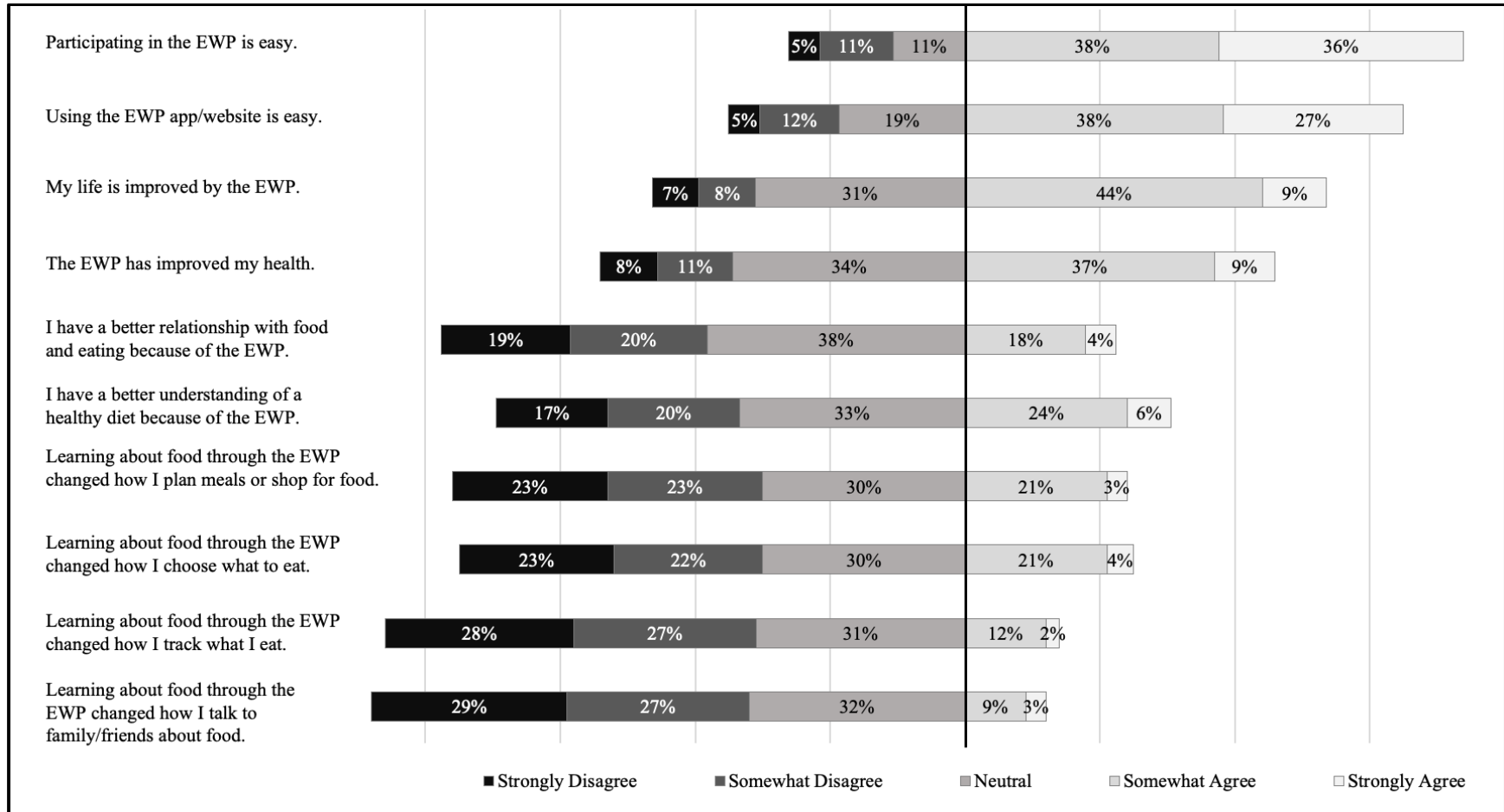
Of note in Table 9, across all categories, most people indicated they participated to some extent in the EWP, either previously or currently. Similar to technology responses reported above, it makes sense for a high percentage of respondents in a survey about the EWP to have participated in the EWP. This is likely one reason for the disparity between the 86.6% of my survey respondents who were EWP participants, past or present, and the 40% reported by the UMN EWP. However, another important reason for the difference in numbers is that the EWP is reporting the percentage of eligible employees who participate *fully*, earning the insurance premium reduction. My survey question only asked if they participated *at all*. Internal meeting minutes noted that a higher percentage of employees earn *some* points than the percentage who participate fully; in 2016 a total participation rate of 62% was reported, with 41% earning the full premium reduction (BAC, December 8, 2016).

#### **User Sentiment about the EWP**

Two key questions were included to gather data about EWP user sentiment. Both were matrix questions with a series of statements asking survey respondents to indicate on a Likert scale their agreement or disagreement with the statements. They were broken into two questions to help reduce survey fatigue and improve survey usability; the results are combined in Figure 4 (on the next page).

**Figure 4**

*User Sentiment Survey Responses*



In Figure 4, the stacked bars are all aligned at the mark between strongly and somewhat agree, and neutral to disagree answers, in order to visually emphasize the divergence of opinion on the different sentiment statements. The data shows that most people felt using the EWP website and/or app was easy, and feel positive or neutral about whether the UMN EWP has improved their lives and their health. As statements shifted toward the impact of eating-related programming, however, sentiment shifts toward the negative. Most survey respondents did not feel the UMN EWP had a positive influence on their relationship with food, or that it had much impact on their eating habits or discourse. In other words, the *story* I am telling with this data visualization tells is that, while most survey respondents found engaging with the EWP to be easy, most respondents did not feel that the EWP had a positive influence on their relationship with food, or that it had much impact on their practices in terms of eating habits or how they talk about food. The quantitative user sentiment data presented here will be elaborated on extensively in Chapter Five and Chapter Six, where I dig into my qualitative survey and interview data to demonstrate how employees enact food and wellness, how the EWP links neoliberal health citizenship to the idea of being a good employee and interpellates people as always-already pre/patients through surveillance and intervention, and how there are fundamental mismatches, or irreconcilable differences, in how the EWP and employees enact wellness.

**Chapter Five:**  
**“Bread and roses, in Helen Todd’s words” —**  
**How Employees Enact Food and Wellness**

The quote in the title of this chapter comes from a survey respondent’s answer to the question “What does wellness mean to you?” and is a demonstration of how wellness can be framed by some as both holistic and a moving target, or constant striving toward ideal wellness (which is conflated with ideal able-bodiedness, as I discussed previously).

The full quote is:

To me, wellness is about living a meaningful life. It's not a static (or even achievable) state; it's a continually-evolving understanding of the elements that bring meaning to my life, a vision that shapes my actions. I think these elements differ for everyone, but generally, encompass the material basics (having everything you need to sustain yourself and those you love; food, housing, healthcare) as well as more intangible necessities like social support, safety, & access to whatever brings joy/fulfillment. Bread and roses, in Helen Todd's words.

In Chapter Three, my kairology demonstrated how the UMN EWP is deeply entangled with the UMN’s history of employee health insurance, a tie that binds the EWP and its model of wellness to an ableist medical model of the diseased/disabled/at-risk body as deficient and in need of cure. Drawing on evidence from my praxiographic modified grounded theory analysis of archival data, in Chapter Four, I demonstrated how the UMN EWP is discursively promoting food as/for wellness while enacting food as/for medicine through its incentivized programming because of food as/for economics, or the aim of addressing rising healthcare costs. Similarly, I found that the UMN EWP is *talking about*

wellness as/for holistic health but *doing* wellness as/for medicine *because of* wellness as/for economics.

Building on these analyses, in this chapter I present my analysis of how employees enact food and wellness based on my participant data (qualitative survey data and narrative inquiry interviews). Throughout my analysis, I will identify the source of my participant data by referring to people as either a ‘survey respondent’ or an ‘interviewee’ or ‘interview participant.’ Additionally, in most of my qualitative analysis I will not include frequency of codes/responses because frequency is not necessarily a reliable indicator of salience (Saldaña, 2016, p. 253), especially as I aim to resist generalizing experience and instead to center individual voices as a move toward social justice. As a reminder, quantitative results from my survey were presented in the *Entremet* “Data Stories” immediately preceding this chapter. In this chapter, first I return a final time to my Rhetorical Questions first posed in Chapter One, where I provided some answers based on scholarly literature, and which I also addressed in Chapter Four, where I discussed EWP practices. In this chapter, I offer answers to these rhetorical questions based on my participant data. After that, I return to the food and wellness *as/for* framework for enactments laid out in Chapter Four, examining employee enactments of food and wellness.

### **Rhetorical Questions (Part Three)**

In Chapter One, I posed questions that I framed as rhetorical, or as not having stable, global answers that hold fast across even small amounts of time and space. As I described there and in Chapter Four, these questions are rhetorically contingent and contextual. I do not aim to concretely or definitively answer these questions, despite their centrality to my project. Instead, I work to explore how health, wellness, and healthy



eating are practiced materially and linguistically in various rhetorical contexts and for various stakeholders, and how those various practices may align, differ, and/or conflict. Importantly, the terms “health,” “wellness,” and “healthy eating” are at the heart of my project and require discussion throughout the dissertation. Here, as part of my analysis of qualitative survey data and narrative inquiry interviews, I return briefly to these questions in order to begin this chapter with discussion of how employee practices enact health, wellness, and healthy eating.

In the remainder of this section, I will draw on my participant datasets to sketch out some of the meanings attributed to “health,” “wellness,” and “healthy eating,” and how they operate in the context of my research on the EWP. Importantly, my survey presented the questions “What does wellness mean to you?” and “What does healthy eating mean to you?” to all respondents, so I am able to draw on answers to those questions in this section. I did not ask “What does health mean to you,” but because my Rhetorical Questions are prior questions (Segal, 2005), I begin there in order to ground my discussions of “What is wellness?” and “What is healthy eating?”

### **What is Health?**

In Chapter One’s discussion of “what is health?” I concluded that this remains a rhetorical question, as ideas of health vary from person to person and culture to culture across time and space. However, a theme that arose from the literature is that health can be understood in mainstream dominant biomedical discourse in the U.S. to be the absence of disease, the striving toward an ideal state of perfection, and a mechanism through which institutional power seeks to shape bodies and workers. The pervasiveness and centrality of a biomedical model—one that is defined by the opposition of health and disease, in which maintaining and improving health is a moral obligation—in U.S. health

discourse bleeds beyond the borders of the medical establishment, as demonstrated by dictionary definitions of health (see “What is Health?” in Chapter One) and the ways extra-medical institutions like the UMN EWP talk about and enact health (see “What is Health?” in Chapter Four).

As I will describe when tackling the next two questions—what is wellness, and what is healthy eating—the term healthy gets used by people in ways that both replicate and resist the biomedical model of health. The term “health” was used frequently by my survey respondents and interviewees as part of circularly defining “wellness.”

For example, 1,608 of 1,717 respondents answered my survey question “What does wellness mean to you?” and about 40% of those answers (n=728) included health in their definition. While health and wellness are concepts that are closely tied together, many people essentially equated health and wellness, with about 80 responses simply saying “overall health” or “overall health and wellbeing,” another 20 saying “feeling healthy,” and about 120 saying “being healthy.” Some of these answers included nods to holism, with many survey respondents appending more than one dimension of health, such as “overall health - physical and mental” or “overall health in mind and body.” Here then, I turn to the Rhetorical Question “What is wellness?” to further unpack elements of holism in answers to “What does wellness mean to you?”

### **What is Wellness?**

In Chapter One’s discussion of the rhetorical question “what is wellness?” I suggested that the modern wellness movement typically describes wellness as a continuum or scale, with ill at one end and well at the other (Ardell, 1977; Derkatch, 2018; Travis, 1975), although this scale is often operationalized as a binary (illness/wellness) or at best, a three-point scale (illness, borderline, and wellness). The

idea of constant striving is central to the continuum/scale model of wellness; wellness is a moving target as the means of enhancement are constantly evolving in a capitalist society where health and medicine are heavily commercialized and commodified (Derkatch, 2018; Elliott, 2003). I concluded in Chapter One that the positioning of wellness as opposed to illness reinforces ableist ideas about bodies because it positions the ideal able body as opposed to any body less-than-well, including not just those with acute, passing disease but those with chronic illness and disability as well. In this way, the term wellness does rhetorical work in the world by definitionally foreclosing the possibility that people with chronic illness or disease can ever achieve wellness. Building on this, in Chapter Four's discussion of Rhetorical Questions, I demonstrated how the UMN EWP's material-discursive practices enacted wellness as holistic early in the EWP's history, but that over time it moved away from holism and toward a quantified, surveilled, biomedical version of health maintenance. Importantly, wellness discourse (both broadly in society and in the UMN EWP) reinforced the neoliberal biomedical model that positions people as responsible for their health status, their health status as reflective of their values and moral worth, and working toward an ideal healthy and able body as compulsory. In the remainder of this section, I present evidence from my participant data that works to answer the Rhetorical Question "What is wellness?"

In my survey, 1,608 respondents wrote an answer to the question "What does wellness mean to you?" As noted in the "What is health?" section above, a significant number of these responses circularly defined wellness as overall health, though some of those framed overall health as being across multiple dimensions. Overall, the vast majority of survey respondents defined wellness in holistic ways, including through using the word "holistic" or describing multiple dimensions of wellness such as physical,

mental, and spiritual. These definitions reflect those of broader discourse around wellness, such as the National Wellness Institute's and UMN EWP's framing of wellness as multidimensional, or consisting of practices addressing wellness across intellectual, physical, spiritual, social, occupational, and environmental dimensions (National Wellness Institute, n.d.a; University of Minnesota, 2003). Institutional discourses about wellness influence people's individual ideas as institutions work to shape docile bodies through a "multiplicity of minor processes" (Foucault, 1979, p. 138), like regular engagement with EWP discourse, inviting people to participate willingly in conforming to dominant capitalist norms. Some survey respondents recognized this in their definitions of wellness, such as one who said, "it's \*not\* connected to the ways I'm told to measure it (my body size, for example)" and another who defined it as "People deciding what I should do and be."

A biomedicalized version of wellness appeared in my survey responses as well, with respondents describing their beliefs using a language of symptoms, surveillance, illness-avoidance (e.g., diabetes, chronic disease), and factors positioned as risks for illness such as BMI/weight, cholesterol, and blood pressure. As one survey respondent put it, wellness means "Good numbers for blood pressure, cholesterol, weight, feeling loved and supported by family and friends." Or, as another said more generally, "Having energy to complete daily tasks. Exercising and sleeping on a regular schedule. Living without health complications or chronic illness." Like this survey respondent, many respondents defined wellness as, in some way, avoiding chronic illness or disability. I interpret this as a manifestation of the dichotomization of wellness and illness, which rhetorically forecloses the possibility that people with chronic illness or disease can ever achieve wellness. One survey respondent directly argued that the EWP is ableist, defining

wellness as “A scam for HR to charge disabled people and parents more in violation of federal civil rights legislation, but they keep getting away with it.”

Additionally, many survey respondents talked about “making healthy choices” or “taking responsibility” in their definitions of wellness, reflecting the dominant neoliberal, biomedical discourse of individual responsibility. To underscore this, a handful of survey respondents talked about wellness as the ability to be productive, connecting neoliberal ideas of worker productivity to personal models of wellness. In contrast, however, a number of people talked about work/life balance as part of their definitions of wellness, though this usually showed up in more holistic definitions. However, even in mostly holistic definitions among my survey respondents, as Colleen Derkatch (2018) found in her research, people described wellness-oriented behaviors as paradoxically relying on “processes of surveillance and intervention that resemble those of the illness model [wellness-oriented behaviors] are meant partially to displace” (p. 147). For example, one survey respondent wrote that wellness is

A combination of mental and physical health, not necessarily associated with "losing weight" or "getting fit," but of having acceptable medical ranges (such as blood pressure, blood sugar) for physical health, and being happy/accepting of your wellness state, or actively seeking to be happy/accepting of wellness state.

While this survey respondent included multiple dimensions of wellness (mental and physical), they elaborated that wellness is evaluated through “acceptable medical ranges” and invoked biometric measurements. Further, a few survey respondents talked about wellness in ways that replicated Elliott’s (2003) and Derkatch’s (2018) theorization of wellness as a moving target. One survey respondent responded that wellness is “a thing that is in constant flux because it is not ever fully achieved because it requires constant care to stay in a state of wellness.” Discourses of individual responsibility and wellness

as a moving target dovetail to suggest that wellness, as a practice, is both up to the individual and, essentially, unachievable. The quote that opened this chapter also touched on themes of wellness as both holistic and a moving target,

Ramón, an interview participant who spent much of his life in Europe before moving to the U.S. about fifteen years ago, pushed back against the biomedical model, describing health and wellness as something more than an end to work toward:

I think the very idea of wellness, again, it's a moral, it's a moral standpoint. And sometimes some of the Wellbeing Program is more reactive rather than proactive. It's more, oh, there's a problem, there's a problem. Let's fix it, instead of trying to fix the origin of the problem. All this wave of yoga and meditation, which is fine, if people find their mojo doing that, that's great. But sometimes we may wonder, we would like maybe to look at the origins of stress. Are we maybe working too much, or are we not giving time for meals? Are we not giving time for relationships with others? So sometimes some of those wellbeing, it seems again, a means to an end. And so we're doing all these things so that we are healthy as though health were the end and not just the consequence of living in harmony with our peers, in harmony with our immediate environment, eating the seasonal food, and commenting on the ways to cook it. That seems to be a higher level of culture for me than just, okay now I guess I need to eat some baby carrots because that's going to improve my wellbeing, right. I don't know. So sometimes I have some, uh, not rejection, but some concerns about how accepted this idea is that stress and anxiety is here to stay. There's nothing you can do. And you therefore need to do some yoga or do something to repair it instead of preventing what may be more like disharmony. When you're not in harmony with the important things in life. So I think [the EWP is] great. I think it's a great program. But I have sometimes, some values concern, in the way our society sees health. Like it seems like it's a means to an end, and it's not the same to eat the baby carrots in a parking lot because your app tells you to do it than to eat some, I don't know, roasted carrots and rosemary with your friends. And so for the body in terms of the proteins and all that may be the same, but at the cultural level is not. And I think sometimes we miss that little layer of meaning that I think all cultures, including the American one, carry through the meals and the food and the healthy habits, et cetera. There is an aspect of wellness. The practice, the meditation, the yoga, I think, and again, for people who really enjoy it and for people who really find the benefit, that's great. I do think it's not neutral. I do think it is not ecumenical. It does, it expresses a specific type of values of your body, the sense of individuality, et cetera, which is great. I do have students who are Muslim. They pray five times a day. And I can see, not for me, but for them maybe, all this yoga, maybe more of a contrast with how they achieve nirvana, transcendence,

meaning. You know, call it whatever you want. So sometimes, yes, it, while I really support these programs, this idea of, of mindfulness, it is not ecumenical. It is not culturally neutral. And I don't think there's any way that it can be. Okay, so in that sense, it chooses one over the other, which, I prefer if we, we chose everything. Sometimes putting on, you know, a yoga mat next to a, maybe a little chapel. Right? (Ramón, research interview participant, 2020)

There are multiple themes at work in Ramón's answer, including acknowledgement of the biomedical model of wellness's surveillance and intervention when he spoke of the EWP as being "reactive" and working to identify and fix problems after they become problems, rather than addressing the root of the problem, which is reminiscent of a deficit model. Ramón describes how, to him, wellness in the EWP feels like it is not attuned to culture, community, or diverse morals/values. He also loops in ideas about what healthy eating is, which I will return to in the next section. Overall, in this excerpt, I see Ramón talking about the EWP's model of wellness as oppressive through its expression of white, Western, biomedicalized ideals.

For some survey respondents, wellness was a loaded term. They described it as an "empty buzzword," an "industry term" or "corporate scam" designed to profit off of feelings of shame, discomfort, and inadequacy. A few survey respondents described wellness as a privileged term "primarily accessible by wealthy white people," a "keyword to look for misinformation," or as "an indicator of a fad and presumes things that also presume a lot of privilege." One survey respondent described wellness as "a marketing catchall. It includes everything from legitimate health treatments, medications, and preventive programs to really unscientific exercises in magical thinking." Another survey respondent wrote: "It's a corporate term that used to have a meaning of health being stats measured by physicians, such as mental and spiritual health, but now conjures a corporate strategy to offload healthcare into employees and meddle in their personal lives through tracking their eating and exercise behaviors." One simply replied "bullshit."

A significant number of survey respondents defined wellness vaguely or circularly, with short answers about “feeling healthy,” “having a healthy lifestyle,” “balance,” or “being fit,” without additional specifics, and, in one case, a survey respondent just wrote “wellness.” My analysis of these vague definitions of wellness as “good health” without invoking any holism or multiple dimensions of wellness is that they are a byproduct of the current pervasiveness of the term; like the people identifying it as “meaningless,” many people do not have a concrete definition of wellness because it is slippery, commercialized, and ill-defined across medical, industry, and popular spheres. As one survey respondent wrote: “It’s a pretty nebulous Rorschach test of a term though.”

### **What is Healthy Eating?**

In my discussion of “What is healthy eating?” in Chapter One, I detailed how the dominant model of nutrition in the U.S. is hegemonic (Hayes-Conroy & Hayes-Conroy, 2013). Hegemonic nutrition relies on the idea that the food-body relationship can be standardized and quantified (a calorie is a calorie to everyone) (Mudry, 2009), reductively views food as a conglomeration of nutrients and their specific roles in the body (Scrinis, 2013), and decontextualizes food from culture, bodies, and the environment, and privileges expert knowledge which is disseminated through biomedicine, the media, the diet industry, and social institutions (Hayes-Conroy & Hayes-Conroy, 2013). Further, hegemonic nutrition models link eating practices with neoliberal discourses of individual responsibility and morality, positioning fatness as the result of lack of self-control, making poor choices, or having poor morals (Biltekoff, 2013; Derkatch & Spoel, 2017; Guthman, 2011; Hite & Carter, 2019). The idea of self-improvement through hegemonic ideas of “healthy eating” has been used to mark, other,



and devalue fat bodies, especially those that are disabled, gendered, and racialized (Gerber, 2020). In Chapter Four, I demonstrated that while the EWP's employee-facing materials did not directly define healthy eating, the focus on the DGA, weight loss, and nutrition science advanced a model of healthy eating that reified broader hegemonic nutrition discourse. And, ultimately, the reliance on a hegemonic nutrition model meant the UMN EWP was materially-discursively practicing "healthy eating" in ways that reify moralistic judgments about eating and systemic medical ableism, or the marking of fat bodies as non-ideal.

Given the prevalence, influence, and longevity of U.S. governmental guidance on nutrition through over 40 years of the DGA, it is unsurprising that the vast majority of my survey respondents answered the question "What does healthy eating mean to you?" with discourses of quantification and nutritionism. Many survey respondents even invoked DGA models like the pyramid, the food groups, and MyPlate. A few went further to talk about science—"guidance from the FDA or peer-reviewed research"—and authority—"nutritional guidelines published by authoritative sources (like the FDA, medical professionals, or certified nutritionists)." One survey respondent who noted they work in the natural food industry provided a detailed breakdown:

I eat 6-8 servings of vegetables daily (2-3 servings of dark leafy greens), 1-2 serving of fruit (mostly low-glycemic fresh berries) daily. I also eat nuts, seeds, and meats daily, as well as small amounts of dairy (usually yogurt and cheese). I consume grains very rarely - almost ketogenic diet, but not quite because I also eat starchy vegetable such as sweet potatoes. I consume sweeteners and deserts almost never. I practice intermittent fasting by eating from 11am-7pm daily. I often weigh my food, and know what 30, 85, 100, and 150 grams looks like for various foods. My animal proteins are usually 3-4 ounce portions. All this might seem like a lot, but I've worked in the natural foods industry for 20+ years.

In this survey response, I see hegemonic nutrition appearing in the survey respondent's use of quantification in terms of talking about their eating practices in terms of number of

servings of different foods per day, prioritizing some sources of nutrients over others (vegetables and fruits are a yes, but sweeteners and desserts are to be avoided), and portion sizes. It is interesting that even someone who self-identified as working in the natural foods industry used DGA-like discourses of quantification and nutritionism to describe their idea of healthy eating.

Of the 1,717 responses to my survey, 1,606 provided answers to the question “What does healthy eating mean to you?” Of those, I coded 1,363 (about 85%) as demonstrating evidence of a hegemonic nutrition model through the survey respondent’s word choices, which I interpret as representing their eating practices. The sheer domination of quantification through words like “calories,” “portion sizes,” and “servings,” and of nutritionism through terms like “macronutrients,” “vitamins,” and “empty calories,” demonstrates how pervasive hegemonic nutrition discourse is and how much it shapes people’s ideas of what it means to practice eating healthy.

Quantification and nutritionism are likewise at play in the common metaphor of food as “fuel” for the body as “machine” (Scrinis, 2013). The idea of food as fuel reinforces the need to measure food intake through the idea of quantifying the body’s output or energy expenditure through calories (Scrinis, 2013). Fuel becomes entangled with moral judgments about food, as demonstrated by one survey respondent who wrote:

One should treat their body as a high-performance automobile. If you fill its fuel tank with low-grade gasoline, you should expect low-grade performance. If you fill your body with low-grade food, you should expect low-grade health as a consequence.

In this quote, the survey respondent extended the food as fuel metaphor in their description of “low-grade food,” which they said leads to “low-grade health,” implying that some food is good for you and some food is bad for you. Many survey respondents

framed healthy eating as choosing good or bad foods, specifically noting “bad sugars,” “bad carbs,” “bad fats,” and “eating clean” (a term whose opposite is “dirty”). These responses invoked the framing of food as moral and ethical that is rife in hegemonic nutrition discourse: the idea that some food is inherently good and some is inherently bad, and thus our food choices and diet are also either good or bad. Even when trying to escape the idea of foods as “good” or “bad,” survey respondents relied on discourses of quantification and nutritionism, such as one survey respondent who replied “Eating balanced portions of nutrient rich foods without restricting certain foods or labeling foods as ‘bad.’” Yet phrases like “nutrient rich,” or more commonly “nutrient-dense” which shows up in many survey responses and in the DGA, are euphemisms for “good” food (Scrinis, 2013). One survey respondent also, likely inadvertently, invoked ideas about good and bad while simultaneously trying to resist the moralization of food:

Healthy eating is the process of providing your body with foods that fuel it. It's not focused on what foods are "good" or "bad," but what foods work best for you and keep you well. It's avoiding foods that make your body feel poorly or have too many synthetic ingredients.

Here, the survey respondent frames food as fuel—a metaphor common in discourses of quantification and nutritionism—and then directly rejects focusing on “good” and “bad” but goes on to say that healthy eating includes avoiding foods with synthetic ingredients. Many survey respondents talked about avoiding processed food, which would contain those “synthetic ingredients,” in favor of whole or natural foods. Often, synthetic ingredients are associated with processed foods (e.g., fast food, frozen prepared meals, soft drinks, corn chips, and snack cakes) vilified in healthy eating discourse, which pits them against organic foods, despite there being no clear delineation between natural and processed foods nor any strong evidence that organic foods are quantifiably better than

their non-organic counterparts (Scrinis, 2013). In other words, both “synthetic” and “processed” act as euphemisms for “bad” foods (Scrinis, 2013) Further extending the moral judgment related to food was people’s discussion of “healthy eating” as incompatible with tasty or pleasurable foods. Survey respondents described healthy eating as “rabbit food,” “eating for function rather than pleasure,” “bad tasting stuff,” “limiting delicious foods that could adversely affect my health,” and “eating only for fuel, not for fun or addictions.” This association of “unhealthy” or “bad” food with pleasure and indulgence replicates the dominant morality, leftover from the U.S.’s Puritanical roots, that indulgence in pleasure is dangerous (Klein, 2010).

Another key aspect of dominant hegemonic nutrition discourse, as evidenced by the DGA’s (2020) foregrounding of the links between diet, obesity, and disease, is the idea that food and individual eating practices are at the root of fatness, health status, and that, in turn, food can be used to prevent or cure weight-related health risks or disease. A number of survey respondents discussed the practice of using food as medicine in their responses, such as one who suggested healthy eating means “When disease comes up, looking at what you're eating or not eating that could bring you back into good health.” Another survey respondent entangled pleasure with the idea of food as medicine when they described healthy eating as “limiting delicious foods that could adversely affect my health.” Further, some survey respondents with health issues talked about using eating practices as part of their treatment, such as one who commented “I have several autoimmune disorders, so eating healthy is eating what is going to heal and fuel my body.” One of my interview participants, Alice, described a similar struggle with health issues, lap band surgery, and food:

I have had lap band surgery and that has had a direct impact on my life. Because

of my issues with my kidneys, because of my issues with lap band, I find that many times beef is a problem. I never eat pork, pork's a problem. But I have found something that I really like and that's, uh, pho. P-H-O, pho? And so I made some yesterday and it takes, it's quite a process to make it. I use a quick recipe that I like. And so, and I can eat that and I don't get a reaction from it because I have just come back from having my uh, upper GI tested and I do have some erosion of my esophagus and that's from the lap band and eating the wrong thing and being sick. Do you know what I mean? After you eat. So it seems when I eat a food like [pho] it goes down much better. I'm not one to eat a hamburger much or things like that. You know what I mean? Roast beef doesn't agree with me, but I have used, the only kind of steak I usually eat is tenderloin because that'll go down. You change your eating. (Alice, research interview participant, 2020)

Alice opted for lap band surgery after struggling with her weight for many years, but while she initially lost a lot of weight and has kept it off, that surgery and some other, unrelated surgeries, left her struggling with food. Alice's doctors told her the kidney issues she mentioned above stemmed from eating too much protein after her lap band surgery, and then her A1C (a blood sugar test) became elevated, which her doctors think was likely due to diet and activity changes during the pandemic. For Alice, eating practices are a core component in her medical treatment. Many people like Alice, for a variety of reasons, need to incorporate dietary practices in ways that support or at least do not exacerbate their medical conditions; this is not inherently problematic, however, a model that divorces food from culture, pleasure, and sociality on a larger scale and sees food only as a means to an end (health), especially in hegemonic one-size-fits-all models like the DGA, is worth critical consideration.

A small minority of my survey respondents described food as part of a holistic model of wellness, such as one respondent who wrote: "Healthy eating means to grow, chop, cook, and consume foods that nourish a person - mentally, physically, emotionally, spiritually." Another survey respondent described healthy eating as part of wellness while acknowledging the complexities of dominant nutrition discourse:

I have a hard time with this one, as there is a lot of misinformation and skewed reporting (butter is good for you! bacon and cheese are good for you! coffee is good, no bad, no good but only one cup, no good but only 4 or more cups, etc.) I would personally say that healthy eating is eating that can be free from guilt/shame, eating that nourishes the body, eating that truly helps you feel healthy, eating that aligns with your moral compass. (It doesn't necessarily mean "health food" or "organic, whole, natural, unprocessed, etc.")

Some survey respondents looped in ideas about healthy eating practices as connected to sustainability and the environment, such as one who commented that “It is as much about the types of food consumed as well as the behaviors around eating, impact on the environment, and impact on animals/animal welfare.” Connected to this, many survey respondents defined healthy eating using journalist and activist Michael Pollan’s (2008) wording from his popular book, *In Defense of Food: An Eater’s Manifesto*: “Eat food. Not too much. Mostly plants.” In the book, Pollan pushes back against nutritionism, arguing that instead of focusing in a reductive way on the nutrient components of food, people should simply focus on eating whole plant-based foods and avoiding processed foods. Pollan’s argument clearly resonates with people; further, some who used his wording talked about moving away from obsessively tracking calories and harmful diet culture in the U.S.

Diet culture—the idea that thin bodies and weight loss are ideal— came up a lot in my survey and interviews, predominantly as connected to disordered eating, which many survey respondents reported. Eating disorders (ED) are included in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)*, the taxonomy of mental health disorders published by the American Psychological Association. About 9% of the U.S. population will be affected by an ED in their lifetime, though it is likely that number is a low estimate as many people who experience EDs may go undiagnosed, especially BIPOC, LGBTQ+, and people in larger bodies (Caceres, 2020; National

Association of Anorexia Nervosa and Associated Disorders, n.d.). The majority of people with EDs also experience other mental health issues such as anxiety, substance abuse, and impulse control (National Institute of Mental Health, n.d.). Further, while it is not yet formally recognized by the DSM-V, many health professionals are diagnosing people with orthorexia, or an obsessive and extreme focus on “clean eating,” which as noted above is tightly connected to hegemonic nutrition discourses. EDs is a huge topic in and of itself, and while it came up across my participant data, especially in relation to people’s definitions of “healthy eating,” it is beyond the scope of this dissertation to fully explore the links between EDs and hegemonic nutrition; that said, people’s combined experiences with EDs and the UMN EWP are within scope. For example, one survey respondent wrote about triggering messages in the EWP:

Tricky one--I have an eating disorder, so for me this phrase means eating in a way that does not serve to exacerbate or be a substitute for mental and emotional health. All foods fit. BTW, the wellness program at the U frankly is rife with opportunities to trigger people with EDs--from the language and how you discuss "healthy" food and eating (there are no "healthy" foods) to the emphasis on weight loss. I really wish it would do a better job of being more inclusive to this population. Given that doing the wellness points is really the only way I can afford health insurance, I'm forced to immerse myself in a situation filled with triggers and harmful language. Seems odd to me that that's the price I have to pay to have access to health care.

In this quote, the survey respondent both describes how the EWP’s discourse was triggering and how they feel forced to participate for financial reasons; the latter is something I will return to in more depth in Chapter Six. In a similar vein, one of my interviewees, Jessica (whose story also appears in the *Entremet* after this chapter), discussed her experience with the EWP and her EDs:

[My] relationship with food is rather disordered. I have been treated for an eating disorder, now, this is my fourth time, beginning in high school. I believe that I was misdiagnosed for a majority of my life because a diagnosis that I would give

for myself is orthorexia, and I, that was not necessarily a common diagnosis for a long time. I actually only just learned about it this year kind of as I've been entering recovery again and I was like, wow, there is a word that describes my experience. I had a hard time identifying with eating disorder previously because it didn't it just didn't quite fit. Those diagnoses, anorexic in high school, bulimic in college, which was the right diagnosis for me at that point, there was a binge-purge cycle so that that was accurate. But, so I have a really hard time having a neutral relationship or even a positive relationship with food. I definitely have assigned value. Things are good or bad, things are healthy or unhealthy and I have focused really heavily on, you know, I would never use the phrase clean eating. Um, I was pretty wrapped into kind of wellness culture. And so I used all the right phrases but, in a totally disordered way to use them. So I would say that I thought about balance and everything could be had in moderation, but I was definitely paying attention to how much of the bad things I was eating. I think that in many ways, wellness plans encourage diet culture which feed into disordered eating, and my experience joining Weight Watchers through the wellness program, that kind of re-triggered a long-term disordered relationship with food. I probably would've ended up that route anyway. I think it was just going to happen in my life, but the door was really wide open because it was, there was an incentive for me from a bunch of different angles, this desire to lose weight, this discount on my insurance, this reimbursement. Like there was a lot of forces coming together and I know they don't do [Weight Watchers] anymore, which I think is really important and I'm, I'm glad that they took that off. But I think that there's still a lot of diet culture-y things that are part of wellness programs. (Jessica, research interview participant, 2021)

Jessica talked a lot in our interview about how the self-tracking aspects of both Weight Watchers and the EWP feed into her disordered eating and her tendency to be obsessive about tracking and numbers. Participants in my study—both in the survey and interviews—talked about feelings of shame, guilt, and the negative mental health effects of tracking food through a lens of “good” and “bad” choices. In this way, the term “healthy eating” was seen by some survey respondents as “a dog whistle for diet culture judgments around food” and “a skewed and fatphobic term that legitimizes disordered eating.”

Lastly, some survey respondents talked about healthy eating in terms of access and privilege, noting that not all people have the same access to certain types of food considered healthy (e.g., fresh fruits and vegetables), are food-secure, or can afford



different foods. While only a few people brought this up, it is a critical element of healthy eating in terms of this dissertation because hegemonic nutrition provides a universal model of eating that is inaccessible to many people, especially those marginalized along axes of race, class, and ability. The 2020 DGA nodded to economic factors through its acknowledgement of “budgetary considerations,” although the resources it linked to on its website for “thrifty food plans” present wildly outdated data—the most recent food prices included are from 2003-2004 and the thrifty food plan report is from 2006—and ignore issues of access (U.S. Department of Agriculture, n.d.a, n.d.b). The MyPlate “Healthy Eating on a Budget” page presents tips for meal planning like “make a grocery list” and for shopping like “find fruits and vegetables in the produce section, frozen foods, and in the canned and pantry food aisles ... compare prices to find the best buys” (U.S. Department of Agriculture, n.d.a), again, ignoring issues of access to food sources and relying on a deficit model of science communication (e.g., if people just *knew* that vegetables were in the produce, freezer, and canned foods sections of the store, they would buy them!). As noted earlier, the deficit model of science communication has been critiqued as ineffective for decades (Gross, 1994; Miller, 2001).

Ultimately, not only is healthy eating something that raises questions about access and disparities, it is also mobilized in neoliberal ideas of individual responsibility. If people simply understood what healthy eating meant (according to the DGA), they would improve their eating habits and be healthier; the reverse of this is that people who are fat or have health issues linked to weight are seen as having a lack of control, making poor choices, or having poor morals (Biltekoff, 2013; Derkatch & Spoel, 2017; Guthman, 2011; Hite & Carter, 2019). The idea of self-improvement through hegemonic ideas of “healthy eating” is one that has been used to devalue, other, and “regulate disabled,

immigrant, gendered and nonwhite bodies throughout U.S. history” (Gerber, 2020, p. 3). In this way, even something that might seem innocuous like “healthy eating” can be mobilized to mark and judge bodies deemed to be non-ideal, which in U.S. diet culture and through biomedical assessments like BMI means fat bodies. As I have argued throughout this dissertation, the ideal body is both thin and able-bodied, and fat bodies are seen as non-ideal due to risky behavior like “unhealthy” eating and association with obesity and, by extension, chronic illness and disability.

### **Health, Wellness, Healthy Eating, and Medical Ableism**

In this “Rhetorical Questions (Part 3)” section, I returned to the prior or rhetorical questions around health, wellness, and healthy eating that I outlined in Chapters One and Four. In Chapter One, I drew on various dictionary definitions and scholarly literature to outline some possible answers. In Chapter Four, I tried to surface how the UMN EWP’s material-discursive practices provide insight into their definitions of health, wellness, and healthy eating by drawing on data in my archival dataset. In this section, I drew on survey and interview data to demonstrate how employees’ material-discursive practices might provide some answers. In the next section of this chapter, I turn to my analysis of how employees’ practices enacted food and wellness *as/for*.

### **Enacting Food and Wellness**

My overarching methodology, as described in Chapter Two, centers people’s lived experience. I used a model centering lived experience through praxiography and multiple ontologies theory (Graham, 2015; Kessler, 2020b, 2022; Mol, 2002; Molloy, 2015; Pender, 2018; Teston et al., 2014) that foregrounds practice, or the ways in which meaning, objects, realities, and entities are *enacted* in contexts and situations.

Praxiography and modified grounded theory methods helped me to trace practices in

people's stories and to look for themes around those practices. Further, praxiography helped me to understand the different *meanings* that enactments of food and wellness set in motion and their relationship to how people experience their bodies and their health in their daily lives. In Chapter Four, I detailed the UMN EWP's enactments of food and wellness. As this chapter presents analysis from my participant data (survey and interviews), my goal in this section is to trace in more depth employees' enactments of food and wellness.

In the "Enacting Food and Wellness" section of Chapter Four, I detailed how I use the distinction "as/for" to frame the two ways I see enactments taking place. *As* indicates "in the same way" or a comparison of equivalence, and aims to get at how some things are enacted *as* other things, in essence becoming them. *For* indicates "in order to," adding the nuance of purpose or outcome, and aiming to get at how some things are enacted *for*, or in order to achieve, other things. Further, in order to foreground issues of power and oppression, I must look both at the practices that enact wellness *and* behind them for implicit/invisible hidden forces and goals. Therefore, in this section I aim to describe how food and wellness were enacted by the employees while also considering the larger socio-political forces that shape who gets to practice wellness and what practices are valued or devalued. I use as/for with a slash to indicate that, while each is important on its own, the two ways of enacting are entangled and often inseparable, especially in health and medical contexts. In what follows, I draw on my participant data (survey and interviews) to discuss the ways that employees' practices enacted food and wellness *as/for* through their material-discursive practices. I present analysis of enactments of food and wellness across two subsections in order to get at the ways employees enact food as a component of wellness, and ways wellness is enacted more

broadly, but also to tease apart some of the entangled and circular ways that food, eating, and wellness are enacted *as/for* each other. Importantly, in this chapter I center people's lived experience with the EWP through their stories.

### **Enacting Food**

While enactments of food and eating varied significantly, depending on a multitude of factors including culture, health, and economics, three broader themes arose out of my praxiographic modified grounded theory analysis of archival data (see Chapter Four): food *as/for* wellness; food *as/for* medicine; and food *as/for* economics. In the context of food, an enactment of food *as* medicine would mean food becomes or is equivalent to medicine, but also that food is being enacted *for* the same purpose one takes medicine—the prevention or curing of disease. As detailed in Chapter Two, my modified grounded theory analysis of archival data led to the development of a coding structure that informed coding of my qualitative survey and interview data. For this reason, one of my starting points in analyzing participant data was my food *as/for* and wellness *as/for* framework. In this section, therefore, I begin with the food *as/for* wellness, medicine, and economics framework as a way of understanding employees' enactments of food.

#### ***Food as/for Wellness***

Building on the theoretical frameworks detailed in Chapter One and on findings from my analysis of archival materials, in Chapter Four I defined *food as/for wellness* as the idea that eating the right foods can lead to complete individual holistic well-being by improving the already-healthy person. In Chapter Four, I argued that food *as/for* wellness was enacted in the UMN EWP primarily through discourse in promotional materials around the links between eating and wellness and through programming such as the farmers market and cooking for wellness classes. In the remainder of this section, I

demonstrate how food is enacted as/for wellness in employee's lived experiences.

One of the key practices I framed as an EWP enactment of food as/for wellness was the farmers market. However, while the farmers market demonstrates holism, it is not a points-eligible activity under the EWP. Further, the farmers market is only accessible in specific locations during brief time-frames. On the Twin Cities campus, it only takes place once per week over lunch in a single location on the Twin Cities campus from about mid-July through about the end of September (University of Minnesota, 2018b). A large number of employees work a prohibitive distance from the market, may be unable to leave their jobs to visit, or may be on nine-month academic year contracts and away from campus in July and August. Many of my research participants discussed the difficulty in accessing the farmers market from the smaller St. Paul campus in the Twin Cities, noting that the travel time between St. Paul and Minneapolis (about a 10 minute drive one-way with extremely limited parking options, or 20 minutes each way on the campus bus) kept them from being able to attend. One survey respondent complained that "I wish the farmer's market had longer hours or more days. Sometimes I can't always leave work to get there." Another survey respondent elaborated:

I love the Farmer's market. I wish it would be a bit longer or more times offered so there was more flexibility, even if half the vendors came on a Monday and the other half on a Thursday. It also pushes the "type" of a Farmer's market, but it would be nice if MN local things like grains/flours/breads, meat producers/proteins were available. That would work better if like Mondays at lunch had fruits/veggie producers and Thursday afternoon/evening had bakery-type and proteins/meats (so people could take it right home to their fridge).

Despite access issues, many survey respondents included shopping at farmers markets (generally, not just the UMN farmers market) as part of their food practices, noting the benefit of being able to buy "organic," "local," or "farm-fresh" items.

Food as/for wellness was enacted in similar ways across many employees'

experiences, as seen in survey responses talking about eating in a way that, as one respondent put it, “support[s] overall physical health AND mental well-being,” or as another said, “is compatible with wellness/thriving. For me, this means variety and balance. Some foods bring me joy, some foods give me the energy I need to do what I want to do, some foods bring me together with others.” In these quotes, notably, survey respondents are including food as holistic, or connected to multiple dimensions of wellness, including emotional, social, and physical. Sociality was a strong theme among employees in their enactments of food as/for wellness, with many survey respondents and interview participants talking about food practices as a meaningful part of family gatherings, holidays, and connecting with colleagues and students on campus as well.

Additionally, many of my survey and interview participants talked about food as/for wellness in ways that fit with their cultures. One of my interviewees, Priyanka, a young woman who spent her early years with her family in India before moving to the U.S., expressed a desire for more cultural diversity in the EWP while relating her experience with phone counseling and one of the cooking for wellness classes:

I don't know who does the [EWP] planning and stuff, however, I think maybe the person should also be, whoever is doing it, culturally competent, I think is very important as well. For example, like I said, the dietitian is, it was really useful, however, it would be nice to have, I don't know, an Indian dietitian which is not, you know, impossible. If they're doing it for the entire University of Minnesota, I think they can actually come up with more people. [In the cooking class] I think the white person could be providing the ingredients for, for example, I don't know, an Indian snacks, but then I'm sure she's gonna receive backlash is asked to like, oh you spell this wrong. So I think it's um, you know, I think it would be nice to have actually a person of color talking about how to make things. So I think just because I feel like I personally really like that granola snacks [from the cooking class], however, I cannot imagine an Indian family doing a granola snacks, you know, so I think even if they have, maybe not necessarily like you have to have an Indian dietitian, however, like, I don't know someone, somewhere from different continents. And they could really target it as well. I think that would be nice. But I don't know how many dietitians are out there. I guess there's

some like fine line, but that one just kinda came up to my mind because as I was thinking about the snacks, healthy eating can be defined in every culture very different. So like growing up for me, for example, rice was so healthy, you know, white rice and curry. That's what was the healthiest. However, here for example, white rice is considered a lot of carbs, you know, and brown rice, I never even heard about brown rice and we, brown rice is kinda considered tasteless for us. And growing up I would have a plate of white rice. So if I tell my mom that is unhealthy, she's not going to understand it, you know? So I feel like the definition of healthy is very different. (Priyanka, research interview participant, 2020).

As discussed in Chapter One, hegemonic nutrition models privilege white, Western, upper-class ideas about food and healthy eating. In her interview, Priyanka linked food to both her culture and to her definitions of health, something that some survey respondents also did in their responses to the question “What is healthy eating?” One survey respondent noted that “I also have concerns about how ‘healthy eating’ is culturally appropriate for non-white populations,” while another defined healthy eating as, “giving thanks and eating Indigenous foods with family and friends.” Thus, food is social and cultural, and survey respondents often talked about them together. Roberta and Wanda, two of my interviewees, both talked about how food connects their families and grounds them in Black culture and history, with Wanda elaborating:

Food that is meaningful is more, kind of, cultural, and so, food is huge for African-American families. It makes me feel more connected with my family when I have those foods, soul foods. So for example, Thanksgiving and actually this Christmas, I am the one who cooks. It kinda changes up depending, you know, kind of what we have a taste for, but for example, Thanksgiving. I cook like a meatloaf, I made collard greens. I made candied yams, I made baked mac and cheese. I made homemade dressing. Like I did a, we had peach cobbler and sweet potato pies. And so, so when we have those foods, especially when we're together as a family, it feels good because it again, it just brings, it just makes you feel more connected to your family. And also a lot of the things, those of course came up throughout the years within our community. And so being able to be in a position where I can provide that for my kids and learned how to cook it from my mom and my grandmother and so on and so forth. (Wanda, research interview participant, 2021).

In this way, for employees, food practices around family, social gatherings, and cultural

traditions are enactments of food as/for wellness. A holistic view of wellness embraces multiple dimensions; as the UMN EWP defines it, this includes among other things physical, spiritual, emotional, and social wellness (University of Minnesota, 2003). In this way, employees' enactments of food as/for wellness that include family, culture, and feeling good about food demonstrate the idea that eating the right foods can lead to complete individual holistic well-being by improving the already-healthy person.

### ***Food as/for Medicine***

In Chapter Four, I defined *food as/for medicine* as the idea that eating food, as enacted in dominant Western hegemonic nutrition models, can help cure current individual disease or illness, or intervene as a treatment for a disease risk factor such as overweight or obesity. It is worth noting here again, as I did in Chapter Four, that my definitions of food as/for wellness and food as/for medicine are similar, because both focus on the use of food to improve health. However, food as/for wellness is focused on improving and enhancing the already-healthy person, while food as/for medicine aligns with the biomedical model of intervention aimed at healing illness or disease. Notably, in Chapter Four, I concluded that while the UMN EWP promoted food as/for wellness, it was really doing food as/for medicine. In the remainder of this subsection, I demonstrate how food as/for medicine was enacted in employees' lived experience, drawing from my survey and interview data.

As noted above in the section on "What is healthy eating," responses to my survey question "What does healthy eating mean to you?" relied predominantly on hegemonic nutrition ideas. Nearly 85% (1,363 of 1,606) of employees wrote something that replicated hegemonic nutrition through a focus on calories, nutrients, or DGA models. As one survey respondent wrote, "eating a variety of foods from the 5 food



groups of MyPlate and doing your best to closely follow the MyPlate eating guideline.” I interpret these mentions of hegemonic nutrition models as enactments of food as/for medicine due to the links between hegemonic nutrition, fatness, and risk, which get mobilized broadly in the U.S. through claims like the one that opens the 2020 USDA DGA: “The foods and beverages that people consume have a profound impact on their health ... [and] following a healthy dietary pattern—can help people achieve and maintain good health and reduce the risk of chronic diseases throughout all stages of the lifespan” (p. vii). In particular, I interpret the use of the word “achieve” in this DGA quote as implying that it may be impossible to be healthy unless one follows what the DGA outlines as a “healthy dietary pattern.”

While invoking hegemonic nutrition is an enactment of food as/for medicine due to the links between hegemonic nutrition, fatness, and risk, some survey respondents also directly discussed food as a means to avoid disease, like one who wrote that healthy eating is:

Eating food that satisfies macro- and micro-nutritional needs while avoiding excesses that increase disease risk. More concretely this includes not eating too many calories as to make one overweight or obese, and eating a foods with a variety of nutrients rather than only foods that are palatable but nutritionally narrow (e.g., fresh vegetables versus refined sugar).

Even some survey respondents who pushed back on the idea of weight as a measure of health still relied on hegemonic nutrition (quantification and nutritionism) in their answers, such as one respondent who said:

The focus on weight often comes across as unnuanced. BMI is not a good indicator of obesity for individuals. Nutrition programs should include a macro-based approach, which is a very effective tool for understanding how foods work in the body, especially for people who are already active and healthy.

In this answer, the survey respondent was both rejecting BMI as a measure while

simultaneously mobilizing hegemonic nutrition ideas like understanding how nutrients work in the body as the key to healthy eating when they used the term “macro-based approach,” which invokes nutritionist ideas that some macronutrients are better than others. This quote underscores how fully hegemonic nutrition and its promotion of food as/for medicine have taken root in the public sphere. The replication of hegemonic nutrition in the UMN EWP is both one of the key ways I interpreted as enacting food as/for medicine, and the same is true in my analysis of participant data in terms of enactments in employees’ lived experience. Employee delineations of healthy eating repeatedly invoked ideas of food as/for medicine, like one survey respondent who said “I am interested in lowering my cholesterol” (their full response to the question about defining healthy eating), or another respondent who described how “I went through a pre-diabetes training that was very good and helped me to be aware of what I ate and the amounts that I ate.”

In my survey and interviews, a number of employees also discussed using food practices directly as part of their medical care, such as one who talked about avoiding “inflammatory foods because I have lupus” and another who mentioned “eating the foods that are right for me and my health issues.” Another example was Alice, the interview participant I discussed in the earlier section on “What is healthy eating?” For Alice, food was a core component in her medical treatment; while she had originally opted for lap band surgery to help her lose weight, that surgery and some other unrelated health issues left her with kidney and blood sugar issues that she treats through carefully regulating her intake of protein and sugar, respectively.

Ultimately, as I concluded in the section on “Food as/for Medicine” in Chapter Four, there is nothing wrong with food as/for medicine, generally speaking. People have

been practicing food as/for medicine for millennia with good reason: the overwhelming evidence is that food is an important part of health. That said, it is important to recognize that food as/for medicine is predominantly enacted in the U.S. in ways that are based on and reinforce white, upper-middle-class ideas about food and biomedicalized norms about body size based on statistical correlations (Biltekoff, 2013; Biltekoff et al., 2014; Hite & Carter, 2019). In other words, the dominant U.S. model for food as/for medicine is rooted in racist, classist, and ableist ideas about eating and bodies. The UMN EWP, through its eating-related programming, enacts food as/for medicine in a way that aligns with these dominant ideals and that replicates systemic racism, classism, and ableism. Importantly, institutional wellness discourse deeply shapes individual beliefs (Derkatch, 2018) and I interpret employees' strong reliance on a hegemonic model of food in their responses, even in some cases where employees worked to resist aspects of hegemonic nutrition or diet culture, as enactments of food as/for medicine in employee lived experience.

### ***Food as/for Economics***

In Chapter Four, I demonstrated how the UMN EWP's enactment of food as/for medicine was driven by measures of population health risks and return-on-investment (ROI) evaluations, which incited the university to monitor and evaluate employee health data, both self-reported through the EWP and gathered via the administration of the employee health insurance plan. Overall, I found that the EWP deployed hegemonic nutrition-based eating-related programming because of budgetary concerns and rising health insurance costs. In other words, due to institutional priorities, neoliberalism, and incentivizing weight-loss, the UMN EWP enacted food as/for economics.

Ultimately, however, I did not find evidence of employees enacting food as/for

economics. The closest analogue would be employees seeking to reduce their health insurance premium by participating in the EWP. Even when my survey respondents and interview participants talked about engaging in eating-related EWP programming, they also noted doing it in order to earn their points. In other words, based on my participant data, employees are practicing *wellness* (rather than food) as/for economics, which I will discuss in more detail in the next major section, “Enacting Wellness.”

### ***Enacting Food as/for Wellness and Medicine but not as/for Economics***

In this section on “Enacting Food,” I defined and discussed the idea of food as/for wellness, medicine, and economics. While employees, in many ways, enacted food as/for wellness and as/for medicine in similar ways to the UMN EWP, only the EWP enacted food as/for economics. Employees, I found, predominantly enacted wellness (rather than food) as/for economics. In the next section, I will present my analysis of employee enactments of wellness, including especially wellness as/for economics.

### **Enacting Wellness**

Like food, enactments of wellness in my archival data varied significantly, depending on a multitude of factors including culture, health, values, and economics. Three broader themes arose out of my praxiographic modified grounded theory analysis of archival data (in Chapter Four): wellness as/for holistic health, wellness as/for medicine, and wellness as/for economics. I use the as/for distinction here in the same way as in the “Enacting Food” section above. Thus, in the context of wellness, an enactment of wellness *as* medicine would mean wellness becomes or is equivalent to medicine, but also that wellness is being enacted *for* the same purpose one takes medicine—the prevention or curing of disease. Likewise, as in the “Enacting Food” section, I drew on my as/for framework from Chapter Four. In this section, therefore, I discuss what it

means to enact wellness *as/for* something else, meaning both “in the same way” and “in order to.” I use the three main themes of wellness *as/for* holistic health, *as/for* medicine, and *as/for* economics to delineate how wellness was enacted in employees’ lived experience.

### ***Wellness as/for Holistic Health***

In Chapter Four, I defined *wellness as/for holistic health* as the neoliberal, ableist premise that ideal health means being individually responsible for and continually striving toward perfection across broad physical, mental, and social dimensions. Further, I demonstrated how the UMN EWP’s enactments of wellness largely promoted ideas of wellness *as/for* holistic health, as defined here. Drawing on this definition and my analysis in Chapter Four, in this subsection I discuss employee enactments of wellness *as/for* holistic health.

Wellness *as/for* holistic health was a strong theme in my qualitative survey and interview data. A significant majority (about 74%) of survey respondents to the survey question “What does wellness mean to you?” answered in ways that reflected holism by talking about multiple dimensions, most often physical and mental, and, as one respondent put it, working “constantly in small or large ways working towards bettering oneself.” Some survey respondents also discussed wellness as a continual practice, or a constant striving, such as the survey respondent whose quote opened this chapter, who described wellness as unachievable:

To me, wellness is about living a meaningful life. It's not a static (or even achievable) state; it's a continually-evolving understanding of the elements that bring meaning to my life, a vision that shapes my actions. I think these elements differ for everyone, but generally, encompass the material basics (having everything you need to sustain yourself and those you love; food, housing, healthcare) as well as more intangible necessities like social support, safety, & access to whatever brings joy/fulfillment. Bread and roses, in Helen Todd's

words.

The neoliberal idea of individual responsibility for health was expressed regularly, though indirectly most of the time, through wording around personal habits, goals, and states of being. As one survey respondent simply replied, wellness means “taking responsibility for staying healthy and happy.” And while individual responsibility and constant striving were predominant among survey respondents’ ideas around wellness, one survey respondent pushed back on that, saying:

As used by organizations and the media, a term that encompasses healthy eating, exercising, and taking time for yourself while also never letting any of your responsibilities slip and by generally giving everything 110% and not being stressed out. It has always struck me as a particularly elitist term.

Likewise, the ableist wellness/illness dichotomy was prevalent in many answers, with people regularly defining wellness as being free from or avoiding illness, disease, and disability. As one survey respondent said in response to the question about what wellness means to you, “Being healthy - free from chronic disease or disorder, being a healthy weight, being relatively fit, eating healthy, etc.” These answers often demonstrated the ableist conflation of pain and disability through inferring or directly stating that a disabled life must be one with discomfort, pain, limitations/restrictions, or an impairing lack of energy. In these ways, employees mirrored the university’s enactment of wellness as/for holistic health by echoing language signaling neoliberalism and ableism.

Notably, a few employees pushed back against the wellness/illness dichotomy and a neoliberal, ableist definition of wellness. For example, one survey respondent wrote about working toward wellness as someone with chronic illness:

Wellness is something I aspire to. I have a holistic view of wellness. I believe it incorporates physical, emotional, mental, and spiritual togetherness. I struggle with chronic pain and multiple conditions but despite that I feel slightly more

"well" because I have gotten more of a handle on my mental health and practice gratitude and that has changed my mindset.

While this answer notably invokes ideas of constant striving through wellness being something the survey respondent aspires to, it also talks about how they can feel well despite struggling with health conditions. In this way, I interpret this survey respondent (and those who gave similar responses) as pushing back against ableist ideas of wellness by understanding wellness within their context as people living with chronic conditions. While the illness/wellness dichotomy discursively forecloses the possibility for ill people to also be well, especially those with chronic illness who may never achieve ideal able-bodiedness or able-mindedness, the example above demonstrates how some chronically ill people reframe wellness as something they can work toward through a focus on dimensions of wellness they have control over or are able to improve. Overall, I found that most employees told stories about how they practiced wellness that included holism, or multidimensionality, but that also replicated broader, ableist wellness discourse around constant striving toward ideal able-bodiedness.

### ***Wellness as/for Medicine***

In Chapter Four, I defined *wellness as/for medicine* as the reductive idea that intervening in and modifying individual behavior can treat or cure a preventable disease risk factor. Notably, the main differentiation between wellness as/for holistic health, as defined above, and wellness as/for medicine is the focus in the former definition on striving toward ideal health and in the latter definition on treatment or curing of biomedicalized risk factors. As discussed above in “Wellness as/for Holistic Health,” employees often discussed wellness as holistic but entangled it with ideas about the avoidance of pain or disease. I interpret this as an ableist conflation of pain and disability that reinforces the wellness/illness dichotomy. More importantly, it also appears in

wellness as/for medicine in terms of employees directly discussing their biometrics, risk factors, and chronic illness. For example, survey respondents talked about wellness as “being free of disease risk factors,” “being free from pain, risk, injury, sickness and discomfort,” and “not creating any chronic conditions for myself.” A few even defined wellness as preventive medicine. Overall, however, employees predominantly spoke about wellness as a holistic, personal practice. Therefore, while my analysis in Chapter Four showed that the EWP was primarily practicing wellness as/for medicine, employees less commonly practice wellness as/for medicine.

### ***Wellness as/for Economics***

In Chapter Four, I defined wellness as/for economics as the neoliberal, ableist premise that collectively engaging in health risk reduction can help solve (cure) both individual and population-level issues of rising healthcare-related expenses and related budgetary issues. Further, in Chapter Four, I argued that while weight-related risk factors drove the prioritization of eating-related programming, economic motivations underpinned the entirety of the EWP. In other words, the EWP was *predicated* on wellness as/for economics, as demonstrated by the EWP’s internal discussions of and emphasis on healthcare cost savings. In this subsection, I will demonstrate how employees are enacting *wellness* as/for economics, although in quite different ways than the EWP. Notably, while my discussion of enacting wellness in Chapter Four emphasized the ableism and population-level healthcare-related expenses parts of the definition, both ableism and national rising healthcare costs were rare elements in my participant data. Therefore, based on my participant data (survey and interviews), in this section I offer a modified definition of *wellness as/for economics*: the premise that engaging individually in health risk reduction can help solve (cure) rising *individual* health insurance costs. In



other words, *doing* wellness can help save individuals money out of their own pockets.

Overwhelmingly, employees talked about participating in the EWP only in order to earn the health insurance premium reduction, such as one survey respondent who wrote:

They are nice resources, but aside from the Farmer's Market, 99% of my reason for participating in the programming is to get the points. If it weren't for the requirement to get points for my insurance premiums, I doubt I'd access the program.

Only one person in my survey (out of 1,717 respondents) reported just generally loving the EWP and finding it to be useful.<sup>16</sup> Even when others said positive things about their experience with the EWP, it was always followed with a literal or metaphorical “but.” For example, one survey respondent wrote about the EWP, “I would love the Cooking for Wellness classes, but can't afford the cost.”

Repeatedly, survey respondents reported “the financial piece of it is the most motivating” and “I participate when I need wellness points for our health insurance.” Further, many survey respondents who reported only participating for the premium reduction complained about feeling like they had to “jump through hoops” or, as one respondent put it, “I participate mostly in order to earn the points needed (with some resentment that I have to “play this game” and can't be trusted to just be healthy).” Importantly, many participant stories also lamented not getting anything valuable out of their efforts because the EWP did not provide them with new or useful health information. For example, Chase, an interviewee who is an ultramarathon athlete, talked

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<sup>16</sup> While this may be remarkable, it is possible, if not likely, that this is due in part to bias in my sample due to how my survey questions were structured (though I aimed to reduce bias in the questions) or the “negative review” effect where consumers are more likely to leave a review or respond to a survey if they are unhappy with something. That said, one of the strongest and most consistent themes I saw across both user data as reported in BAC minutes and in my own participant data was that people are just generally unhappy with the UMN EWP, or they may be happy with some parts of it but dissatisfied with other parts. See Figure 2 in the *Entremet* “Data Stories.”

about the financial incentive to participate and being glad the university provides the EWP while also expressing frustration about not being able to get much out of it, partly because of his unique needs as an athlete and partly due to being at an outstate location in Minnesota without access to much of the EWP's programming:

Like I said, it's like, a little bit harder because I would like to actually attend several of the courses that they have in-person and I think that I'd get a lot out of that, but being so far from the Cities, it's, it's impossible for me though. ... So I thought it was, I thought it was, like, good basic, good *basic* information. So I did the, uh, I had a, uh, a diet coach actually, one year and talked with her and I do ultrathons and so I have a little bit of a different diet than most. And I felt like that wasn't all that helpful because it was just in general like, don't eat as much junk food and whatnot. And I, I mean, I very rarely have what would classify as true junk food, I feel like I never eat potato chips or stuff like that. So I felt like it wasn't quite relevant to people that might have different athletic abilities or whatnot. And it was kinda focused more on just the basic understanding what the different things are. And I didn't see anything that allowed you to kind of delve into a specific subset that you, you wanted to get into. So the coach was nice. She did her best to try to give me some ideas of what to do and some recipes and whatnot. But it just wasn't quite as custom-made to some of the things I wanted to achieve as I would like, but I think as a just good general basics of, you know, why do you need protein and why all the different things, you know, what a portion size of vegetable is versus meat and whatnot. It was good for that information, but it didn't have much for the specifics on how to accomplish some of the other things that might be atypical. You know, I feel quite often, our world's kind of changing where, like, companies take advantage of employees. And there's some situations in the university where I feel like I'm just a number. But it's nice to have this kind of whole [EWP] system to ensure that, you know, wellbeing. You are healthier and they know you're going to be a better employee. I think that having the financial benefit of that drives a lot of people to do it. So having the wellbeing program, the whole package, I guess, from the University is good. But there are just, I mean, the more online content you can get the better. And just having more like specific modules for different activities. I know, like I said, as a person who's kind of an anomaly in terms of my diet and my athletic things, it's a little bit harder. (Chase, research interview participant, 2020)

The theme of the EWP as not providing useful information was common. Over and over, survey respondents and interview participants reported that what the EWP presented in terms of health information wasn't helpful, was "too general to be useful,"

“overly simplistic,” and “far too basic and putzy for anyone with even basic knowledge.” Additionally, like Chase above, many people talked about the general nature of the EWP’s information in terms of wishing for a more individualized fit. The basic nature of the EWP’s health information and programming was especially pernicious for people who felt they were already healthy, as they often indicated frustration at having to spend their own time doing the EWP in order to receive the financial benefit without any new, useful, or value-added health information. As one survey respondent wrote:

I HATE THE WELLBEING PROGRAM. ABSOLUTELY HATE IT. It makes me jump through hoops to get the stupid points. I am already healthy and live a very healthy lifestyle yet every year, I still have to do these stupid things, usually in a rush because I forget and don't do anything until the summer (making the entire process even worse). I HATE IT.

In her interview, Nhia wished for a more individualized program as well, suggesting that:

With the university's approach, they could do more. And maybe, you know, maybe I have to keep in mind, that's where I'm at. Maybe I do a lot more research than other people. And so maybe other people who, who haven't done as much are getting more out of this health coaching, getting more out of this very basic information. But maybe, maybe what I'm saying is that the U needs different levels, beginner, intermediate and advanced. (Nhia, research interview participant, 2021)

What these participants are reacting to is the EWP’s reliance on an information deficit model of science communication, or the idea that if people simply had information about their health risks, behavior change would follow; however, it is worth noting again (as I did above) that the deficit model has been critiqued as ineffective for decades (Gross, 1994; Miller, 2001). Half of the information deficit model in the EWP is about informing people of their health risks, and the other half is informing them how to change those health risks through changes in diet, exercise, and disease management. Yet, in addition to the prevalence of employee voices saying they already know basic information about

healthy habits, which follows the pervasiveness of healthy eating discourse in the public sphere generally, many reported also already knowing their own risks. As one survey respondent wrote:

I don't believe I learned that much from my participation as I already was very aware of my health risks, have long cooked my own meals with a lot of fruit and vegetables, purchased my food at farmer's markets when produce is in season, and exercise regularly.

So, if employees feel like they aren't learning anything, why do they participate at all? Universally, the answers they gave revolved around the economic benefit of the health insurance premium reduction. Sam, another interview participant who is a competitive cyclist, provided a similar story to Chase and Nhia, but also underscored the premium reduction as a motivator:

[The EWP is] annoying. It seems to be geared towards people who are couch potatoes and it's a pain in the ass for people who kind of already have their shit together. And you need the points though, right, in order to get the discount in your insurance. And so it really feels largely like busy work. And so I really wish that there was some kind of mechanism by which folks who kind of have their shit together could just have their shit together. Do you know? But it doesn't work that way. And so I find it largely annoying. It's been pretty queer phobic in the past because you weren't able to select your gender identity if you were off the binary, which I am. It's been pretty disability unfriendly in the past, I'm not as familiar with the new vendor because I haven't really started doing anything with it. That's about all I got. I was really glad when they started incorporating like bike commutes more seriously because for a while you can only earn like this pittance of points for commuting every day, which I do. And I was like really? It's only worth 10% of the points I need to get to? And I have to feel like some of it, I don't know how everybody feels, but I certainly hear from some people that it's kind of condescending in a way like it's, I don't know. I don't think I'm the only one who's annoyed from my perspective, of having my shit together. You know, like I don't need this to help me. I'm simply doing it, it's taking away energy from things I could spend on, you know, from energy I can spend on other things like other pieces of my job. I have heard other people say that they find it kind of condescending and like they're being treated like children. I did something because I needed like 50 more points to get my discount. And I remember just rushing through it and feeling like I was getting nothing out of it. And, you know, it's just like checking a box to get my discount kind of a thing. (Sam, research

interview participant, 2021)

Amusingly, almost everyone I talked to said they did not learn new information about their health from the EWP, but they all assumed that level of information must be useful for someone out there. Many people, like Chase and Sam, reported being healthy enough already that they struggled to find enough ways to earn points and did not learn anything useful. Others that reported health risks also talked about how the EWP's information is not useful because they are already managing their health risks with their regular healthcare routines and providers. For example, one survey respondent wrote:

Most of the information provided in these programs is not helpful to me. My health and diet are managed by me in coordination with my medical team. Most of the programs and advice/coaching available don't apply to me, as they either cover basic things which I already know and apply, or the advice is inconsistent with what I need to do for my medical conditions. I really only participate to get the discount on my health insurance, but I feel it is mostly a huge waste of my time and effort to do so. I do not find it helpful.

Above, for the purposes of this section of analysis based on participant data (survey and interviews), I defined *wellness as/for economics* as the premise that engaging individually in health risk reduction can help solve (cure) rising *individual* health insurance costs. I found that the overwhelming majority of employees in my research are enacting *wellness as/for economics* in order to alleviate their own rising health insurance premiums. The premium reduction is crucial here; no employees talked about reducing the costs of their healthcare visits or expenditures on health items like medications, they *only* talked about the incentive of the premium reduction. Whereas I found in the “Enacting Food” section above that employees were not enacting *food as/for economics*, they are overwhelmingly enacting *wellness as/for economics*.

### ***Talking about Wellness as/for Holistic Health and Doing Wellness as/for Economics***

In this section on “Enacting Wellness,” I defined and discussed the ideas of

wellness as/for holistic health, medicine, and economics as they appeared in my participant data (survey and interviews). In Chapter Four, I concluded that the UMN EWP is primarily enacting wellness as/for medicine because of wellness as/for economics. In contrast, employees are generally enacting wellness as/for holistic health in their daily lives and separately, in the context of the EWP, enacting wellness as/for economics in order to reduce health insurance premiums. By this, I mean that employees report as a general goal working toward holistic health in their daily lives, but they only participate in the EWP for economic reasons.

### **Conclusion**

In Chapter Three's kairology, I noted that the EWP incentive of a reduction in health insurance premium of \$500 or \$750 was not insignificant, and the EWP is marketed as easy and beneficial, yet only about 40% of eligible employees earned enough points for the insurance premium reduction each year. This finding led to the question of why more employees are not participating. While I found a variety of reasons for non-participation in my datasets (archival materials, survey, and interviews), the overarching theme was one of a poor fit between the EWP and people's own personal practices, values, cultures, or goals. One clear mismatch is that the EWP is primarily practicing wellness as/for medicine, through centering a risk-based framework reliant on an information deficit model. Employees, on the other hand, are primarily practicing wellness as/for holistic health; they want to be healthy and happy across multiple dimensions in their lives, but they report that the EWP does not help them achieve that goal as it is overly simplistic and not individualized enough. By extension, it can be inferred that the 40% who do earn the premium reduction do so because the financial benefit is persuasive to them. So what about the other 60%? In addition to the mismatch

of EWP practicing wellness as/for medicine when employees practice wellness as/for holistic health, in my data analysis, I identified a number of barriers to participation. In the next chapter (Chapter Six), I present additional analysis of these barriers, many of which are issues of UX.

## ***Entremet: Diet Culture***

*Stories about food also connect to stories about bodies and health in important ways. Jessica told me a really powerful story about how the UMN EWP influenced her relationship with food and her body in a negative way. In Chapter Six, upcoming, I work to underscore how the larger system of power has a subtle yet strong influence on employees, something that really comes through in Jessica's description of her struggle with the UMN EWP and disordered eating.*

[JESSICA] I think this complaint that I'm going to have and probably continue to have for a long time is that, I think that in many ways, wellness plans encourage diet culture which feed into disordered eating, and my experience joining Weight Watchers through the wellness program, that kind of re-triggered a long-term disordered relationship with food. I probably would've ended up that route anyway. I think it was just going to happen in my life, but the door was really wide open because it was, there was an incentive for me from a bunch of different angles, this desire to lose weight, this discount on my insurance, this reimbursement. Like there was a lot of forces coming together and I know they don't do [Weight Watchers] anymore, which I think is really important and I'm, I'm glad that they took that off. But I think that there's still a lot of diet culture-y, things that are part of wellness programs that is just, it's not based in science. Health at every size is what we should be working on. I'd love to see some things about intuitive eating more, understanding other determinants of health and things like that. So I guess my complaint, If I had to make a complaint about it right now, it would be related to inclusion and and to just recognizing that health is more than what you eat and your activities. And so when I'm talking about diet culture, I'm talking about the idea that weight loss is an ideal and that thin bodies are to be desired. And that health comes from being thin. And that diet culture is all about controlling your food and eating. Eating clean, or eating healthy, and healthy does not include a wide spectrum of things. And I think diet culture feeds into associating feelings of guilt and shame with the types of food and diet that you eat, guilt and shame around the size of your body. And so it's the opposite of health at every size, its healthiness is reserved for thin, small bodies, not accessible for large bodies.



[DANIELLE] Thank you, I appreciate that. I think that you have done a pretty good job of talking about this already, but if you wanted to expand on it at all, how do you feel about the diet and nutrition information in the in the well-being program?

[JESSICA] Yes. I am not satisfied with it because I'd like to see it be more inclusive to, um, well, I mean, what we've already talked about, like, I would like to see it move away from diet culture. I'd like to see it move towards health at every size, move towards intuitive eating, mindful eating. Some of those strategies. Away from tracking and things like that. Oh, I will also mention, I did do coaching, I did the in-person coaching for nutrition and then I did physical therapy and both of those experiences, it left me something to be desired. With the nutrition person at that point, I had said to them, this was before [I re-joined] Weight Watchers and I said to them, you know, I have a history of eating disorder and I'm just trying to to like work on healthy eating. And these are some things that are triggering for me, like whatever. And I just didn't feel like I came away with a lot of resources or information to help. And then I think that because I felt like there was something to be desired is, like, why I went to Weight Watchers, but anyway, yeah, I'd like to see it move towards intuitive eating, move towards health at every size for the information that's [in the EWP]. The other thing I wonder about and don't know because I've stopped looking at it, but I'm wondering how inclusive it is to to access to food. Like are we giving information that is relevant for people who are not making necessarily enough money? Me, I don't know if the information takes into consideration that not everybody can afford certain types of foods, or that people might live in food deserts or those types of things. I don't know how inclusive it is to that. And I would I would be interested to know, but if I had to guess, I think usually these types of things aren't, don't take that into consideration. So I think there's a lot to be desired and some different ways that those programs could go.

[DANIELLE] Thank you. Can we chat a little bit more about how, if at all, you feel like the Wellbeing Program, its diet, nutritional programming, and things like Weight Watchers had impacted your relationship with food?

[JESSICA] Yeah. So I you know, I'm not going to blame the wellness program because this was something that I struggled with before. And I had been on Weight Watchers before when I had an active eating disorder. And so I

will say that it made it *easy* for me to re-enter a disordered relationship. I was incentivized because I could meet several goals at once. And so I think that as a result of that confluence of events, the ability to join Weight Watchers for a reduced price, the ability to use Weight Watchers to get a discount on my health insurance, and then also I was incentivized to do Weight Watchers because to get those things, the discount and the points and the reimbursement, I had to go to Weight Watchers a certain number of times. And then in the Weight Watchers model, once I lose enough weight and I maintain my weight loss, I get Weight Watchers for free. So I was incentivized to do those things within the timeframe that the U of M would still pay for it. And so I did, I went very hard and like totally spiraled. It was not like a slow, gradual decline. It was very quick because I was intending to do it within the timeframe that I could get all of these things at a reduced price so that it would be free for me at the point at which I ran out of reimbursement or the point at which that I couldn't get any more points for it through my health insurance. So I would say that there is a direct correlation with how things progressed, how quickly they progressed, and how I just was like, provided an opportunity. So a negative relationship between what was available to me through the wellness program and my relationship with food. But again, I would never assign the blame there. However, I don't know that for other people, ... you know, they get into this with good intentions and not having history with eating disorder or anything like that. And they are encouraged in this behavior. And then our society and diet culture reward small bodies. And then, you know, all of the other things like mental health and tying your feelings of self-worth to your weight and to your food choices.

*When Jessica described her struggles with food, she sometimes struggled to find the right words. It was emotional, but in a very different way than Sam's, Roberta's, or Nhia's (upcoming after Chapter Six) stories that I highlight in other Entremets. For Jessica, and the many other people in my research who talked about struggling with eating disorders, food is complicated. James, another interviewee in recovery for a binge eating disorder, talked about using food for emotional support. Jessica talked a lot about controlling her life and her body by controlling her food choices when her orthorexia was active. Both of them described how difficult it was to navigate the UMN EWP*

*because of its strong emphasis on food (one survey respondent said “if the focus were less RELENTLESSLY on weight loss and more on pleasure through food, it would be awesome” which sums it up well, I think). What Jessica’s story really highlights is how the interplay of incentives, institutional power, diet culture, her own history with food, and a short time-frame for EWP points was a strong influence in her own journey with disordered eating. The EWP aimed to improve health, but by deploying hegemonic health and nutrition information, it risked causing more harm than good in some cases.*

## Chapter Six:

### “I am afraid to go to a doctor I didn’t choose” —

#### Citizenship, Pre/patients, Irreconcilable Differences, and Resistance

The quote in the title of this chapter comes from Kelly, one of my interview participants, describing how the UMN EWP’s wellness practices were a mismatch with how that she would prefer to practice wellness. The full quote is:

One change [the EWP] made, and it's only because of COVID and I hope to God they keep it post-COVID is this time they let you do your biometric screening with your doctor and they said have them sign off and why they haven't done that every other time, I have no idea. And I probably will argue with them next year if they change it back to be approved to do that because that is a *really personal thing*. And for a myriad of reasons, it takes a lot of time to find somebody you trust. And I got a biometric screening in July. Like, I'm not afraid to go to the doctor, but I am afraid to go to a doctor I didn't *choose*. (Kelly, research interview participant, 2021, emphasis original)

In this quote, Kelly talked about the difficulty of finding a doctor she can trust, but more importantly, she described a reaction to feeling compelled to monitor her health in the workplace. By linking the difficulty of finding a doctor she could trust with the EWP’s biometric screening practices, in this quote Kelly demonstrates how the UMN EWP interpellated people as always-already pre/patients, something I unpack later in this chapter.

In Chapter Three, my kaiology demonstrated how the UMN EWP is deeply entangled with the UMN’s history of employee health insurance, a tie that binds the EWP and its model of wellness to an ableist medical model of the diseased/disabled/at-risk body as deficient and in need of cure. Drawing on evidence from my praxiographic modified grounded theory analysis of archival data, I demonstrated how the UMN EWP is discursively promoting food as/for wellness while enacting food as/for medicine

because of food as/for economics, or the aim of addressing rising population-level healthcare costs. Similarly, I found that the UMN EWP is *talking about* wellness as/for holistic health but *doing* wellness as/for medicine *because of* wellness as/for economics. In concluding Chapter Five, I reiterated that the UMN EWP itself reports only about 40% of employees participate fully each year and earn the health insurance premium, a rate that has remained stagnant for about a decade despite increasing programming options and incentives. While I found a variety of reasons for non-participation in my datasets (archival materials, survey, and interviews), the overarching theme was one of a poor fit between the EWP and people's own personal practices, values, cultures, or goals. Additionally, I identified a number of themes in terms of barriers to participation.

In this chapter, I draw from both my archival (materials dated 1981-2019) and participant (survey and interview) datasets in order to pull together these threads of my analysis. In order to understand the how the mismatches between EWP and employee practices are especially problematic, in this chapter I will begin by discussing how the EWP links neoliberal health citizenship to the idea of being a good employee and interpellates people as always-already pre/patients through surveillance and intervention. I then detail how the idea of 'eating right' as framed through the UMN EWP positioned what it means to be a 'good eater' as connected to dominant norms around self-discipline and a well-regulated lifestyle, key aspects of being a 'good citizen' and by extension, a 'good employee.' Then, based on analysis of EWP and employee practices in Chapters Four and Five, I discuss what I call Irreconcilable Differences, or key fundamental mismatches between how the EWP and employees enact food and wellness. Lastly, I discuss employee resistance to the EWP as an opposing strategy or form of power, rather than just an issue of EWP non-use or poor UX.

## Health Citizenship and the Interpellation of Employees as Pre/patients

As noted above, because the EWP is essentially locked into doing wellness as/for economics—to the neoliberal, ableist premise that individuals are responsible for collectively engaging in health risk reduction in order to solve (cure) rising population-level healthcare expenses and related institutional budgetary issues—it cannot escape its own need to measure, quantify, and evaluate the EWP through biometric markers, health risk prevalence, and ROI. While my analyses in Chapter Four focused on how the UMN EWP enacted food and wellness, in this section I examine how the UMN EWP practices enacted *employees*. As an employer, UMN’s material-discursive practices and institutional power frame ideas around what it means to be a “good” employee that are tightly linked to individual health. In other words, much like *food* and *wellness*, the UMN EWP enacted *employees* in a certain way. Therefore, here I discuss how the EWP links neoliberal health citizenship to the idea of being a good employee and interpellates people as always-already pre/patients through surveillance and intervention.

In what follows, I first discuss ideas of citizenship as they connect to workplaces, health, and eating, and then demonstrate how the UMN EWP links health citizenship, ableist ideas about fatness, and being a “good eater” to being a “good employee.” Then, I will elaborate on how power and incentives work coercively toward making submission to surveillance and self-tracking compulsory for employees. Building on that, I will discuss how the UMN EWP interpellates employees as pre/patients through enacting *all* bodies as in need of medical surveillance and intervention, even without the presence of illness or disease. Finally, I will touch on ways that employees resist normative ideas about bodies, risk, and health in the workplace.

## **Good Citizenship**

Importantly, citizenship here is not about one's eligibility for a passport in one's home country, but rather, an idea of the citizen as "articulated in the language of social responsibilities and collective solidarity" (Halse, 2009, p. 50). A "'good' citizen is therefore an 'active' citizen, and active citizenship is the means by which one both commits to and becomes immersed in and part of" a community by "actively demonstrating the moral virtues of ... wisdom, temperance, justice and courage" (Halse, 2009, p. 50). Further, through disciplinary power, the neoliberal project of "good citizenship" has been shaped into a personal desire whereby "individuals act upon themselves and their families in terms of the languages, values and techniques made available to them by professions, disseminated through the apparatuses of the mass media or sought out by the troubled through the market" (Rose, 1999, p. 88). Rose argued that "citizenship should be studied at the level of the practices, technologies and mentalities within which citizens were to be formed" (1999, p. 226) and I take this up in studying the entangled ways citizenship around health and eating manifest in the workplace as part of what it means to be a "good worker."

## ***Workplace Citizenship***

The concept of organizational citizenship behavior (OCB) arose in the fields of management and organizational psychology in the early 1980s and was originally defined as "individual behavior that is discretionary, not directly or explicitly recognized by the formal [workplace] reward system, and that in the aggregate *promotes the effective functioning of the organization*" (Organ, 1988, p. 4, emphasis added). The good organizational citizen went "beyond the call of duty" (Organ, 2018, para. 2) and could thus be seen as "good soldiers" (Organ, 1988). Since then, much research has adopted,

expanded, and critiqued the original model of OCB, however, the general trend of this research is toward nuancing the model of OCB while acknowledging it as a major component of organizational effectiveness and success (Podsakoff et al., 2018). Specifically, as jobs became less well defined in the late 20th century, OCB became less tightly connected to the idea of “discretionary” work (Orban, 1997). Today, while OCB “can be extra-role, or outside the job description, most citizenship behaviors are not strictly extra-role but rather discretionary amounts of ‘in-role’ behavior ... they are types of behaviors in the realm for which employees are compensated to perform, but contributed at levels not specifically required or expected” (Brown & Roloff, 2015). That said, conceptualizations of workplace citizenship remain focused on evaluating voluntary effort and its role in promoting organizational effectiveness.

Absent from foundational theory on OCB in management and organizational psychology is any discussion of the role of institutional power. Here, Foucault’s theories of disciplinary power and biopower are fruitful. According to Foucault (1979), a key feature of disciplinary power is its aim of normalization, or imposing specific standards by which people are judged normal or abnormal; examinations and standards in schools, medicine, and workplaces all combine observation with normalizing judgment. Disciplinary power works to produce docile bodies shaped into malleable, controllable, and useful parts of the overall organizational machine (Foucault, 1979). Further, while power is disciplinary and normative, aiming to effectively administer, optimize, and control bodies, it is also dispersed among various interconnected networks throughout society (Foucault, 1990). In other words, there is no material center to power, no one person or institution in charge, rather, power permeates the whole of society (Foucault, 1990) and works to discipline bodies through a near-invisible “multiplicity of minor



processes” taking place within families, workplaces, and other institutions (Foucault, 1979, p. 138). Knowledge and observation are key elements of power: through observation comes knowledge, and through knowledge comes control (Foucault, 1979).

Institutional bureaucracy is an apparatus of power: it defines, observes, and normalizes bodies and behavior through “conceptions of regular procedures, normal participants, and typical processes” (Titchkosky, 2011, p. 9). Bureaucracy shapes subjects through disciplinary power, constituting what counts as being a good worker. Through a lens of power, OCB seems less voluntary and altruistic, and more like a process of power aimed at shaping compliant individuals who take personal responsibility for advancing organizational efficiency and effectiveness. This connects, as well, to neoliberal discourses of productivity that conceptualize “good” people as ones who contribute positively to a capitalist society (Harvey, 2007). Therefore, good workers are like “good soldiers” who go “beyond the call of duty”: docile bodies that willingly reshape themselves to match dominant norms, including contemporary norms about productivity, working overtime, and getting more done that are prevalent in the workplace.

The UMN has, for a number of years, branded itself with the phrase “Driven to Discover,” using this core positioning statement to anchor individual brand campaigns:

We are all born with a passion to search, with a fundamental need to discover. At the University of Minnesota, this curiosity is part of our collective DNA. We provide a thriving community for those with an overwhelming drive to teach and to learn, to research, and to serve. At the U of M, we continually inspire the next great generation of innovators and empower each other during our search for knowledge. (University of Minnesota, 2018e)

The “About Us” page for the university highlighted “Our Dedicated and Driven Staff” who are “known for being exceptionally dedicated” (University of Minnesota, 2019c). And, on the human resources website, a message from the university Vice President

urged that:

Everyone [sic] single person here has important work to do, and we are counting on you to make the next discoveries, inspire students, and contribute to the communities where we all live and work. We are fortunate to have a rich legacy of excellence to inspire us. If you walk down Scholars Walk and visit the Wall of Discoveries on the Twin Cities campus, you will see what I mean. We follow in the footsteps of innovators who created drought resistant wheat to feed the world, laid the groundwork for the Internet, led the way in AIDS and Alzheimer's research and made many other discoveries in every field of study. (University of Minnesota, 2018f)

I interpret language like “we are all born with a passion” and framing the university community as “for those with an overwhelming drive” as situating “driven” as inherent, natural, and ideal. Touting “exceptionally dedicated” staff in public-facing messaging underscored the expectation that employees would be “driven,” and messaging like “we are counting on you to make the next discoveries” alongside a list of the laudable, although exceptional, accomplishments of a few people reinforced the message to employees that the expectation is working hard and working a lot.

The university's discourse was part of the bureaucratic function of normalizing OCB, or voluntarily contributing a high level of in-role work and/or extra-role work. The message to employees encouraged visiting Scholars Walk and the Wall of Discoveries (collections of plaques honoring people who received major university, national and international awards) for inspiration. However, what is absent from those monuments are the huge multitude of staff (from the research lab to the accountants to the IRB consultants to the custodians) that make that work even possible. Overall, the “Driven” branding—which is omnipresent on campus sidewalks, in and on buildings, on letterhead and websites, and all over promotional materials for the UMN EWP—neoliberally positions individual productivity as a core value of the university and privileges the labor of a few notable individuals over that of the multitude.

In the next section, I take up the idea of health citizenship and healthy eating and discuss how it manifests through the UMN EWP in the workplace. Importantly, employment-based health insurance fundamentally links neoliberal health citizenship to the workplace through EWPs. As noted in Chapter One, employment-based health plans became widespread in the wake of World War II through major hospital system expansions and federal tax laws encouraging employers to offer health plans as part of their fringe benefits in order to attract workers (Hoffman, 2012). One of the key tasks in devising insurance plans was to find ways to balance individual and institutional responsibility while safeguarding against the pooled risks “produced by an economic system based upon the private contract of employment, and the dangers inherent in production for profit” (Rose, 1999, p. 82). Further, as healthcare costs have increasingly skyrocketed in the late 20th and early 21st centuries in the U.S., greater and greater responsibility has been placed on individuals to maintain their health in order to reduce healthcare expenditures, while eliding the role of the medical, pharmaceutical, and insurance industries in those rising costs. And, as demonstrated earlier in this chapter, the UMN EWP arose directly out of and is tightly bound to the university’s health insurance, UPlan. Through the ties of neoliberal health citizenship to health insurance generally, and health insurance to the UMN EWP’s ableist and risk-reduction-based model of wellness, the EWP made possible the shaping of employees as health citizens in the workplace.

### ***Health Citizenship and Healthy Eating at Work***

Charges to ‘take responsibility’ and make ‘good choices’ in order to live a ‘healthy lifestyle’ have become ubiquitous in contemporary U.S. culture. Increasingly, responsibility for health and wellness, and for minimizing health risks and associated costs, has been shifted from the state to the individual (Biltekoff, 2013; Derkatch &

Spoel, 2020). The ‘good citizen’ is one that takes responsibility for their health by being informed about and practicing a healthy lifestyle according to hegemonic definitions; this neoliberal emphasis on individual responsibility for health is a new form of citizenship (Biltekoff, 2013; Derkatch & Spoel, 2020; Petersen et al., 2010; Spoel et al., 2012, 2014). Health citizenship has a particular emphasis on not just the responsibility but the obligation of individuals to maintain their health through lifestyle and behavior in order to serve the greater good (Derkatch & Spoel, 2020). The changing economics and landscape of healthcare and health information in the internet age meant the modern citizen had to become a better consumer, both in terms of products and information (Biltekoff, 2013; Tomes, 2016). Further, good health citizenship was often “portrayed as the path to ‘freedom’ and ‘fulfillment’” through empowerment and choice (Petersen et al., 2010, p. 394). As the *2018-2019 Program Guide* for the UMN EWP extols: “you [can] achieve personal health goals, reduce stress, maintain a healthy habit, or manage a chronic condition ... [to] achieve your personal best” (University of Minnesota, 2018b).

Additionally, in a neoliberal system designed to push responsibility to individuals while increasing profits for the medical-industrial complex, the imperative of health citizenship has financial implications for individuals, especially during a time in the U.S. when a serious illness can result in lifelong debt or bankruptcy even with health insurance coverage. Despite growing attention to social determinants of health and disparities produced through medical racism, classism, and ableism, the obligation of health citizenship remains essential to what it means to be a good citizen (Spoel et al., 2012). People are considered in the abstract aggregate, disregarding context and environment and supporting the prioritization of individual responsibility over making changes to underlying systemic inequities (Hite & Carter, 2019). Importantly, neoliberal health

citizenship invokes ideas about what it means to be healthy that mirror the positive eugenics underlying hygiene programs of the early 20th century (Rose, 1999). Positive eugenics included practices like socially reinforcing the propagation (or not) of people in certain groups as well as nutrition and exercise programs aimed at shaping ideal bodies. The ideal body to strive for was, as Goffman (1963) described it, white, male, heterosexual, of proper weight, and physically fit if not a sportsman.

As noted earlier in this chapter, the history of American eugenics is deeply entangled with the history of American universities. While eugenic science gained funding and legitimization in university research corridors and, in important cases, led to negative eugenic practices like forced sterilization, the university itself was a place for performing positive eugenics, or the idea of optimizing and perpetuating desired groups through admissions, hygiene programs, and eventually through placements in the workforce (Dolmage, 2017). Universities promoted eugenics—or the idea that preferred groups could be improved through nutrition, exercise, and preventive healthcare—through both hygiene programs of study and lifestyle expectations for students, faculty, and staff (Dolmage, 2017). Notably, the central obligation of health citizenship to take responsibility for one’s health through a good lifestyle (Derkatch & Spoel, 2020) is highly reminiscent of eugenics broadly, and EWPs are a modern manifestation of this ideology (Dolmage, 2017). As noted in Chapter One, it is possible to draw a somewhat straight line from positive eugenics to university hygiene programs to neoliberal health citizenship to EWPs. For example, the UMN EWP said in its early definitions of wellness: “Our health is our responsibility. Our lifestyle choices and decisions make a big difference in our health” (University of Minnesota, 2004a). This language about responsibility and choice echoes that of neoliberal health citizenship and eugenics.

The 2010 Affordable Care Act (ACA) incentivized employers to offer EWPs and to differentiate rewards for participation, including health insurance premium rates, based on health status (Basas, 2014; Kirkland, 2014a; Minich, 2016). As Julie Minich explains, “The ACA thus encodes into law the perception that it is an individual’s responsibility to maintain him/her/themself in a state of maximum able-bodiedness” (2016, p. 2). Wellness discourse that focuses on health as personal responsibility also reproduces neoliberal health citizenship imperatives. As civil rights and legal scholar Carrie Basas argues, “Wellness neoliberalism empowers certain actors to be monitors or gatekeepers of measuring health, primarily employers, human resources professionals, and insurance companies ... [and through it] we see a scaling down of resources for a spectrum of health and wellness and, in their places, a focus on market intervention and individual failing” (2014, p. 1052). In EWPs generally, self-improvement and optimization are the goal, and taking action toward wellness is thus an aspect of being a good health citizen and an expression of a commitment to the greater social good (Basas, 2014). Poor health citizenship is therefore correctable through wellness programs if they can persuade people to change their personal ‘bad’ behaviors. Additionally, ideas around “good” health behaviors are predicated on white, Western, upper-middle-class values (Biltekoff et al., 2014; Derkatch & Spoel, 2020; Hite & Carter, 2019). Therefore, when mobilized as hegemonic norms, these ideals perpetuate systemic ableism, racism, and classism, categories which Kafer (2013) argues are “constituted through and by each other” (p. 32).

Eating habits are a “lifestyle choice” often taken up in health citizenship and EWP discourse. “Teaching people to ‘eat right’ inevitably involves shaping certain kinds of subjects and citizens,” those who demonstrate self-discipline in making responsible food choices (Biltekoff, 2013, p. 4). Self-discipline is a key component of eating habits in

neoliberal health citizenship through the connection of choice to outcome through rhetorically constructed ideas of cause and effect (Biltekoff, 2013; Guthman, 2011; Halse, 2009; Hite & Carter, 2019). Guthman (2011) and Biltekoff (2013) argued that the neoliberal subject is expected to exercise self-discipline and self-control in eating habits, which are directly reflected in an individual's weight, and that, through obesity discourse, these values of neoliberalization are both advanced and normalized. Hite and Carter (2019) elaborate that "in the case of dietary approaches to the prevention of chronic disease, cause-effect relationships are established rhetorically, rather than empirically," arguing that "interventions that target obesity to prevent chronic disease assume cause-effect relationships between these interventions (such as dietary changes or exercise programs), obesity, and chronic disease outcomes that are highly contested" (p. 153-154). Further, Hite and Carter suggest that "the values of those in positions of expert authority bridge the logical gap between the 'is' of scientific claims of fact and cause-and-effect and the 'ought' of public health policy" (2019, p. 154). In other words, while scientific research correlates fatness and disease risk, correlations that are contested, as discourse moves from the realm of scientific research into public health policy, those correlations lay the groundwork for normative ideas about what people should do. And, what people should do is practice self-discipline in their eating habits in order to make responsible food choices for one's own body and health as well as the benefit of institutions and larger societal structures.

Obesity discourse reflects neoliberal values and works to normalize the idea that fatness is a result of personal choice (Biltekoff, 2013; Guthman, 2011; Halse, 2009). Food choices are moralized through hegemonic nutrition, or a reductive focus on quantification of nutrients and their role in the body, positioning some foods as 'healthy'

or ‘good’ and others as ‘unhealthy’ or ‘bad’ (Biltekoff, 2013; Mudry, 2009; Scrinis, 2013; Spoel et al., 2012). Biltekoff (2013) describes how the “discourse of dietary health around body size” centers on “the persistent equivalence between thinness and self-control,” and that obesity discourse makes “the consequences of being a ‘bad’ eater more serious than ever before” (p. 111). Thus, a ‘good’ health citizen is thin and a ‘good’ eater who does not burden society with extra healthcare costs associated with fatness, and, by extension, a fat person must be a self-indulgent eater with poor self-control, or a ‘bad’ eater and ‘bad’ citizen by ignoring the interests of the common good (Biltekoff, 2013; Halse, 2009). Health citizenship and obesity discourse also deploy quantification of bodies, like BMI calculations, which reduce individuals to numbers amenable to reductive categorization and comparison (Halse, 2009). In other words, being a good citizen means being a responsible eater with a normal BMI.

BMI is a core measurement of health in the UMN EWP, as discussed previously, and makes possible the biomedicalization of fatness as a target for medical intervention even without the presence of illness (Berlant, 2007; Brown, 2015; Jutel, 2009; Sadler, 2014). Further, the conflation of body size and health is an ableist delineation of what ideal bodies should look like and do; fatness is connected to disability and disease through biomedical obesity discourse, and the ideal body is framed as thin and able-bodied. Earlier in this chapter, I demonstrated how EWP discourse around “healthy eating” and BMI mobilized medical ableism to mark and judge bodies deemed to be non-ideal. Further, I established that the EWP uses a neoliberal medical model of wellness that places responsibility for health onto individuals. In turn, the EWP deploys hegemonic nutrition-based eating-related programming and incentivizes weight-loss, and it does this in order to address institutional budgets and rising healthcare costs.



### ***Eat Well to Work Well***

As expressed in 2008, the three objectives of the UMN EWP were to: “Improve the health and productivity of University employees. Help to control health care costs. Enhance the reputation of the University as a good place to work.” (BAC, 2008c). The university linked the EWP to the UPlan health insurance program from the start in order to achieve these goals. Notably, the university positioned the EWP as both a way to attract new employees and to improve their productivity. Discourses of productivity are typically neoliberal and, in turn, are linked to discourses around OCB or ‘going beyond the call of duty.’ Importantly, discourses of productivity are especially pernicious for disabled people and people with chronic illness (Price, 2018). In other words, neoliberal discourses of productivity are ableist, and tie good citizenship at work to able-bodiedness. I interpret the UMN EWP’s reliance on discourses of productivity as positioning disease and disability as potentially disrupting people’s productivity. Further, through centering productivity as a goal and framing disease and disability as key impediments to reaching productivity goals, the UMN EWP enacted disability as non-productive. Through language in the EWP about responsibility and pursuing wellness in order to be your best, good organizational citizenship is linked to good health citizenship. And, through the centering of hegemonic nutrition and diet programming in the EWP, good health citizenship is connected to being a good eater and having an ideal body size. Thus, being a ‘good employee’ means being a ‘good eater’ and having a thin, able body.

### **Interpellating Employees as Pre/patients**

Louis Althusser (1972) advanced the idea of interpellation as a process whereby individuals acknowledge and respond to dominant ideologies, thereby becoming subjects to those ideological apparatuses. This could be seen as similar to Foucauldian

disciplinary power and the way it shapes subjects, though Foucault tended to focus on institutions as objects of his study and placed ideologies within them. Althusser, on the other hand, placed ideologies above institutions, arguing that schools, families, churches, and workplaces function as apparatuses for higher ideologies by subjecting individuals through interpellation. He elaborated:

Ideology ‘acts’ or ‘functions’ in such a way that it ‘recruits’ subjects among the individuals (it recruits them all), or ‘transforms’ the individuals into subjects (it transforms them all) by that very precise operation which I have called *interpellation* or hailing, and which can be imagined along the lines of the most commonplace everyday police (or other) hailing: ‘Hey, you there !’ Assuming that the theoretical scene I have imagined takes place in the street, the hailed individual will turn round. By this mere one-hundred-and-eighty-degree physical conversion, he becomes a *subject*. Why? Because he has recognized that the hail was ‘really’ addressed to him, and that ‘it was *really him* who was hailed’ (and not someone else). (Althusser, 1972, p. 174, emphasis original)

While the “Hey, you there!” example is a temporal and interpersonal example, Althusser (1972) insisted that interpellation is not a cause-and-effect process, but rather, it happens simultaneously and through both the act of hailing and ideological apparatuses. Ideology is ever-present, and through interpellation, “ideology has always-already interpellated individuals as subjects, which amounts to making it clear that individuals are always-already interpellated by ideology as subjects, which necessarily leads us to one last proposition: *individuals are always-already subjects*” (Althusser 1972, p. 176, emphasis original).

In the case of the UMN EWP, ideology about workplace citizenship is entangled

with health citizenship and systemic ableism, racism, and classism. In addition to the disciplinary power inherent in the worker-institution relationship, the EWP adds significant monetary incentives in order to persuade employees to participate year after year. In the remainder of this section, I will first explore power, incentives, and surveillance, and then describe how the EWP's use of incentives and surveillance contribute to interpellating employees as pre/patients.

### ***Power, Incentives, and Surveillance***

“New! Money back for weight loss” and “Get paid to exercise,” argued the *Discover Wellness 2010* brochure from the UMN EWP. The employer-employee relationship is transactional: the employer trades money for the employee's labor (and in many cases, also for an employee's health). The EWP is transactional as well, in that an employee trades labor (working on their Wellness Points) for money and alleged health improvement. In this way, the employer-employee and EWP-employee relationships are almost tautological: the employee trades their labor and health for money, then the employer trades money back for labor and health (though EWP efficacy has questionable impacts on health).

Broadly speaking, biomedical obesity discourse positions fatness as a financial burden to employers. In a special issue of the *Journal of Law, Medicine & Ethics* on the implications of the ACA for public health, Kristen Madison and colleagues (2011) highlighted how employers have utilized studies that associate fatness with economic burden to expand incentivization of EWPs, suggesting that employers are swayed by arguments in medical literature that “obesity-related medical and absenteeism costs range from more than \$400 to more than \$2,000 per obese employee per year” (p. 455). Further, other medical studies have argued that obese workers' medical costs are 35-42%

higher than those of normal weight individuals (Froehlich-Grobe & Lollar, 2011; Madison et al, 2011). As of the mid-2000s, around 60 percent of American adults and 30 percent of children are obese and “one out of every three children born during or after the year 2000 will be afflicted with an obesity-related disorder such as diabetes mellitus, or type 2 diabetes” (Berlant, 2007, p. 771). A self-insured organization like the UMN must bear these costs directly, and thus is incentivized to reduce them. In my analysis of enactments of wellness earlier in this chapter, this perceived economic burden is the underlying reason why the UMN EWP is practicing wellness as/for economics.

Earlier, I noted that the EWP reports that only about 40% of eligible employees complete the EWP and earn the health insurance premium reduction each year, a rate that has remained stagnant for over a decade despite increasing programming options and incentives. In Chapter Four, I demonstrated how a mismatch between EWP and employee enactments of wellness is a key driver behind stagnant, low EWP participation rates. What is important here (which I also expand on in Chapter Four) is that many employees did participate due to the significant incentive of the health insurance premium reduction: \$500-750 per year is not an insignificant amount of money for many people. The power dynamic of the employer-employee relationship is entangled with imperatives for health citizenship and with financial incentives. Institutions use biopower to control bodies through delineations of what health is and how to maintain it, while disciplinary power works to make bodies docile by shaping them to conform willingly to dominant norms (Foucault, 1979, 1990). The employer uses power to both shape people into compliant workers and to shape their enactments of health, their citizenship, and their bodies, and incentives and surveillance are key apparatuses of power.

Disciplinary power typically operates through continuous minor processes until

people comply unconsciously (Foucault, 1979). A central component of disciplinary power is observation. Foucault used the Panopticon—a circular architectural design for prisons, asylums, schools, hospitals, and factories put forward by Jeremy Bentham wherein a supervisor placed at the center can invisibly surveil every moment and every movement of the prisoners, students, patients, and workers placed in cells around the periphery—as a metaphor for disciplinary power and social control. The Panopticon’s major effect is to “induce in the inmate a state of conscious and permanent visibility that assures the automatic functioning of power” (Foucault, 1979, p. 201). Surveillance is both permanent and discontinuous, as the perfection of power renders unnecessary the actual exercise of power overtly because it engages people in bearing the power themselves; in other words, the normalization of constant surveillance is an exercise of disciplinary power that shapes people into docile bodies willing to be surveilled and to self-surveil. The Panopticon also functioned as a laboratory for experiments “with medicines and monitor[ing] their effects ... [and] to teach different techniques simultaneously to the workers, to decide which is the best” (Foucault, 1979, p. 202-203). Lastly, the Panopticon operated at all levels: in the central tower the director may observe all their employees, including supervisors at lower levels, and “judge them continuously, alter their behaviour, impose upon them the methods he thinks best; and it will even be possible to observe the director himself” (Foucault, 1979, p. 204). In this way, the Panopticon represents the distributed system of disciplinary power and how it operates through observation and surveillance.

While the university itself, as an employer, is a Panopticon monitoring its employees’ work performance and compliance, the EWP adds the layer of monitoring employee health behavior as well. Within the EWP, monitoring takes place both through

the institution gathering data on employees, through gathering Wellness Assessment and biometric screening data, and by the institution encouraging employees to self-monitor. Logging food intake via self-tracking activities, along with tracking other health data like exercise, is a key component of programming designed to effect eating behavior change. Internal and external texts argued the benefits to employees of self-tracking, especially via activities such as weight loss programming, the Wellness Assessment, the biometric screening, and the use of EWP vendor websites and apps, all of which generate and share numerical health data with the EWP. In the points system, in order to receive points for any activities, tracking and reporting engagement is required. Likewise, weight management programs such as Weight Watchers at Work heavily promote digital tools and apps for self-tracking, arguing that self-tracking is a key component of long-term behavior change, particularly as applied to eating-related practices. Further, while use of self-tracking was voluntary, the incentivization of the EWP encouraged, and possibly coerced, employees into monitoring themselves (Lupton, 2016). Sociologist Deborah Lupton argued “there is a fine line between consensual, pushed, and imposed self-tracking” in wellness programs, because despite a “discourse of choice . . . people may have little option of opting out” (2016, p. 124). Institutional power and financial incentives blur the line between optional and imposed self-tracking. In the UMN EWP, incentivization (greatly reduced health insurance premiums) strongly encouraged employee self-surveillance.

In the UMN EWP, financial incentives are paired with discourses about risk, chronic illness, and fatness: they are the carrot and the stick respectively. The EWP promotes knowledge as power over risk and disease through language like “gauge how your health habits are affecting your risk for developing illness and disease” (University

of Minnesota, 2010a) and “The numbers that indicate if your cholesterol is high or tell you what you weigh figure into your chances for developing illnesses such as heart disease or diabetes” (University of Minnesota, 2009). As outlined in Chapter One, chronic illness must be included under the umbrella of disability in order to better nuance ideas about impairment (Kafer, 2013), acknowledge the precarity of disability and problematize discourses of productivity (Price, 2018), and recognize the unaccommodatable nature of chronic pain and fatigue (Wendell, 2001). While not all disability involves pain or suffering, people frequently assume or assign pain onto disability (Siebers, 2010). This conflation of disability with pain and suffering is ableist; it characterizes the disabled life as not worth living (Reynolds, 2017). Further, pain “represents for most people a source of terror and an affront to human dignity ... nothing seems more horrifying to human beings than to imagine a lifetime of future suffering” (Siebers, 2010, p. 183). In this way, the fear of pain, and the ableist conflation of pain with disability, gives rise to a fear of disability and justifies the need for intervention (Reynolds, 2017; Wendell, 2001). Thus, ableism is at the heart of medical ideas of cure and is tightly bound to rhetorics of risk; the ableist conflation is inherent in the EWP’s use of a risk-based framework to identify and intervene in the risk of future disease or disability. Further, through disciplinary power, the UMN EWP invites employees to reshape themselves in order to fit hegemonic norms about health and body size. While the associations between fatness and chronic illness are debated and fraught, they are presented as scientifically certain in the UMN EWP and used to rhetorically mobilize a fear of future illness in order to motivate health behavior change.

### *Always-Already a Pre/patient*

Interpellation is the simultaneous existence of ideology and the hailing of

individuals who, through acknowledging and responding to that ideology, become subjects (Althusser, 1972). Althusser uses the term “always-already subjects” to indicate how, in the observation and acknowledgement of an ideology, the features of that ideology seem to precede observation, making it ever-present. He gives the example of a child who is always-already a subject even before its birth, through the forms of family ideology in which the child is expected (Althusser, 1972). The biomedicalization of pregnancy and birth interpellate both the mother and unborn child as patients through the framing of pregnancy as risky and in need of medical intervention (Barker, 1998; Jensen, 2016; Schuster, 2006). For most people in the U.S., engagement with the medical establishment is lifelong even for those who are or consider themselves healthy, from childhood illnesses and vaccinations to checkups and physical exams for insurance coverage. Because of this, I argue that we are routinely interpellated as the subject of biomedicine. Even those who lack health insurance or routine access to medical care might visit a school nurse, an emergency room, a pharmacist, or a neighborhood clinic. In this way, each of us is always-already a patient from birth.

By itself, I do not view interpellation as a patient as problematic, especially within healthcare settings or situations. However, through an ecological rhetorical lens, elements of rhetorical situations “simply bleed” (Edbauer, 2005). The “bleeding” is where interpellation as a patient becomes problematic in my view. Wellness extends and complicates always-already patienthood through its pervasiveness across medical and nonmedical settings, its commodification, and its culture of surveillance.

Outside of EWPs, home wellness guides and the natural supplement industry employ discourse that fuses the idea of holistic health with biomedicine through claims that map activities supporting health (i.e., enhancing the already-healthy body) onto ideas



of treating illness (i.e., restoring the ill body) (Derkatch, 2012). Derkatch (2012) gives the example of black cohosh, a supplement that claims to support health during menopause, but through material-discursive connections to medical symptoms like hot flashes, can be positioned as a treatment or medication for illness. Wellness promotes a culture of self-surveillance, of constantly monitoring oneself while striving for an ideal, unattainable perfection. Through wellness, “ordinary sensations such as feeling tired or stiff in the morning may be ominous signs of a potential ailment; the body may become, in a sense, an object of suspicion” (Derkatch, 2012, p. 6). Derkatch argues that, in this way, “the contemporary notion of wellness may lock individuals into the same patterns of thinking and acting [inherent in the biomedical model] that they seek to escape” by turning to wellness in the first place (Derkatch, 2018, p. 156). I argue this is especially true in an EWP model like the UMN’s that is deeply connected to discourses of surveillance and risk.

Surveillance and self-surveillance are essentially required in order to participate in the UMN EWP. Because the EWP is bound to the UPlan health insurance program, it is locked into evaluating its own efficacy in terms of population-level risk reduction and concomitant reduction of healthcare expenses, which makes data crucial. Thus, the EWP prioritizes tracking, collecting, and evaluating biomedical markers and evidence of behavior change (e.g., participating in a diet program, using GPS to log bike commuting, using an app daily to click through health information programming or log health behaviors). Wellness activities—like cooking healthy meals without logging them in an app or bike commuting without the required GPS tracker—that do not generate data for the EWP do not map onto the points system and thus do not *count* as wellness. On the 2018-2019 menu of about 30 possible points-earning activities in the EWP, only a few

cooking and exercise classes do not generate data for the university (beyond that one participated), and those come with extra out-of-pocket costs for employees (University of Minnesota, 2018b).

Risk is likewise a core consideration in the UMN EWP. Risk has been biomedicalized as a marker of potential disease (Conrad, 2007). “Risk-factor medicalization is that version of medicalization which declares as disease those conditions that put someone at a probabilistic risk of (another) illness or injury” and obesity is a recent and widespread example of risk biomedicalization (Sadler, 2014, p. 143). The UMN EWP’s reliance on a risk-based model centered around risks associated with fatness is especially pernicious because of the pervasiveness of obesity discourse framing obesity as having a cause-effect relationship with chronic illness/disability such as cardiovascular disease and type 2 diabetes. This causal discourse and incentivized, possibly coercive, privileging of biomedical health markers and self-surveillance interpellates everyone as at-risk for obesity and, thus, disability. The increasingly popular discourse of early detection and intervention positions nearly everyone as “‘at risk’ or a ‘pre-patient’ for something” (Guthman, 2011, p. 38). Biomedicalized risk then produces high levels of self-monitoring of bodily states as there are an “increasingly large number of people who are regarded as *potentially* ill” (Conrad, 2007, p. 151, emphasis original). By extension, people at risk for chronic illness are at risk for disability, which feeds into the disability studies idea of disability as inevitable or “the one identity category that all people will embody if they live long enough” (McRuer, 2017, p. 398).

Therefore, risk factors position everyone’s health as precarious and in need of monitoring and preventive intervention. As Kelly Pender (2018) demonstrated in the case of genetic risk for breast cancer, risk itself becomes a chronic illness. Screening for breast

cancer enacted risk through practices designed to detect cancer, and in turn, the at-risk body is a source of knowledge about cancer. In other words, there “is a real overlap between risk and disease” (Pender, 2018, p. 102) that can cause people to enact their health through some of the same risk monitoring and intervention practices they would if they had the disease itself. Thus, the UMN EWP’s framing of weight-related risks as in need of preventive intervention both enacted risk *as* disease and impels employees to do the same through surveillance. As Marie Moeller puts it, “we are all patients in some way—or, at the least, patients-in-waiting” (2015, p. 52). I use the term “pre/patients” with a slash for the same reason I use “as/for”: to indicate that, while being a patient and being a “pre-patient” or “patient-in-waiting” are perhaps distinct states, they are enacted in entangled and often inseparable ways, especially in wellness contexts.

As discussed above, the UMN EWP ties good organizational citizenship to good health citizenship, and the imperative of health citizenship is to actively pursue and maintain optimal health and body size. Health citizenship and obesity discourse work together to position thinness as ideal, as delineated by problematic measures like BMI. Thus, the EWP links the ideas of being a ‘good employee’ to being a ‘good eater’ and having a thin, able body. In addition to that, inclusion of practices like health risk assessment and disease management programs in the EWP invoke a model of biomedicalized self-surveillance and preventive intervention, reproducing hegemonic ideology about what it means to be healthy that is pervasive in the public sphere. In other words, the EWP’s ideology around health interpellates employees as pre/patients.

### **Irreconcilable Differences**

Throughout Chapters Four and Five, using multiple ontologies theory and praxiography as a methodological lens, I have demonstrated in my analysis how various

practices of the EWP and employees enact food and wellness. Further, as noted in the conclusion of Chapter Five and the introduction to this chapter, I found a number of barriers to employee participation in the EWP, which may contribute to low participation rates. In this section, I return to these barriers in order to examine key fundamental mismatches between how the EWP and employees enact food and wellness. One of my survey respondents described the fundamental mismatch well when they said:

The Wellbeing Program is predicated on constantly 'improving' health along a single, inflexible definition of what optimal health/wellbeing is. For example, in my Health Coaching session, I was told that although I scored extremely high on everything except sleep and work productivity that I needed to still do better. The sleep measurement was based on the assumption that everyone needs the same amount of sleep. As a result, the work I put in on my own to develop sleep habits that are optimal for me and my personal well-being, I was informed that I needed to make changes. This just doesn't make sense.

One advantage of multiple ontologies theory is that it facilitates understanding different enactments of wellness as resulting in different *wellnesses*, much like different enactments of atherosclerosis in Mol's (2002) study enact different atheroscleroses. Thinking of different wellnesses as different entities enacted through practice allows me to avoid framing different wellnesses as different perspectives on a single, stable *wellness*. As discussed in more detail in Chapter Two's Methodology section, perspectivalism can result in the privileging of one perspective over another (e.g., the doctor's expertise over the patient's lived experience). In multiple ontologies theory, that hierarchy is flattened, situating different enactments as equally important.

That said, one limitation of my application of multiple ontologies theory to wellness is that wellness is slippery, messy, and ill-defined, which is one reason why I repeated discussion of my Rhetorical Questions, as enactments shift in different contexts when different entities are involved. Multiple ontologies theory has often been used to

examine things that at least generally share significant common ground. Mol studied enactments of atherosclerosis, and while the entities enacted by the doctor, or the patient, or the lab technician are ontologically distinct, they “tend to hang together somehow” (2002, p. 5). Studying a specific condition might make it easier for multiple ontologies to hang together. Atherosclerosis, which Mol (2002) studied, is a relatively stable object as it is easier to put boundaries around enactments of atherosclerosis. Mol describes various ways that multiple ontologies of atherosclerosis coordinate in order to hang together: through association within networks, patient paperwork, and physical hospital spaces, through adding up, calibrating, and translating test outcomes and patient lived experience. Mol argues that even when multiple ontologies are enacted, “*the body multiple* is not fragmented.” Mol elaborates:

The "atherosclerosis" diagnosed and treated need not be the same. It doesn't necessarily pose problems if they are different. If *this* atherosclerosis is diagnosed and *that other one* treated, each variant has a site of its own. Thus, there are no competing sides to choose between or to fight for. There isn't necessarily fragmentation either, because there is flow. The object enacted does not cohere, but there is an itinerary (held together with forms, appointments, conversations) along which a patient may move from one site and situation to another. (2002, p. 115-116, emphasis original)

“Hanging together” is a key element of how Mol’s multiple ontologies work: they cohere rather than fragmenting. Ostomy, Kessler’s (2020a, 2020b, 2022) subject of study, is somewhat less stable and easy to put boundaries around, and genetic risk for breast cancer (BRCA) is defined by Pender (2018) as a messy object and is significantly less stable or able to be bounded than either atherosclerosis or ostomy, however both ostomy

and BRCA hang together. Wellness, however, is perhaps the messiest of objects, as it can encompass different practices for every person. So, what happens if multiple ontologies fail to hang together and instead fragment?

In the case of atherosclerosis or ostomy or even genetic risk for breast cancer, there are still forms, appointments, diagnoses, physicians, and specific areas of the body affected that help it hang together. Wellness does not cohere in one realm; it blurs preventive and interventive care, biomedicine and CAM, and multiple dimensions of health. Wellness is designed to bleed, unlike atherosclerosis, which is hard to separate from the medical realm (and, it's worth noting, Mol conducted her praxiography within a hospital setting only). With EWPs, there is not necessarily anything to help it hang together other than the employer-employee connection (and the associated EWP forms, websites, apps, etc.), and the employer-employee relationship is complex and power-laden in ways that are both similar to and crucially different from the doctor-patient relationship.<sup>17</sup> The doctor-patient relationship and the employer-employee relationship are both transactional; in one, money (even if not out of the patient's pocket) is traded for health, and in the other, money is traded for labor (and in many cases, also for an employee's health). Both relationships aim for compliance; the doctor seeks patient compliance with a treatment plan, and the employer seeks employee compliance with policy, process, and expectations for productivity. Further, they both have a power imbalance rooted in ideas of authority or expertise that favor the institution (whether the medical industry or the employer). Power is where there is a salient difference between doctor-patient and employee-employer relationships, notably in the ways biopower and

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<sup>17</sup> Much has been written about the doctor-patient relationship in many fields. My goal here is not to dig deeply into the doctor-patient relationship, but rather to sketch out some ways important to the study of workplace health promotion that power and authority in the doctor-patient relationship are similar to and different from the employer-employee relationship.

disciplinary power manifest. As I discussed earlier, biopower is a technique used by institutions to control bodies through delineations of what health is and how to maintain it, while disciplinary power works to make bodies docile by shaping them through continuous minor processes until people make the unconscious choice to conform willingly to dominant norms. Both the medical industry and employers use biopower and disciplinary power, though I argue that the employer compounds the power dynamic, especially in incentivized EWPs, by layering employer power on top of biomedical power. In the employer-employee relationship, the employer uses power to both shape people into compliant workers and to shape their enactments of health and their bodies. For example, one survey respondent wrote about the issue of power and employer reach in their life:

I am VERY resentful that I need to perform and report in a particular way in order to have lower-priced health insurance. I think workplaces have gone way too far in exerting influence in our life choices. They own my 8 hours a day, they don't earn access to my eating and exercise habits because of that. I find it frankly kind of dystopic.

In my analysis of all my datasets (archival materials, survey, and interviews) I found enactments of food, wellness, and health that were fundamentally contradictory; for example, an employer enacting wellness as a vital aspect of workplace behavior is incompatible with an employee enacting wellness as a private matter with no place at work, as in the survey response above. However, the UMN EWP enacted wellness as a rewarding opportunity paired with the UPlan health insurance:

The University of Minnesota wants to support your overall health and wellbeing. Whether that means helping you achieve personal health goals, reduce stress, maintain a healthy habit, or manage a chronic condition, the University of Minnesota Wellbeing Program offers a variety of options to help you achieve your personal best.

The Wellbeing Program is available to all University employees and their spouses who are covered by the UPlan Medical Program. By participating in wellbeing activities, you will:

- Gain confidence with knowing more about your health.
- Feel your best while achieving personal wellbeing goals.
- Be rewarded for improving your health while earning points throughout the year.

(University of Minnesota, 2018b)

This excerpt from the *2018-2019 Wellbeing Program Guide* uses language like “achieve your personal best,” “gain confidence,” and “be rewarded” alongside eligibility information (UPlan coverage). Through this discourse, the EWP enacted wellness as a positive pursuit connected to the workplace through medical coverage and care. Yet, this contradicts some employees’ enactments of wellness as outside the scope of the employer. Echoing the sentiment of the survey response above about how the university owns their “8 hours a day” but has not earned access to their health habits, a different survey respondent elaborated:

I cannot say enough about how much I hate employer-sponsored wellness programs. No one has produced consistent, credible evidence that these programs work. It feels like an intrusion into my private health information by my EMPLOYER. And I feel like if the U honestly cared about my ‘wellness’ as a person, they would PAY ME a salary that did not require me to have extra jobs on the side, working more than 40+ hours a week most weeks of the year, and to figure out how to train unit leaders and dept chairs to create healthy workplace cultures instead of the toxic cesspools that are characteristic of most units in [my college]. Perhaps if the U tackled those HUGE issues first, THEN I might believe they gave a shit about my ‘wellness’ - instead, the U's wellness program always comes across like a ploy to lower the cost of healthcare (which, again, no proof that it does), or to keep the ‘cogs’ just healthy enough to keep squeezing more work out of us.

I interpret this employee as enacting wellness in a way that is incompatible with the UMN EWP’s version of wellness and that, through the EWP, the UMN puts responsibility for wellness completely onto the employee. In other words, the employee is enacting their personal wellness as something outside the scope of their employer’s



model of wellness. The employer-employee relationship is the factor that might help these two enactments of wellness to “hang together” ontologically, but my analysis is that they do not. Mol argues that the aim of multiple ontologies is to look “*at* the practices that enact ... [and] not *behind* them for hidden forces or agendas” (Pender, 2018, p. 78). However, as I have argued throughout this dissertation, in the case of employee wellness, I believe we must look behind enactments of wellness at implicit/invisible goals because of biopower and disciplinary power, which position health and wellness as both a moral imperative and an expression of successful normativity (Berlant, 2007; Foucault, 1979; Scott, 2003). Further, wellness, especially in EWPs, is inherently ableist through advancing the idea that ideal health means being completely free from disease or disability. In this paired example (the EWP enacting wellness as a rewarding opportunity and the employee enacting wellness as an invasion of privacy), wellness is enacted by employer and employee as multiple, staged differently through different practices, giving way to multiple realities, but these realities do not hang together. The *wellness multiple* fragments.

Mol (2002) framed the ways multiple ontologies hang together as happening through forms of coordination. One mode of coordination Mol (2002) describes is to “*add up* test outcomes” (p. 84). Mol suggests that in multiple ontologies, to add up test outcomes “does not suggest that tests have a common object” but rather that tests can be seen as “*suggestions for action*” (2002, p. 84). Another form of coordination might be the “*calibration* of test outcomes,” or the process of actively making tests outcomes “comparable with one another” (2002, p. 84-85). Association is another important aspect of multiple ontologies hanging together; one patient’s atherosclerosis coheres through association within networks, patient paperwork, and physical hospital spaces.

Coordination and association are productive methods for understanding how multiple ontologies hang together, especially in Mol's context of studying atherosclerosis.

In terms of wellness, I see many ways that wellness can hang together, even as a slippery term doing varied rhetorical work and appearing in diverse practices across time and space. The centrality of things like multidimensionality and overall, optimal health appeared in material-discursive practices of both the UMN EWP and its employees. However, as noted in the example earlier in this section, sometimes, in my analysis, the *wellness multiple* fragments when EWP and employee enactments of wellness are fundamentally contradictory (e.g., the EWP practices wellness as within its purview as employer, but employees practice wellness as beyond the purview of the employer). Perhaps, then, irreconcilable differences between employer and employee enactments of wellness are important and meaningful places to explore what it means for multiple ontologies to refuse to hang together, and instead fragment.

This fragmentation is important for two reasons. First, my focus on social justice means foregrounding employees' lived experience with the EWP, and the ways that institutional power works to shape bodies and invite people to conform to ableist, racist, and classist norms around food and health. Second, places where enactments of food and wellness fragment are also places where employees might *resist* those dominant norms, which I will discuss more in the last section of this chapter.

Notably, in my archival data, I found repeated conversations about barriers to participation for employees (BAC, 2004a, 2004c, 2009, 2010a, 2013c, 2015a, 2015b, 2017, 2018a, 2019). For example, in 2018, feedback from a BAC-led employee feedback survey included the comment that

Classes and Fitness options are way too expensive for lower paid workers to pay

for, and not reimbursed enough to make them within reach. You are now required to join the Rec Center even before you pay for fitness classes! It has become a system of paying for points and lower paid people can't afford to pay to get an important premium reduction. (BAC, 2018a, p. 6)

Both through anecdotal data presented by BAC members and through employee satisfaction surveys administered by the EWP and reported on at the BAC (like the above quote), the UMN EWP is highly aware of the role of barriers in relation to the stagnant, low participation rate. As recently as 2019, the Wellbeing Program Coordinator reported that proposed “changes to the program are intended to make it more inclusive and accessible and increase engagement” (BAC, 2019, p. 3). Indeed, many changes the EWP has made over the years have been aimed directly at reducing barriers and increasing participation, from the incorporation of custom pledges via “Wellness My Way” that would award points for personal activities in 2012 to making materials available in other languages like Somali (BAC, 2015b) to allowing employees to report EWP progress by paper if they do not have access to a computer (BAC, 2018b).

In my survey analysis, I identified and coded for thirteen different barriers mentioned by employees: cultural, disability, financial, game/joke/con, geographic, insurance, poor individual fit, privacy/trust, science, time, too healthy, usability, and usefulness (see Table 5 in Chapter Two for a full set of codes and sample coded text). Many of these barriers mirrored employee feedback as presented in BAC minutes, yet, despite the EWP's awareness of and ongoing efforts to reduce barriers, participation remained low. As my praxiographic modified grounded theory analysis of qualitative survey data progressed and I worked to elevate initial codes into conceptual categories, I focused less on specific types of barriers and more on what EWP practices enacted barriers and how those barriers, in turn, shaped the practices that employees enacted. My conceptual analysis and attention to practice led to the findings I present in this section.

I argue that a fragmented *wellness multiple* is an underlying reason for low EWP participation rates and why efforts to reduce barriers and increase participation have not worked. In other words, while the barriers may have manifested in specific practices, such as up-front fees for classes and fitness options, I interpret the UMN EWP's inclusion of programming with up-front fees in the first place (and inability to remove those fees despite continued feedback about how they are a barrier) as a practice that enacts *what counts as wellness* and *who gets to pursue wellness*. In the remainder of this section, I highlight those enactments more broadly. I argue that *what counts as doing wellness* and *who gets to pursue wellness* are two key ways that enactments of wellness fragment.

### **What Counts as Doing Wellness**

The first way that enactments of wellness fragment is around what counts as *doing* wellness. As demonstrated above, the UMN EWP enacted wellness as/for economics which has led to the prioritization of tracking, collecting, and evaluating biomedical markers and evidence of behavior change (e.g., participating in a diet program, using GPS to log bike commuting, using an app daily to click through health information programming or log health behaviors). At one point early in the EWP, employees did not even have to opt in to wellness programming like they did in later versions, as “using medical and pharmacy claims data [was] one of multiple ways that people [were] invited to participate in coaching programs” (BAC, 2011d). As one survey respondent elaborated:

Every year I would become ENFURIATED [sic] when a staff member of [the EWP's vendor] company phoned me at work (and always minutes before I had to catch my bus home) and endeavor to get me to sign up for extra special weight loss programs. I work in a cubicle and was always HUMILIATED to have to respond to their questions while all my neighboring co-workers could hear. After

several years I started forcefully arguing back with these people that they were harassing me and questioning how did they know I was obese. I even phoned the U's HR department and contacted my own HR department to report the harassment, but never received any kind of response.

I heard many stories from survey respondents and interview participants about the EWP targeting employee health in ways that employees did not understand, as in the above survey response when the respondent asked “how did they know I was obese,” because the UMN EWP did not tell employees it was using their data in this way. While these practices have changed over time as Wellness Assessments and biometric screenings were added, at the outset, the UMN EWP made its own determinations of what to prioritize in terms of wellness based on medical and pharmacy claims data, which reinforced a biomedical model of health and which, based on my participant stories, tended toward targeting fatness (which aligned with the EWP’s identification of weight as a top health risk from its inception).

Notably, BAC minutes capture recurring complaints that people’s personal practices cannot be counted in the points system (BAC, 2010a, 2013b). Many of my survey respondents and interview participants discussed struggling to find ways to earn all their points as they were self-identified as already healthy or already living a healthy lifestyle. Jessica, one of my interviewees, discussed this struggle:

I didn't feel like [the EWP] actually encouraged people to maintain wellness if they had already had kind of a baseline level of wellness. I, as a very active person, felt frustrated that I couldn't get very many points for the types of things that I did. So, like, you could buy your Weight Watchers membership and you can get tons of points for that. and they'll reimburse you for some of it, but it's expensive. You can get points for going to the gym, but you have to buy a gym membership and they reimburse you. But it's still, you know, it's still a thing you have to pay for. And I could get points for, I could self report one race or activity, but only one, which was frustrating for me because I'll do a triathlon, I'll do a 5K, 10K, half marathon. I'll do a bike tour. And I could only get one set of just total points for all of those activities. And I felt like, you know, I'm really doing a lot of things and I'm already living a healthy lifestyle. (Jessica, research interview

participant, 2021)

Here, Jessica complains that she could only get a single set of points for a large number of physically demanding activities. Doing a triathlon, a 5k, a 10k, a half marathon, and a bike tour in one year would only earn as many points for Jessica as solely doing a 5k, but buying a Weight Watchers membership would get “tons of points.” The EWP’s points distribution disproportionately provided many points for someone who would sign up for a weight-loss program (implying they identified as overweight), but provided only a few points for people regularly engaging in physical fitness activities on their own. In other words, if one’s personal enactments of wellness—be it cooking healthy meals without logging them in a diet program, or exercising without engaging the gym membership or bike commuter tracking—did not map well onto the points system, they did not *count* as enacting wellness in the EWP.

### **Who Gets to Pursue Wellness**

The second way that enactments of wellness fragment is around who gets to *pursue* wellness. In my analysis of participant data (survey and interviews), employees nearly universally practice wellness in some way in their lives. While this may be because it was a survey about wellness, and/or because the survey directly asked them about wellness through the question “What does wellness mean to you,” even respondents who called wellness “bullshit,” a “buzzword,” “a privileged term,” or a “crap term developed by companies to sell ‘wellness’ products” went on to describe their own efforts toward wellness through practices like “incorporating physical activity, mental health, and healthy diet to the best of one’s abilities, in the goal of achieving overall health” or “doing your best to be healthy within your own lifestyle and circumstances, eating healthy, mitigating stress, pursuing enjoyable activities, exercise, yoga, etc.”

People talked about their eating, physical activity, mental health, medical care, interpersonal relationships, and work/life balance; even if they reported not having time, they felt that wellness was an activity they *could* pursue and that overall good health was something they *wanted* to pursue.

In contrast, through its practices, the UMN EWP enacted the person who could pursue wellness as: covered by UPlan health insurance; not already healthy but also not disabled; with disposable income; having a low level of knowledge about health; having access to and facility with technology; with enough time and energy for EWP activities; with a personal model of what wellness that matches a biomedical model of health; and having a willingness to share personal health data. In the rest of this subsection, I will expand a bit on each of these points, and then to conclude this subsection, I will touch on how these irreconcilable differences contribute to the perpetuation of systemic ableism, classism, and racism.

### ***Covered by Health Insurance***

Enrollment in the UPlan is required in order to be eligible to participate in the UMN EWP (other than going to the farmers market). Data are collected through the UPlan (insurance claims) and the EWP (assessments and biometric measurements) for the purpose of evaluating the EWP's reduction of population-level risks and ROI. The director of benefits in Human Resources underscored the primacy of data when he argued against opening the EWP to "a group of people ... that the University is not receiving data on because they are not in the [health insurance plan], [as this] dilutes the data collected ... [and this] would have an unknown effect on the program that could not be measured" (BAC, 2006b). By limiting the EWP to only employees enrolled in the UPlan, the university is enacting through practice wellness as only accessible to those enrolled in

their health insurance plan.

### ***Not Healthy but Not Disabled***

On the points-based menu of programming options of the EWP, greater value is given to health coaching (250 points), weight-loss programming (200 points), basic fitness classes (150 points), medication therapy management (150 points), and gym memberships (200 points). Points options for people to log the healthy habits they already do max out at 125 points (“Wellness My Way”) and 150 points (“Challenges” such as completing a marathon) (University of Minnesota, 2018b). Notably, BAC minutes capture recurring complaints that the EWP does not provide credit for people who are already healthy, something echoed repeatedly in responses to my survey and in my interviews. By differently weighting programming options in a way skewed toward behavior change (e.g., weight loss, exercise habits), the EWP is enacting through its practices wellness as primarily being for, as one survey respondent put it, people who are “unhealthy, overweight, physically dormant.”

Paradoxically, however, the EWP is also not designed for people with disabilities or many chronic illnesses, which underscores my ongoing argument about how the EWP replicates ableism. While the EWP does provide points for disease management, it is through a medication therapy management program that requires either being diabetic or taking four or more prescription medications in order to participate (University of Minnesota, 2018d). A number of survey respondents reported that the EWP did not have appropriate programming to support their disability/chronic illness. For example, one survey respondent reported that “As somebody that struggles with bipolar disorder, I did not feel supported or understood by the program.” Others noted that “I need something I am able to do. I cannot stand in the kitchen to cook with arthritis. I have very limited



abilities to chop food with arthritis in my hands,” “I’m disabled, and so the benefits are not attainable to me,” and “I have chronic health problems and the options available are not correct for me.” By focusing only on inclusion for specific types of disability/chronic illness for its own financial priorities, as disease management efforts have been shown to more than pay for the EWP (Nyman et al., 2009), the EWP is enacting through its practices wellness as excluding many disabled people.

### ***Disposable Income***

Many programming options in the EWP require out-of-pocket or up-front costs to be paid by the employee, such as Weight Watchers fees, university classes (exercise, cooking for wellness, financial literacy, mindfulness), gym memberships, and even the bike commuter program (because it costs money to own and maintain a bicycle). Almost half of the options on the 2018-2019 EWP menu required some out-of-pocket investment on the part of the employee. The only way to earn the required points for the health insurance premium reduction without out-of-pocket costs is by completing some combination of a Wellness Assessment, biometric screening, and/or health coaching. Paid programming options were another very common source of complaint noted in BAC minutes and throughout my survey and interview data. As one survey respondent put it, “Many of us in the bargaining unit can’t afford to pay up front for some of these great programs. Sure, I’d love to participate, but it’s not financially smart.” As noted in the *Entremet* “Data Stories,” the bargaining unit (Labor Represented) includes the lowest mean and median average salary among EWP-eligible employees and, along with Civil Service, has a higher percentage of employees of color than other job categories. Through its inclusion of (and as noted above, disproportionate points value given to) so many paid options, the EWP is enacting wellness as something attainable for those with disposable

income (i.e., middle class or higher), which is a clear example of how EWP practices reproduce systemic classism and, because they are deeply entwined, systemic racism, which I return to at the end of this subsection.

### ***Low Health Knowledge***

As discussed in Chapter Five, the UMN EWP deploys an information deficit model of health and risk communication, meaning it assumes that people simply lack enough information about their health risks and what they can do to be healthier. Further, it assumes that the cause-effect rationales for suggested interventions—such as eating habits as the cause of fatness and dieting as an effective way reduce weight-based risk—are accurate, that there are no other significant causes, and that employees have the ability to act on identified causes in a meaningful way, for example by changing their eating practices (Hite & Carter, 2019). Not only does this assume a problematic cause-effect relationship, it entirely elides social determinants of health and individual health conditions that might complicate weight gain and loss. Additionally, many survey respondents and interviewees reported that they already knew the information provided by the EWP, that it was too basic, not useful, and often patronizing. As one employee said in my survey: “It would be nice if the program also allowed for people who actually know and understand nutrition and well being.” By only providing basic information, especially year after year in a program that encourages annual participation, the EWP is enacting through practice the wellness-seeker as someone who has a perpetually low level of knowledge about health.

### ***Access to Technology***

As the EWP has developed over the years, digital technologies have taken an increasingly central role; this has been especially salient during the COVID-19 pandemic

when everything pivoted online and people's only way to engage the EWP was through digital technology. In many ways this is a double-edged sword: on one hand, some survey respondents and interviewees reported that this increased their access to the EWP, especially outstate people like Chase who said "the more online the better" in his interview; on the other hand, it has certainly exacerbated access issues for employees with limited technology literacy or internet access at home. While Chase was younger, in an age group generally more accustomed to technology use, and also an athlete who routinely used personal fitness technologies, another of my interviewees, Gary, presented a different experience with EWP technology practices. Gary was older than Chase, closer to what we would consider retirement age in the U.S., and struggled with both the generic nature of health apps and also the impersonality of technology:

And frankly, when I look at, I do look at the technology, and this is a kind of a disappointment I have with, um, even our wellbeing program is, they really treat it, two ways, it's confusing for me. One is, most of those programs, they're almost implicit that the person is unhealthy and needs to learn how to be healthy. And they don't acknowledge a person that's already on a wellness path and already is healthy but wants to maintain their health. And for that reason I, I've, you know, I've looked at software, tech kinds of programs. But they've never been very satisfactory. They've been pretty, pretty generic. So, you know that, that was the big thing. You know, that just, that they, they're they're too blunt of an instrument. They haven't really helped me. But, I really value it and I think we're fortunate that we have it. I think, I've written actually to HR (long pause) often because again, you know, like for me, for instance, fitness is really important to me. So I hire a physical trainer through our recreational sports program. And I work out three days a week, two hours a time. And I pay someone to do that. I get one point for that in the wellness program. But if I join a group of a bunch of people who aren't very fit and it's, it's half the exercise that I get through a trainer, I get 150 points for that. And I tell them time and again, take into account the person that's already healthy and is just wanting to maintain their health. Plan and simple. And and the university, you know, I don't recall the program we started with, but then we moved into [previous vendor] and that was okay. But again, you know, when I would talk to them, they, you know, I'd say, take into account, I exercise more than most people, most faculty and staff. But I get fewer points, you know, and I always make my 750. But they make it too hard to attain. Now that we've moved to [newest vendor], even to use a, um, like, I use a nutrition coach and [previous

vendor] was really good. Now with [newest vendor], I suppose the university is doing it for cost savings, but it's kind of antithetical to wellbeing because I can't get to a warm body, I have to do everything with technology. And so it's actually very discouraging. You have to really be hungry to get those points. It's the wrong incentive. You get points for insurance as opposed to points for wellbeing. And I think the university is I, I don't know the rhyme or reason behind how they choose these agencies. But so far [newest vendor] is getting about a big D from me because they're just so inaccessible. I actually, it's funny, as we talk here, I've got right in front of my computer, health coaching with [newest vendor] and I have two phone numbers. I have yet to be able to connect with them. The value of these wellness and wellbeing programs are, I think, are profound. In many ways. It's, it's not, it shouldn't just be about insurance, but I think that's a brilliant motivator to belong. I just think that they need to be more user-friendly and a little less, again, you know, I think I understand the technology, but wellbeing and not being able to get hold of a warm body are contradictory. And so the university, they need to understand truly what wellbeing is. And that human interaction at certain levels is essential. In our discussion right now, you and I could do this over the phone. But there's a, there's a level higher that I can see you, I can see you smile [on our video call], you can see me smile. And that's really a, a really important part of wellbeing. And I think sometimes, um, I'll speak for the university because I don't know any other wellbeing programs. Sometimes it seems like that element is lost even though that's, that's the headline, wellbeing ... wellness. Okay. Then allow the human contact appropriately. You know. That's what I would say. I mean, I've been in the university for 40 years, so I know how to weave my way through bureaucracy. But you know, if I have to have two different numbers and I'm on my sixth attempt to get a hold of my, just to continue my health nutritionist, well, what percentage of people would just say nuts with this, and just throw their hands in the air? And so it defeats the whole idea of wellness and wellbeing. (Gary, research interview participant, 2020)

Gary's interview resonated with Chase's, and so many others, who felt that the EWP was not a good fit for someone already healthy, already "on a wellness path" as Gary said. Importantly, though, Gary also talked about his struggles with connecting to people as part of participating in the EWP. Chase's main struggle, as an outstate employee doing forestry research in a rural location, was access to EWP programming predominantly located on the Twin Cities campus; more technology equaled more access for him. Gary was also an outdoor person, as an environmental educator, and was also at a coordinate campus (outside the Twin Cities), but for him, technology became a barrier. Gary's story above underscores how, for him, connecting to people was crucial. After he said, "it

defeats the whole idea of wellness and wellbeing,” he threw his hands up on our video call and continued, “And I know it cause I, I’m an outdoor and environmental educator. Being out in nature and wilderness and an outdoor experience, and again, it’s, its connection with nature, but also connection with *people*. The social piece is very much so a wellness thing, as COVID is showing us.”

Facility or comfort with technology was not just something that showed up in relation to age in my participant data. One survey respondent wrote, in response to the question about why they do not participate in the EWP:

It was too confusing as a new employee, especially having never had benefits before, so it has always been something that feels too complicated to learn. I believe I created an account with [EWP vendor], but there were so many clicks to find it, I have a hard time in understanding how to find it again, and how to use it -- and I'm an avid technology user!

Like Chase, this survey respondent identified as in a younger age group that is typically more comfortable with technology, and reported being an “avid” technology user but also being unable to figure out how to access the EWP vendor’s website, which is required in order to log points. Importantly, the people I heard from about technology issues were those who were still able and willing to participate in my internet-based survey near the beginning of the pandemic, not long after the university shifted to remote work. I believe there was a gap in my data here in terms of underrepresentation of employees from job classes that tended to be lower-paid, to not use computers in their jobs (e.g., custodians, food service workers, and facilities staff), and who may not have had consistent access to technology at home and thus might not have been able to participate in my survey. While issues with internet/technology access at home was not directly supported in my data, I believe this was because I was likely unable to reach employees with these issues while conducting my research online due to the pandemic. Importantly, internet and technology

access were issues that disproportionately affected lower-paid employees who, at the University of Minnesota, were more likely to also be BIPOC. Ultimately, through its reliance on vendors that required use of websites and/or mobile apps and that generally promoted daily login for points, the EWP enacted through its practices people able to seek wellness as those with access to and facility with technology.

### ***Time and Energy***

Time is a huge part of participating in the EWP: it takes time to get a biometric screening done through the EWP, it takes time to attend classes, it even takes time to log in every day and track/log data. The majority of EWP activities (other than the Wellness Assessment) must be completed outside work time, as well. Time was the most commonly cited barrier to participation for survey respondents, and in many ways it was one of the most fraught as well, with many noting the intensity of their workload as prohibitive to wellness. As one survey respondent put it:

I work long hours and have a fairly stressful job helping others with their issues, so there is a catch 22 where because I work so hard for the U, I never have time to log in and work on my wellness markers, leave late so there is no time to walk or do outdoor activities and my payment for that is that I must pull full price for my insurance. Thanks for that!

Other survey respondents noted that the extra work of tracking is an “extra burden,” is “difficult,” and is not worth their time. In addition to being time-consuming, some survey respondents described barriers related to the timing of programming, such as one who reported they were “working primarily overnights and sleeping during the hours the screening was available.” Similarly, one of my interview participants, Paul, who worked in facilities management reported:

I think a lot of programs they have on campus are more geared for people at work during the days Monday through Friday, you know, let's say 8:00 to 4:30 or whatever the schedule is. And that, for me, that's gonna rule out most of the stuff

because my work schedule's rather unusual. I work, most of my work week is the weekend. So it's Saturday and Sunday it's 12 hour days and then Monday and Tuesday will be eight hours, but I don't start until noon on those days and, you know, some of these programs they have, well, there's been times when I've gone in and, on my own time, and done some of these things because they're interesting. But a lot of times it's like, well, if they're going to ask for something on Thursday, for example, I don't work that day. So it's not, you know, I don't have a whole lot of incentive to come in just for something that's going to be on for an hour. (Paul, research interview participant, 2020)

For some survey respondents, both the amount of time and timing were a problem, with one respondent noting, the “time didn't work when on campus, I work multiple jobs and just couldn't fit it in.” By constructing an EWP that requires a regular time spent tracking data and/or participating in events on campus (biometric screening, classes), the EWP enacted through its practices the person who could pursue wellness as one with spare time, something that has been harder and harder to come by for employees overburdened by a “do more with less” attitude resulting from budget cuts and staffing reductions over the years.

### ***Biomedical Model of Wellness and Sharing Private Health Data***

Lastly, as one of my survey respondents put it, the EWP has a “single, inflexible definition of what optimal health/wellbeing is.” As I have argued throughout this dissertation, the EWP’s model was one that strongly privileged an ableist biomedical model of health, or one focused on positioning illness or disability as a deficit in need of intervention and cure. Further, the UMN EWP relied heavily on collecting data about employees through both the UPlan insurance program and the EWP.

Employees who enacted food and wellness in ways that were incompatible with a biomedical model, such as many who reported issues with the emphasis on weight loss and diet culture and advocated for a Healthy At Every Size philosophy, are thus excluded from the pursuit of wellness under the EWP. Even when employees who practice food

and eating in ways that diverge from the biomedical model and hegemonic nutrition's emphasis on quantification and nutritionism opt to participate in the EWP in order to earn the health insurance premium reduction, they are forced to grapple with the EWP's material-discursive practices that strongly promote that biomedical model and hegemonic nutrition ideals. For example, James, one of my interview participants, discussed feeling like the EWP was transactional but also that he was compelled to do it for the discount, despite having to wade through language in the EWP that was potentially triggering in relation to his eating disorder:

My interactions with the wellbeing program are almost entirely focused on getting the points to reduce my premiums for the year. I would say 99%. And so what I've done is, you know, procrastinate, procrastinate, and then all of a sudden, oh, it's June first. So I gotta get a few of these. I gotta get a couple hundred points knocked out so I would go ahead and do it. I'd do the biometric screening, the self-assessment, and then whatever else I could find to add up the points. Um, I would not say that I was real *engrossed* in what I was doing, I mean I wasn't necessarily paying an enormous amount of attention. It really, and part of me feels bad about this, but part of me is kind of like, I don't feel bad, but, I just, I just want the points so I don't have to pay as much. And that has been the main interaction I've had. When I say that I try not to pay a lot of attention to it or that I didn't pay a lot of attention to it, that's partially intentional because a lot of that language is not helpful, I don't think. I'm not necessarily somebody who's easily triggered by language or something like that. I'm a writer, you know, that's my job. I understand language, I work with it every single day, and so I feel like I'm kind of able to step outside. You know, take a step back and sort of look at what I'm being presented as, I don't know, as sort of an encapsulated thing. So I can recognize when I see triggering, potentially triggering language, but I'm not necessarily triggered by it. But I do find it very troubling a lot of the kind of, healthy versus unhealthy, clean versus unclean. Here's what you need to be doing, otherwise, you're either failing or you're not living up to something. That type of language, I find really troubling. And I know that a lot of people are, most people probably, are totally fine with that. You know, most people don't have eating disorders. So, I get that. But for, I think a lot of people who do have eating disorders, including me, it's hard to wade through that stuff. And I, my feelings about it are, I feel very frustrated by the fact that I have to plow through that triggering language just to get some money off my health insurance. (James, research interview participant, 2020)



James' sentiment was echoed by one of my survey respondents, who wrote about why they no longer complete the Wellness Assessment and biometric screening:

Privacy, it is none of the University's business about my health status, I find it intrusive and resent that financial rewards 'compel' us to complete it or else we leave money on the table, which then doesn't make you feel good. It is a Catch-22, if I don't complete it I lose out on money that I need, and if I do complete it, I resent it because it is intrusive. Further, when I did complete it, they told me nothing that I did not already know, I felt like I was just there to be part of a data collection machine for the University and [their vendor] or whomever gets the data.

This survey response demonstrates employee concern over the sharing of health data they view as private, as outside the purview of the employer. By strongly incentivizing activities that gather private health data, the UMN EWP enacts through its practices the employee who gets to pursue wellness as one who is comfortable with sharing their private data.

The collection and use of employee health data has caused serious concern among many employees as evidenced by the interview and survey quotes above, however, privacy concerns routinely appeared in my archival data as well. In BAC minutes employees regularly expressed concerns about the university's usage of personal health data. BAC minutes note that "some employees are reluctant to complete the [wellness] assessment because they are suspicious about what the data will be used for," to which the director of benefits in Human Resources responded that he was "well aware of this ... [and] personnel responsible for hiring and firing decisions do not have access to [the] information" (BAC, 2006d, p. 3). While the minutes for this meeting do not explicitly state that members are concerned about losing their jobs because of health data, the pairing of employee suspicion with response about hiring and firing indicates to me that the concern is about job security. Privacy concerns came up repeatedly among my survey

respondents and interviewees, as well, with one survey respondent arguing “I feel the information is best held by a health care professional and not available to an employer who may discriminate.” Thus, whether or not supervisors have access to the personal health data, employees fear that their jobs could be at risk because of their health status or practices. In this way, the EWP enacted through its practices the person able to pursue wellness as one with a personal wellness model that matches the biomedical model *and* who was willing to share their personal health data.

### **Systemic Oppression in the EWP and the Wellness Fragmented**

Overall, as stated at the beginning of this subsection, the UMN EWP enacted through its practices the person who can pursue wellness as: covered by UPlan health insurance; not already healthy but also not disabled; with disposable income; having a low level of knowledge about health; having access to and facility with technology; with enough time and energy for EWP activities; with a personal model of what wellness that matches a biomedical model of health; and having a willingness to share personal health data. Based on my analysis, this means the EWP enacted wellness as accessible to and designed for individuals who are fatter, white, middle-class or above, technologically savvy, but unknowledgeable about basic health and nutrition information. While such individuals might exist, I heard from none in my research (though as acknowledged elsewhere, my sample is not representative and might skew toward people unhappy with the EWP). Overwhelmingly, people in my study reported only engaging with the EWP and “going through the motions” or “playing the game” in order to earn their insurance premium reduction.

Importantly, the UMN EWP’s practices prioritize a target group of predominantly white, middle-class individuals. Such a group has little overlap with groups marginalized

along axes of race, ethnicity, class, and ability who research broadly shows may also experience broader health disparities and issues accessing food and healthcare. Lower-paid employees at the university—for example, custodial staff, groundskeepers, food service workers, and cashiers—who face costs as a barrier are more likely to lack access to digital technologies, fixed office spaces, and healthy foods. The larger categories (civil service, bargaining unit) under which these jobs fall account for about 44% of university staff, but also contain 50% of the total employees of color at the university (refer to *Entremet: Data Stories* earlier in this dissertation). Additionally, many of the lower-income areas in the Twin Cities have been classified as food deserts (Economic Research Service, n.d.). The UMN EWP, as evidenced both by internal discussions in my archival data and employee stories captured through my survey and interviews, seems unaware of or unable to address through their practices how lower-paid employees might face unique challenges that might impact their engagement with or ability to participate in the EWP. As previously discussed, the university has done little to bring healthy food options into the workplace. As one survey respondent complained:

Get the soda out of the vending machines at the U. The U needs to provide healthier, organic, more fresh non-meat vegetarian and vegan options on all dining facilities on campus. The U's choices of vendors and high fructose corn syrup sodas and drinks, junk food snacks and candy in vending machines throughout campus does not support wellbeing. It is very disappointing.

The EWP instead framed weight-related health risks as rooted in personal choice, in turn heavily incenting nutritional counseling and weight management programs. Further, beyond barriers for participation, the UMN EWP's reliance on diet programming like Weight Watchers and promotion of DGA guidelines makes invisible cultural differences in eating-related practices and forecloses the ability for individuals to choose what fits their beliefs, values, and lifestyle in terms of eating within the EWP. The emphasis on

individual responsibility, while eliding institutional and societal roles in issues like weight, contributes to perpetuation of the systemic oppression of marginalized populations that plays a part in the health disparities and risk factors in the first place. In this way, the UMN EWP perpetuated systemic ableism, racism, and classism through its programming.

At the start of this section on “Irreconcilable Differences,” I outlined how sometimes multiple ontologies of wellness fail to “hang together” and instead fragment into fundamentally incompatible *wellnesses*. While the employer-employee relationship provides one way to coordinate multiple ontologies of wellness, even that fails when employees reject wellness as being within the purview of the employer or reject the EWP’s model of wellness, and when the employer enacts wellness in a way that excludes large numbers of employees. In my analysis, a fragmented *wellness multiple* is an underlying reason for low EWP participation rates and is why the EWP’s efforts to reduce barriers and increase participation have not worked. Importantly, this fragmenting, which I have framed in this section as irreconcilable differences, points to interventional possibilities for employee wellness program, something I will discuss in more depth in my conclusion in Chapter Seven. Further, through exploring the places where the *wellness multiple* fragments, I highlighted issues of systemic ableism, racism, and classism that might otherwise be obscured by only looking at various individual enactments of wellness. In other words, with a slippery, messy, and ill-defined object like wellness, it can be productive to recognize and study where and how a multiple ontology might fail to hang together.

### **Resistance in the Time of Compulsory Wellness**

“Where there is power, there is resistance” (Foucault, 1990, p. 95). While

Foucault saw power as everywhere, distributed across networks and manifesting relationally, he also saw points of resistance as a key element of these power networks.

Focusing on discourses, Foucault argued that they

are not once and for all subservient to power or raised up against it... a discourse can be both an instrument and an effect of power, but also a hindrance, a stumbling point of resistance and a starting point for an opposing strategy.

Discourse transmits and produces power; it reinforces it, but also undermines and exposes it, renders it fragile and makes it possible to thwart (1990, p. 100-101).

In other words, Foucault says that while discourse, which I would frame as material-discursive practices, can be an instrument of power, they can also open spaces for resistance. Neoliberal discourses of health citizenship embedded in EWPs may be hegemonic, but they are “not homogeneous: [they are] taken up, negotiated, and potentially resisted or destabilized in diverse and complex ways by particular citizens in particular times and places and for particular purposes” (Spoel et al., 2014, p. 132).

In the previous section, I demonstrated how sometimes a multiple ontology of wellness fails to “hang together” and instead fragments into fundamentally incompatible *wellnesses*. In other words, I demonstrated irreconcilable differences between the EWP’s and employees’ ways of doing wellness, especially when employees reject wellness as being within the purview of the employer and when the employer forecloses wellness in a way that excludes large numbers of employees. I highlighted how the UMN EWP enacted the wellness-seeker as fatter, white, middle-class or above, and technologically savvy but unknowledgeable about basic health and nutrition information, and discussed how this perpetuates the oppression of people marginalized along axes of race, ethnicity, class, and ability who may also experience broader health disparities and issues accessing

food and healthcare. In this section, I will focus on employee rejection of the EWP's model of wellness, especially as it coalesces around privacy concerns and the resistance of employer surveillance and dominant ideologies or norms around health.

A set of assumptions underlies the UMN EWP's programming: give people information and incentive and they will change their risky health behaviors. Yet, as discussed previously, this assumption rests on an information deficit communication model, or the idea that people do not have basic health information and thus educating them will lead to behavior change. Overwhelmingly in my survey and interviews, employees reported already knowing the health and nutrition information provided by the EWP; of these individuals, those that participate in the EWP do so only in order to earn the health insurance premium reduction. Further, many of these people, like James above, resented having to participate in order to earn the incentive. For some, the incentive was simply not enough, such as one survey respondent who commented, "It is not worth my time. I can eat well and exercise without a program to guide me. The incentives offered are equivalent to working for less than minimum wage, and so do not motivate me." Additionally, I described above how the EWP gathers user experience (UX) data from employees in annual satisfaction surveys, yet because of its financial priorities, the EWP cannot escape its own need to measure, quantify, and evaluate the EWP through biometric markers, health risk prevalence, and ROI. Therefore, while it has made adjustments to programming in response to UX feedback, participation rates have remained low and stagnant, because the EWP can only make adjustments that will fit within its medical-economic model of wellness, and it focuses on *use* as the sole framework for understanding participation.

UX scholars have critiqued the idea of 'use' as a framework for understanding

participation, arguing that “if our view of non-use is that it is simply a state that people move through before they become users, then those who, for a variety of reasons, stage active resistance ... seem irrelevant ... [yet] to the extent that those who resist a technology contribute to these debates and these ongoing processes of negotiation, they are deeply relevant” (Satchell & Dourish, 2009, p. 11). Non-use sheds light on the broader network of power, including surveillance and neoliberal capitalism, that leads some users to decline certain technologies (Green, 2020). Especially for people experiencing systemic oppression, resistance is an opposing strategy or form of power (Green, 2020). Resistance to the EWP can be seen as a way of intervening in the information deficit assumption that people simply need more or better access to information, as a way of resisting surveillance and the use of technology for self-surveillance, and/or as a way of resisting the overall ideology that links organizational citizenship and health citizenship.

As an example, Linda, one of my interview participants, discussed her resistance to surveillance and to the idea that the EWP could or should work to improve her health:

It kind of bothers me that I have to tell my employer what I do. I don't know if there's anyone monitoring aside from for the points, but why should they know that I do twelve thousand steps a day or that I do these things like, I don't think it's any of their business. So there's also the whole privacy thing, which is why I don't like the devices that track your movement and stuff like that. I don't want Apple, I don't want Gamit or whoever the company is to know this, as I don't want the University of Minnesota. And so again, I don't think it's their business. [In the EWP] you see a few sentences of some little nugget of information, like, how helpful is that for someone to really make any real changes in their life? So I would never go to the website for any *real* information. I don't think it's useful. I don't think the whole thing is. I think here's my other two cents about it, I think the whole industry, whoever started this industry has convinced employers that this is necessary. And it's getting a whole lot of money out of a whole lot of companies and institutions and organizations to run these programs. And probably without benefit, and making their employees go crazy because they gotta get all the stupid points. I mean, I can always look at the other side of things, you know,

I'm a lawyer so I was also trained to do that, so, I understand that employers are concerned about the cost of health insurance. And certainly if someone is unhealthy, if they eat fast food, and don't exercise, and smoke and all of these things that can have an impact on the health care costs, and on the employer's bottom line, I get that. But I don't think this is the way to get employees to improve their health and thereby potentially reduce their healthcare costs. I think the choices that people make in terms of exercise, food, are much more complex than can be addressed in a stupid website that requires you to get apps or requires you to get points. Everyone knows, yeah I should exercise more, I should eat better. But obviously, to get people to do that is, that's the hurdle. So I just think there needs to be a reassessment of, if that's our goal as an employer, to help our employees get healthier, what is a, what is a better way to do it? Or, I mean, I don't feel like I should be penalized because I'm already healthy and because I've had an exercise habit for decades where I exercise every day and I eat well and I do all of these things. So why am I penalized that I still need to jump through the hoops to get the points? So I think, again, if that's the goal of employers, which is a reasonable and legitimate goal, what's a better way to accomplish that? How can we better help employees? Yeah, I don't think that gamification with the points and the challenges, and these infantile shout outs, and those things is the way to do it, where you're treating employees kinda like children. (Linda, research interview participant, 2021)

In this long quote, Linda strongly resists the idea that her health is within the purview of her employer alongside expressing larger concerns about privacy and self-surveillance that make her uncomfortable with personal mobile devices that track fitness data. Linda also reiterates the point many of my survey respondents and interview participants made about the uselessness of the EWP's health information, and feeling like she already lives a healthy lifestyle. To Linda, like so many others, the EWP is a series of gamified hoops to jump through just to get a health insurance premium reduction. Interestingly, Linda acknowledges that EWP's goals are linked to reducing employee healthcare costs, something that came up multiple times with my survey respondents and interviewees. On top of demonstrating how employees resist the EWP through non-use, it illustrates how the bond between the EWP and institutional health insurance costs is transparent to some employees, despite the EWP advancing a strong discourse of wellness as the means to achieve ideal health and happiness.



## Conclusion

In this chapter, I demonstrated how the UMN EWP links together organizational and health citizenship, neoliberally positioning the employee as responsible for going ‘beyond the call of duty’ both in terms of work performance and in striving to improve their health. Further, the idea of ‘eating right’ as framed through the UMN EWP is ultimately not holistic, nor is it just about weight loss or a hegemonic nutrition model. It is deeply infused with subjective cultural politics and power, positioning what it means to be a ‘good eater’ as connected to dominant norms around self-discipline and a well-regulated lifestyle, key aspects of being a ‘good citizen’ and by extension, a ‘good employee.’

Earlier in this chapter, I noted that though the insurance premium reduction was not insignificant (\$500 for a single employee or \$750 for one with family coverage), and though the EWP is marketed as easy and beneficial, the EWP reports that only about 40% of eligible employees earn enough points annually for the premium reduction. I interpret this as predominantly due to barriers to participation in the EWP, which I framed above as irreconcilable differences between how the EWP enacts, through its practices, what counts as doing wellness and who gets to pursue wellness, and how employees report practicing (or wanting to practice) wellness. Many of the issues around barriers are issues of UX.

The EWP appears to be invested in UX, as it runs regular employee satisfaction surveys and has made efforts to modify its programming in order to respond to some employee feedback. Yet, the participation rate remains low and employees in my study discuss the same barriers and concerns that have been reported for years. I believe the fundamental mismatches, or irreconcilable differences, in how the EWP and employees

enact wellness are the key to low participation. Because the EWP is essentially locked into doing wellness as/for economics through its ties to UPlan insurance, it cannot escape its own need to measure, quantify, and evaluate the EWP through biometric markers, health risk prevalence, and ROI. Therefore, it can only make adjustments based on UX feedback that will fit within this model. In other words, the EWP is unable to practice wellness in any other way than wellness as/for economics. It does not cater to already-healthy people because of its financial priorities, and because already-healthy people meet the preference for the ideal, thin, able body, albeit in a reductive way that elides dimensions of wellness beyond physical health and invalidates the ongoing pursuit of wellness as a practice for the already-healthy. Building on my analysis chapters (Three through Six), in Chapter Seven I will conclude my dissertation by returning to my research questions, and also considering what a socially just model of employee wellness might be like.

## ***Entremet: School Lunches***

*Stories about food can be filled with joy, like Sam's story about blueberries in the first Entremet. Food is often also deeply connected to our culture, traditions, and history. Many of the people I interviewed were kind and generous in sharing stories about their very personal cultural, social, and familial practices around food. In this Entremet, I share a story that Nhia told me about her first encounters with school lunches in the U.S.*

[NHIA] I love food. And I love talking about food and everybody I know knows that, and I belong to so many food groups on Facebook groups. And I have another Vietnamese friend, I think it's in our blood. Like every time people hear us talking in the breakroom it's about food. So it's just how we relate to each other culturally. And, and so to deny yourself and to eat not good food is just, it doesn't feel right to me. And so it's part of enjoying life. I guess that's what I want to say. Eating food is enjoying life. And to, and my husband's Vietnamese-American too, but he doesn't get as excited about food as I do. So I will look at pictures of food and put up posters of a food, you know *[laughing]* in my office, and so, that's how much I love food and save them as my wallpaper and my Zoom background. So I mean, that's how I feel about food. It can be beautiful and nutritious and satisfying and a great way to bond.

[DANIELLE] Thank you. Can you tell me a story about food that feels meaningful to you?

[NHIA] Trying to think of among the many, I guess, the ones that, that stick out the most are ... .. you know, and in childhood we, so we came to the US as refugees. And I was really small and so grew up very poor. And I'm just thinking about the things that my mom used to cook that I didn't appreciate when I was little. I wanted the pizza, I wanted the hamburgers, and a lot of the really traditional home-cooked Vietnamese foods that you can't get in, you don't find in Vietnamese restaurants like soups, usually a traditional Vietnamese meal, home-cooked meal consists of a stir-fry dish, some sort of vegetable dish, a soup that you pour over rice and then some sort of salted meat, salted protein. So it could be like eggs, tofu, pork, fish. And so my mom would make those salted, caramelized salted meat dishes.

We call that Kho. And oh my gosh, I hated it. I was so sick of it. And now that I'm older, I've been finding myself gravitating, finding, trying to find those old recipes and maybe recreate more modern versions of it. Because I remember hers were like really salty and really dry and she always used like the leanest cut of meat. And like now, you know, the thinking about fat has changed and I've really been embracing that. And then using the pork belly, I'm very purist in that I'm using the, not being afraid of fat, making it true to how the food should be. And I think that I've been trying to do a lot of that, like for example, there are some Vietnamese desserts that use coconut milk and like, you know, we're a nation of lactose intolerant people. And I'm horrified when I see people try to put half-and-half in there and I'm like, no, you're messing with the recipe, this isn't how it was really created and can you really even be having this without having stomach issues? So, yeah, I think my mom even back in the seventies was making those modifications based on the health information that she was given at that time that was so prevalent, you know, eat sugar because it's zero calories, but don't eat the fat. So yes, trying to get a taste of that and it's important for me to introduce my kids to it as well. My son really leans towards Westernized dishes but my daughter is more open to trying a lot of traditional Vietnamese foods and so she'll try it. And I want to expose her to a lot of those things that maybe she'll like and, and understanding that taste buds change over time. So that, I guess that's one, some of the, when my mom made some dishes. I have an older brother and we used to fight over food too. And so I remember certain things she would cook, she would have to split it in half exactly because he ate faster than me and I would like, I would sit there and savor the food, it was crab, I remember, I would savor the seasoning on it and my brother was like *[makes sucking noise]* you know, eat it all. So I remember a lot of memories of childhood was a lot of competition about food. As you open up that can of fruit cocktail, who gets the maraschino cherry in it.

[DANIELLE] *[laughing]* Because there's only ever one, right?

[NHIA] *[laughing]* There's only one. Like I don't know why. My dad likes to remind me of when I was little, I was very picky about food. And, oh do you mind if I tell you another story? So now it's coming back to me. Yeah, when we first came to America, so I just stayed at home the first few years until I was actually starting school and I just barely ate anything. And so I had that reputation as the picky eater in the home. So like my dad would try, he would bend over backwards to try to get me to eat. So he'd do

whatever, he would feed me whatever I wanted. And my mom was more like, no, no, you eat what we have. And so like, I love fried eggs, but then, they couldn't pop the yolk. If they pop the yoke, then I didn't want it. And so my brother would always be the one who ate the discard. And so he got like eight eggs, and I got like one. And my parents love to remind me of that. But when I went to elementary school, I couldn't eat because I wasn't used to American food and so I would sit there at the lunch table and just pick at the food and then throw it in the garbage. And so the teachers must have noticed and they got concern and they call my dad and so he came and sat with me to watch me eat. And I was horrified because I didn't ... who wants their parent there? I just have memories of, you know, like I remember corn dogs were weird to me. Mac and cheese. Just anything cheese was really odd. And now I love all that stuff, but I just remember sitting there with my dad next me feeling so embarrassed and just teardrops dropping on the tray, the plastic tray. *[laughs a bit sadly]* And also knowing that he knew, he then knew that I wasn't eating the food.

[DANIELLE] That's a big adjustment though.

[NHIA] It is, it really is. I think I definitely have gone through different stages of relationships with food.

[DANIELLE] Thank you. I love that story. I mean, I feel bad for you that you had to have your dad come and sit next to you at school and watch you eat. I can't imagine that.

[NHIA] But I think it's a common immigrant experience, I thought that's why I would share it with you because um, adjusting to food can be very hard.

*Like with Sam, and like in so many of my interviews, listening to Nhia talk about the immigrant experience and the culture shock of suddenly being confronted with very American school lunches and with being surveilled by the teachers and reported to her parents made me think: this is why I am doing this research. Because hegemonic nutrition models just bulldoze right past the nuances of diversity. And, as Nhia talked about, it even starts with small children in the U.S., so it is not surprising when I try to explain my research to friends and they say things like, as one recently did, "Except it*

*really is all about calories-in-calories-out. Obesity is a disease, and people who are fat just need to eat less. And, the body really does need all those nutrients. You can't just deny that. Like, sure, the Food Pyramid was a load of crap sponsored by the grain industry, but that doesn't mean that nutritional science is wrong." In response, I worked to try to explain how these models are reductive, or based on correlation more than causation, but it was a tricky conversation. Hegemonic nutrition is so deeply embedded in our collective social fabric in the U.S. after decades of DGA shaping everything from healthcare provider advice to diet programs to school lunches. My mom was in charge of a school lunch program a few years back, and I heard a lot about the struggle of trying to feed a wide range of children, with all sorts of dietary restrictions, a reasonably healthy lunch (her words) within the budget and parameters given to her. Nhia's story, my conversation with my friend, and my mom's experience running a school lunch program underscore something important about my research: my critique is aimed at the systems that shape our health, eating habits, and wellness, and not the programs or people running them. At the end of Chapter Four, I argued that the UMN EWP can only make program adjustments based on UX feedback from employees that will fit within its biomedical, economically driven model. The people running the EWP are, in my experience and conversations with them, kind and thoughtful and are trying to do their best for UMN employees, but they are stuck with a model of employee wellness rooted in hegemonic ideas about health and economics because those ideas are so firmly entrenched that it is hard to see beyond them. To abuse a tired metaphor, they are so deeply stuck in the box that they can't even see the box. In the next chapter, my conclusion, I will spend a little time trying to imagine what employee wellness might be like outside the box.*

## **Chapter Seven:**

### **“Points for insurance as opposed to points for wellbeing” —**

#### **Conclusion**

The quote in the title of this chapter comes from a quote from one of my interview participants, Gary, which was highlighted in the “Irreconcilable Differences” section of Chapter Six. Gary said, “You have to really be hungry to get those [wellness] points. It’s the wrong incentive. You get points for insurance as opposed to points for wellbeing. ... The value of these wellness and wellbeing programs are, I think, profound. In many ways. It’s not, it shouldn’t just be about insurance ... And so the university, they need to understand truly what wellbeing is.” Like so many of my survey respondents and interview participants, Gary reported that he deeply valued wellness as a practice in his daily life, but also felt a fundamental mismatch between his wellness practices and those of the UMN EWP.

In the final section of Chapter Six, I demonstrated how employees resisted the EWP through non-use and illustrated how the bond between the EWP and institutional health insurance costs is transparent to some employees. Linda, another of my interview participants, touched on similar themes to Gary in terms of feeling like she already had a healthy lifestyle and perceiving a fundamental mismatch between her wellness practices and those of the UMN EWP. Linda also wondered how we might do wellness at work better, as seen in this shorter excerpt of her interview quote:

I understand that employers are concerned about the cost of health insurance. And certainly if someone is unhealthy, if they eat fast food, and don't exercise, and smoke and all of these things that can have an impact on the health care costs, and on the employer's bottom line, I get that. But I don't think this [EWP] is the way to get employees to improve their health and thereby potentially reduce their

healthcare costs. I think the choices that people make in terms of exercise, food, are much more complex than can be addressed in a stupid website that requires you to get apps or requires you to get points. Everyone knows, yeah I should exercise more, I should eat better. But obviously, to get people to do that is, that's the hurdle. So I just think there needs to be a reassessment of, if that's our goal as an employer, to help our employees get healthier, what is a, what is a better way to do it? Or, I mean, I don't feel like I should be penalized because I'm already healthy and because I've had an exercise habit for decades where I exercise every day and I eat well and I do all of these things. So why am I penalized that I still need to jump through the hoops to get the points? So I think, again, if that's the goal of employers, which is a reasonable and legitimate goal, what's a better way to accomplish that? How can we better help employees? (Linda, research interview participant, 2021)

Throughout this project, over the last few years, people regularly asked me, how can we do employee wellness better? I see this as a crucial question, though it is one which is both outside the scope of this dissertation (which is aimed more at theory-building than intervention or amelioration) but also critical for me to engage. In the last section of this chapter, “Implications and Future Considerations,” I will return to this question and present some thoughts. Before that, however, I circle back to my research questions in order to address how my analyses provide some answers.

The central question I grappled with as I began developing this project was: How does the UMN EWP affect people’s lives? I broke down my overarching question into four research questions that guided my study:

RQ1: How does the EWP incorporate and discuss eating habits?

RQ2: How do people experience the EWP's eating-related discourse and programming?

RQ3: How does the EWP’s eating-related programming impact people’s daily lived experience?

RQ4: How does the EWP facilitate and/or restrict access to wellness?

To explore these questions, I developed a three-phase, sequential, mixed methods study that triangulated data from three sources (archival materials, survey, and interviews) in



order to unpack what the EWP does and why, and how that in turn impacts employees. Importantly, the sequential study design supported the order of the questions above. I needed first to understand what the EWP was doing and saying about wellness before I could understand how the EWP impacted people's lived experience with food and eating. Also, as noted in Chapter One, the fourth question was added during initial stages of the project, as I became attuned to issues of oppression and marginalization in my archival data. In what follows, I demonstrate how my analyses in Chapters Three through Six provide some answers.

**RQ1: How does the EWP incorporate and discuss eating habits?**

My analysis revealed that the UMN EWP both arose out of and replicated through its programming overarching systemic oppression (ableism, racism, and classism). In my kairology in Chapter Three, I demonstrated how the EWP had roots in the wellness movement in the U.S. in the 1970s and early 1980s. This historical wellness movement is closely associated with whiteness and wealth—particularly with middle-class or higher, middle-aged, white women—especially as it surfaces in practices like westernized yoga, associations of weight, food choices, and health, and commercialized wellness supplements and products (Derkatch, 2022). Additionally, while interest in having an EWP on the part of employees dated back to the early 1980s and the proliferation of EWPs nationwide and in major Twin Cities companies, it was not until UMN faced major budget crises in the late 1990s and early 2000s that arguments for implementing an EWP gained traction. That kairotic moment, like subsequent ones in the EWP's history, fundamentally shaped the EWP and its practices. In the face of major shortfalls, UMN opted to switch from the Minnesota state health plan (SEGIP) to operating as a self-insured organization in order to reduce costs. In this context, the argument—found at the

time in popular news coverage of EWPs as well as scholarly literature in fields like health promotion and occupational medicine—for EWPs as a means of institutional cost-savings on health insurance were successfully persuasive.

Because a budget crisis was what finally led to establishment of the EWP, its original goals included reducing health insurance costs and increasing employee productivity, which led to a population-level risk reduction model and ROI calculations for evaluation of efficacy. The focus on risk reduction leads to a prioritization of collecting and evaluating biomedical markers of health through EWP programming like the Wellness Assessment and Biometric Assessment. While EWPs are typically tied to health insurance (Cederström & Spicer, 2015; Song & Baicker, 2019), the knot that binds the UMN EWP to the UPlan health insurance is particularly tight. The EWP is administered through the Office of Human Resources' benefits unit, which I find is a large part of why the EWP remains focused primarily on cost savings realized through a biomedicalized risk-based model of wellness.

In Chapter One, I posed what I called “Rhetorical Questions” or prior questions: what is health; what is wellness; and what is healthy eating. In Chapter Four, I presented answers to these questions based on my analysis of EWP archival materials. I found that in terms of health, overall, the UMN EWP mobilized a model of wellness anchored in a biomedical model of health that focused on diet and exercise habits, disease management, and biometric measures of health, as noted above. Importantly, the EWP's biomedicalized model also adopted ideas at the core of the wellness movement, namely that wellness is constant striving toward ideal health and able-bodiedness. In terms of wellness, I found that the UMN EWP's definitions of wellness shifted further toward biomedical models of health and biometric health measurements as time progressed.

Ultimately, the UMN EWP framed wellness as holistic, but instead mobilized a biomedical model of health (disease intervention and cure) through its material-discursive practices. Lastly, in terms of healthy eating, I found that while employee-facing EWP materials did not directly define healthy eating, the focus in the EWP on the DGA, weight loss, and nutrition science advanced a model of healthy eating that reified broader hegemonic nutrition discourse (or a focus on quantification of food and privileging of some nutrients over others). And, ultimately, the reliance on a hegemonic nutrition model meant the UMN EWP was enacting “healthy eating” in ways that reify moralistic judgments about eating and systemic medical ableism, or the marking of fat bodies as non-ideal. The ideal body is both thin and able-bodied (Biltekoff, 2013; Goffman, 1963; Guthman, 2011), something my participants described as “diet culture,” or the broader, pervasive idea that weight loss is ideal, thin bodies are desirable, and thinness and health are correlated. The fat body, on the other hand, is risky due to behavior like “unhealthy” eating and fatness’s association with obesity and, by extension, chronic illness and disability.

In sum, the UMN EWP defined health, wellness, and healthy eating through a largely biomedicalized model of risk that reinforced neoliberal ideas about individual responsibility, eating choices as a reflection of personal morals or self-control, and which elided systemic factors in food availability, fatness, and health status. Importantly, the UMN EWP’s reliance on a neoliberal, biomedicalized version of wellness both arose from and replicated systemic ableism, racism, and classism found more broadly in Western biomedicine and healthy eating discourse like in the DGA.

In terms of operationalizing these ideas, I turn to my Chapter Four analysis of how the UMN EWP enacts food and wellness through its material-discursive practices.

Overall, I found that in tangling and differently incenting holistic and biomedical practices, the EWP mobilized ideas about food, “being well,” and “eating well” that privileged the quantification of food and health while advancing the idea of weight as a serious health risk in need of intervention. In other words, while the EWP *talked about* food as/for wellness, it was *doing* food as/for medicine. Similarly, I found in enactments of wellness that the UMN EWP is talking about wellness as/for holistic health but doing wellness as/for medicine because of wellness as/for economics. In other words, while the UMN EWP specifically enacted practices around food in order to address perceived weight-related impacts on healthcare costs, it also more broadly enacted practices around wellness in order to address institutional budget issues and rising healthcare costs.

In particular, the EWP’s connection to the UPlan health insurance is a tie that binds the EWP to an ableist medical model of the diseased/disabled/at-risk body as deficient and in need of cure. The bottom line for the institution *is* economics, a concern that continually prioritizes monitoring, regulating, and working to norm employee bodies toward a medical model of health. Because the EWP is essentially locked into doing wellness as/for economics—to the neoliberal, ableist premise that individuals are responsible for collectively engaging in health risk reduction in order to solve (cure) rising healthcare-related expenses and related institutional budgetary issues—it cannot escape its own need to measure, quantify, and evaluate the EWP through biometric markers, health risk prevalence, and ROI.

Through language in the EWP about responsibility and pursuing wellness in order to be your best, good organizational citizenship—or the idea that the good employee goes beyond the call of duty—is linked to good health citizenship—or the idea that the good citizen takes responsibility in practicing a healthy lifestyle in ways that align with

dominant norms. And, through the centering of hegemonic nutrition and diet programming in the EWP, good health citizenship is connected to being a good eater and having an ideal body size. Thus, I found that in the UMN EWP, being a ‘good employee’ meant being a ‘good eater’ and having a thin, able body. Further, inclusion of practices like health risk assessment and disease management programs in the EWP invoke a model of biomedicalized self-surveillance and preventive intervention, reproducing hegemonic ideology about what it means to be healthy that is pervasive in the public sphere. When directed at employees, this health discourse interpellates people (in the Althusserian sense), or hails them as subjects through the observation and acknowledgement of the hegemonic ideology. In other words, the EWP’s ideology around health interpellates employees as pre/patients.

Therefore, in answer to my RQ1 of “How does the EWP incorporate and discuss eating habits?” I found that the EWP relied on a highly biomedicalized model of health and healthy eating that reproduced hegemonic nutrition and ableist diet culture ideas about thinness being desirable and correlated with health and productivity.

**RQ2: How do people experience the EWP's eating-related discourse and programming? RQ3: How does the EWP’s eating-related programming impact people’s daily lived experience?**

I address RQ2 and RQ3 together here because they were tightly linked in my analyses of participant data (survey and interviews). In Chapter Five, I returned to my Rhetorical Questions, providing evidence about how employees described what health, wellness, and healthy eating meant to them (and through those descriptions, offered insight into their lived experience with wellness and eating practices). Health was often invoked in ways that were circular: defining health as wellness, or wellness as health.

Overall, though, the vast majority of my survey respondents talked about wellness holistically, or as one's health across multiple dimensions. Some survey respondents described wellness in biomedical terms, however, using language around symptoms, surveillance, and avoidance of chronic illness or disability. Further, many survey respondents framed wellness as an individual responsibility, reflecting broader neoliberal health discourse, and as a moving target or ongoing process, reflecting broader wellness discourse around enhancement. And, again reflecting broader societal discourse, most of my survey respondents defined healthy eating in ways that aligned with hegemonic nutritional models like the U.S. DGA. Importantly, as demonstrated in my *Entremet* "Data Stories," responses to sentiment questions in my survey showed that most employees did not feel that the EWP had a positive influence on their relationship with food, or that it had much impact on their practices in terms of eating habits or how they talked about food. In Chapter Six, I highlighted how the EWP and employees' enactments of food and wellness are a mismatch, resulting in irreconcilable differences in terms of what counts as wellness and who gets to pursue wellness. So, in many ways, the answer to RQ2 is that employees predominantly have negative experiences with the UMN EWP, and that the EWP's eating-related programming has little to no impact on people's daily lived experience. However, it is worth digging into my findings from Chapters Five and Six a bit more in order to understand why this was the case.

In terms of ways employees' practices enacted food and wellness, I found that the UMN EWP and employees, in many ways, enacted food as/for wellness and as/for medicine in similar ways to the UMN EWP, meaning that they practiced food as a part of working toward improving the already-healthy person, and also as a way of treating or intervening in illness or a weight-related disease risk factor. However, I did not find that

employees were enacting food as/for economics; that only appeared in EWP practices. In terms of wellness, I found that employees talked about and practiced wellness as/for holistic health in their daily lives and, separately, enacted wellness as/for economics by participating in the EWP primarily in order to reduce their health insurance premiums.

I have noted earlier that the EWP incentive of a reduction in health insurance premium of \$500 or \$750 was not insignificant, and the EWP is marketed as easy and beneficial, yet only about 40% of eligible employees earned enough points for the insurance premium reduction each year. While I found a variety of reasons for non-participation across my research datasets (archival materials, survey, and interviews), the overarching theme was one of a poor fit between the EWP and people's own personal practices, values, cultures, or goals. One clear mismatch is that the EWP is primarily enacting wellness as/for medicine, through centering a risk-based framework reliant on an information deficit model. Employees are primarily enacting wellness as/for holistic health; they want to be healthy and happy across multiple dimensions in their lives, but they report that the EWP does not help them achieve that goal as it is overly simplistic and not individualized enough.

In my survey data analysis, I identified thirteen different barriers to participation in the EWP mentioned by employees: cultural, disability, financial, game/joke/con, geographic, insurance, poor individual fit, privacy/trust, science, time, too healthy, usability, and usefulness (see Table 5 in Chapter Two for a full set of codes and sample coded text). Many of these barriers mirrored employee feedback as presented in BAC minutes, yet, despite the EWP's awareness of and ongoing efforts to reduce barriers, participation remained low. As my praxiographic modified grounded theory analysis of qualitative survey data progressed and I worked to elevate initial codes into conceptual

categories, I focused less on specific types of barriers and more on how EWP practices enacted barriers and how barriers, in turn, influenced the practices of employees. In Chapter Six, I argued that the divergence of EWP and employee practices demonstrated how a multiple ontology of wellness fragmented, or did not hang together, and that was an underlying reason for low EWP participation rates and why efforts to reduce barriers and increase participation have not worked. In other words, while the barriers may have manifested in specific practices, such as up-front fees for classes and fitness options, I interpreted the UMN EWP's inclusion of programming with up-front fees in the first place (and inability to remove those fees despite continued feedback about how they are a barrier) as a practice that enacts *what counts as doing wellness* and *who gets to pursue wellness*.

In the UMN EWP, if one's personal enactments of wellness—be it cooking healthy meals without logging them in a diet program, or exercising without engaging the gym membership or bike commuter tracking—did not map well onto the points system, they did not *count* as enacting wellness in the EWP: they both literally did not count for points and also did not carry meaning as wellness practices. Further, through its practices, the UMN EWP framed the person who can pursue wellness as: covered by UPlan health insurance; not already healthy but also not disabled; with disposable income; having a low level of knowledge about health; having access to and facility with technology; with enough time and energy for EWP activities; with a personal model of what wellness that matches a biomedical model of health; and having a willingness to share personal health data. Importantly, the UMN EWP's practices prioritize a target group of predominantly white, middle-class individuals. Such a group has little overlap with groups marginalized along axes of race, ethnicity, class, and ability who research broadly shows may also



experience broader health disparities and issues accessing food and healthcare.

In concluding Chapter Six, I discussed employee non-use of the EWP as resistance. I focused on employee rejection of the EWP's model of wellness, especially as it coalesced around privacy concerns and the resistance of employer surveillance and dominant ideologies or norms around health. From a UX perspective, non-use sheds light on the broader network of power, including surveillance and neoliberal capitalism, that leads some users to decline certain technologies (Green, 2020). Especially for people experiencing systemic oppression, resistance can be an opposing strategy or form of power (Green, 2020). Resistance to the EWP can therefore be seen as a way of intervening in the EWP's assumption that people simply need more or better access to information, as a way of resisting surveillance and the use of technology for self-surveillance, and/or as a way of resisting the overall ideology that links organizational citizenship and health citizenship.

**RQ4: How does the EWP facilitate and/or restrict access to wellness?**

The answer to this fourth research question is threaded throughout the discussion of my first three research questions above. The UMN EWP talks about holistic health, but largely mobilizes a program centered on biomedicalized health promotion practices that privilege biometric assessments of disease risk (especially weight-related disease), self-surveillance, and disease (read: chronic illness) management programming. In this dissertation, I have demonstrated how the EWP's roots in biomedicine and the modern wellness movement reify whiteness, and replicate systemic oppression embedded in the medical and food industries more broadly. While I found ableism and classism to be clear themes supported well by my data—ableism through EWP positioning of the ideal body as thin and able-bodied, and classism appearing in practices like charging up-front fees

for EWP programming—the data supporting racism was thin. As I have noted elsewhere, my data collection was impacted by the COVID-19 pandemic and though I noticed the underrepresentation of employees of color in my participant data, it was not something I was able to address directly, though it is a clear avenue for my future research agenda. That said, systemic ableism, classism, and racism are deeply entangled, and wellness has been found in other research to reify whiteness (Derkatch, 2022; refer also to Mire, 2018). Despite this, I feel that my analysis of the EWP’s enactment of *what counts as doing wellness* and *who gets to pursue wellness* demonstrates how the EWP facilitates access to wellness for a narrow set of employees (predominantly white, middle-class people who identify as having a bit of weight to lose). On the other hand, the EWP’s practices around what counts as wellness and who gets to pursue wellness present significant restrictions on access to wellness within the workplace in ways that likely disproportionately disadvantage employees across axes of race, gender, sexuality, ability, and class, who may also experience broader issues of access to healthcare and food.

So, what does it matter if the EWP replicates ableism, racism, and classism found in broader systems in the U.S.? Employees can choose not to participate, though as Deborah Lupton argued, “there is a fine line between consensual, pushed, and imposed” participation in incentivized wellness programs, because despite a “discourse of choice . . . people may have little option of opting out” (2016, p. 124). Even though, in Chapter Six, I framed non-use as a productive way of resisting dominant norms and ideals, EWPs are here to stay in the U.S. Framing EWPs as an individual opt-in choice elides issues of institutional disciplinary power and invokes neoliberal ideas of individual responsibility and good citizenship. Instead, I argue, we should be asking, as Linda did in her interview quoted at the beginning of this chapter, “if that’s our goal as an employer, to help our

employees get healthier ... what is a better way to do it?"

### **Implications and Future Considerations**

In this section, I discuss key implications and areas for future consideration. First, I discuss insights into takeaways from my work for the fields of RHM and TPC. Second, I briefly imagine what it might be like to do employee wellness better. And third, in conclusion, I touch on future considerations for EWP research informed by RHM and TPC.

### **Insights for RHM and TPC**

My project contributes both theoretical and methodological insights to RHM and TPC. In terms of RHM, my project responds to recent calls for more RHM research that foregrounds broader health practices in order to shed light on how people experience health and wellness outside biomedical institutions (Derkatch, 2016; Scott & Melonçon, 2018), as well as research aligned with critical theory and focused on topics like ethics, user experience, and the impact of personal health technologies (e.g., mobile digital devices, apps, wearables) (Hiefferon, 2017; Melonçon & Frost, 2015). Expanding RHM research is important because “health involves more than what happens in hospitals, clinics, doctors’ offices, laboratories, or medical schools” (Angeli & Johnson-Sheehan, 2018, p. 3). Further, “knowledge produced through research in RHM advances critical understanding of how our values, beliefs, and behaviors as health citizens are constituted through prevalent and ideologically inflected discourses of health and well-being” (Derkatch & Spoel, 2020, p. 29). My dissertation study contributes in these areas through centering social justice, UX, and critical theory aimed at revealing power dynamics and systemic oppression in order to demonstrate how material-discursive practices that enact health and wellness operate outside medical settings.

In particular, I have taken up rhetorician Colleen Derkatch's (2018) call for further examination of the powerful, yet often hard to discern, ways that institutional wellness discourse shapes individual lives and beliefs. Derkatch argues that wellness has "the capacity to expand the domain of illness" and to encourage everyday health practices dependent on institutionalized programs that turn individuals into "the disempowered, medicalized patients they seek not to become" (2016, p. 196). My dissertation project contributes to emerging theory in rhetorics of wellness through examination of the UMN EWP and employees' material-discursive practices with food and health and their bodies. Both my *as/for* model of enacting food and wellness and my discussion of irreconcilable differences and resistance contribute to our broader understanding of health and medical practices by theorizing how people and non-medical institutions *do* wellness, and how institutional wellness replicates systemic oppression and dominant Western biomedical understandings of health. In this way, as Derkatch argued above, I have shown how EWPs expand the domain of illness and encourage everyday health practices that biomedicalize and interpellate people as pre/patients under the guise of holism and positive health promotion.

In terms of insights for TPC, my project takes up Jones et al.'s (2016) call to resist ableism historically perpetuated by technical communication widely, if not inadvertently.

As Jones et al. explain:

An important but less prominent thread of scholarship [needed to expand the scope of TPC and shift its focus] addresses disability and accessibility as a means of becoming more inclusive by resisting ableism. This work rejects assumptions of access that exclude particular students, users, and others from fully engaging with forms of technical communication. Indeed, disability scholars remind us that

in focusing on efficiency and innovation, TPC has widely embraced an ableist agenda. The need for integrating disability rhetoric and accessibility into the field has only begun to be addressed, but as we craft an inclusive technical communication, disability, accessibility, and questions of normalcy illuminate ways forward. (2016, p. 218)

Further, technical communicators have an ethical obligation to consider UX, both intended and unintended, and the ways that technical medical information can reproduce ableist narratives of normalcy (Moeller, 2015). Through incorporating critical disability studies and centering issues of systemic oppression, especially ableism, my project provides an example of productively surfacing ableism within technical communications (e.g., the UMN EWP's promotional materials). Therefore, my study offers an example of how we might approach understanding justice and UX through people's lived experiences with complex programs/systems like EWPs, which could be used to examine other types of health promotion programming, both within and outside medical institutions. Further, in Chapter One, I framed my project as something of an antenarrative of employee wellness, demonstrating a productive application of Jones et al.'s (2016) antenarrative as methodology.

RHM and TPC have a long history of intersection (as evidenced through multiple special issues on RHM in TPC journals as the field of RHM was emerging). To that, my project adds an example of productively pairing methodologies used in RHM (multiple ontologies and praxiography), those used in TPC (social justice, UX), and modified grounded theory (used in both RHM and TPC) in order to study health discourse and practice within the workplace. Further, my project provides an example of productively pairing archival research with human subjects research in order to develop a richer

understanding of people's lived experiences that were never captured in archival materials. My use of modified grounded theory in my archival material analysis (Stambler, 2021) has already been described as providing a "particularly rich methodological apparatus" (Hanganu-Bresch, 2021, p. 120). My use of a UX-focused large-scale survey and narrative inquiry interviews builds on TPC scholarship and in turn provides back to TPC another example of those methods applied in research. Further, my use of praxiography extends previous RHM work on praxiography through demonstrating how praxiography can be productively paired with other methodologies like UX and modified grounded theory.

Lastly, and perhaps most importantly, this dissertation demonstrates that, as sites of study, EWPs facilitate researching what "healthy bodies" and "healthy eating" mean, and how those ideas impact bodies that are excluded, marginalized, or otherwise made unable to participate in the pursuit of wellness. To date, I have found no other studies of EWPs specifically in the field of TPC or rhetorical studies. While there is a significant amount of research on EWPs in other fields, that research is predominantly in medical and business (e.g., personnel, human resources) fields and, with few exceptions, takes an approach I would describe as non-critical. By that, I mean that EWP literature I found in medicine and business tends to approach the examination of EWPs in terms of efficacy and increasing employee/patient compliance with biomedical norms. However, my study takes a critical approach that underscores the mismatch between the UMN EWP and the experience of program participants, which signals a need for the development of EWP models that support people's personal wellness practices and work toward social justice by reframing wellness as something open to and attainable by all. This dissertation is an example of how social justice-oriented critical rhetoric and TPC research can find a

problem in the world (people aren't participating in the EWP) and, through rhetorical and UX analysis, identify likely reasons for the problem (the mismatch between EWP and employees' practices), and in turn open possibilities for amelioration of the problem. In the next section, I turn to imagining, albeit briefly, what it might look like to do employee wellness better.

### **Doing Employee Wellness Better: Toward an Anti-Oppression Model**

The UMN EWP is a successful wellness program, by their own measurements of ROI and risk reduction. This dissertation is not about evaluating the EWP's efficacy or success, however, I would argue that regardless of their measure of success, my research has surfaced serious issues in terms of irreconcilable differences between the EWP's programming and employees' experiences. As Natasha Jones argued, "If we accept that the pursuit of social justice is inextricably connected to transforming the human experience, then it holds that identifying the ways in which the human experience ... can be transformed provides ideal entry points for critique and intervention" (2016, p. 474). In other words, through understanding people's lived experience with the EWP, we can find entry points for intervention.

One of my survey respondents wrote in response to my question near the end of the survey asking if there was anything else they would like to share:

I don't like wellbeing programs at all. I've read about random control studies that show they don't actually work to change people's behavior, they simply reward some people and punish others for behaviors that they already maintain. I am one of those privileged people in the group that is consistently rewarded, and even I think it's not fair for the other people who aren't able to meet these certain benchmarks of "wellness."

I'm just living my life how I would anyway, with the extra burden of having to track my behaviors to get certain financial benefits. It's super intrusive for me and I don't currently have any kind of disability or illness that would make it hard to participate. I can imagine how hard it must be for many other people, who are no

less deserving of being cared for, no matter what benchmarks they can or can't meet.

I just think our entire society would be better served by universal free health care services, including dental health and mental health care. This “wellness” model where one must jump through hoops and measure behaviors in order to earn discounts in health care is really, really shitty for most people. I hate it. I am healthy right now and I hate it. Because our health is temporary. We're all going to get sick and die and this system that rewards “wellness” is really not here for us when we all eventually fail.

This survey response echoes so many of the themes I highlighted in previous chapters (privacy, participating for the financial benefit, disability), though the final paragraph directly addresses something I have said whenever I talk about my research and people ask me how EWP could be better: if we had universal healthcare in the U.S., it could fundamentally change the predominant model of employee wellness. As mentioned in Chapter One's Rhetorical Questions discussion of “What is wellness,” the modern wellness movement has its roots in the identification of and intervention in health disparities (Dunn, 1957). However, contemporary wellness has become highly commercialized, commodified, and privileged. Contemporary wellness reifies whiteness, yet, I see EWPs as programs that potentially could productively intervene in health disparities, if only they were done differently.

In Chapter Three, my kairoslogy demonstrated how the UMN EWP is deeply entangled with the UMN's history of employee health insurance, a tie that binds the EWP and its model of wellness to an ableist medical model of the diseased/disabled/at-risk body as deficient and in need of cure. In other words, because of the deep connection to health insurance, the EWP reproduces a preference for able-bodiedness predominant in the larger medical model. I do not believe we can get around that until we have universal health care in the U.S., because of how much of our larger, problematic healthcare system is driven by our current employer-provided health insurance system. In other words, the



EWP-biomedicine connection is a loop we cannot get out of as long as health insurance is a key factor in health and wellbeing.

At the end of Chapter Six and in the *Entremet* “School Lunches” that followed, I argued that the UMN EWP can only make program adjustments based on UX feedback from employees that will fit within its biomedical, economically driven model. In workplace health and safety research on EWPs, Tang et al. (2016) concluded in part that “pushing to achieve health and wellness goals defined by management or health professionals in a top-down manner is likely to discourage employees from participating and benefiting from EWPs as well as creating resistance and resentment in extreme cases” (p. 431). The people running the UMN EWP are kind and thoughtful and are trying to do their best for UMN employees, but they are stuck with a model of employee wellness rooted in hegemonic ideas about health and economics because those ideas are so firmly entrenched that it is hard to see beyond them. For the UMN EWP, improving employee health is still narrowly defined: it is improving the health of EWP-eligible employees (for those with individual health insurance coverage) and their spouses (for those with family coverage and spouses willing/able to participate) as measured by the reduction of their health insurance/healthcare usage or costs. The UMN EWP is stuck in the loop. As Derkatch argues, “wellness as it currently manifests in western culture ultimately does not live up to its promise of improving lives increasingly lived under ever higher stakes and increasingly scarce resources” (2022, p. 190). Touching back once again to the quotes that opened this chapter, the EWP is focused on “points for insurance as opposed to points for wellbeing,” as Gary put it. And, as Linda said, “if that's our goal as an employer, to help our employees get healthier ... what is a better way to do it?” So, what might an EWP look like if it could break out of the loop and do wellness

differently?

Food and eating-related programming are the primary focus of my analysis of the UMN EWP. I have spent much of this dissertation critiquing the EWP's reliance on a hegemonic model of nutrition and how that replicates dominant white, upper-class norms around food and eating. One of the key ways that the EWP could do wellness differently would be in refiguring its discourse and practices around food (for a bit more about the power of language, keep reading after the end of this chapter for an *Aperitif*). While the EWP did drop Weight Watchers in 2019, it stated on its website that it would be researching different programs for the future that are “more nutrition-focused rather than centered on weight loss” (University of Minnesota, 2019). The continuation of a focus on nutrition means a continuation of a model of nutrition based on broader nutrition science and discourse like the DGA. Jessica Mudry, in her study of the DGA, argued that

we need a new language that describes food and eating ... this does not mean disregarding or ignoring the last hundred years of nutrition research and scientific evidence. Nor does it mean eliminating the use of numbers in discussions of food. But it does mean attempting to understand food, eating, and health in ways that are not simply reduced to mathematical formulae. (2009, p. 173)

In a similar vein, Hayes-Conroy et al. (2014) suggest that while “essential requirements for nutrition have been established ... dietary guidance should be based on acquiring essential nutrition and establishing current health and well-being. Because many different dietary patterns may do this, nutrition advice ought to depend on the individual, not on government policy guidelines” (p. 57). Hayes-Conroy et al. (2014) suggest a few potential methods for refiguring dietary guidance, including individualization, developing a critical dietary literacy approach, and thinking about an ecological nutrition model that

incorporates issues like environmental impact of food production and the economic vitality of farmers, farm workers, and rural farming communities. To this, I would add that nutrition advice ought to foreground issues of culture, tradition, pleasure, and eliminate a focus on dieting, thinness, and BMI as a measure of health. While all of this is beyond the scope of my dissertation work, I point to these avenues as productive ways to consider, in the future, how we might talk about food in a way that promotes food practices rooted in food as a social, pleasurable, nourishing thing, rather than fuel for the body or a quantifiable means to an end. As one of my survey respondents put it:

It is really discouraging how much of the [EWP's] food programming focuses on weight loss. I would like to see more content about how to reach nutrient goals like ways to increase protein or fiber in dishes, incorporating more servings of fruit and vegetables, and ways to adjust favorites to be more sustainable for fat/salt/cholesterol/sugar and/or the environment (many people are looking to reduce meat for ethical/environmental AND health reasons but might not have a good handle on how to get a good amount of protein while doing so). These things are valuable for everyone no matter what their weight but right now the content feels more targeted towards "here, you fat people, do this" when cancer and heart disease can be a problem of people at any weight if they are eating an unhealthy diet. Excessive focus on weight=health has damaged my metabolism and my joints and has not made me a happier or healthier person. When you hate your body, that does not incentivize taking care of it. When you are approached like you're weaker and more stupid than other people, that doesn't encourage anything but resentment. Is it easier to be healthy at a lower weight? Yes. But diet plans to hit a target, no matter how much we talk about "lifestyle" imply a beginning and ending, a place where you'll be able to stop. Instead of building new relationships with food, comfort, emotion and reward/celebration, it is just setting people up to be discouraged and burn out when they realize that the restrictions they've set on themselves to diet have to become permanent or they start gaining again. At this point in my life, I've seen the "this is what a cup looks like, this is a half-cup, this is a teaspoon" and the Harvard Plate a million times. What would be better is "when I'm sad or afraid or tired, how do I make myself feel better? is that a good choice? Can I make a better one? What can I do to make sure I have good options easily available? How can I shop and plan meals to make sure veggies get eaten instead of rotting in the crisper drawer?" I don't need to know what a serving of salad is, I need to know "okay, carrots will stay good basically forever, but you need to make something with those green peppers within the next three days or they'll just be rotten slimy sadness by the time you

get to those fajitas, and if you were planning to make stir fry with those bean sprouts it needs to be tonight; you know what is also crunchy and goes well with noodles is broccoli slaw, which lasts a LOT longer in the fridge!" And if you have a limited budget for fresh veggies, what are the best canned and frozen choices? There are SO many ways we can talk about food choices and health that don't have to do with weight.

As the survey respondent in the quote above notes, weight is a key area of discourse in the EWP around food and health, currently. If the EWP changed the way it talked about and enacted practices around food, it would also be able to change its reliance on weight as a measure of health. In turn, this could support a shift away from material-discursive practices that promote ableist ideals around able-bodiedness and ideal body size, which would open up all sorts of possibilities for promoting diverse ideas about health and bodies and ability. Beyond simply not replicating and promoting ableism, racism, and classism found more broadly in society, the EWP could take up working toward and actively promoting anti-oppression and social justice.

However, attention to the role of systemic oppression and neoliberal discourses of individual responsibility and productivity are crucial as well. By resisting the EWP, participants in my study are, like those in Spoel et al.'s (2014) study of the rhetorics of health citizenship, "perform[ing] a modality of health citizenship that reconfigures the terms of the debate from the simple, reductive question of what do individuals need to do to achieve healthy living to the more complex, political, and structurally-oriented question of what should the state be doing to better help all citizens achieve this goal" (p. 145). Likewise, Anna Kirkland, in her critical EWP research, argues that

if we were to attribute poor health outcomes to structural inequalities that require systemic fixes ... corporate interests and individual striving would become marginal to any solutions. Nothing is wrong with striving for self-improvement per se. But it cannot be the answer to the problem of health care costs and health

inequalities in a society that is much more than groups of corporate employees.  
(2014, p. 974)

The UMN EWP places total responsibility for health on the individual without acknowledging its own role in the health of the overall workplace. In particular, I saw across all my datasets mention of stress, workload, and pay as areas where the university elides its own role in wellness.

While stress was not a focus of my research like food was, stress was consistently the number one most prevalent health risk at the university, just ahead of weight (BAC, 2006d, 2010b, 2011d, 2013b, 2015a). Importantly, many of my survey respondents and interview participants talked about their jobs as their primary source of stress, and stress management as a key part of their wellness practices. People also talked about how the EWP only added to their stress because it was another task on top of an already high workload, such as one survey respondent who said: “my job with U of M is very busy and I found agitation in the time the [EWP] took to participate. So much so, that it caused me stress to try to complete the items each year, so I stopped.” Time and money were closely connected in my participant data (survey and interviews), with one survey respondent describing the health insurance premium reduction incentive as being “equivalent to working for less than minimum wage” in terms of their time investment. Or, as one survey respondent argued, “I feel like if the U honestly cared about my ‘wellness’ as a person, they would PAY ME a salary that did not require me to have extra jobs on the side, working more than 40+ hours a week most weeks of the year.”

One small way of doing employee wellness better would be to find ways for participation to not require so much time investment, not in terms of doing things like exercising or cooking healthy meals, but in terms of not requiring employees to spend so

much time, as my interview participant Hannah put it, “just like click, click, click, click, clicking through things.” In order to address issues of stress, the EWP has added programming around mindfulness and stress management over the years (much of which requires an up-front fee from the employee) that many of my participants (survey and interviews) lauded as one of the more useful aspects of the EWP. Despite mindfulness’ usefulness, another, larger change could come from UMN addressing its own institutional responsibility for a healthy workplace by reducing people’s workloads and increasing salaries in a meaningful way, rather than suggesting (or perhaps nearly requiring) more things to do with their limited time and money.

The EWP’s reliance on the disease management program’s high ROI as an indicator of success also reproduced neoliberal narratives of individual responsibility alongside information deficit-oriented programming that assumes that people simply need information and they will (and are able to) make health behavior changes. However, as Bennett argues in framing diabetes as a disease that requires systemic intervention, bodies with diabetes “are but signs of larger systemic ills related to available food choices, medical accessibility, and the luxury to make healthy lifestyle decisions like exercising” (p. 23). Additionally, Hite and Carter (2019) argue that situating weight as connected to individual choice

implies that the population seen as most in need of a health intervention was not already making appropriate choices about food and activity (ostensibly as evidenced by higher rates of obesity). Further, it implies that chronic disease prevention can be best assisted by the adoption of wealthier, white lifestyles and diets, rather than, for example, increased access to affordable healthcare or a living wage. (p. 161)

As discussed in Chapter Four, BAC minutes have captured employees asking the university to explore offering more healthy food options on campus, something that was echoed in my survey and interviews, such as one survey respondent who commented that “The U's choices of vendors and high fructose corn syrup sodas and drinks, junk food snacks and candy in vending machines throughout campus does not support wellbeing. It is very disappointing.” Rather than addressing those issues, though, the university president responded to similar feedback in a BAC meeting that while he “appreciated the comments, he reminded members that there is an element of personal responsibility when it comes to a healthy lifestyle...the University can help provide the structure, [but] it ultimately comes down to personal responsibility” (BAC, 2012, p. 2). I interpreted this BAC exchange as evidence of how the university sidesteps its role in food practices in the workplace while reifying a neoliberal model of individual responsibility.

The UMN is one of the largest employers in Minnesota, with a huge presence especially in the Twin Cities, and as a land-grant research institution, one of the three key pillars of its mission is outreach. The UMN “About Us” page says “We partner with communities across Minnesota to engage our students, faculty, and staff in addressing society's most pressing issues” (University of Minnesota, 2019c). This positioning statement is especially pernicious when considering the university president’s sidestepping of the BAC request to explore changing food options on campus. In my view, it makes the outreach mission read as engaging communities *except for* the UMN’s own community, which seems fundamentally contradictory because the UMN serves over 60,000 faculty, staff, and students across the state, and those people and their families are all a part of the broader Minnesota community.

In my survey and interviews, employees talked about wellness in many ways that

did not map onto the EWP points system, and not just being already healthy or too healthy, as I discussed in Chapter Five and Six. People talked about their families, their communities, and the importance of other people to their wellness. The National Wellness Institute, the organization whose definitions of wellness the UMN EWP has adopted and centered, in 2019 refigured their model of wellness as a “multicultural wellness wheel” that includes “worksite” and “community” as important dimensions of wellness alongside “personal & family” (National Wellness Institute, n.d.a). The community wellness wedge of the wheel includes things like advocacy, policies, and community partnerships along with considerations of race, ethnicity, age, gender, socio-economic status, sexual orientation, education, and religion/spirituality. In a section on their multicultural wellness page, the National Wellness Institute argues that “standardized programs don’t work” and that, instead, worksite wellness programs should focus on multicultural competency for the “social good” because

The CDC predicts that worksite wellness programs become part of a national public health strategy to address an increase in chronic diseases that could cost the U.S. healthcare system an estimated \$4.2 trillion annually by 2023. Chronic diseases linked to health disparities are connected to, among other things, variances in cultural health norms, healthcare literacy, and provider delivery systems, as well as the provider’s culture and multicultural competency. Worksite wellness programs can only achieve a notable impact on national public health by reducing chronic diseases if those programs effectively reach groups that are most impacted by chronic disease. (n.d.a, n.p.)

If we reimagined the UMN EWP as a community wellness program rather than an employee wellness program, the possibilities multiply. Community-level wellness could



mean shifts as small as moving the Farmers Market from the Minneapolis campus into the nearby Northeast Minneapolis neighborhood, which is an FDA-designated food desert, an area of the Twin Cities with higher racial and ethnic diversity, a greater level of economic depression, and also home to many UMN employees and students.<sup>18</sup> The UMN has a large outreach center in Northeast Minneapolis that could potentially assist with bringing the Farmers Market into the neighborhood, and has the transportation infrastructure to at least support employee access to the Farmers Market there as it does in its current location. Community-level wellness could also involve advocacy or activism efforts in terms of police reform (a major issue in Minneapolis), carceral reform, and improving access to K-12 educational opportunities.

On March 22, 2022, after I had written the first draft of this conclusion, I attended a webinar on “Building a Culture of Health and Equity Through Well-being” by Dr. Alonzo L. Plough, Vice President of Research-Evaluation-Learning and Chief Science Officer of the Robert Wood Johnson Foundation (RWJF), which was sponsored by the UMN Earl E. Bakken Center for Spirituality and Wellbeing (a partner of the EWP). The webinar was formally linked to the EWP as eligible employees could earn wellness points for attending. Plough’s talk, based on a book he edited (Plough, 2020), focused on community wellness and allying with communities to address systemic inequities. Plough anchored the talk in health disparities, discussing how there can be large gaps in health even in small geographic neighborhoods, highlighting a nearly 10-year difference in life expectancy in different neighborhoods in Manhattan and Chicago. Plough’s and the RWJF’s research showed that individual and community wellbeing are “inextricably

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<sup>18</sup> For a relevant example of this in action, see this article about how a University of Minnesota Duluth professor’s research helped address their local food access problems: <https://www.thebarkumnd.com/arts-entertainment/2017/10/12/umd-professors-research-helps-solve-duluths-food-access-problems>

linked” and that “we cannot have individual wellbeing if we don’t think about what community wellbeing looks like” (Plough, 2022). Systemic oppression was at the core of Plough’s argument in the webinar: oppression has a profound impact on not just health, but wellbeing, and those impacts on wellbeing impact us all. They have ripple effects. In order to truly build a culture of health and equity, Plough suggested, we must address individual health alongside structural and policy barriers that foster health inequities, climate change, housing affordability, the opioid crisis, and the marginalization of indigenous populations. Quoting the late Minnesota senator Paul Wellstone, Plough emphasized that “we all do better when we all do better.” While the webinar was incredibly salient to me, based on my research, I would call on the UMN EWP to not just include these ideas in an employee-facing webinar, but rather to embrace and actively enact diversity, equity, inclusion, and justice through community wellness.

Ultimately, if we lift up our whole communities, and improve everyone’s wellness in ways that fit their cultures, beliefs, values, and lifestyles, we could not only also improve employees’ wellness and that of their families, we could do so in a way that ameliorates systemic inequities that are at the root of things like health disparities in the first place. While efforts like these are beyond the scope of my dissertation work, in the next and final section, I turn to considerations for future research into employee wellness.

### **Future Considerations for EWP Research**

While my dissertation project makes important contributions, described above, to RHM and TPC, I see it as the beginning of a larger research agenda. Throughout the course of the project, I found myself circling back to the question of scope: what was inside the scope of this dissertation, and what was outside of scope (for now).

For the purposes of keeping the dissertation manageable, I focused fairly tightly

on food and eating-related programming. Keeping the project bounded around food was productive from a scope standpoint but also salient because of the sheer predominance of eating-related programming and the UMN EWP's reliance on weight as a risk factor. However, I saw important threads for examining stress and mental wellness (as noted in the section above). Mental health discourse is increasingly prevalent in the U.S., including the impact of the workplace on mental health, something that has surfaced especially during the COVID-19 pandemic, from the stress and precarity of front-line workers to the varied effects of working from home. Additionally, both in my own experience and in anecdotal stories I have heard, many workplaces are simultaneously telling workers that they should care for their mental wellbeing and take time for mental health but also that because of pandemic challenges we all must learn to do more with less. Especially in education (both K-12 and higher ed), people are expected to do things like reflexively pivot back and forth to online or hybrid learning, which often requires double the preparation of teaching normally in one modality. (But, the EWP is offering mindfulness classes for free on Zoom this year! If one has the time, of course.) Slight sarcasm aside, I see the tensions between mental health discourse, productivity discourse, and workplace stress as a productive area for investigating employee wellness more fully and in realms beyond the physical. This work could also contribute insights into the growing area of mental health rhetoric research in RHM.

Another area with strong potential for EWP research is literacies. As Kristin Bivens et al. suggest, "health literacy is an embodied, multisensory experience that is invariably mediated by healthcare technologies ... [and] these technologies enable, constrain, and integrate multisensorial literacy practices in ways that complicate the concept of health literacy" (2018, para. 3). Drawing on Kelli Cargile Cook's (2002)

concept of layered literacies, Bivens et al. argue for addressing multisensory literacies—aural, visual, and tactile—in order to push back against Cartesian binaries like mind/body and illness/disease and consider health literacy as something embodied and sensorial. Because EWPs provide health information mediated by healthcare technologies (e.g., websites, apps, wearables), they raise issues around digital, cultural, social, technological, health, and dietary literacies, at least. While I have engaged literacy as a research topic in other areas (through my work with the Building Digital Literacy collaborative and in a current collaborative project on misinformation, health literacy, and the accommodation of microbiome research in popular media), literacy was something that I had to deem outside of scope for this dissertation project. However, like mental wellness, I believe that wellness and layered literacies is a promising avenue for future research, especially in terms of the implication of EWPs in perpetuating health disparities and the potential for EWPs to work toward ameliorating them.

Lastly, I believe a major strength of the project is in theory-building and methodology, but a major limitation is in practical impact or amelioration for affected communities. Another major limitation of the project was in terms of my challenges (largely COVID-19 related) gathering data that more directly addressed systemic racism in the EWP. Given the critical importance of health disparities, and (as discussed in the previous section) the potential for EWPs to engage in work toward community wellness, additional research is needed here. I suggest that community-engaged research would be a productive next step for examining and, potentially, putting into practice better EWPs. Community-engaged research would further support efforts toward socially just wellness programs by centering the affected communities, especially communities marginalized along axes of ability, class, race, ethnicity, gender, and sexual orientation.

### ***Aperitif: Power, Language, and Pants***

*Throughout this dissertation, I've included stories that didn't fit neatly into my analysis, but that I still found powerful and important, in the Amuse-Bouche (preface) and Entremets between chapters. Stories are fundamental to my research, and to how we, as humans, more broadly engage with and understand the world. As a rhetorician, I know language matters, it has material impacts on the world, something that has become even more achingly clear as I've studied in graduate school and dissertated through the years of the Trump presidency and the COVID-19 pandemic. In Chapter Seven, my conclusion, I presented some ways we might talk about and do wellness differently. Again, language matters, and it has real impacts on practices and bodies. Here, in this Aperitif, I want to juxtaposition two different stories from my interview participants to underscore this point.*

*First, the power of language came up when talking with James about the EWP and his struggles with disordered eating.*

[JAMES] I don't think that anybody gets, starts sort of using food in a disordered way just based on messages they get from the culture. I don't think that's the case. I think it's, it's kinda like, you know, there are a lot of people who are predisposed, um, to using certain things in order to, to using certain behaviors in order to to compensate or escape, you know, difficult emotions, trauma, that sort of thing. I mean, I think that's where addiction comes from. And I think eating disorders are maybe not a form of addiction, but the behaviors mimic some addictive behaviors. So I don't think the wellness program is going to cause an eating disorder. I think when people are predisposed to those sorts of behaviors, the messages reinforce the validity of those behaviors. And um they, or they reinforce the validity of what you're feeling that sort of prompts you to use those behaviors, those symptoms. And it's that language, I feel like it's that language that's like, you know, I, I'm going to go out on a limb. So you know how um, you know how hate crimes and everything have just spiked over the past four years. And, and a lot of people have talked about the fact that Trump, his rhetoric is a contributing factor to that. I mean, you know, there's, there's nobody out in the hills who, who heard Donald

Trump say that Mexicans are rapists and decided to go kill a whole bunch of people based solely on that one statement. But when, obviously when you get that kind of language from, from an authority figure, someone who is literally in charge and is in the position of being arguably the most powerful person on earth, it's a validation of that message. And, while the wellness program isn't necessarily an authority figure, it's coming from our employer. And that I think the difference between, in the hierarchy between the employer and employee, I mean that, that dynamic creates sort of more sense of authority. Especially coming from the U, from the University of Minnesota, creates a sense of authority that this language is correct. So I think when, when people who are predisposed to eating disorders run into that kind of language, whether it's here or in just media, or any other place, any, any sort of external place that they view as even the slightest bit of authority or, or holding even the slightest bit of expertise, they ... it contributes to, it can contribute to their likelihood of engaging in the behaviors.

*In this quote from James, I see disciplinary power at work, and I appreciate how James has identified how language from places of authority can really reinforce negative ideas or behavior. Next, here is a quote from Nhia about her kids and the power of language.*

[NHIA] On the whole body positivity movement and, I've always been stockier and fatter than most Vietnamese people. And so it's, it's definitely, it has certainly done a number on me in terms of growing up. And I think it wasn't until I started belly dancing, where I started, there has been this huge body positivity movement, in that we don't have stick-thin dancers. And so I think it, it takes a lot of years to undo some of that. So I think that's why I'm really ... having a daughter too, is just making sure that the messaging to her is, you know, it's not how much you weigh, because she is, she's been weighing herself and I said stop it, you know, don't, you don't have to do it every day as you look healthy, you look like you need to, exactly what you need to be as a 13-year old and I don't know if you saw there's a post out there. I don't know, this is circulating on Facebook, with somebody was saying that her daughter was nine and was trying on pants that were too tight. And she said everybody needs to think this way, her daughter, instead of saying, I'm too fat, she says, my butt and my legs are too powerful for these pants.

*I believe that reframing the language we use around things like health, weight, and body size can truly help us reach a better place in terms of wellness. A body*

*positivity model may be more productive than the predominant diet culture discourse that I, and so many others, have struggled with for years. So, I say, in truly finally closing this dissertation, to all of you, especially those of you who (like me) have perhaps gained a bit of weight during the pandemic (which news articles report as widespread or, in sensationalistic articles, the next big health crisis): maybe it's just that our butts and our legs are too powerful for these pants.*

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## Appendix A: Archival and Historical Materials

As discussed in more depth in Chapter Two (methods) I worked with a total of 163 documents during Phase One of my research: 84 sets of meeting minutes, reports, and proposals from the university archives dated 1987 to 2019; and 79 marketing and promotional materials from the University Archives and the Internet Archive dated 1981 to 2019. Tables A1 (meeting minutes, reports, and proposals) and A2 (marketing and promotional materials, including news stories) contain complete lists of these documents by category (in date order within category), item name, date, and archive.

**Table A1**

*List of Meeting Minutes, Reports, and Proposals*

Category	Item Name	Date	Archive
Meeting Minutes	Board of Regents Meeting Minutes	1997, November	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Health Benefits Advisory Committee Minutes	2001, January 18	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Health Benefits Advisory Committee Minutes	2001, February 1	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Health Benefits Advisory Committee Minutes	2001, February 15	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Health Benefits Advisory Committee Minutes	2001, June 7	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Health Benefits Advisory Committee Minutes	2001, August 30	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.

Category	Item Name	Date	Archive
	Benefits Advisory Committee Minutes	2001, September 20	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2001, November 10	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2002, January 17	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2002, January 31	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2002, February 14	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2002, February 28	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2002, March 14	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2002, May 2	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2002, June 6	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.

Category	Item Name	Date	Archive
	Benefits Advisory Committee Minutes	2002, June 20	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2002, August 29	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2002, September 19	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2002, October 17	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2002, November 7	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2003, February 20	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2003, April 3	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2003, April 24	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2003, May 1	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.



Category	Item Name	Date	Archive
	Benefits Advisory Committee Minutes	2003, September 4	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2003, October 23	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2003, December 18	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2004, May 6	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2004, May 20	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2004, August 5	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2004, August 27	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2004, September 23	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2004, October 7	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.

Category	Item Name	Date	Archive
	Benefits Advisory Committee Minutes	2005, February 17	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2006, January 19	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2006, May 4	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2006, September 7	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2006, October 19	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2006, November 16	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2008, January 24	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2008, March 27	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2008, May 15	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.

Category	Item Name	Date	Archive
	Benefits Advisory Committee Minutes	2008, June 5	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Board of Regents Meeting Minutes	2008, June 12-13	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2008, August 7	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2008, September 18	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2009, September 17	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2010, March 4	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2010, May 20	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2010, June 24	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2010, September 16	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.

Category	Item Name	Date	Archive
	Benefits Advisory Committee Minutes	2010, November 18	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2011, January 20	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2011, February 17	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2011, March 24	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Senate Committee on Faculty Affairs	2011, March 29	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2011, April 21	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2011, May 19	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2011, November 17	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2012, January 19	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.

Category	Item Name	Date	Archive
	Benefits Advisory Committee Minutes	2012, February 28	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2012, April 19	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2012, July 26	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2012, September 20	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2013, April 18	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2013, May 16	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2013, July 18	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2014, September 4	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2014, December 11	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.

Category	Item Name	Date	Archive
	Benefits Advisory Committee Minutes	2015, June 4	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2015, October 8	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2016, February 11	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2016, June 9	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2016, September 8	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2016, December 8	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2017, February 9	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2018, April 12	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2018, October 4	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.

Category	Item Name	Date	Archive
	Civil Service Senate Minutes	2018, December 6	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Benefits Advisory Committee Minutes	2019, July 8	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
Reports/ Proposals	Final Report And Recommendations of the Civil Service Benefits Advisory Committee	1987, May	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	Health Plan Task Force Recommendations	2000, November 16	Retrieved from the University of Minnesota Senate website.
	Update on Health Benefits—Board of Regents	2002, June 30	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.
	2003 Annual Report—University of Minnesota	2003	University Archives, Archives and Special Collections, University of Minnesota. Retrieved from the University of Minnesota Digital Conservancy.

**Table A2**

*List of Marketing and Promotional Materials*

Category	Item Name	Date <sup>a</sup>	Archive/Source
EWP Website Screen Captures 2003-04 AY <sup>b</sup>	Gopher Health Walk and Wellness Fair	2003, December 10	Internet Archive
	U of M UPlan Wellness - About the program	2004, July 1	Internet Archive
	U of M UPlan Wellness - Dimensions of Wellness	2004, July 1	Internet Archive

Category	Item Name	Date <sup>a</sup>	Archive/Source
	U of M UPlan Wellness - Emotional Resources	2003, August 7	Internet Archive
	U of M UPlan Wellness - Environment Resources	2003, December 10	Internet Archive
	U of M UPlan Wellness - Intellectual Resources	2003, August 7	Internet Archive
	U of M UPlan Wellness - Occupational Resources	2003, August 7	Internet Archive
	U of M UPlan Wellness - Physical Resources	2004, July 1	Internet Archive
	U of M UPlan Wellness - Social Resources	2003, August 7	Internet Archive
	U of M UPlan Wellness - Spiritual Resources	2004, July 1	Internet Archive
	U of M UPlan Wellness - Wellness Events	2004, October 14	Internet Archive
	U of M UPlan Wellness - Wellness Resources	2004, October 14	Internet Archive
	U of M UPlan Wellness Home	2004, June 22	Internet Archive
	Wellness Fair presenters	2003, December 20	Internet Archive
EWP Website Screen Captures 2005-06 AY	U of M OHR UPlan Wellness-Energy Quest	2005, November 19	Internet Archive
	U of M OHR UPlan Wellness-Farmers Market	2005, November 14	Internet Archive
	U of M OHR UPlan Wellness-Home	2005, November 21	Internet Archive
	U of M OHR UPlan Wellness-Take Time to be Active	2005, November 22	Internet Archive



Category	Item Name	Date <sup>a</sup>	Archive/Source
	U of M OHR UPlan Wellness-Trek Across the U	2005, October 28	Internet Archive
	U of M OHR UPlan Wellness-Wellness Events	2005, November 14	Internet Archive
	U of M OHR UPlan Wellness-Wellness Resources	2005, November 15	Internet Archive
	U of M UPlan Wellness - About the program	2006, March 12	Internet Archive
	U of M UPlan Wellness - Self Care	2006, March 12	Internet Archive
EWP Website Screen Captures 2010-11 AY	Farmers Market	2011, February 25	Internet Archive
	Health Coaching	2011, July 19	Internet Archive
	Health Screenings	2011, July 11	Internet Archive
	Healthy Living Programs	2011, June 19	Internet Archive
	Weight Management for UPlan Members	2011, March 5	Internet Archive
	Welcome to Wellness	2011, January 16	Internet Archive
	Wellness Assessment	2011, June 11	Internet Archive
	Work Life and Wellness Home	2011, June 11	Internet Archive
EWP Website Screen Captures	Assessments	2012, September 12	Internet Archive

Category	Item Name	Date <sup>a</sup>	Archive/Source
2012-13 AY	Exercise Fitness	2012, September 7	Internet Archive
	Health Management	2013, June 18	Internet Archive
	Nutrition	2012, September 29	Internet Archive
	Stress Management Resources	2012, December 17	Internet Archive
	Weight Management for UPlan Members	2013, January 8	Internet Archive
	Wellness Points Bank 2012	2013, May 31	Internet Archive
	Wellness Resources on Campus	2013, June 19	Internet Archive
	Wellness Work Life	2012, October 22	Internet Archive
EWP Website Screen Captures 2017-18 AY	Additional Wellbeing Resources	2017, September 25	Internet Archive
	Bike Commuter Program	2017, September 25	Internet Archive
	Farmers Market	2017, September 25	Internet Archive
	Weight Watchers on Campus Schedules	2017, September 25	Internet Archive
	Wellbeing Champions	2017, September 25	Internet Archive
	Wellbeing Program Points Chart	2017, September 25	Internet Archive
	Wellbeing Program-home	2017, September 25	Internet Archive

Category	Item Name	Date <sup>a</sup>	Archive/Source
EWP Website Screen Captures 2018-19 AY	Additional Wellbeing Resources	2018, September 25	Internet Archive
	Farmers Market	2018, September 25	Internet Archive
	Weight Watchers on Campus Schedules	2018, September 25	Internet Archive
	Wellbeing Champions	2018, September 25	Internet Archive
	Wellbeing Program-home	2018, December 11	Internet Archive
EWP Website Screen Captures 2019-20 AY	Farmers Market	2020, February 22	Captured from live website at the time
	Wellbeing Program-home	2020, February 22	Captured from live website at the time
EWP Marketing and Promotional Materials	Email from University President Bruininks	2004, June 2	University Archives, Archives and Special Collections, University of Minnesota.
	2010 Wellness Brochure	2010, January	University Archives, Archives and Special Collections, University of Minnesota.
	2012 Wellness Points Bank Benefit Fair Handout	2011, October	University of Minnesota Employee Wellness Program Office
	2013-14 Wellness Points Guide	2013, Fall	University of Minnesota Employee Wellness Program Office
	2017-18 Program Guide Book	2017, Fall	University of Minnesota Employee Wellness Program Office

Category	Item Name	Date <sup>a</sup>	Archive/Source
	2018-19 UMN Program Guide	2018, Fall	University of Minnesota Employee Wellness Program Office
	2019-2020 Program Guide	2019, Fall	Downloaded from live website at the time
News Stories	Various UMN <i>Brief</i> (internal newsletter) notices 1981-2005	Various dates (clipped and pasted on a single page)	University Archives, Archives and Special Collections, University of Minnesota.
	UMN <i>Brief</i>	1981, January 7	University Archives, Archives and Special Collections, University of Minnesota.
	UMN <i>Daily</i> newspaper: "Civil Service Workers' [sic] enthused over possible wellness program"	1981, October 8	University Archives, Archives and Special Collections, University of Minnesota.
	UMN <i>Daily</i> newspaper: "Workers, bosses joining wellness wave"	1982, October 4	University Archives, Archives and Special Collections, University of Minnesota.
	UMN <i>Daily</i> newspaper: "Civil service group lobbies Keller for wellness policy"	1987, February 24	University Archives, Archives and Special Collections, University of Minnesota.
	Minnesota <i>Star Tribune</i> newspaper: "U health plan opts for self-insurance"	2001, June 7	NewsBank, Inc. (database)
	Minnesota <i>Star Tribune</i> newspaper: "U confronts reality of scaling back plans"	2001, June 9	NewsBank, Inc. (database)

Category	Item Name	Date <sup>a</sup>	Archive/Source
	UMN <i>Brief</i>	2003, January 8	University Archives, Archives and Special Collections, University of Minnesota.
	Minnesota <i>Star Tribune</i> newspaper: "More U budget woes seen down the road"	2003, June 14	NewsBank, Inc. (database)
	Minnesota <i>Star Tribune</i> newspaper: "U unions turn up the heat in contract talks"	2003, August 20	NewsBank, Inc. (database)
	St. Paul <i>Pioneer Press</i> newspaper: "Clerical workers to strike U today"	2003, October 21	NewsBank, Inc. (database)
	Minnesota <i>Star Tribune</i> newspaper: "U clerical workers hit picket lines"	2003, October 21	NewsBank, Inc. (database)
	Minnesota <i>Star Tribune</i> newspaper: "U strike - State contract isn't best model"	2003, October 24	NewsBank, Inc. (database)
	UMN <i>Brief</i> : University's New Wellness Initiative	2004, March 20	Internet Archive
	Minnesota <i>Star Tribune</i> newspaper: "U saves 16 million through self-insurance"	2004, June 12	NewsBank, Inc. (database)
	UMN <i>Brief</i> : Energy Quest	2005, January 19	University Archives, Archives and Special Collections, University of Minnesota.

Category	Item Name	Date <sup>a</sup>	Archive/Source
	UMN <i>Daily</i> newspaper: Farmer's market opens for business on campus	2005, July 13	University Archives, Archives and Special Collections, University of Minnesota.
	UMN Press Release: "University of Minnesota Farmers Market Returns July 11 on Twin Cities Campus"	2007, July 9	University Archives, Archives and Special Collections, University of Minnesota.

<sup>a</sup>The Internet Archive captures websites periodically, but not daily. The dates in this column represent the dates of specific Internet Archive captures of specific webpages (also see b below).

<sup>b</sup>AY stands for academic year. As an annual program, the EWP does not change much during the year, and is roughly tied to the university's academic calendar (September through May) and/or fiscal year (July through June). Thus, I tried to capture a version of each page from Internet Archive within a specific academic year span.

## Appendix B: Survey Questions

Included below is a full set of my survey questions. As noted in Chapter Two (methods), questions were piped such that some questions were only displayed to survey respondents if they answered other questions in certain ways. Blue and grey boxes inserted in the list below note these piping/display rules.

Q1) How often on average do you use a computer? (choose one)

- Yearly
- Monthly
- Weekly
- Daily

Q2) How long have you been using a computer? (choose one)

- Less than 1 year
- 1-2 years
- 3-5 years
- 6-10 years
- 10+ years

Q3) What kind of device do you use most often to access the internet? (choose one)

- Desktop computer
- Laptop computer
- Tablet computer
- Mobile phone

Q4) How often on average in the last year have you used online health resources to get information and/or treatment for a health condition (choose one)

- Never
- Less than once a month
- At least once a month
- At least once a week

*Display Q5 if Q4 = Less than once a month, At least once a month, or At least once a week*

Q5) What device have you most often used to access online health resources to get information about and/or treatment for a health condition? (choose one)

- Desktop computer
- Laptop computer
- Tablet computer
- Mobile phone

Q6) How comfortable are you with using the internet? (choose one)

- Very comfortable
- Somewhat comfortable
- Neither comfortable nor uncomfortable
- Somewhat uncomfortable
- Very uncomfortable

Q7) How long have you been an internet user? (choose one)

- Less than 1 year
- 1-2 years
- 3-5 years
- 6-10 years
- 10+ years

Q8) Do you own a smartphone (mobile phone with internet capabilities)? (choose one)

- Yes
- No

*Skip To: Q18 If Q8 = No*

Q9) What kind of smartphone do you own? (choose one)

- iPhone
- Android Phone
- Windows Phone

Q10) How often do you visit websites using your smartphone? (choose one)

- Never or rarely
- Monthly
- Weekly
- Daily

Q11) How often do you use apps on your smartphone? (choose one)

- Never or rarely
- Monthly
- Weekly
- Daily

Q12) Do you use apps on your smartphone to track your eating (for example, through a diet app)?

- Yes
- No

*Display Q13 if Q12 = Yes*



Q13) How often do you use smartphone apps to track your eating? (choose one)

- Rarely
- Monthly
- Weekly
- Daily

Q14) Do you use apps on your smartphone to track other health data (for example, step counter, exercise tracker, glucose monitor, etc.)?

- Yes
- No

*Display Q15 if Q14 = Yes*

Q15) How often do you use apps on your smartphone to track other health data? (choose one)

- Rarely
- Monthly
- Weekly
- Daily

Q16) Do you use a wearable smart device (for example, a FitBit, Apple Watch, or other smartwatch) to help track your own health data?

- Yes
- No

*Display Q17 if Q16 = Yes*

Q17) How often do you use a wearable smart device to track your own health data? (choose one)

- Rarely
- Monthly
- Weekly
- Daily

Q18) Please indicate your primary job classification at the University of Minnesota. Or, if you are covered under your spouse's UPlan health insurance, please indicate your spouse's primary job classification. (choose one)

- Faculty
- Professional & Administrative (P&A)
- Civil Service
- Bargaining Unit

Q19) Please indicate the percentage of time of your overall University of Minnesota job appointment. Or, if you are covered under your spouse's UPlan health insurance, please indicate your spouse's percentage of time in their overall job appointment. (choose one)

- Less than 75% time (less than 30 hours per week)
- 75% time or greater (30 hours per week or more)

Q20) What does "wellness" mean to you?

[Open-ended text box answer]

Q21) What does "healthy eating" mean to you?

[Open-ended text box answer]

Q22) Please indicate if you have ever participated in the Employee Wellbeing Program. (choose one)

- I am currently participating in the Wellbeing Program
- I previously participated in the Wellbeing Program but am not currently participating
- I have never participated in the Wellbeing Program

*Display Q23 if Q22 = I previously participated in the Wellbeing Program but am not currently participating*

Q23) Please say a little bit about why you are no longer participating in the Wellbeing Program.

[Open-ended text box answer]

*Display Q24 if Q22 = I have never participated in the Wellbeing Program*

Q24) Please say a little bit about why you do not participate in the Wellbeing Program.

[Open-ended text box answer]

*Display Q25 if Q22 = I am currently participating in the Wellbeing Program, or I previously participated in the Wellbeing Program but am not currently participating*

Q25) To what extent do you disagree or agree with the following statements (Likert scale: strongly agree, somewhat agree, neither agree nor disagree, somewhat disagree, strongly disagree):

- My life is improved by the Wellbeing Program
- The Wellbeing Program has improved my health
- Participating in the Wellbeing Program is easy
- Using the Wellbeing Program website and/or app is easy
- I feel like I have a better understanding of a healthy diet because of the Wellbeing Program
- I feel like I have a better relationship with food and eating because of the Wellbeing Program

*Display Q26 if Q22 = I am currently participating in the Wellbeing Program, or I previously participated in the Wellbeing Program but am not currently participating*

Q26) To what extent do you disagree or agree with the following statements (Likert scale: strongly agree, somewhat agree, neither agree nor disagree, somewhat disagree, strongly disagree):

- Learning about diet and nutrition through the Wellbeing Program has changed how I plan meals or shop for food
- Learning about diet and nutrition through the Wellbeing Program has changed how I choose what I eat
- Learning about diet and nutrition through the Wellbeing Program has changed how I track what I eat
- Learning about diet and nutrition through the Wellbeing Program has changed how I talk to my family/friends about food

*Display Q27 if Q26 = Learning about diet and nutrition through the Wellbeing Program has changed how I talk to my family/friends about food [ Strongly agree ] or [ Somewhat agree ]*

Q27) Because you agreed with the statement that the Wellbeing Program has changed how to talk to your family/friends about food, please say a bit about how things have changed.

[Open-ended text box answer]

*Display Q28 if Q22 = I am currently participating in the Wellbeing Program, or I previously participated in the Wellbeing Program but am not currently participating*

Q28) Please indicate if you have ever completed the Wellness Assessment as part of the Wellbeing Program. (choose one)

- I completed the Wellness Assessment in the past year
- I previously completed the Wellness Assessment, but did not in the past year
- I have never completed the Wellness Assessment

*Display Q29 if Q28 = I previously completed the Wellness Assessment, but did not in the past year*

Q29) Please say a little bit about why you are no longer completing the Wellness Assessment.

[Open-ended text box answer]

*Display Q30 if Q28 = I have never completed the Wellness Assessment*

Q30) Please say a little bit about why you do not complete the Wellness Assessment.

[Open-ended text box answer]

*Display Q31 if Q22 = I am currently participating in the Wellbeing Program, or I previously participated in the Wellbeing Program but am not currently participating*

Q31) Please indicate if you have ever completed the Biometric Health Screening as part of the Wellbeing Program. (choose one)

- I completed the Biometric Health Screening in the past year
- I previously completed the Biometric Health Screening, but did not in the past year
- I have never completed the Biometric Health Screening

*Display Q32 if Q31 = I previously completed the Biometric Health Screening, but did not in the past year*

Q32) Please say a little bit about why you are no longer completing the Biometric Health Screening.

[Open-ended text box answer]

*Display Q33 if Q31 = I have never completed the Biometric Health Screening*

Q33) Please say a little bit about why you do not complete the Biometric Health Screening.

[Open-ended text box answer]

*Display Q34 if Q22 = I am currently participating in the Wellbeing Program, or I previously participated in the Wellbeing Program but am not currently participating*

Q34) Please indicate if you have ever participated in WW at Work (Weight Watchers) as part of the Wellbeing Program.

- I currently am participating in WW at Work (even though it is not included in the Wellbeing Program in 2019-2020)
- I previously participated in WW at Work as part of the Wellbeing Program but am not currently participating
- I have never participated in WW at Work

*Display Q35 if Q34 = I previously participated in WW at Work as part of the Wellbeing Program but am not currently participating*

Q35) Please say a little bit about why you are no longer participating in WW at Work.

[Open-ended text box answer]

*Display Q36 if Q34 = I have never participated in WW at Work*

Q36) Please say a little bit about why you do not participate in WW at Work.

[Open-ended text box answer]

*Display Q37 if Q34 = I currently am participating in WW at Work (even though it is not included in the Wellbeing Program in 2019-2020), or I previously participated in WW at Work as part of the Wellbeing Program but am not currently participating*

Q37) To what extent do you disagree or agree with the following statements (Likert scale: strongly agree, somewhat agree, neither agree nor disagree, somewhat disagree, strongly disagree):

- My life is improved by WW (Weight Watchers)
- WW has improved my health
- Participating in WW is easy
- I feel like I have a better understanding of a healthy diet due to WW
- I feel like I have a better relationship with food and eating due to WW

*Display Q38 if Q34 = I currently am participating in WW at Work (even though it is not included in the Wellbeing Program in 2019-2020), or I previously participated in WW at Work as part of the Wellbeing Program but am not currently participating*

Q38) To what extent do you disagree or agree with the following statements (Likert scale: strongly agree, somewhat agree, neither agree nor disagree, somewhat disagree, strongly disagree):

- Learning about diet and nutrition through WW has changed how I plan meals or shop for food
- Learning about diet and nutrition through WW has changed how I choose what I eat
- Learning about diet and nutrition through WW has changed how I track what I eat
- Learning about diet and nutrition through WW has changed how I talk to my family/friends about food

*Display Q39 if Q38 = Learning about diet and nutrition through WW has changed how I talk to my family/friends about food [ Strongly agree ] or [ Somewhat agree ]*

Q39) Because you agreed with the statement that WW has changed how to talk to your family/friends about food, please say a bit about how things have changed.  
[Open-ended text box answer]

*Display Q40 if Q22 = I am currently participating in the Wellbeing Program, or I previously participated in the Wellbeing Program but am not currently participating*

Q40) Please indicate if you have ever participated in other eating-related programming as part of the Wellbeing Program. (choose all that apply)

- I have participated in telephone-based Health Coaching
- I have participated in the Create Your Weight program
- I have participated in Cooking for Wellness classes
- I attend the Farmer's Market to purchase food items
- Other (please specify)

Q42) Is there anything else you would like to share about the Wellbeing Program, Create Your Weight, WW at Work (Weight Watchers), or other eating-related programming in the Wellbeing Program?

[Open-ended text box answer]

Q43) Please indicate your age. (choose one)

- 18-24 years old
- 25-34 years old
- 35-44 years old
- 45-54 years old
- 55-64 years old
- 65-74 years old
- 75-84 years old
- 85-94 years old
- Prefer not to answer

Q44) Please select the gender you identify with. (choose one)

- Female
- Transgender Female
- Male
- Transgender Male
- Genderqueer/Nonbinary
- Intersex
- My identity was not listed (please specify)
- Prefer not to answer

Q45) Please indicate your race (choose all that apply).

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Prefer not to answer

Q46) Please indicate your ethnicity. (choose one)

- Hispanic or Latino
- Not Hispanic or Latino
- Prefer not to answer

Q47) What is your highest level of education? (choose one)

- Did not complete high school
- High school/GED
- Some college (no degree)
- Associate's degree
- Bachelor's degree

- Master's degree
- Advanced graduate work or Ph.D.
- Other (please specify)
- Prefer not to answer

Q48) Would you be interested in being contacted to participate in a voluntary follow-up interview?

- Yes
- No

*Display Q49 if Q48 = Yes*

Q50 Please provide your name and either a phone number or email address so the researcher can contact you for a follow-up interview.

[Open-ended text box answer]

## Appendix B: Narrative Inquiry Interview Questions

Note that in narrative inquiry, questions are meant to be guidance for the interview but not necessarily followed in order like a script. The list of questions below was my starting point for my interviews (see Chapter Two for detailed methods). I've noted for each question how I see it as connecting to the four commonplaces: temporality, place, inward conditions (feelings, hopes, reactions), and external sociality (existential conditions, environment) (Jones, 2016a).

Can you tell me a little bit about your experience with the Employee Wellbeing Program?  
(Follow-up: Can you tell me a little bit about your experience with eating-related programming in the Wellbeing Program?)  
*Commonplace(s): Inward conditions, external sociality.*

Can you walk me through a normal day for you in terms of food? Where and when and with whom do you normally eat?  
(Follow-up: What is important to you about food? About your diet?)  
*Commonplace(s): Temporality, place, inward conditions, external sociality.*

Can you tell me a little bit about how you feel about the diet and nutrition information in the Employee Wellbeing Program?  
*Commonplace(s): Inward conditions.*

How would you describe your relationship with food? (Follow-up: Can you tell me a story about food that feels meaningful to you?)  
*Commonplace(s): Inward conditions.*

Can you tell me a little bit about how, if at all, the Wellbeing Program has impacted your relationship with food?  
*Commonplace(s): Inward conditions.*

Can you tell me a little bit about how you use technology in your daily life in relation to eating, like websites or apps?  
*Commonplace(s): Temporality, place, inward conditions, external sociality.*

Can you tell me a little bit about how you feel about the self-tracking aspects of the Wellbeing Program?  
*Commonplace(s): Inward conditions, potentially external sociality.*

Is there anything that I didn't ask that you would like to discuss? Anything you would like to add?