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**Health, eating, and ‘healthy eating’:  
How New Zealand Pakeha ‘Key Kitchen People’  
relate food and wellbeing**

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## Abstract

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Food practices and health are complex cultural constructions. In Western cultures people construct and negotiate them with reference to a variety of health messages, experiences, and strategies for coping with the plethora of food choices they must make daily. Beliefs about food and health are important both for understanding people and cultures, and for applied reasons such as providing culturally appropriate and effective healthcare and advice. In New Zealand ideas of 'health' are increasingly linked to ideas about food and eating through media and medical discourses and everyday conversation, making an exploration of these ideas timely and relevant.

This thesis focuses on 'Key Kitchen People' (people who are the main food shoppers and preparers for their household, after Douglas, 1973), how they conceive of 'health', and what this means for the types of food they choose. Eight face-to-face, one-on-one, semi-structured interviews were conducted, along with observations of participants' pantries and fridges and discussions about their contents with regard to participants' conceptions of food-health connections. This project focuses on non-problematic eating and health and does not deal with eating disorders, weight problems, or chronic disease. Instead, I discuss how health is thought about, how food and health are connected, and how Key Kitchen People deal with the food anxiety this creates. The research demonstrates that 'health' is socially and personally constructed with reference to values, health messages, bodily feedback, and experience, and that food is inextricably connected to individuals' health experiences and conceptions. Because food was linked with health, participants also expressed feeling some anxiety over the foods they chose to eat, but coped with this by using 'common sense' and 'rules of thumb'.

The life practices that participants employed with reference to their ideas about health resulted in a range of negotiations between various tensions they encounter (for example, in relation to ideas about nutrition, processes of control and release, anxiety and risk, personal experience and received health messages) that both effect, and result from, connecting food with health. Participants created their own truths in the face of these complex and often contradictory discourses. In a society supposedly controlled by corporations and media, health, food, and eating are remarkably improvised and personal constructions.

## Acknowledgements

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## Chapter 1

## Introduction and Methods

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“No other fundamental aspect of our behaviour as a species except sexuality is so encumbered by *ideas* as eating...”

Mintz (1996:8)

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Food is important to everyone. Whether people are concerned about what they eat or not, every body must be fuelled by some form of food. Most people *are* interested in what they eat, however, and that makes food a fascinating and important area of academic enquiry. Scholars in the past were hesitant to study food at an everyday level because of its association with bodily functions. Traditionally, only pursuits of the mind were thought to be worthy of investigation; food was "gross" (Belasco, 2008:2-5), reductionist, a 'female subject', or simply went unnoticed (Beardsworth & Keil, 1997:3-4). Food, however, is an important topic (Caplan, 1997; Counihan, 1999:6), and an area that is of great interest to anthropologists (Mintz & DuBois, 2002:100). One reason for this is that food has powerful "psychological, economic, physiological and political meanings" (Harbottle, 1997:87) which are intertwined and individually nuanced. Food is also "a critical contributor to physical well being, a major source of pleasure, worry and stress, a major occupant of waking time and, across the world, the single greatest category of expenditure" (Rozin, Fischler, Imada, Sarubin & Wrzesniewski, 1999:163). Alongside this importance, food means many different things cross-culturally and deserves a great amount of scholarly attention to unravel the many intricacies involved in its purchase, preparation and consumption (Counihan & Van Esterik, 1997:1).

Despite this complexity, Belasco (2008:ix) says: "There is nothing more basic than food", and he is correct; eating is one of the simplest functions an animal can perform, and one of the basic building blocks of life (Beardsworth & Keil, 1997:50). However, he goes on to explain that our cultural treatment of food is anything but basic: "[food is] our biggest industry, our most frequently indulged pleasure, and perhaps the greatest cause of disease and death". He explains that "we can't live without food, but food also kills us". The implications of this last point are perhaps what makes the study of food quite so complex, contradictory, and fascinating: the idea that while people love food, they are also afraid of it.

One could be forgiven for thinking that in New Zealand we are geographically far enough away from the culture of food fear that appears to be developing in the UK and USA (cf. Pollan, 2006) for it not to affect us. Both academic and anecdotal evidence suggests otherwise. Veart (2008:295) says that “New Zealand food culture has changed more in the past 30 years than it has in the previous 100” (see also Chamberlain, 2004:468) and that “never before in human history have people been so scared of what they eat...”, even here in New Zealand. A New Zealand exploration into ideas and concerns about food is important. One facet of this concern is food’s connection to health (Lupton, 1996:6), and this is where the main focus of this study stems from: the desire to know how this food-health connection manifests itself in those who cook for others.

This thesis is an exploration of the meanings of ‘health’, healthy eating, and food choice among a selection of Pakeha<sup>1</sup> Key Kitchen People (KKP) living in north Auckland, New Zealand. A Key Kitchen Person is the person in a household who is primarily responsible for meal planning, food shopping, and cooking (Douglas, 1973:17). This research is focussed on the ways some New Zealand Pakeha KKP conceptualise these themes and act on their conceptualisations. I have centred the research in this way because ideas around health, food, and food habits are far from universal; they are instead socially constructed (Chen, 2009:53; Conner & Armitage, 2002:7; Germov & Williams, 2004:4; Madden & Chamberlain, 2004:584). This means that food and eating are very much about ideas as well as nutritional sustenance. Mintz (1996:8) goes as far as to say: “No other fundamental aspect of our behaviour as a species except sexuality is so encumbered by *ideas* as eating...”. Anthropology, as the study of social and cultural behaviours and ideas, is uniquely positioned to investigate this aspect of food, and in doing so reveal information about people’s “social and cultural selves, as well as...[their] individual subjectivities” (Caplan, 1997:1).

Academically, I chose this topic because both food practices and health beliefs are identified as being important – both for understanding people and culture, and for more practical reasons such as designing appropriate and effective health campaigns. In New Zealand, ideas of ‘health’ are increasingly linked to ideas about food and eating. For example: there are government funded advertisements on television and in magazines explaining what constitutes ‘healthy eating’ and a number of food magazines

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<sup>1</sup> ‘Pakeha’ is used to mean a self-identified New Zealander of European descent.

and websites now either contain a 'healthy cooking' section, or are entirely focused on helping New Zealanders eat healthier. One example of this is the popularity of the magazine *Healthy Food Guide*, which is published monthly, with each issue being read by 330,000 people (*Healthy Food Guide*, 2010). The magazine includes a large variety of advice on food-health related topics, such as fibre, vitamins, eating for pregnancy, and eating with various allergies, as well as a monthly selection of 'healthy' recipes developed and tested by nutritionists. On the New Zealand Ministry of Health website for the *Healthy Eating, Healthy Action* initiative, four of the eight key health messages are food related, such as "eat a variety of nutritious foods", "eat less fatty, salty, and sugary foods", and "eat more fruit and vegetables" (Healthy Eating, Healthy Action, 2010). There have been a number of studies done in other countries (mainly the U.S.A) that look at this connection between health and food (e.g. Blaxter, 2010; Seal, 2002; Smith, 2002); this study aims to add a New Zealand perspective to this growing body of knowledge.

From a personal perspective, food is of great interest to me. Food in my family is given a central place in daily life – a day without a tasty, well-prepared meal is almost a day wasted. My mother and I (both KKP ourselves) have often wondered what other people think about food, and this research was my chance to peek at one aspect of this question: food and health. The 'health' focus of this project has a personal significance also. Through both my own and a friend's experiences with long-term illness, the kind that must just be 'waited out' – in my case for a year, in hers a lot longer – food became one path to health recommended by everyone. Friends, parents, doctors, and alternative health practitioners all spoke of food as key to health. The recommended eating behaviours differed, though, leading me to question how people connected food to health. Clearly these things are linked for many people, so combining my own passion for food and the interesting questions around how people see it as connected to health resulted in this choice of research.

Consequently, the key issues to be investigated in this research are 1) conceptions of health; 2) how food and health might be connected; and 3) how food choices are navigated. No one has, to my knowledge, previously investigated these three things in connection, especially not in New Zealand, giving this research a unique focus and perspective. Another way my study differs from many others is that it focuses on KKP. Neither the term 'Key Kitchen Person', nor the idea behind it is widely used or researched. Despite, what seems to me, the obvious importance of this person within the

home, much modern research fails to account for them. The older research (before the 1990s) is focused more on women feeding their children and pleasing their husbands, but few studies looked at healthy eating or healthy eating attitudes (Margetts, Martinez, Saba, Holm, & Kearny, 1997:24). It seems to me that in this age of concern over diet and health, the people doing much of the food shopping and cooking should be more of a focus. Combine with this the fact that research into how people make sense of health in their everyday lives is becoming more popular (Sargisson, 2004:7) and the significance of this project is apparent.

### **Aims**

Pollan (2008:8) explains that “food is about pleasure, about community, about family and spirituality, about our relationship to the natural world, and about expressing our identity”. Here is where cultural anthropology can really be useful. Anthropology can be used to investigate why people do what they do, how they feel and why, and most importantly, can do so in a way that is non-judgemental, and often involves no ‘corrective’ action. This study looks at the food-health connection, not from a scientific or nutritional health basis, but from a phenomenological approach, based on people's own reports of their behaviour, experiences, and motivations. It is recognised that this approach can give a deep and rich understanding of eating habits and food related behaviours (Cohn, 1997:193). This study aims to:

- a) explore how and what KKP think about ‘health’
- b) find out whether and how they connect food and health, and
- c) understand how they make food choices in light of this

By answering these questions, I hope to gain a better understanding of how some Pakeha people in New Zealand understand their food-health experiences.

Much of the food-related literature within anthropology is concerned with food meanings and symbolism with regards to gender, power, and security, but generally not in terms of health perceptions. In this regard, Mintz and Du Bois (2002:111) point out that “...anthropologists are in a good position to make useful contributions to the development of policy in regard to health and nutrition....By and large, though; they have not taken full advantage of this opportunity”. This study aims to use anthropological method and theory to investigate ideas about health and eating so as to better understand what these issues mean to people 'on the ground'.

This has both academic theoretical significance and a wider, more practical significance. Theoretically, I am exploring an area no one else has looked at – KKP food-health conceptual linkages in New Zealand. This contributes, albeit modestly, to the body of knowledge we have about food and health from other countries (for example: Australia, Sweden, U.S.A, and Britain). It also adds to academic discourse about food-health conceptions and behaviours in general. Linking this research with that of established scholars in the area, in each chapter I apply other scholars' theories to my own research population in a somewhat comparative way. Practically, this research may be of use to those designing health campaigns, as it gives insight into one area of health that can be overlooked: the existing health beliefs people have, and how they affect behaviour.

### **Methods**

While health and food are important issues for everyone, this study needed to centre on a particular group or area within society to be manageable in the time frame provided. Ideally, multiple studies would be done, focussing on different cultural groups and what health and eating mean to them, but practically this research could only focus on a small number of research participants. I suspect that members of different social and ethnic groups have very different ideas about what health is and what constitutes 'healthy eating', so I limited my sample to a small number of Pakeha New Zealanders who reside in the Auckland region of New Zealand.

Maori and Pacific Island people are often the target of health messages and initiatives, and while it is important to study and understand this group so as to further these programmes, I am not a member of either group and did not feel comfortable researching in this area. I do not have any special knowledge of either group and did not feel that I would be able to do them justice in the time I had available for this study. New Zealand Pakeha participants were appropriate for me to research because I am a member of that group myself and have previous experience researching them. Herda and Banwell (1988) found that Pakeha people (women, in the case of their study) were far more concerned with food, and talked about food and health a lot more than their Maori or Pacific counterparts.

To reiterate: the use of the word 'Pakeha', here, means a person of European descent who was born in New Zealand, and self-identifies as a member of this group (as opposed to thinking of themselves as 'Dutch', for example). Within this group of

Pakeha New Zealanders, my focus is on people who are the main food-providers, on a regular basis, for at least one other person in a domestic setting. I define this as a person who regularly purchases and then prepares meals for one or more other person(s) at least four times a week. Eight 'Key Kitchen Person' participants were recruited using the above criteria and a snowball technique, three of whom were male, and five female. I also have a mixture of ages (ranging from 20 to 50) and a range of domestic situations, from flatting, newly married, couples with grown up children or younger children still at home, and remarried divorcées with joint custody of children.

Because food is such a complex and personal subject for many people, the main research method used in this research was semi-structured, in-depth, face-to-face interviews. This research method has been used and recommended by a number of food researchers (cf. Caplan, Keane, Willetts, & Williams, 1998; Herda & Banwell, 1988; Hubert, 2004; Lewis, 2003). Lewis (2003:58) says, for example, that very complex subjects are best addressed using one-on-one interviews because it allows for a depth of focus and permits the researcher to clarify points and ask questions. Similarly, Hubert (2004:45) states that when researching food in the home "conversations should be held with the person in charge of cooking and/or shopping", which is what I have done. Because of my focus on Key Kitchen People, I elected to conduct the interviews in the private homes of my interviewees, which had two main benefits. Firstly, Lewis (2003:58) points out that it may be easier to get beyond 'socially desirable' interview answers if the interviewee is in a space they feel comfortable in, and secondly, interviewing in the home, and more specifically at the kitchen table, had the added benefit of situating the interview within the setting I was investigating: the kitchen and dining room.

I had originally planned to include food diaries in this study, following the example set by Herda and Banwell (1988). After much thought on this, and re-reading their discussion of their food diaries, I abandoned this idea. This is because I did not want to place too much of a burden on my participants, and Herda and Banwell explain that their participants found filling in food diaries time consuming and a hassle, and that much of the information recorded was not useful anyway. In the interest of time management and participant concern, I did not elect to use food diaries in my research.

In terms of the interviews themselves, I adapted questions from Hubert's (2004) work to use as prompts for discussion (see Appendix C), but let participants take the conversation where they wanted. This led to a number of interesting points brought up

by participants themselves, which gave me insight into what was really important and relevant to them. I followed Caplan et al.'s (1998:172) example, and "made every effort to elicit the reasons people themselves gave for eating or not eating certain foods". However, people are not always honest or aware, "thus [Caplan et al.] followed standard anthropological practice and [sought] to manifest some implicit and recurring themes and patterns...". For me, this meant not only talking to my participants about what they bought and cooked for themselves and others, but having a look at and discussing the contents of their pantries and fridges with them. It was hoped that this would reveal any contradictions between belief and behaviour that are so notoriously present when asking people about food (discussed below). This worked to some extent, in that I as a researcher could more clearly understand what participants were talking about and gain a better understanding of their ideas about health, but participants themselves did not point out contradictions, only explained exceptions to the rule. I took photographs of participants' pantries and fridges, and have included some of those photos in this research to illustrate certain points. It is possible that some participants 'tidied up' their fridges and pantries before I came, but I didn't see any obvious evidence of this. A couple of participants told me they had meant to "have a clean up", but did not get around to it. I took this to mean that my looking through their fridges and pantries was not a particularly high priority or worry.

When researching food in the literature one consistently encounters the idea that belief and behaviour, or reported action and actual action can be very different things. This can have serious repercussions for food researchers, both in the social sciences and nutritional sciences. The idea is that just because an informant tells you something, or claims to value something, does not mean it happens in practice (Ajzen & Timko, 1986; Caplan, 1997:7; Charles & Kerr, 1988:131; Medina, 2004:59). It can, in fact, be quite difficult for researchers to build up an accurate picture (Allan & Crow, 1989:1), and "One can not lose sight of the fact that there is a gap between subjects' discourse and their actual practices" (Medina, 2004:60). This gap can happen for a number of reasons such as perceived social desirability, cultural values, embarrassment, guilt, miscalculation, and forgetfulness (cf. Macdiarmid & Blundell, 1997:199). The way respondents present themselves and their lives is often not quite how it is, and health knowledge does not necessarily translate into health behaviour. I tried to overcome this disparity in number of ways. Firstly, I used face-to-face interviews, so respondents would feel responsible and personally accountable for the information they gave me. I

conducted these interviews in a relaxed and non-judgemental way in an attempt to get past social biases and find out what my participants really thought. I also did not ask for any information regarding the amount of food my participants ate, so under-reporting in terms of quantity is not a problem in this case. Lastly, I looked at and discussed the contents of my participants' pantries and fridges in an attempt to highlight any contradictions found there with the information they had given me during the interview. In actual fact, I did not find evidence that my participants had misrepresented their behaviour to me.

While these fridge and pantry rummages were very interesting, I became aware that what I was looking at in my participants' kitchen was predominantly the food they had *not* eaten. Many of the pantries and fridges displayed mostly the remnants of past meals, or foods that were minor components of meals, such as sauces, marinades, and spices (see figure 1 and figure 2). This suggests that my participants go shopping often to stock up on fresh foods.



**Figure 1: Peter's fridge filled mainly with condiments (June, 2010).**



**Figure 2: Evan's fridge, the day before going grocery shopping (June, 2010).**

While I looked at participants' fridges and pantries to gain insight into their cooking and eating behaviours, I recognise that disparities are still probably present between what they told me and their actual behaviours, but feel that my participants were as open and honest with me as they could be, and the behaviours and beliefs they reported were how they saw themselves as living. Because one aspect of this research concerns how beliefs affect behaviour, these issues were important for me to consider, but on the other hand, the research is about Key Kitchen People's feelings, and I did not get the impression that they distorted these. While contradictions, distortions, and disparities to do with reported versus actual behaviour are important, I do not feel that they have impacted significantly on this research.

Some of the research choices I have made differ from those made by other researchers. I have chosen, for example, to research middle-class Pakeha New Zealanders. Much research into food focuses on marginal or minority people, or cultures that are not the researcher's own. My study differs in that I am a member of the

culture I am studying, which is the, so called 'mainstream' middle class Pakeha culture of New Zealand. I chose to do this for two reasons. Firstly, because I am an insider I feel I may have a different understanding of the culture than an outside researcher, even someone from the UK or USA, and that because of this I can offer different insights than a non-native researcher. I chose Pakeha New Zealanders because very little research has been done on how they think about health or food, many health campaigns are *not* aimed at them, and as Herda and Banwell (1988) found, Pakeha people are very concerned about and interested in food (it was in fact, very difficult for them to get information from Maori or Pacific Islander participants). I only interviewed middle class participants, firstly because they were the only ones to volunteer to take part, and secondly because other researchers have found that middle class citizens are more likely than anyone else to be concerned about and act on ideas about health (Backett, 1992:257; Markwick, 2009:37). I chose to research in Auckland because of convenience.

Another difference in my research is that I chose to include men as well as women in my study. A number of works focus only on women, especially when discussing food shopping and preparation, or health within the domestic sphere. Some research suggests that men are becoming more involved in KKP duties (Kemmer, Anderson & Marshall, 1998), so I chose to include them. Similarly, Caplan, et al. (1998) felt it was important to include men in their study, but stated that "It did, however, prove somewhat more difficult to recruit male informants.... Many men tended to consider food a female topic...". I did not encounter this problem, perhaps because my research was conducted at least a dozen years after those cited here. Including men was very worthwhile because, as will be discussed in the next chapter, men and women can have very different ideas about health and healthy behaviour, so to include both in a discussion of Key Kitchen People is important.

There have been definite shifts in gender related power and responsibility within the home. Researchers such as Charles and Kerr (1988) found that women had nearly all of the food duties in a home, and felt very responsible for their whole families' health, but had very little power to choose what foods were served. This power fell to the man of the household, generally a father or husband. This pattern has now somewhat reversed itself. I found that, for my participants, women KKP had a lot of power to choose family meals, but did not report feeling particularly responsible for their families' health, while the male KKP reported deferring to their female household

members' food preferences – especially with regards to 'healthy' food. The fact that women appear to have greater power in the kitchen than men may be because of their long-standing identities as KKP and that they are thought to have more knowledge and a greater investment in family wellbeing. These changes reflect larger societal changes regarding gender equality and the growing agency of women, and the increasing acceptance of stay-at-home fathers, house husbands, and male KKP.

As well as including men, I am not taking an explicitly feminist approach to this research. During the planning stages, a feminist perspective was my aim, but after doing some reading and preliminary research I began to feel concerned about the invisibility of men within the topic of food in general, and definitely in the domestic space. Within many texts males were left out or semi-vilified (cf. Snape & Spencer, 2003:9), which did not match my experiences with food and gender. Thus, I designed this project to include both men and women (although more women have been interviewed because they do still do most of the work in the kitchen). As Cohn (1997:193) says: "Recently it has been recognised that an anthropological concern with food would benefit from alliance with the renewed interest in phenomenological concepts of embodiment and lived experience", and in my research this means the lived experiences of both men and women. It also means that no longer do we want to just read food as a form of text which can reveal things about a culture to us; we want to know how people do it, feel it, live it, and experience it. Cohn (1997) goes on to say that "...by concentrating on the textual aspects of food culture, individual dietary choices, the experience of eating, and how these relate to personal ideas about the self and the body are ignored" (p.193). I took this to heart when analysing the data for this thesis. I paid particular attention to the personal ideas my participants revealed to me, and focussed on their individual experiences and explanations. In doing this I was able to identify recurring themes in the interviews, both within and between participants' explanations, and formulate answers to the aims stated above.

### **Ethics**

Ethically, this project was not high-risk. In the interest of getting my thinking in order before starting the research, however, I applied for, and received, approval from the Massey University Human Ethics Committee (MUHEC) using a full ethics application. There was little risk associated with the interview participants, unless they chose to talk about something that was emotionally distressing for them. It is widely recognised that

many people have unresolved negative issues surrounding food, so talking about it to a researcher may bring these issues out or make the participant uncomfortable. This did not eventuate, but in the event that it had, I was prepared for participants to reschedule the interview for another time, take a break, or leave the study altogether. They were under no pressure to answer any of the interview questions, or any of the questions asked during the pantry/fridge rummage.

Potential interviewees were contacted either in person or by email, and were emailed an information sheet about the study (see Appendix A). If they were still interested an interview time was set up to suit them. At the interview they were given a hard copy of the information sheet to re-read and keep and were given the opportunity to ask any questions about the research before committing. After they were satisfied, they were asked to sign the interview consent form (see Appendix B) and to provide a pseudonym to protect their identity. Most participants felt very comfortable with the research topic and elected to use their nickname or middle name. Many expressed the idea that anonymity was unnecessary, but I felt it was good practice. The interview then commenced, roughly following the guide in Appendix C. At the conclusion of the interview we looked through and discussed their fridge and pantry, and I took some photos. All participants were more than happy to show me around and talk about their food. Again, they were free to ask questions.

Two weeks to a month after the interview I posted each participant their interview transcript, a photo sheet, and a transcript release form (see Appendix D). Participants were asked to check their transcripts and to sign any photographs they felt happy to have me use. Some interviewees made minor changes to their transcript to clarify points they felt they had not expressed as well as they liked, or to take out information they wanted to keep private (specifics such as workplaces, dates, and family members' names). Changes were minor and did not affect the meaning of the content. All signed the transcript release, and all photographs were given permission to be used. During the writing process some participants were contacted via email to clarify points or offer further explanation. Every care has been taken to ensure that their words and images have been used respectfully, in the correct context, and with academic integrity.

Many of my participants commented that they enjoyed the interview process, and that it had got them thinking about things they usually took for granted, or were unconscious of. Many were proud of their pantries and fridges. Jo's pantry was

especially organised and diverse (see figure 3). Despite seeming comfortable with the fridge and pantry rummage, many participants remarked that they usually had more fruit and vegetables than were evident while I was there, even though a couple of participants had large, well stocked fruit bowls in their kitchen. In many of these cases my participants told me that the interview had fallen on the day before shopping day, meaning their food stocks were depleted. Anna proudly showed me around the shed inside her garage which was full of recently killed and butchered beef (see figure 6), which had come from a cow she had raised, and asked me to take some pictures of it for my research. Everyone seemed to enjoy talking about food and their experiences and thoughts about it, making this research a pleasure to conduct.



**Figure 3: Jo's very organised pantry (June, 2010)**

### **Participants**

All participants of this study were volunteers, and were chosen regardless of their life stage or domestic situation. Kemmer (2000:330) explains that it is important not to focus on a 'normal' family or domestic situation, because she argues that, today, there are none. She states that families that could be described as 'normal' or 'nuclear' now make up less than a quarter of all the households in Britain. This is increasingly true for New Zealand also (Statistics New Zealand, 2010:4), with different household types such

as single-person, and non-family groups set to increase at a greater rate than ‘family’ households. For this reason, male and female KKP were recruited in all their variety.

*Cath* is 25 and works part-time at a retail store while she is studying her MA. She lives with her boyfriend and cooks for him nearly every night. She is very interested in food and enjoys cooking new things from different countries and finding healthier ways to cook everyday foods.

*Elizabeth* has just turned 50 and lives with her husband and adult son, and has an adult daughter away at university who comes to visit. She prepares three meals a day for whoever is home, and has been doing so since she started a family. She says she enjoys cooking, but sometimes wishes she could take a break, or that someone else would do it for a few days.

*Evan* is 21 years old and is taking a gap-year working as a film projectionist. He lives with, and cooks for, himself and his male flatmate in a small apartment. He enjoys cooking a lot, and despite being a big fan of Jamie Oliver, rarely uses recipes, preferring the freedom of making it up as he goes along – which works surprisingly well.

*Peter* is in his mid to late twenties and works in traffic control. He lives with his wife of one year, Sara, and does nearly all the cooking. He likes to be adventurous with the flavours he uses and says he is in the process of teaching his wife to enjoy more spicy and flavourful foods.

*T.J.* is in his mid to late forties and works as an electrician. He lives with his partner, Jane, and has shared custody of his two teenage children. While his partner does some of the cooking, she works longer hours than he does, so T.J. takes responsibility for most of the shopping and food preparation. He describes the bulk of their meals as ‘European’, meaning English, Italian, and Mediterranean inspired.

*Marie* is a newly married 22 year old student who lives with her husband. Because of his demanding job, she has ended up doing most of the household foodwork, even though she does not particularly enjoy it. She is both health and time conscious, and

likes to spend as little time cooking as possible, but says she does enjoy eating the results of her work with her husband.

*Jo* lives with her partner and two children, both of whom are now at an age where they can start helping in the kitchen. *Jo* is a (fish eating) vegetarian, while neither her children nor her partner are. Despite having an increased workload and longer hours, she does most of the family's cooking and shopping, and is quite health conscious about it.

*Anna* has three children, all in their mid to late teens, and a husband who she cooks for. She lives on a lifestyle block and has a selection of farm animals which the family raises and home-kills for meat. She is very health conscious, and while she does not enjoy cooking particularly, she does enjoy eating.

### **Structure of thesis**

I will move on, in chapter two, to a discussion of the literature relevant to food, health, and KKP. Following this, in chapter three, I discuss how health ideas were formed by my participants, what sources of information they utilise, and their personal definitions of health. I come to the conclusion that there is a dominant public discourse about health, as well as alternative, and more personally relevant sources of information and experience, and my participants construct their own life practices in relation to these discourses, but in various and shifting combinations of acceptance, rejection and modification. This leads into chapter four, where I explore how these ideas about health connect with food.

Because my participants linked the food they ate with the health they experienced, they felt anxiety over their food choices. I discuss this, and the coping strategies they use to minimise these worries in chapter five. Once again, these coping strategies are devised in response to an evaluation of information from different sources, and a selective acceptance, rejection, and modification of ideas. In chapter six, I summarise the research with regards to future direction and what could have worked differently in the project. I conclude that my participants show a remarkable degree of agency in a culture so supposedly 'controlled' by the media, and that health, food, and eating are personal, complex, and remarkably improvised constructions.

## Chapter 2

# Literature Review

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“...food should be of critical importance to anthropologists since it affects all human beings and their relationships and activities...”.

Marwick (2009:33)

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This study originated as a response to Herda and Banwell’s (1988) work with New Zealand women. They were researchers in a nationwide study on the place of alcohol in the lives of New Zealand women, but the sheer amount of information that was incidentally collected about women’s views on food was deemed important enough to warrant separate investigation. Herda and Banwell, therefore, looked at the *Meaning and use of food among New Zealand women*. The fact that food was so important to women, especially those with families, that they would talk about it even when asked directly about something else, sparked my interest in this area. Herda and Banwell’s work also introduced me to the idea of ‘Key Kitchen People’ (KKP – a term originally from Douglas, 1973), and the over-arching ideology behind this research that “people’s use of food, while seemingly illogical to nutritionists and economists, is sensible within the context of the social sphere in which they operate” (Herda & Banwell, 1988:15; cf. Blaxter, 2010:89). This is a key point on which I built this research: that everyone’s behaviour is right for them, and makes sense within their own system of meanings. I have tried to remain impartial and non-judgemental with regards to the ‘rightness’ of participants’ ideas. While many works in this area are undertaken to help improve health or to find better ways to educate people (cf. Backett, Davison, & Mullen, 1994; Charles & Kerr, 1988; Mead, 1943; Pollan, 2006), I sought only to understand how people made sense of food and health in their lives.

I chose to use the concept of KKP because I felt these people would have the important and sustained contact with food, and a responsibility to others, that would mean they had a deep relationship with food. There are, of course, many people who have a deep understanding and relationship with food, not just KKP, but I wanted to work with people who cooked for those they love, because the themes I wanted to explore (responsibility, health, risk, negotiation) seemed as though they would be particularly salient. I included male participants as well as female because there is evidence (see below) that they are becoming more common as KKP, as opposed to 1988

when Herda and Banwell did their research. My research is heavily influenced by the increasing importance of ideas to do with ‘health’ connecting with food.

Shaping this research further was Margetts et al.’s (1997:24) assertion that “...few studies have looked at what consumers understand by healthy eating or their attitudes to healthy eating”. I found some research to guide me in this area (cf. Backett, Davison, & Mullen, 1994; Davison, Davey-Smith, & Frankle, 1991), but while ‘health beliefs’ and their formation is the subject of much research in Western culture (cf. Lorber & Moore, 2002; Senior & Vivash, 1998; Shukla, 2001), how this fits in with food and healthy eating is not as widely explored. For example, Davison et al. (1991) used ethnographic research methods such as participant observation, semi-structured interviews, and informal discussion to investigate lay understandings of health in Wales, with special attention paid to cardiovascular health. They had participants describe ‘the kind of person who gets heart trouble’ and analysed responses to see how participants formed these ideas. They came to the conclusion, as does much research in this area (eg: Aldridge, 2004; Seale, 2002) and as do I, that lay people’s health beliefs are developed with reference to a wide range of sources including health messages, advertising, family, friends, and personal experience. I have used Davison et al.’s (1991) work to guide my thinking about how lay and scientific understandings are linked. In particular, they identified a wide range of social and cultural influences on health beliefs, including a strong influence from scientific/biomedical messages, which were useful to my analytical framework.

Also relevant to my investigation was Backett et al.’s (1994) work, which combines three ethnographic studies from Scotland, England, and Wales to investigate how people think about health and incorporate public health messages into their ideas. They found, similar to Davison et al. (1991), that social and cultural knowledge has an impact on how, and whether, people accept and act upon health messages. This was a useful point to keep in mind during the interviewing process, as it prompted me to dig deeper into participants’ reasons for their actions to try and elicit their understanding of how their culture affected their food and health beliefs. However, neither Davison et al. (1991) nor Backett et al. (1994) investigated how people then acted on, or used, the beliefs they so carefully created and negotiated. I used Wardle, Haase, Steptoe, Nillapun, Jonwutiwes, and Bellisie’s (2004) work to fill this gap. They studied the effects of health beliefs on healthy food behaviour and found that beliefs about health have a significant effect on actions involving food, eating, and food choice (see also:

Conner, 1993). Their research was survey-based and spanned 23 countries (of which New Zealand was not one), and focussed on gender differences in healthy eating. They found that “Gender differences in beliefs in the importance of healthy eating explained a substantial amount of the gender differences in food choice...” (p.13), and that different health beliefs led to different behaviour. My research adds to the evidence that health beliefs and food choice are connected.

Unlike Wardle et al. (2004), my research is anthropological in nature. I drew on previous anthropological work in the area of food to guide my methods and thinking. As Beardsworth and Keil (1997:57) point out, different emphases have come in and out of fashion when it comes to the social sciences and food research, and while my work fits in with the current interest in health, nutrition, and eating, earlier research provides an important context and platform. Modern anthropological food research has been influenced by Mead in the 1940’s (Mead, 1943), Levi-Strauss in the 1960’s (cf. Caplan, 1997; Levi-Strauss, 1973; Lupton, 1996:9; Mennell, Murcott, & van Otterloo, 1992), Douglas in the 1970’s (cf. Caplan, 1997; Douglas, 1978; Douglas, 1998), and Mintz in the 1980’s (Mintz, 1986). What sets these anthropologists apart from their earlier counterparts is that they studied food within their own societies, a trend that has continued in current food research.

These anthropologists all saw food as an important cultural system that can be examined and interpreted to say something meaningful about a society or culture. Mead (1943) was part of a special government task-force set up after the First World War in North America to try to assess and improve the population’s diet. She analysed how food worked in a social and cultural context, and how the acceptance or rejection of foods connected with identity. She explains that people (even in the 1940’s) were subject to moral evaluations of ‘good’ foods and ‘bad’ foods, and that their choices about these were influenced by their self-identity. Specifically, she says that males may purposefully choose ‘bad’ options as a way of asserting their maleness and control (p.137). Hence, Mead learned about how gender, power, and food were related in North American culture at the time. This is still relevant, and scholars are still investigating these issues (Counihan, 1999:12, 124; Fiddes, 1997), and the idea that our food choices are linked to our identity is still a powerful one (see Caplan’s (1997) edited book *Food, Health and Identity*, or Lupton’s (1996) *Food, the Body, and the Self*).

Levi-Strauss (1973:87) believed that food could be treated as a language and ‘deciphered’ to tell us about a culture, especially constructs within a culture that may be

unconscious. He maintains that within cultures one can observe different ‘levels’ of foods, which are only eaten by certain members of that culture, delineating attributes of power, prestige, and class. One example he gives is that of fried or boiled foods, which were considered different from roasted because they are more ‘cooked’ and therefore more ‘cultured’. Levi-Strauss maintains that whether a society values this in a food or not indicates whether the food is of high status or low. He explains that roasts used to be thought of as ‘common food’, with boiled and fried food being ‘higher class’ because they were more cooked, and therefore more cultured. In the 21<sup>st</sup> century, however, the opposite is true. Modern Western food is thought to be ‘more cultured’ when it has had less cooking, a notion directly related to health and nutrition beliefs, as well as trends in taste. By looking at ‘foodie’ magazines such as *Cuisine* we see that roasting is now trendy with the middle class, and with the rise of the raw organic movement, uncooked food has become classy, desirable, and even morally superior; cultural ideas about “raw and cooked” have changed a great deal (for further discussion of how Western societies are changing their ideas about ‘nature vs. culture’ in food, see Caplan, 1996:215, 222; Fiddes, 1991:45).

Following this, Douglas also believed that food could be treated as a language, but chose to focus not on individual foodstuffs or cooking methods, but on the symbolism of the structured meal (1972) and on concepts of purity and danger (1978). Unlike Levi-Strauss, she concentrated on decoding food messages at the level of “small-scale social relations” (1972:62), which she argued was where the codes and languages of food are created. In her work *Deciphering the Meal* Douglas maps out how the pattern of a family meal can be analysed to give information about the time of day and year, a person’s life cycle, and the emotional closeness of the people being fed to the person doing the cooking (1972:66). She says that, with food, “The message is about different degrees of hierarchy, inclusion and exclusion, boundaries and transactions across the boundaries” (1972:61). Later in this same article, and in her book *Purity and Danger* (1978), these boundaries are discussed not only in terms of social boundaries, but in terms of what is edible and what is not; what is culturally deemed ‘pure’ food, and what food is ‘unclean’ or ‘dangerous’. These ideas were especially relevant to my work because they link with concepts of food ‘pollution’ and ‘safety’, which has a strong connection to cultural conceptions of food related health. As pointed out previously, Douglas is the creator of the term ‘Key Kitchen Person’ (Douglas, 1973:17).

What these anthropologists have in common is that, as well as treating food as a symbolic language to be deciphered, they all draw attention to the fact that food is a highly cultural object and source of activity. Mintz's (1986) widely cited and respected work on sugar makes this point explicitly. In *Sweetness and Power* he details the rise of sugar from being relatively unknown in the west in 1000AD, to a luxury good by 1650, to a necessity by 1800, to making up one-fifth of the calories in the English diet in 1900 (pp.5-6). He explains that this rapid rise in popularity has been due not only to taste, but to the power and prestige that sugar came to represent. As he points out, "What constitutes 'good food'... is a social, not a biological matter" (pp.8). If, as has been found by these anthropologists, food preferences, tastes and ways of thinking about food are cultural constructions, it stands to reason that food related health will have a strong connection to society and culture, despite the scientific/biomedical focus it is often given in public discourse.

Interestingly, historically the anthropology of food has had little focus on health and how it connects to eating practices and ideas (with the exception of Mead, 1943), but this is starting to change. Lupton's (1996) book *Food, the Body and the Self* is a much respected anthropological work, which while not focussed on the health aspect of food, does touch on it, especially in her discussions of 'good' and 'bad' foods and the morals that develop around them. She says, for example, that eating 'bad' foods can denote weakness and a lack of self-discipline, while 'good' foods carry connotations of purity and moral rightness (p.27). Counihan (1999), another key writer on the anthropology of food, also focuses on the morals of eating and how they can connect to health, pointing out that even as people try to follow nutritional/moral guidelines, they may only have a vague understanding of what they are eating and why. This linking of a wider moral discourse with health and eating has come to be prominent in the literature (cf. Coveney, 2006; Rozin, 1997). I explore ideas around food, health, and morals in chapter four.

Furthering this modern anthropological concern with food and health is the book *Food, Health and Identity*, edited by Caplan (1997). This book, and Caplan's introductory chapter in particular, was key to the development of this thesis, as she maintains that food is intimately connected with health (p.3). Caplan suggests that a way to understand new trends in food consumption and health is to find patterns in thought and behaviour (p.5). She proposes that discourses of 'risk', 'moderation', 'balance', and the idea that 'unhealthy' behaviours can be life-enhancing (p.20) are key

to understanding food and health from an anthropological perspective. These themes became very apparent in my research, and I was able to follow up many leads and references from Caplan's work to enhance the theory and analysis of my own (for example: Beck's (2002) seminal work on 'Risk Societies' and Fischler's (1988) work on the 'Omnivore's Paradox'). Further encouraging my approach, Mintz and Du Bois (2002) in their book *The Anthropology of Food and Eating*, insist that anthropologists have not paid enough attention to food and health, and that anthropology could provide very useful tools to help understand and improve these areas of our lives (p.111).

Anderson's (2005) *Everyone Eats: Understanding Food and Culture* helped refine some of my thoughts about using anthropology to understand food and health. He warns against making food and food choices seem more structured than they really are (as anthropologists tend to do when treating food 'as a language'), saying that food is messy, improvised, and disorganised in everyday life (p.111). This was a caution about making too many generalisations in my work, and seeing patterns when perhaps there were none. However, in the course of interviewing participants, I found their food beliefs and activities to actually be fairly structured and organised. As Anderson points out, people may have an innate need to control their environment, leading to food choice being an important factor in this control, and to food choice being relatively organised and systematic. This contradiction is resolved with Anderson's statement that "Experientially and phenomenologically... people are simple functionalists sometimes, complex meaning-generators at other times" (p.7).

Because food is so inextricably linked with culture, anthropology is the ideal discipline with which to study it. Markwick (2009:33) sums it up perfectly when she says "As humankind's most important concern, food should be of critical importance to anthropologists since it affects all human beings and their relationships and activities...". Food is so tied up with culture because taste is socially constructed (Chen, 2009:3-8), as are ideas about what constitutes food (Meigs, 1997), what is socially appropriate, and what is 'healthy' (Shukla, 2001). Within anthropology, nutritional 'facts' are less important than social values, beliefs and meanings (Atkinson, 1980:79). This means that I was not concerned about assessing my participants' nutrient intake, or whether they were 'really' eating 'healthily'. The focus is, instead, on what they think and feel, and how they experience food, eating, and health. I take the approach that food practices, eating, and health are all social constructions, and that there are no 'right' or 'wrong' behaviours, foods, or ideas. This means keeping an open mind and being non-

judgmental towards a variety of different food and health ideas and behaviours in order to do justice to my participants' understandings and experiences.

Since food preferences and health are social constructions, it comes as no surprise that there are geographical and cultural differences in how people think about them. Americans, for example, see food and its consumption as a key method for working towards and maintaining health (Rozin et al., 1999). French people, on the other hand, see food mainly as a source of pleasure (Rozin et al., 1999). The truly interesting finding here is that the French are, on the whole, healthier (in terms of heart disease) than American people. New Zealand was not one of the countries surveyed in Rozin et al.'s (1999) study, and Markwick (2009:33) points out that there are big gaps in the literature when it comes to New Zealand. Rozin et al.'s findings that food and health ideas can vary by region means that it is quite likely that ideas in New Zealand will be different from those in other western countries. While some of the ideas in this research have been explored by other researchers (such as the social construction of health and food choice coping strategies), none have, to my knowledge, been conducted in New Zealand, and it is important that New Zealand contributes to a greater understanding of food and health ideas.

### **Key Kitchen People**

'Key Kitchen Person' is not a term that is used widely in the literature, despite its usefulness. I came across it in only three places (Douglas, 1973; Herda & Banwell, 1988; Markwick, 2009), even though many food studies focus on the person in a household who does the cooking. They are generally labelled 'mother', because traditionally this person was almost always a woman caring for a husband and children. Today though, as we will see below, many more men are taking over household cooking and shopping responsibilities (as are children and flatmates, for example) so the gender neutral 'Key Kitchen Person' is a useful and appropriate term. Within the field of nutrition, the term 'nutritional gatekeeper' (cf. Wansink, 2003) is used to describe the person in a household who controls food purchase and preparation. The idea is that most food must pass the nutritional considerations of this person. I use 'Key Kitchen Person' instead because this is not a study of nutrition, and I do not wish to imply that my participants are making nutritionally based choices when they may not be, or reduce their food-based tasks and conceptions of health to only nutritional considerations.

KKP is a useful term because it is specifically related to food activities, whereas 'mother' is loaded with other meanings and connotations, such as feminine, caring, and nurturing. There are overlaps between the notions of KKP and 'mother', such as those around nurturing and responsibility, but 'mother' does not cover the wide range of people or domestic situations within which the KKP role is enacted, such as male KKP, flatting situations, or older children cooking for a parent who works late. The term helps convey some of the importance of this position within a household. The KKP really is 'key' to food behaviours and activities. It is a position of power in terms of decision-making for others, but involves dimensions of servitude; cooking for a family is not 'just cooking' - it involves therapy, sociability, tradition, economics, and politics (Bahr Bugge & Almås, 2006:207), as well as careful negotiations of taste, nutrition, and culture. Key Kitchen People are significant in the home because they are the central food shopper and preparer, meaning household members are freer to do other things. KKP ensure the smooth functioning of food related activities and meal times and can become experts in the area of shopping and cooking, doing these tasks faster than another household member, as well as being (but not always) the 'nutritional gatekeeper' of the household. This means that they may well be conscious of food-health connections and strive to keep their household healthy through the food they purchase and prepare. This makes the KKP an important and integral part of many households.

Central to this research is the presumption that KKP are concerned with the health of the food they give those who are dependent on them (friends and loved ones). Some studies have found that health is a large concern for those who cook for others (Charles & Kerr, 1988:114) (although none used the term KKP to talk about these people), with most people working hard to ensure the health of their families (Graham, 1984:59; Murcott, 1983:2; Wood, Robling, Prout, Kinnersly, Houston, & Butler, 2010:54). On the other hand, Kemmer et al. (1998:64) found that "for most of [their] informants health did not seem to be a significant issue in informing food choices" and Svenfelta and Carlsson-Kanyamab (2010:453) found that their informants were most concerned with "quality, price, and taste", not health. Despite these findings, Wood et al. (2010:54) state that "A number of mothers were proud of their responsible attitudes to family nutrition" and therefore health. It would appear, judging from these different findings, that KKP are concerned with giving their families healthy, nutritious meals, but that 'health' is not a strong factor in food choice. This seems contradictory, and it is

widely recognised that people's beliefs and actions can be very different when it comes to food and health. This means that while they may believe health to be important, they might not act on this belief for any number of reasons, such as cost, taste, other values, or cultural reasons. I aim to add another perspective, that of New Zealand KKP, to the discourse around food, health, and food choice, and to find out if my participants act on their health beliefs and what issues may affect this.

Charles and Kerr's (1988) influential study of women in the family kitchen is a respected and much cited piece of work, mostly focused on the amount of work women must do in the kitchen and the lack of power they feel they have over what they prepare, and Coxtton (1983) found that men, in 1983, only did kitchen work when there was not a woman in the house to do it (p.173). While women are still the KKP in most homes, recent studies show they now have more control over what they cook (Kemmer et al., 1998:50) and that male KKP are more common than in 1988 when Charles and Kerr did their research. I have not, however, focussed on the differences between men and women in their cooking behaviours and health beliefs. This has been covered extensively by other scholars (cf. Beardsworth, Bryman, Keil, Goode, Haslam & Lancashire, 2002; 98:471; 110:293; Herda & Banwell, 1988:30; Lupton, 1996:59; Madden & Chamberlain, 2004:583; Madden & Chamberlain, 2010; Mennell, Murcott & van Otterloo, 1992:94; Rozin et al., 1999:176). While gender is an important issue within the home, and food-work, I do not feel that with my small sample size I could analyse my data in terms of gender. Having only three male participants, all of whom live in very different situations (married, single and flatting, and divorced with children), I could not separate gender difference from those caused by personality or domestic situation.

### **Health and food**

Lay concepts of health, that is the ideas that non-expert members of the public hold about health, are increasingly being recognised as important (Smith, 2002) and research into this area progressively more popular (Sargisson, 2004:7). This is because of the substantial increase over the past 10-20 years of options available to people, both food-wise and health-wise. People in the West now have a plethora of different foods, health programs, and health claims to choose from. Caplan (1997:23) points out that as anxieties over basic needs such as housing and sustenance are satisfied, people start looking towards these other concerns. These areas have become very profitable,

meaning that various advertisements encourage the public to think more about these topics. This increased interest and importance is reflected by an increase in the popularity of the subject for social science research; as it grows in importance in people's lives, it becomes more important to research and understand food and health.

Health is important to how we think about food (Madden & Chamberlain, 2010:292). Conner and Armitage (2002:ix) say that "...recently, increased concentration from the media has focussed public attention on the food we eat, and its influence on physical health and mental wellbeing", and Chen goes as far as to say that food exists on a continuum with medicine (2009:x). The links between food and health are, now, "an inescapable fact of life", but there are 'endless variations' in how this connection is conceptualised and acted upon (Beardsworth & Keil, 1997:125). Beardsworth and Keil (1997:125) say that our connection of diet and health can be thought of in terms of positive and negative associations. Positive foods are ones we see as benefiting our health, while negative connections are made through malnutrition or toxic/diseased foods. This is a common way of conceptualising food and health in the West (other cultures sometimes do it differently, as with Asian/African hot-cold systems), but just which foods might fall into either category and what their perceived effects might be is where the variation comes in. What foods are put in the positive category and what in the negative is both culturally and personally constructed – through socialisation and experience – leading to much variation in the details of food-health connections. Research into these constructions is important because a greater understanding of how they are formed and then put into practice might mean that health campaigns can become more holistic, and less about living 'the right way' and more about wellbeing, as we gain a deeper understanding of what matters to people and how they achieve it.

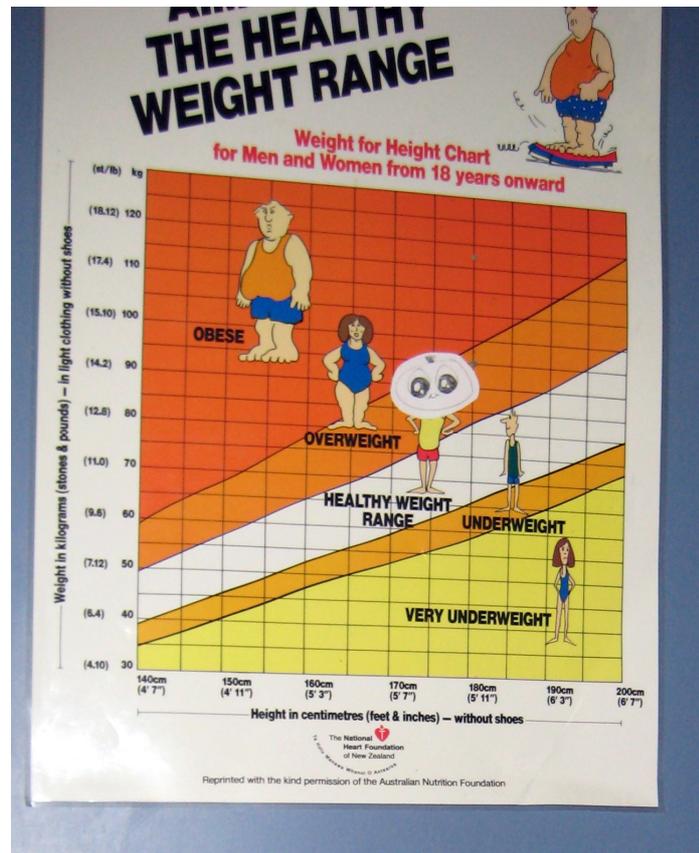
Public health messages tend to promote a narrow concept of health (Brannen, Dodd, Oakley, & Storey, 1994:67; Pollan, 2008:144), specifically the idea that 'health' equals a lack of illness. The idea that health is about the absence of illness and an 'appropriate' body weight have become key western ideas about what health is (Charles & Kerr, 1988:119; Herda & Banwell, 1988:29-30; Kemmer et al., 1998:62). Indeed, most health literature focuses on illness (cf. Murcott, 1983), with many studies linking behaviour and ill health. Some people, however, are starting to realise that a lack of illness is not necessarily the same as wellness (Shaw Hughner & Schultz Kleine, 2004:396; Williams, 1983:108). In fact, Blaxter (2010:2) reports that lay people can

have a range of ideas about health including physical fitness, being considered 'normal', and mental wellness (also: Chamberlain, 2004). In this vein, Murcott (1983:2) maintains that “Good food is more than a mere matter of nutritional value – a balanced diet more than just a matter of health”. Health is also more than an absence of illness, and people may conceive of it in many different ways (Williams, 1983:109). Anderson (2005:150) says that “For all of us, food is about much more than nourishing the body. It is nourishment for the soul”. This is a point that much nutritional research misses. For food and health connections to be understood, one must also look at how both link to mental, and sometimes spiritual, wellbeing.

However, food is very much about the body as well. Food and body shape are inexorably linked, as are body shape and perceived health (Hayes & Ross, 1987:120; Herda & Banwell, 1988:30; Scapp & Seitz, 1998:6), meaning that bodily experiences of change and health are perhaps the most talked about way that people conceive of the connection between food and health. Figure 4 shows a weight-chart belonging to one of my participants, which sets limits for ‘normal’, ‘healthy’ weight and body shape. Our bodies are very important to us, they are a 'project' to work on and food related health is one way we do this (Caplan, 1997:16; Charles & Kerr, 1988:126; Pill, 1983:117). Because of the importance of the modern body, when Belasco (2008:2) points out that “we can't live without food, but food also kills us”, it suggests that there is anxiety and confusion surrounding food and its place in/with the body. KKP are responsible for their own and others' food, and therefore their health and bodies. No research has been done into how these people feel or act on this, and my work aims to fit into this gap by exploring how KKP cope with the anxiety caused by food choices.

Because food is so important to our survival, health, and sociability, it is a source of anxiety. People worry about what they will eat, what they have eaten, how it might affect their health, and how their behaviour and body might look to others. Food choice anxiety and its causes and solutions are discussed fully in chapter five. I have made this a part of this research because it was not only a salient theme in the literature (cf. Anderson, 2005; Beck, 2002; Caplan, 1997; Coveney, 2006; Fischler, 1988; Pollan, 2006; Rozin, 1976; Rozin, 1999), but in my discussions with my participants also. Interestingly, while food choice anxiety was such a large theme in my research and in other scholarly works, there was a lack of research done into how people actually experience and cope with it. Because of this lack of experiential focus, Green et al.'s (2003) article on food anxiety and coping was key to this research. They used focus

groups and a health science/sociological perspective to gain insight into how their participants felt about food, conceptualised food anxieties, and then overcame these anxieties to choose food and eat in a relatively stress-free way. I have used this work as a launching point for my own in this area. In chapter five I compare my findings to those of Green et al. (2003) to highlight similarities and differences.



**Figure 4: A weight chart on one of my participant's pantry doors (June, 2010)**

Also key to this discussion of food anxiety and coping is Beck's work on 'Risk Society' (see also Caplan, 1997:23), Fischler's (1988) ideas about the 'omnivore's paradox', and the idea present in many anthropological works on food that food choices are also moral choices (cf. Coveney, 2006; Fischler, 1988; Gough & Conner, 2006; Madden & Chamberlain, 2010). Beck explains that within industrial societies, alongside the manufacturing of goods is the manufacturing of 'dangers'. In modern times, Beck explains, we must not only deal with naturally occurring, non-human caused disasters, but be on the lookout for man-made risks, ranging from factory fires caused by faulty wiring, to food poisoning from our local restaurant, crime, and pollution. Many of these risks are the result of modernity. This applies to food also. We are now more aware than

ever of the risks our food carries, thanks to modern scientific investigation, and are exposed to more risk due to pollution, poor food hygiene practices, and the importing of goods from other countries. Beck's work on risk contributed greatly to my understanding of why food anxiety is so widespread in today's Western culture. Fischler also helped clarify this with his explanation of the 'Omnivore's Paradox' – the idea that humans need and want a wide variety of foods, but are scared of new foods because of the risks they can pose to health. Adding to both these things is the fact that food choices can be moral choices, and that choosing to eat the wrong food in the wrong situation can have social consequences. These ideas are explained in chapters four and five, and have been included in this research not only because they offer an excellent analytical framework for the expressions of risk and anxiety, but because there has been no New Zealand investigation of these ideas, nor any works that combine these themes into an overall investigation of food anxiety and coping.

## Chapter 3

## Health as a Social Construction

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“So if you want to go and climb a mountain, then your body has to be in certain shape, and if it’s not and that’s what you want to do, then for that purpose you’re not healthy”.

Anna

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The World Health Organisation (WHO) defines health as “a state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity” (WHO, 1986, para. 3). This definition is a step forward from many medical classifications of health in that it is a holistic view (though some would argue that ‘spiritual health’ should be included) and reaches more widely than simply physical wellbeing (Fieldhouse, 1995:ix). However, the question must be asked: is any person ever in a ‘complete’ state of wellbeing; can we define health this way if no one ever experiences it? This definition is not particularly useful if one is interested in what the lived meaning of ‘health’ is. It fits in with WHO aspirations for health, but does not contribute to ‘on the ground’ understandings. Rather than trying to define health objectively in an all-inclusive sentence, we need to understand that it is “a subjective experience that is socially constructed” (Shukla, 2001; cf. Hughner & Kleine, 2004:417; Lorber & Moore, 2002:1).

‘Health’ is constructed by both individuals and societies. Health may be defined broadly in society in a way that is more or less generally accepted (as we shall see below), but which individuals respond to, accept, negotiate, or moderate with regards to their own concerns (Senior & Viveash, 1998:3-5). By looking at health messages from health professionals, the government, and in television advertising and magazine media we can build a picture of our society’s prevailing ideas about what constitutes ‘health’ (Bradby, 1997:213; Seale, 2002:1) and particularly ‘good health’. Lupton (1995:106) points out that these ‘mass’ messages are a key strategy of health promotion. I will begin by discussing the influence of these messages on my participants’ perceptions of health, then cover four other areas which I believe contributed to my participants’ conception of health:

- a) Alternative health messages

- b) Bodily feedback
- c) Personal values and philosophies, and
- d) Social interaction and knowledge through the ages.

I will conclude with a discussion of how these areas are intermixed and negotiated to create a personally useful and individually shaped definition of health.

### **Mainstream health messages**

‘Mainstream’ health messages are those that are widely promoted to the public, have a base in biomedical health and science, and form the dominant discourse about health and illness in this society. They are the “ideas, attitudes, or activities” related to health “that are shared by most people and regarded as normal or conventional” (Oxford Dictionary Online: para.1). These ‘mainstream’ messages emerge from the intersection of a number of different agencies, such as the government, medical doctors, and food producers, and both popular and industry-based magazines. My participants took many of these messages on board, but did not do so uncritically, nor were mainstream messages their only source of health information. The creative construction and negotiation of health messages to form a personally relevant definition of ‘health’ is the focus of this chapter, and we will begin by exploring mainstream health messages and how my participants made sense of them and incorporated them into their lives.

Medical-based (or mainstream) health professionals include medical doctors, nutritionists, many psychiatrists and health psychologists, and people who work in the fitness industry (cf. Conner and Armitage, 2002). The two widely available publications I surveyed were *Healthy Food Guide Magazine* (HFG), one of New Zealand's most widely read health magazines, and *Fitness Life* magazine, which claims to be New Zealand's best selling fitness and health magazine. Both magazines are written and edited by health industry professionals. While one focuses on food and the other on fitness, there is a remarkable degree of overlap in the health advice given. Both magazines included particular ideas about diet, fitness, and mental wellbeing in their implicit definitions of health.

Overall, the message that emerges from these publications is that 'health' is a long life free from disease (cf. Fiddes, 1997:255; Kussler, 2009:34). Indeed, much of the health information concerns minimising the risk of disease or managing/minimising illnesses or disorders one already has (cf. Carr, 2010:22-29; Williams, 2010:47-50). Weight loss is also shown to be a large part of health in these publications, with only

slim people appearing in the magazine and a range of weight-loss related articles in many of the issues (for example, the HFG in October 2010 was a special weight-loss edition, and searching 'weight-loss' on either magazine's website provides a wealth of results). From these publications, the main ideas we get about health are that it includes bodily health, avoiding illness and living as long as possible, and losing weight and being slim.

Government health messages take an active approach to health by promoting specific behaviours and actions that are thought to lead to improved bodily health. By looking at the publication *Eating for healthy adult New Zealanders* (Ministry of Health, 2007) and the advertisement campaign run on national television advising everyone to 'make half their plate vegetables' (Feeding Our Families (a government funded organisation), 2007), it is immediately apparent that these messages from government propose that health is a result of individual choices and action; health is a life lived in the 'right' way. These messages suggest that by performing healthy actions an individual can 'achieve' health in that they will avoid illness and weight gain. There is also a focus on the body functioning correctly - all the organs performing their jobs and a person having an adequate level of fitness to achieve everyday tasks. Government health messages tell us that health can be about changing food consumption to reflect 'good' choices (i.e. eating plenty of vegetables), and to assist the body to function optimally.

The non-government organisations I looked at were the Heart Foundation and 5+ a Day. Both these organisations had a very specific focus: heart health and eating fruit and vegetables respectively. From the advice given on their websites, and in print and television campaigns, their ideas about what constitutes health are focussed on bodily health, diet, and the avoidance of illness. The Heart Foundation in particular is almost exclusively focused on illness management or avoidance. Similarly, the 5+ a Day messages stress eating fruit and vegetables for nutritional health, which means getting enough of the correct vitamins and minerals for the body to function well. These messages say very clearly to the public that health is about 'proper' bodies, lack of illness, and living 'correctly' to achieve these things. This introduces a moral discourse to health: that there is a right and a wrong way of doing things (cf. Aldridge, 2004:44; Coveney, 1999:23; Gustafsson & Sidenvall, 2002:164; Williams, 1997:151).

The popular media offer many ideas about health, but from browsing the more common publications such as *Woman's Weekly*, *Marie Claire*, and *Cleo* (all magazines), a clear focus on weight-loss and appearance as keys to health can be seen, as well as a

focus on women's issues such as avoiding breast cancer (Flemming, 2009d). From these publications we can see that the individual walks a line, doing what they can to enhance health on one hand, while avoiding 'bad' health on the other, lest they be blamed for their own ill-health (cf. Lawrence & Germov, 2004:124). Our society thus gives a lot of agency, responsibility – and potentially blame – to the individual. Articles such as *Fat you can't see* (Flemming, 2009b), *The French paradox* (Flemming, 2009a), and *Carbs that burn fat* (Cleo, 2010) have a focus on both visible and non-visible fat, not only as indicators of health, but as being part of 'health' itself. There is also a focus on health as avoiding risk and disease (Flemming, 2009c; Tsekouras, 2010:254). Again, these messages say to the public that health is about the body, about beauty, and about living in the right way to achieve these things. There is some focus on mental health as well, with articles such as *How to be happy now* (Cleo, 2009) which promote the idea that there is a mental component to health also.

Health industry messages are health messages that come from food production, manufacturing, and pharmaceutical companies, though they are often disguised as unbiased health advice. In this type of health message particular products are promoted as being 'healthy', and from these messages we can get an idea of what 'health' is thought to be. New Zealand Beef and Lamb, for example, has both print and televised advertisements advising on the health benefits of including red meat regularly in the diet. These messages focus on the proper functioning of the body at a nutrient level, citing the importance of iron, zinc, fat, and various vitamins in the body (Beef + Lamb New Zealand, n.d.). Similarly, a brochure titled *Family Health Diary* can be picked up from some supermarkets and pharmacies. It is actually an advertising brochure and website (published by 'Brandworld') disguised as a health brochure, and the advertisements and promotional articles inside are almost entirely focused on health as disease prevention or symptom relief, and the proper functioning of the body. These sources construct health as being about bodily function and illness avoidance or relief (cf. Keane, 1997:173). This is a narrow concept of health when compared with the more holistic approaches of non-medical health, or even the health magazines I reviewed, but these ideas are the ones that the public is exposed to the most (Seale, 2002:1) and are an important part of how our society constructs health. Some of the messages from these sources focus on specific signs of health that are invisible to the everyday person, such as cholesterol or nutrient intake, but there is also a very strong focus in advertising media on the (supposedly) visible signs of health, such as a youthful appearance,

slimness, and energy. When I asked my participants to describe a healthy person, much (but not all) focus was on physical attributes, showing that these messages are a part of how health is understood. Evan, for example, when asked this question, said:

[I look for]...probably the most general, stereotypical thing, and that would be weight. I mean, I know it's not just to do with health, there's metabolism and stuff, but yeah. How they generally... just normal weight. Um, and how they look, so whether they are really oily or like, their eyes... and, probably their dress as well, to a certain extent. I always feel that people who dress badly [aren't healthy].

While health messages do not explicitly mention clothing or body shape (other than 'normal' weight), it is possible that Evan has picked these ideas up from the images and ideals contained in health promotion. Although he says he knows weight is influenced by other factors, he can not help himself from feeling it is connected to health. The emphasis is also on 'normality' (cf. Blaxter, 2010:4; Lorber & Moore, 2002:3) and this is heavily emphasised in mainstream health promotion. Recommended daily intakes, exercise amounts, and health advice are given based on 'normal' individuals, with very little reference to anyone with different circumstances or special needs. Only mainstream problems, such as common illnesses, allergies, or deficiencies are given attention, promoting the idea that Evan expresses: that being healthy is to be 'normal'.

It appears that to be 'normal' is to be, if not knowledgeable, then at least aware of health messages. All participants discussed health messages and used them in their own ideas about health. Evan, for example, developed some of his health ideas with direct reference to mainstream health messages, saying "Always eat your vegetables. Why else would you have to eat them?... it's probably just the media and stuff, all the stuff about eating well and 5+ a day and all that...". While his attitude towards the messages seems casual, they formed a large part of his overall health conception. This is similar to the rest of my participants, showing that public health messages are having an effect on the ideas people develop about health.

Health messages are both a reflection of a society's views about health and a means for changing or focusing these views. Marie said, when asked about healthy behaviour:

I'd probably stay away from buttery stuff, whereas oil is ok, because it has the good fats.... [and] I do like to keep up with food and health information. Like this omega-3 thing, that we didn't know about a few years ago. So from that I'll have fish oil tablets, or eat more tuna or something.

And

We do happen to like a lot of the things advertised, like 5+ a day, though I know I don't eat that many vegetables....I think [the campaigns] are relevant to me. They serve as a good reminder for me to check what I'm doing, plus I agree with them anyway. They don't make me feel guilty, like I need to change my life, but they do remind me to think 'how much fruit have we eaten?'

Current health campaigns to do with omega-3, fats, and vegetables have considerably influenced how Marie thinks about health. In Figure 5 we can see she has bought 'good oils' such as olive oil, and has multiple cans of salmon in her pantry. Marie uses these promoted concepts loosely, and her understandings may be vague, as in the case of "good fats" (cf. Backett, 1992:271; Counihan, 1999:117). Marie points out in the second quote above that health campaigns "don't make me feel guilty..." or as if she has to change; she is trying to point out that she does not buy into the idea that many campaigns promote: that she must live in the correct way to be healthy.

While Marie may not feel guilty, she is talking as if she is acting in particular ways in order *not* to feel guilty. She is monitoring her own and her husband's diet, checking the degree to which she is deviating from the received messages about what is 'good'. Evidently, the personal responsibility that Marie has taken upon herself to act on 'experts' advice and scientific information is an effort to be guilt-free, and to be seen as acting in the 'right' and 'healthy' way. However, she emphasises that she 'doesn't need to change her life'. We can see she does change her life, however: in her first quote she says she will eat more fish or fish oil in response to omega-3 messages. Marie is trying to perform a balancing act between her responsibilities towards acting 'right' and her need to feel self-determination and control.



**Figure 5: Marie's 'good oils' top right, and canned salmon bottom left (June, 2010).**

In the examples of mainstream health messages above "the core message of many health educational campaigns is that 'there is only one right way to live and the one you're living is not it'" (Germov and Williams, 1996:103; cf. Seale, 2002:2), hence the often morally tinged tone to the messages (Aldridge, 2004:44). Therefore, we might expect people's ideas about health to be about avoiding illness, losing weight, and living in the 'correct' way. Many studies show that the public's knowledge and views on health are modified versions of those broadcast in the media (Bradby, 1997:213; Davison et al., 1991:7; Lupton & Chapman, 1995:477), and the public is generally most interested in whatever is currently being promoted (Mackinson, Wriedent & Anderson, 2009:570). However, while there is a significant area of overlap between lay health ideas and scientific/media messages, there is "a well developed lay epidemiology" that has an effect on how public health messages work (Davison et al., 1991:1). This means that people's notions of what health is can differ from what is promoted (Wood et al., 2010:53), and after interviewing my participants, some varied ideas about what health can mean became apparent, as well as sources that differ from the 'mainstream'.

### **Alternative health messages**

‘Alternative’ health messages are ideas about health that are different from those of mainstream messages, and are generally not biomedically based. They tend to have a greater variety of principles and practices than mainstream messages, so only a very small selection of the most popular alternative ideas can be discussed here. Alongside the practitioners described at the beginning of the previous section, there are other types of health professionals, such as naturopaths, homeopaths, aromatherapists, and spiritual guides and healers. Their views on health can be very different from medical professionals’, tending to be more holistic with a focus on mind-body, and often spiritual and environmental, connections.

The website ‘Alternative Complementary Health NZ’ says that “Health and disease are conditions of the entire organism, involving a complex interaction of physical, spiritual, mental, emotional, genetic, environmental, and social factors”. They go on to specify that “The ultimate goal... is prevention, accomplished through education and promotion of life-habits that create good health. The emphasis is on building health rather than on fighting disease” (Complementary alternative health clinic, No date, para.3). Similarly, The New Zealand Register of Holistic Aromatherapists says that its mission is to “enhance physical and emotional wellbeing” (New Zealand Register of Holistic Aromatherapists, no date, para.1) and The New Zealand Council of Homeopaths says that it aims “... to assist the patient to regain health by stimulating the body's natural healing forces....[And] concentrate on treating the patient, rather than the disease” (The New Zealand Council of Homeopaths, no date, para.2). These ‘alternative’ ideologies claim that health is not only about disease or disorder prevention, or even treatment, but about ‘wellbeing’ in all facets of life. They point to an ‘unhealthy’ concentration on disease, illness, and bodily functioning (cf. Aldridge, 2004:15; Joralemon, 2006:81) in mainstream messages. On the websites of these groups a lot of importance was placed on the thought that alternative ideas and practices were different from mainstream ones and were much more holistic. In alternative messages, much stock is placed in the holism of alternative health (Aldridge, 2004:15; Wren & Norred, 2003:xiii).

My participants all used a wide spectrum of ideas in formulating their notions about good health. Evan, for example, explained to me that:

[Health means] ...not feeling yuck. So feeling... To me, if you're happy, you don't feel all bogged down, like, from yourself, and feel clean. Both internally and externally. That's what I reckon [health] is.

He introduces a few non-medical ideas that make up his conception of health. Cleanliness was also mentioned by Marie as being integral to health, and this is discussed below. Evan expressed that there is a mental component to health, not being “bogged down”, and that happiness is a central part of health. Many mainstream health messages do not focus on the idea that health has much to do with happiness; happiness is rather seen as an outcome. Alternative health, on the other hand, takes moods, emotions, and general mental wellbeing quite seriously, with many practices designed to relax and rejuvenate mind and body, such as massage, meditation, colour therapy, and music therapy (Wren & Norred, 2003). While Evan's quotes in the previous section show how he has taken on board mainstream messages, there is a place in his health conception for alternative health also.

With regards to Evan's idea that feeling clean is a part of health, Marie says that “health means feeling clean and energetic”, and to her ‘clean’ means:

...how I feel when I've just exercised and eaten lots of fruit and drunk water and breathing deeply as opposed to after a 'heavy' meal of lots of fast food pizza and lollies and coke or something.

These ideas about cleanliness can be linked with Douglas' work *Purity and Danger* (1978). Evan and Marie's concern with feeling clean is not about actual dirt, pollution, or toxins, but instead encompasses ideas about discipline, ethics and making sure one is mindful of what they eat in terms of bodily, environmental, and mental health (Douglas, 1978:44). In Marie's example above, foods that make her feel ‘unclean’ are typically foods that threaten self-control or moderation (people generally want to eat more of them than they think they should). So a clean conscience parallels feelings of a clean, healthy body. Douglas says that clean/pure foods are ones that ‘conform fully to their class’ (p.56). Salad leaves do that as a vegetable (which Evan specified as the healthiest, cleanest food), and Marie's examples of what unclean foods are, are composite foods (i.e. single foodstuffs made up of many different, and often unidentifiable components), or even as Pollan (2008) would classify them: ‘non-foods’. This is an alternative, moral,

and possibly even spiritual (Douglas, 1978:44) way of thinking about health, but one that has clear links to mainstream health messages in terms of eating the ‘right’ foods and controlling intake.

Mainstream ideas about living life correctly are very apparent in the above discussion, but alternative ideas are blended in. In Marie’s explanation below about how she came to believe what she does about health, ideas about naturalness and individuality are apparent. Mainstream health emphasizes the synthetic (drugs, functional foods) and a ‘one size fits all’ system (McKinlay, Plumridge, McBain, McLeod, Pullon, & Brown, 2005:1099). Alternative therapies focus intensely on the ‘natural’ and the ‘individual’, and this view is part of Marie’s conception of health:

[Healthy is] what is natural for our bodies. I guess I think it’s kind of logical that you should get as close to nature as you can. And I know that a lot of what we think is natural these days isn’t natural at all. Like, it really doesn’t have the real nutritional value.

She then goes on to explain that:

I don’t know if it’s hereditary or what, but people have different health concerns. Like I feel like I want a lot of whole milk lately, and I don’t feel like it’s bad for me at all, and I think you need to listen to your body. Like if I want Vegemite then I probably need something that’s in there.

Public health messages tend to take a ‘one size fits all’ approach to what health is, and Marie consciously opposes this point when defining health. This quote shows that Marie knows that full-fat milk is something that is not recommended by some health promotion (HFG, for example, consistently promotes low-fat dairy), but she thinks it is healthy for her own body at particular times, and that people have individual health concerns that may differ from those in the media. This echoes the alternative health idea that individuals must do what is right for their own body.

Marie also discusses ideas about health as being “as close to nature as you can [get]”. This is an idea that is growing in popularity thanks to books such as Pollan’s (2008) *In Defence of Food*, the recent food film *Food Inc.* (Kenner, 2008), and reports of manufacturing food scares in the media (cf. Stoller, 2009:42-45; Wharton, 2009a:38-

39; Wharton, 2009b:40-41). The majority of my participants, including Marie, reported wanting to grow their own food in their gardens so they knew what sprays had gone on it and how it had been grown. 'Close to nature' therefore means foods one can easily *tell* have come from nature (in other words, they look like something that has grown in the ground, or on a tree, or part of an animal) and that have not been subjected to too many 'unnatural' (i.e. 'man made') chemicals (cf. the current high profile of organic foods as 'better for you' because they are 'closer to nature'). This is not an idea found in mainstream advertising media, but it certainly comes through in the alternative health and healing discourses. What is interesting is that some of Marie's ideas clearly come from mainstream advertising, such as her ideas about fats, omega-3, and 5+ a Day, but she incorporates a 'close to nature' message into these. So, she is taking on board some of what public health messages tell her health is, and combining this with alternative messages concerning naturalness and listening to your body in a way that suits her.

The combining of biomedical/mainstream health discourse and alternative discourses was a strong and recurring theme in my research. Not all of my participants combined the messages in the same way, and some, such as Anna, seemed to want to reject mainstream messages. In doing so, however, they used the rejected messages to create alternative views, so the mainstream messages still had an effect on how health was conceived. This is similar to the ideas alternative therapies express in relation to medical ideology; their holism is made all the stronger because they are a reaction against mainstream health ideas. To illustrate this point, Anna said:

Health has changed for me, I think. I used to relate it to, I mean it has absolutely nothing to do with your body size and shape. It's just an absolute misnomer, I think. It has to do with feeling good, and feeling satisfied and happy with yourself. And being able to do what you'd like to do. So if you want to go and climb a mountain, then your body has to be in certain shape, and if it's not and that's what you want to do, then for that purpose, you're not healthy.

She sees health as having to do with capability and as being an individualised construct. She explains that health is not something static, it changes with a person's goals and emotions. This is quite different from the dominant message in the media: that health is having a body that functions 'properly' and weighs the correct amount irrespective of

the individual person's goals, needs, preferences and priorities. Anna consciously opposes these ideas, expressing that health is really about what you want out of life and being able to achieve it. She also points out that health is "feeling satisfied and happy with yourself" (exactly the feelings that are the goal of some alternative practices such as focussed meditation), whereas many of the mainstream health messages are about changing yourself and assume that ill-health and dissatisfaction are the norm (Duff, 2004:149). This shows a direct challenging of public health messages, in terms of defining health, health recommendations, and the 'one size fits all' approach. Anna is certainly aware of health messages and promotion, and chooses to position herself differently in how she defines health, but this position appears to be in direct reference to mainstream media campaigns. Even when Anna rejects mainstream health conceptions, she has combined them with alternative health to create part of how she thinks about health.

### **Listening to your body**

Feedback from their own bodies about how they were feeling and the effects of certain actions or food were very important to how my participants thought about health (cf. Keane, 1997:181). After experiencing something for themselves, they were able to decide whether it was 'healthy' or not. A good example of this is exercise. This is a commonly promoted activity thought to be integral to health (cf. SPARK's *Push Play* campaign), but Evan felt that his bodily experience said differently:

I probably [developed this idea of health] because I wanted to avoid including exercise in being healthy. I mean, I don't feel the need to exercise if I feel good.... I think the thing is, that whenever I've exercised I never... some people exercise and are then like 'oh, I feel really good now'. I've never ever done that. So, exercise isn't a concrete value, it's not something I can feel.

Again here is the blending of health ideas from different areas – mainstream ideas and Evan's own experiences. Evan realises that public health messages include exercise in their definition of health and healthy behaviour. He has not experienced any benefits though, so opposes this idea consciously while still feeling as if he is missing the point. Again, the idea that health is individual and individually assessed brings alternative health ideas into the mix (cf. Wren & Norred, 2003). Health needs to be "something I

can feel”, rather than an abstract concept as often applied in mainstream health. Evan says:

[Health can be] just a general feeling, because that happens. But, if I started, like, suddenly breaking out in pimples, or suddenly gaining weight, or really tired, then I’d look it up.

Health for Evan is a concrete bodily experience: feelings and outcomes rather than, say, cholesterol levels which can seem abstract and have no symptoms.

This view was shared by a number of participants, and it was seen as risky to ignore bodily symptoms and feedback. Elizabeth made this point when she said:

I think it is vitally important, especially as you grow older, to listen to your body and let it tell you when you don’t feel good and work out why. I think a lot of people don’t do that, and it causes them problems, health problems, because they continue to eat something that gives them heartburn, or is too heavy. They just ignore it and continue and create a big problem.

Here we see an integration of alternative health ideas about working out the true cause of a problem (Wren & Norred, 2003:xiii) and the idea that a person can do this for themselves through their own experience and bodily feedback. An example of the perils of ignoring your body came from T.J., who now regrets not paying the ‘right’ attention before he hurt himself. T.J. explained that he had once been too conscious about health messages surrounding fat, and had all but eliminated it from his diet. He says that these days

...when I buy chicken nibbles, which are quite fatty, I don’t mind because I don’t have them every day, so it’s not like I’m overloading, and sometimes you can go too much the other way, and I wonder if that’s why my knees gave up when I was running, because I cut too much fat out of my diet.

These examples show that bodily feedback, ‘listening to your body’, is an important way in which my participants understand health. This has not just to do with the functioning of organs, or physical appearance, but with feelings of health (Shukla, 2001). This way of ‘knowing’ about health is not a standalone source. From these

examples it is clear that health is a social construction involving both society/culture and an individual's own ideas and experiences.

### **Personal values and life philosophy**

One of the influences that makes health such an individual construct, while still being created within our society's dominant health discourse, is personal values and philosophies (Anderson, 2005:150; Medina, 2004:60). These are unique to all of us and can change the way we think about health and how we negotiate health messages. This personal negotiation is apparent in Marie's discussion of how 'unhealthy' behaviour can actually be healthy. She indicates, when talking about food and health, that she doesn't feel that mental, social, and emotional wellbeing are included in the dominant health messages:

...I do think there's an emotional attachment to food that is very important. Food is very... it plays a big part in our relationships. Like, say I'm going out for ice cream with a friend; I wouldn't not have ice cream because it's such a big part of the sociability. I think that's healthy... healthy...in a different way. Mentally healthy, socially healthy. It's also healthy to be relaxed about things. And probably if I was worrying about food a lot, then it wouldn't be very good for my body. And if I'm stressed I might end up not being able to digest my food properly anyway, my body would be stressed. So sometimes it's better to just relax. Like, I read this research that says ice cream makes people happy, so stuff like that... I don't know. It might just be ok, because it has other good stuff.

Marie values sociability, so for her it is sometimes healthier to go against mainstream/biomedical health advice and do something that is not healthy under that paradigm, but is healthy under her own (cf. Caplan, 1997:20). Health (and food) as it relates to social and mental wellbeing is not generally discussed in mainstream health messages, other than in articles about not over-eating at social occasions and how to curb one's emotional eating (cf. Bowden, 2008; Buca, 2010:259; Gebilagin, 2010; Reid, 2009). Marie challenges these ideas, saying that this type of eating can be healthy, and that health encompasses ideas about mental and social wellness as well as the body (cf. Contento, 2000:178). She realises this view is contrary to mainstream advice, but justifies it with other research and her own experiences. She makes the point that stress

is not healthy. This is a more holistic view of health than that found in many mainstream health messages, and is more aligned with those of alternative health practitioners. There is a blending of mainstream, alternative, and personal values to do with health, all coming together to form a coherent whole.

Pollan (2008:144) expresses the idea that something that is healthy for us must also be healthy for the environment, that we are intimately connected. Anna feels this way, saying:

I like animals to have a decent life, so I know they've been happy. I like to know what they're eating. It's just taking responsibility. It's too easy to go to the supermarket and get meat without thinking about where it's been. Everyone who comes here can't understand how I can kill and eat something you've raised, but I can't see how they can eat an animal that's had a horrible life in a crate.

She goes on to say that this is key to her health ideology, that if she were to eat anything that itself had not been healthy (and this includes happy) then she herself could not be either, especially in terms of her mental health and wellbeing. This idea was not present in any of the mainstream health media that I looked at, but Anna felt very strongly that health included a wider responsibility towards animals, foodstuffs, and the environment. Figure 6, below, shows some of Anna's home killed meat, which she says will feed her family for many months. Health and healthy eating fit into a larger lifestyle and philosophy for Anna, which quite possibly stem, in part, from alternative health messages to do with the environment.

Values and philosophies play a large part in how we think about health and when combined with other health messages can result in some quite different ideas, different both from the messages and between individuals. All the ideas above – mainstream health, alternative health, listening to your body, and personal values - help create how a person thinks about and experiences health. We are also affected by others' combinations of these areas through social interaction and knowledge through the ages.



**Figure 6: Home killed beef hanging in Anna's shed (June, 2010)**

### **Social interaction and knowledge through the ages**

Health is a social construction. People have different ideas about it that have been constructed within a social environment. As the literature says, the lay public form their health ideas and opinions with close reference to media, professional, and government messages, but they have also developed their own ideas. Social interaction is another way that my participants reported learning about health. Conner & Armitage (2002:26) point out that "...only a small percentage of human beliefs and attitudes towards foods result directly from our interaction with foods: many beliefs are derived from socially transmitted information". This means that an individual's conceptions of health, which are formed with reference to the areas above, can then go on to affect others' ideas about health also, making the whole processes endlessly reflexive (cf. Reilly & Miller, 1997:239). Cath gave an example of this, saying:

...some of my girlfriends are super health conscious....My friend came for dinner a few months back and she went to the fridge to get some spread to put on the bread we were having. When she saw I only had butter in the fridge she was a bit horrified, and suggested I buy [olive oil spread] instead because it was better for you and much lower in saturated fat.

Cath, because of this social interaction, did go out and buy olive oil spread, and while she decided she didn't like it and switched back to butter, this example shows how other people's health ideas can affect someone. Cath's friend had, more than likely, picked up her ideas about saturated fat from mainstream health media and incorporated it into her view of health, which she then shared with Cath. Anna, on the other hand, tends to take on a teaching role in terms of health, trying to edify those around her as to what she thinks health is. In the case of the example given above about her views on health being connected to the environment, Anna has tried to convince friends that it is better to raise and home-kill your own meat, and speaks strongly and convincingly on the subject whenever it comes up. These two examples show how health is a social construction, with everyone learning from each other what health is.

Another way that my participants told me they learned about what health is was from their parents and grandparents (cf. Joralemon, 2006:71). This knowledge 'through the ages' is closely linked to the above examples on learning about health through social interaction, but was thought to be in a different category by my participants. Social knowledge from outside the home was often thought of in terms of 'pressure' (cf. Gustafsson & Sidenvall, 2002:168), whereas home-centred health knowledge was talked about more in terms of 'learning' and 'teaching'. Peter, for example, explained how he learned about health, and some techniques to work towards it, from his mother and family:

Most of it probably came from growing up, from my family. We had a pretty loose view, neither of my parents were sports nuts or anything. But, mum taught me how to cook, like what you don't need to add to food because it just makes it unhealthy and it's not really necessary.

Jo also says "...my mother was quite a healthy cook", and explains that she continues on this tradition. Jo is now in the position of being a mother herself, and has assumed the role of health educator also, teaching her kids what health is and what is healthy, though she does say her children's peer group exerts an enormous amount of influence over what her children eat when they are outside of the home. She attributes this to social pressures from friends and product advertising. This shows the conflicts that can arise when different messages don't match, but Jo says that her kids do know what is healthy, because she has taught them. These examples show that knowledge

passed down from one familial generation to the next can influence health ideas, and that this type of learning and teaching can be a conscious goal for parents and children. It also shows, however, how conflict can arise due to differences in opinion between message sources. This, and the anxiety it can produce, are discussed further in chapter five.

### **Conclusion**

The ideas my participants have about health are an amalgamation of concepts collected from health professionals, media, personal experience, and other people. I have demonstrated that there are five components that make up peoples' individual constructions of health:

- a) mainstream health ideas and messages
- b) alternative health ideas and messages
- c) 'listening' to their body
- d) values and life philosophies, and
- e) social interaction and knowledge through the ages.

By looking at these areas and my participants' explanations of their health ideas, we can see that health, far from being a clear-cut concept, is a social construction.

This blending and negotiating of health ideas from different sources is not unique to my participants or New Zealand culture. A number of studies have been done in America and the UK (cf. Williams, 1997) about the interaction of everyday people's health ideas with medical conceptions of health and biomedical based health messages. Joralemon (2006:72) gives an example of the Mexican traditional healers, or *curanderos*, he worked with and says that they blend health information from many different sectors into their 'traditional' practices, including biomedical ideas, knowledge through the ages, personal experience and bodily feedback from their patients, and ,although Joralemon does not mention it, I would assume they learn from other *curanderos*. Similarly, in Germany, St John's Wort, a herb used in alternative healing, is often prescribed by doctors to treat depression (Wren & Norred, 2003:87), showing a blending of medical and alternative health.

Kovács (1998:31) rejects more biological definitions of health in favour of 'health' meaning that an individual can function well and happily within normal society. This certainly seems to be what my participants were trying to express; that health is an individualised and personal value and assessment. Anna explained that whether you

were healthy or not was related to whether you could achieve your goals and do what you valued, and Marie and Evan valued feelings of energy, cleanliness, and social connection. This suggests that health is related to what an individual values in life. This is, again, different from the one-size-fit-all health as illness prevention focus of much of the health information available.

At the intersection of all these (sometimes conflicting) ideas about what health is, are the ideas that my participants have formed. Mainstream and alternative health messages, social learning, bodily feedback, and knowledge through the ages all add up to the fact that health is a socially, and individually, constructed idea and value, and how each person views it is differently. Remarkably, despite the huge influence of biomedical health, popular media discourses, and food advertisers, my participants still managed to create and negotiate their own ideas about 'health'. At its core, health is about having and achieving what one values, whatever that may be. One key way that my participants work towards this is through their diet. In the next chapter I will discuss how they see food as relating to health.

## Chapter 4

# Connecting Food and Health

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“Because, you are what you eat pretty much. What you put in is what makes you function, it’s what makes your brain tick...”

Elizabeth

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In the discussion in the previous chapter, and below, the information given about my participants and their ideas about how food and health are connected is not related to their role as a KKP as much as I expected it to be. One of the original aims of this research was to find out how Key Kitchen People not only connect food and health, but how they felt about the responsibility towards their family’s health that this gives them. However, my participants were keen to mostly talk about their own, personal experiences and thoughts about health and food, and not those that have come as a result of their experiences as KKP.

From my preliminary reading of the literature it seemed likely that KKP would connect food and health, and I reasoned that if they made this connection, and were responsible for food, then they would also feel responsible for health. None of my participants brought this up of their own accord, and when they were asked about it directly, many were ambivalent or unconcerned. They conceded that, yes, food affects health, and yes, they were responsible for their household’s food, but that they were not wholly responsible for their family’s health. This is not to say that they did not try to cook healthy things, act responsibly, and look after their family, but that they felt that most food-health behaviour is an individual responsibility.

While I was surprised by this initially, it is actually quite understandable given the media health messages I have already discussed. They quite clearly encourage individuals to take care of and control their own health. In New Zealand some of these campaigns are aimed at KKP, such as the ‘make half your plate vegetables’ campaign, but the issue of whose responsibility it is to eat the vegetables is still quite clearly ‘you’, the individual family member, not the KKP. In taking these messages on board and combining them into their own construction of health, KKP may feel that they are not responsible for their families’ health. When I asked Cath, for example, whether she felt responsible for her partner’s health, she replied:

As far as me feeding him healthily? Do I feel responsible about that? Not as much as I feel about myself. In fact, sometimes I feel like I might be inflicting healthy food on him, I have this feeling that he'd rather be eating pizza from Domino's than meat and salad. Though that's probably unfair, I do think he likes and appreciates what I cook for him. So, yeah, I do feel good, but not as good as I feel about myself, because he has taken no initiative to keep himself healthy.

Another possible explanation is an extension of this and the below discussion on control and release. By combining the concepts of control and release and that one is responsible for one's own health, it follows that one is also responsible for one's control and release behaviours. Food-health is a personally moderated balance, so KKP do not feel responsible because it is the responsibility of the individual to control their intake, not a matter of what the KKP cooks. Marie said, for example, that she does not feel responsible for her husband's health because she "runs the week's meals past him" before she goes shopping, "so he could change something if he wanted to". Marie gives her husband the responsibility for his own health and his own control and release behaviours. Food is also about a lot more than just health, and KKP may feel that they are contributing to their households' lives in many other ways that are more important to them.

This is different when it comes to feelings of responsibility and young children. All my participants who had children said that in their younger years they felt very responsible for their children's health and wellbeing. Elizabeth said her responsibilities as KKP were important, "Especially when your kids are small. Now... I don't need to think about it much". From the answers my participants gave, it seems that by the early teen years, they view their children as able to make many food-health decisions for themselves (or at least are not likely to listen to their parent's advice). Jo (who has children in their early to mid-teens) said, for example, "I'm proud of the fact that my kids don't get sick. They are very healthy kids, and I take some credit for that. I feel like it's partly my responsibility and I take some credit for it". She sees it as only partially her responsibility, though. Once a person has some independence and can be responsible for themselves, they take on responsibility for their own health and eating.

This is different from some of the older literature (cf. Charles & Kerr, 1988), where women are reported as feeling responsible for their children's and husband's

health. I believe this change is the cause of the increased amount of media attention given to health and eating. Everyone is now passively, and even actively through school health programs, taught about healthy eating and the fact that they are responsible for their own health. This means that KKP can now not feel as if they have to be responsible for the family's health because each individual member has the knowledge to make their own informed choices.

### **Healthy food ideas**

A healthy diet is most often portrayed by mainstream health promotion as a diet that promotes proper bodily functioning and reduces the risk of disease (Margetts, Martinez, Saba, Holm, & Kearney, 1997:23). My participants all felt that the food they ate was strongly associated with the feelings of health they experienced, but not just bodily health. There were three components of health that my participants identified as being closely related to food:

- a) bodily health
- b) social health, and
- c) mental health

These are not stand-alone areas and there are large regions of overlap, but for the purposes of this chapter we will look at them in separate sections. These three areas were identified as entailing different negotiations of nutritional 'control' and 'release', which can be closely related to feelings of 'guilt' and 'virtue'. In the quote below, Anna connects feeling ill with health and food, but also associates positive physical feelings and emotions, "feeling good", with food. She has used her own experience to decide that they are connected, and extrapolates this out to food "having everything" to do with health. When Anna was asked if she connected food with health she replied:

Oh, very much. But yeah, you've only got to eat too much of something to feel sick, so there must be that connection.... So absolutely, I think that food has everything to do with it....As far as I'm concerned food is so connected with feeling good and health.

As Shukla (2001) says, "health is feeling healthy", and it is the *feeling* that is the key here. Anna does not mention proper bodily functioning or disease prevention. She did touch on this later in the interview, however, saying that she does use foods specifically

to cure or ward off certain illnesses. This means that Anna sees a direct causal link between food and wellness, and experiences of health.

Cath felt this connection also. She associated food with how she was feeling, both physically and mentally, and identified it as key to health:

Oh yeah, definitely. If I'm not feeling great, food is probably the first thing I look to.... Food can affect how my body feels and how I feel in my mind.

Linking this with Cath's quote below, in the 'mental health' section, she is referring to feeling healthy both in her body and her mind, and uses different types of food to feel better in either situation. She, for example, eats sweet or fatty foods to feel better emotionally, and used foods regarded as healthy (e.g. whole grains, fruits, and vegetables) to feel better corporeally. I explore this idea later in the chapter.

As well as the connection to bodily and mental health described by my participants, Jo added social health to the list of things that connect food and health:

I don't think you can separate any of those things really. Food is fuel, but it's also part of sharing [and] mental health, it is connection, communication, all those things.

Jo, Cath, and Anna connect food and health strongly and this connection consists of social, mental, and bodily feelings, and not just their own but those of their wider social group, as implied by Jo's focus on communication and sharing. As KKP, their main concern was their own health and that of their families, however. This was true for all my participants, and all held similar but varied ideas about what 'healthy food' was.

The merging and navigation of health messages (see chapter 3) and paying attention to bodily feedback and personal experience were common behaviours amongst my participants, while the individual nature of these experiences means that they could have very different and variable ideas about food and health. Interestingly though, it seems that many people select similar messages and/or have similar experiences (or the messages are just so pervasive) that, as Smith (2002:199) says, most people (including my participants) broadly hold the idea that a healthy diet is "one low in fat, sugar, and salt and with plenty of fresh fruit and vegetables". This fits in with mainstream media campaigns. Peter explained to me that:

... from past experience and 5<sup>th</sup> form cooking, the main things are the 5+ a day strategy, lots of fresh fruit and veggies. If you're eating meat, then make it healthy lean meat, cut off excess fat and manage the way you cook it. I guess a healthy diet is a balance, where you have a good variety of food without an excess of the fats and sugars.... Fat, salt, and sugar are the three things I've been taught about. You should really limit those things.

This is almost a direct repetition of Smith's summary, with the nutritional concepts of balance and variety showing up also (more on this in chapter 5). Marie echoed this, saying that 'unhealthy' things were "... sugar and salt and fat". These examples show that my participants are taking on board the nutritional ideas promoted by healthy eating messages, especially in terms of what they should and should not be eating, though the categories are broad. Despite feeling that some foods were 'bad' while others were 'good', they did not rule out the consumption of 'bad' foods. In fact, as we will see below, in some cases 'bad' food is actually 'good' food, as long as its intake is properly moderated. This introduces the concept of controlling, or "managing" as Peter put it, food intake according to nutritional ideas and principles. This, in turn, is connected with feelings of guilt and virtue over whether the 'right' food choices have been made. This will be discussed further in the next section.

Although my participants widely agreed on what food types were healthy and which were not, and that unhealthy foods could be healthy in the right amounts, how much was 'just right' differed. They all agreed on what the 'bad for health' things were, but ideas about how much you could have and where it could come from varied. This suggests that particular foods are not thought of as intrinsically 'bad' for health in themselves. Quantity, context and individual value systems seem to determine the attribution of 'healthy' or 'not healthy' to particular foods.

Marie and Peter, for example, paid attention to fat content and type, trying to steer clear of fatty meat and butter especially, but Marie said that fat from nuts or fish was ok because they were "good fats"<sup>2</sup>. Elizabeth and Anna, on the other hand, embraced butter and animal fat wholeheartedly, explaining that it was good for your body in the right amount, though they did point out that this was a smaller amount than

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<sup>2</sup> These 'good fats' Marie mentions "... include polyunsaturated and monounsaturated types, which are better for you because they help maintain healthy cholesterol levels" (Senior, 2008: para.5), as opposed to 'bad fats' which raise cholesterol levels and are implicated in some heart disease development.

some other things the body needs, and that one should not eat them unrestricted. They ‘trusted their bodies’ to tell them when this level was reached.

While there was some contention over particulars, there was a consistent message that whatever you ate, you should control the amount, and seek ‘variation’ and ‘balance’ (see chapter 5). Nutritional concepts were used often in this way to explain healthy food behaviour and how or why food was integral to health. This begins to show how a nutritional framework is used and accepted by my participants to connect food and health.

### **Nutritionism**

Since the late nineteenth century, understandings of food and health have been characterised by a focus on “nutrient and biochemical composition” (Scrinis, 2008:39). This view of the food-health connection has become very prevalent; one only has to glance at a health magazine or television program to see reference to particular vitamins or minerals from specific foods. Nutritionism is about looking at foods right down to the nutrient building blocks that make them up (Prättälä, 1991:18), and eating, organising, and identifying according to those (Scrinis, 2008:39). For example, eating salmon for omega-3, berries for antioxidants, and oranges for vitamin C. Scrinis (2008:39) says that:

Nutrition scientists, dieticians, and public health authorities—the nutrition industry, for short—have implicitly or explicitly encouraged us to think about foods in terms of their nutrient composition, to make the connection between particular nutrients and bodily health, and to construct “nutritionally balanced” diets on this basis.

The ideology behind this connection has come to be called ‘nutritionism’ (Pollan, 2008:80; Scrinis, 2008:39), and is the dominant health-food connection ideology in the West today. It arose from both scientific work and social moral concerns about the body (Coveney, 1999:24). Pollan (2008:80) says that while nutritionism “has its roots in a scientific approach to food, it’s important to remember that it is not a science but an ideology...”. However, “Regardless of [the] source, discourses around food and nutrition construct particular versions of nutritional health... and produce specific understandings of food, health and identity” (Coveney, 2006:16). It is important

to realise, though, that ‘nutritionism’ is not the same as ‘nutrition’. As the ‘ism’ implies, it is an ideology, which means it is a set of rules for making sense of the world, or, as Pollan (2008:28) puts it, “ways of organising large swathes of life and experience under a set of shared but unexamined assumptions”. The main assumptions of nutritionism are that we eat mainly to promote bodily health, and that it is the nutrients in food that are key to the connection between food and health (Pollan, 2008:28-29). Nutritionism is also about eating foods for specific nutrients, thereby making variety in the diet important to get all the nutrients needed. Because we are a part of this particular culture, this may seem to go without saying, however, there are other cultures who do not view food, eating, and health this way, and they are as healthy as those who do (Pollan, 2008:29). For example, the French do not buy into the widespread American fear of fat, but have comparable or lower rates of heart disease (Rozin, 1999:15); in South America, India, and Asia there are well developed systems of ‘hot’ and ‘cold’ foods that must be balanced and eaten according to bodily states (Fieldhouse, 1995:41-45); and the Japanese have one of the longest average life-spans in the world and tend to eat according to Zen Buddhist concepts of simplicity, freshness, and moderation (Ashkenazi, & Jacob, 2003:20). Thus, nutritionism needs to be seen as a particular contemporary cultural construct rather than an ultimate ‘truth’.

The ideology of nutritionism is important for my participants as Key Kitchen People because it is the cultural paradigm they have inherited and work under. This is the over-arching way food is understood in our culture; it is the way they have been brought up and taught to understand food and health at a basic level. Not only do my participants consider family members' likes and dislikes, what a ‘proper’ meal is, what is socially acceptable, and what is seasonally appropriate, but they also have to take into account food at a nutrient level. What's more, they seem proud of doing this well. Even those interviewees who claim to be relatively unaffected by social ideas and pressures are still working with the ideology of nutritionism, and this means that one way they experience a food-health connection is through nutrient-based discourse. Drawing on Scrinis (2008) and Pollan (2008), the main features of this discourse are:

- a) Food is seen as a bundle of nutrients
- b) We must eat these nutrients to be healthy
- c) Health is about proper bodily functioning
- d) Health is also about being within ‘normal’ ranges in terms of both behaviour and outcomes.

This is similar to the mainstream health messages discussed in chapter 3 and incorporates pervasive biomedical ideas, especially with regard to bodily functioning and the meaning of 'health'. On the other hand, because people do not have an entirely biomedical view of health, they incorporate ideas about social and mental health and this nutritional framework into their own thoughts and ideas about health. Sometimes these areas of health require different food behaviours from those promoted by nutritionism. What this essentially means is that people navigate between complying with and deviating from nutritional advice, and see food and health as related in this way. Nutritionism is such a part of our culture, however, that even deviance is conducted within, or in relation to, the nutritional framework.

Nutritionism is apparent both in theory and 'on the ground' in terms of bodily practice. While talking to my participants it became very apparent that their food related health ideas were connected to nutritional ideology. As one might expect, they reported learning about this in the same ways they learned about health detailed in the previous chapter: through experience, health messages, values/life philosophies, and social interaction. In this, my participants seem very similar to many of those studied in other Western countries, but they did seem more relaxed than people from some regions, mainly Northern America, judging by some of the studies reported in the literature. The eight New Zealanders I interviewed had a much more lenient approach to food and eating, on the whole, than the people reported in Pollan's American research (2006). Pollan writes of the extreme (possibly to the point of phobic) fear around fat in food in the U.S. (p.80; see also Patterson, Satia, Kristal, Neuhouser, & Drewnowski, 2001:37), which he believes stems from nutritional ideology. I found none of that extreme fear, with all my participants saying that some form of fat was actually very important to a healthy diet, with some suggesting that too much attention to food and eating was possibly more unhealthy than what you might eat, which is one of the concerns Pollan expresses with regards to Americans.

There is no existing research as to why this difference might exist, but it may have to do with the fact that New Zealand is a farming country - many of my participants either did, or had, lived rurally - and this perhaps connects them to their food chain more than many in America, giving them a more 'down to earth' view of their place in the food chain. Despite a more relaxed attitude than those Pollan reports, my participants did connect food and health strongly with an evident base in nutritionism, and all subscribed to the four main features of nutritionism listed above.

Elizabeth, for example, demonstrated that nutritional ideology is inherent in her view, even when she feels she has formed her own ideas. When asked if she connects food with her health, Elizabeth said:

Yeah. Because, you are what you eat pretty much. What you put in is what makes you function, it's what makes your brain tick, and I know that if you're on a bad diet and you're missing out on certain... minerals or whatever... you don't function properly. The fuel you put in is vitally important.... A bit of everything, a bit like that pyramid, I guess. And it's my own pyramid, but it probably ends up about the same as the official one. Eat mostly vegetables and fruit, meat I think is in the middle. Eat the tiniest amount of the bad stuff.

She connects food with the proper functioning of the body and mind, and this is reliant on the nutritional building blocks of food, “minerals or whatever”, and each food only contributes a small selection of these, so a “bit of everything” is needed. These are all things inherent to nutritional ideology. However, Elizabeth still desires to feel as if she is ‘doing her own thing’, to not follow health recommendations too closely, as we can see by her assertion that the food pyramid she follows is one of her own creation, even if it is similar to that of health professionals. Linking with the previous chapter, she creates this personal food pyramid in conjunction with her own experiences and ideals, which can differ from the ‘one-size-fits-all’ official food pyramid. The “bad stuff” she mentions is nutritionally restricted foods such as sugar, fat, and salt. That she does not cut them out of her diet completely suggests they must have value outside of the nutritional model, or that small lapses do not matter much.

Another example of how my participants employ nutritionism comes from Anna. She takes the ideas explored in chapter 3, her values and life philosophies as they relate to health, and mixes them with nutritionism to help her understand food-health connections and make food choices. She said:

I'd much rather buy a fresh pineapple. I am aware that things live on the shelf for a long time, and the nutritional value is probably not as good... but there's still that feeling that if it is a fresh fruit, then it is going to be better for you [than canned].

During the interview, Anna expressed some anxiety around ‘processed foods’ and sticks with products she sees as ‘natural’, even though she says she is aware of nutritional findings that say that canned or preserved goods can have more ‘nutritional value’ than their ‘fresh’ counterparts. As we saw in the previous chapter, Anna values the environment and having respect for one’s food, so being able to see where a food has come from and how it has been treated (for example, showing traces of dirt from the ground), is important to her decision about whether it is healthy or not. For Anna, knowing that a food has come from the earth may imply it is healthier and influences the ‘bundle of nutrients’ that makes up the food. However, she also said that because of her busy lifestyle she sometimes had to compromise on the freshness of food, buying cans of fish or beans. This was apparent when looking at her large, well stocked fruit bowl (figure 7), which had a can of salmon next to it. For her, this canned food is a deviation from optimum nutrition, but is done to preserve her mental health and wellbeing by reducing the time she has to spend cooking and preparing food in the kitchen, thereby reducing some of her time constraints. This use of ‘convenience food’ to make meal preparation faster and less stressful was a common behaviour for my participants, even though many of them felt the convenience items were nutritionally inferior to their more time consuming (and often ‘fresher’) counterparts (cf. Gustafsson & Sidenvall, 2002:164). In this way we can see food and health being connected to bodily and mental health through the navigation of compliance to and deviation from nutritionism.

Nutritional concepts are integral to how people link food and health. They may even be *why* people link food and health. Regardless, the way my participants think about food and health is influenced by nutritional ideology, but all have developed their own methods for assessing the health-food connection. This is perhaps because of the anxiety caused by shifting messages from science, personal bodily experience being different from the outcomes of recommended behaviours, and the large amount of food choice that people confront daily (see chapter 5 for further discussion). Despite this, nutritional principles are widely employed when explaining the connections between food and health.



**Figure 7: Anna's bowl of fresh fruit with a can of salmon to the left (June, 2010).**

Nutritionism apparently leads us all into constant negotiations between controlling our desires and release to indulge these desires (or complying with and deviating from nutritional ideology). This idea has stemmed from Williams' (1997) and Smith's (2002) work, both of which explore how food related control and release behaviours are negotiated by people in different social situations (families on holiday and women in prison, respectively). In his work on the spirituality of nutrition, Coveney (1999) introduces the idea that nutritional ideas are based on the Christian denial of bodily pleasures, meaning that foods that are 'good' nutritionally have come to be regarded as less pleasurable than those that are 'bad' (see also Coveney, 2006). This means that people are torn between their desire to be 'good' and 'healthy' and their desire for pleasure and enjoyment. I have taken the idea from these three studies (and also Backett, 1992; Lupton & Chapman, 1995) – that people negotiate between control and release – and explored it in everyday New Zealand family settings.

Nutritional experts tells us what is good for us, it would make sense that we would only desire to eat what is beneficial to our survival. This is not the case, however. Caplan (1997:4) suggests that in the case of food, the influence of culture is actually stronger than any survival or evolutionary pressures on food choice. It is recognised both in the literature and by my participants that the foods we enjoy the most, and which are socially and culturally valuable, are the ones nutritionism tells us we should avoid.

Salt, fat, and sugar – all valued flavour enhancers – are very much enjoyed by people, but therefore also threaten moderation, and in this culture of nutritional ideology, control and moderation of these threats are key. Because nutritionism is so embedded in our culture, so too is the notion of controlling our wants for the sake of our health, but so also is the concept of a release from this control (albeit a controlled release) to ‘treat’ ourselves to these culturally valuable, but health/control threatening foods. This release is especially apparent at social occasions or in times of mental stress or struggle (cf. Ikeda, 2004:303), where one feels it is acceptable to indulge momentarily.

Williams (1997) explains that indulgence is regarded as eating food that is nutritionally bad, and she uses the example of a full cooked English breakfast, which includes a lot of fried, fatty meat (such as sausages and bacon). In her research, these breakfasts are eaten on social occasions like celebrations or holidays, thereby delineating the special and the social from the everyday. Williams (1997:167-8) also describes how many of her interviewees used laughter when talking about ‘treats’, over-eating, or eating nutritionally badly, which she says indicates “ambivalence: guilt and enjoyment of items that are clearly ‘naughty and nice’, and a contradiction between food that is enjoyable... and food that is healthy”. This suggests that ‘being good’ (food-wise) is not enjoying oneself. There is the implicit idea that food that is ‘healthy’ is not enjoyable, but people put up with it because ‘being healthy’ is, itself, enjoyable. Charles and Kerr (1988:126) make this point when they say “Healthy eating...is often viewed as something virtuous, but not enjoyable”. It is also because being ‘healthy’ is socially acceptable; to be fat and diseased is not. So, while ‘bad food’ is suitable to eat on special social occasions, it is not socially acceptable to have a body that shows the signs of eating a lot of ‘bad food’ (cf. Lupton & Chapman, 1995:487). Williams summarises this paradox by saying that “the [social] mandate for discipline clashes with the mandate for pleasure” (1997:168).

This is a complex navigation of guilt, virtue, control, release, pleasure, and discipline (cf. Atkinson, 1983:9; Beardsworth & Keil, 1997:52; Coveney, 2006:iii; Germov & Williams, 2004:19). As we see below, my participants identified three ways of feeling healthy (bodily, socially, and mentally) that they associate with food, and each area requires a different course through the myriad considerations identified above.

### **Bodily health**

The first way that my participants connected health and food was through their bodies. This is similar to the bodily feedback discussed in chapter 3, but has a definite nutritional focus in the case of food related health and specific food related actions and outcomes. In terms of nutrition, bodily health has a strong focus on control: carefully controlling and monitoring one's intake of food according to nutritional principles, which means limiting some foods while consuming the 'right' amount of others. Keane (1997:181) explains that in his research: "Participants' own *embodied knowledge*, i.e. how patterns of food consumption affected them personally, was crucial to their understanding of the relationship between food and health", and notions of nutritional control are key to this experience.

My participants talked about paying attention to their bodies and learning what was 'healthy' that way, but also used nutritional concepts to explain food health and to decide what to eat, and all spoke of having to control their desires in order to maintain bodily health. Elizabeth, for example, said she tries hard not to eat cakes very often because they would cause weight gain and ill-health, even though she enjoys cake a lot. Other participants spoke about not eating 'bad' foods, and instead replacing them with 'good' foods which had more nutritional benefit, such as swapping white bread for whole-grain. This nutritional concern about the body getting the right nutrients was very strong. In the quote below, Jo felt her body was telling her she needed some of the nutrients in fish, even though she felt it was morally wrong for her to eat a fish:

I just stopped eating meat at that point [seventeen years ago]. But, then when I was pregnant with my daughter, I just really felt like fish, so I just thought, well, I'd better go with my body on that one. So, I've stuck with that and it's really suited me.

Jo said she feels guilty about eating fish, because she would not want to kill one herself (and she believes you should not eat something you could not or would not kill yourself), but she felt there were vitamins and nutrients in the fish that her body needed. Jo was trying to negotiate between two different discourses about food: one that food is a substance for human consumption which contains nutrients for fuelling human bodies, and the other that sees viewing other beings as 'food' as an anthropocentric outlook. Jo sees the fish as another being which also has feelings and life, and she is conflicted

about whether to relate to the fish as a fellow being, or as food which is healthy for her body. In this instance, nutritional discourse has prevailed, and Jo eats fish, but carefully controls her intake to minimise deviation from her morals.

Most of my participants told me that if they felt they really wanted something that was a food they considered unhealthy, they would have it. For example, from the previous chapter, Marie felt she wanted a lot of full fat milk, and because she felt this message was coming from her body she didn't think the fat content was bad for her, though she moderated this, saying she would only eat something she felt she wanted, but was unhealthy, "if I hadn't also been eating a lot of it lately". She said that if she, for example, had a desire to eat Vegemite, then it probably meant her body needed something that was in Vegemite, even though she might not know exactly what it was. Similarly, Evan said that if he really felt like chocolate then he would have some, as long as he had not consumed a lot recently. The point here is that my participants listen to their own bodily feedback and this feedback plays a big part in how they connect and experience food and health, but controlling their bodily urges when they do not match nutritional advice, such as a desire to eat cake or 'too much' chocolate, is important.

Two ideas are being combined here: one, that the body knows what it needs and that it is important to listen, and two, that sometimes one desires food that is not good for the body. In both cases the desires are moderated by nutritional ideas of 'moderation', or controlling food intake. This is interesting because these ideas seem to contradict each other. On the one hand, my participants earnestly believed that their bodies knew what was best for them, but they acknowledged that food was not just about nutritional health; it is also largely related to the mind. Bodily knowledge is viewed as 'good' and 'natural', and probably nutritionally-based and biologically advantageous, and my participants attribute their nutritionally 'healthy' wants to their body. There are other food wants, the ones that are perhaps not nutritionally healthy, but are socially or mentally healthy, that are therefore attributed to the mind, which is influenced by cultural ideas about sociability, commensality, and health. For example, 'treat' foods like cake are not linked to nutritional health, but people know that it is socially healthy – indeed an obligation - to have a piece of birthday or wedding cake with others, so such foods can be viewed as 'healthy' in that sense.

The 'mind' and 'body' are apparently seen by my participants as being separate and contributing different inputs to food choice and decision making. One must decide which 'type' of 'health' is best for each individual situation, and therefore, which input

to listen to. It appears to be an explicit and conscious balancing process between body and mind, social and nutritional, guilt and pleasure, and control and release.

### **Social health**

Social health is about feeling liked and accepted by others, and being able to function in society to achieve your goals (Donald, Ware, Brook, & Davies-Avery, 1978:2-3). This was the second type of health that my participants connected with food, and is also a connection made in the literature (cf. Lappalainen, Saba, Holm, Mykkanen, & Gibney, 1997; Sidenvall, Nydahl, & Fjellstöm, 2000; Sidenvall, Nydahl, & Fjellstöm, 2001). My participants saw food as essential to many social occasions, and as Jo said, “Food ... is connection, communication, all those things”. Food behaviour was important to their social health in these situations, and required a delicate balance between controlling intake and indulgent release. It is widely documented in the literature that mainstream health campaigns have created a ‘blame the victim’ environment, and that this leads people to be seen as responsible for their own health and illness, especially when these can be seen as food related (Charles & Kerr, 1986:58; Lawrence & Germov, 2004:124; Madden & Chamberlain, 2004:585). If a person eats a lot of foods that are nutritionally suspect, then their social health may suffer because they will be seen as reckless, irresponsible, and even immoral. On the other hand, too much control is also a problem, an appropriate release from control must be shown, or one risks being seen as uptight, boring, anorexic, food-obsessed, and a health-nut.

Different levels of this control-release balance are apparent in different situations. For example, Williams (1997) found that people were happy to eat a lot more ‘treat’ food on holiday than they would allow themselves at home; her chapter is aptly titled *We never eat like this at home*. The fine and shifting negotiation between control and release (or obligation and pleasure) was walked by all my participants, who recognised it as key to social health. Marie gave an example of this in chapter 3 when she spoke of the social health she felt she fostered by eating ice-cream with her friends, even though she felt a need to moderate that intake because she believes ice-cream is not nutritionally healthy. She feels it would be irresponsible to over-indulge, so she navigates between the correct amount of release for her social health, while not over-indulging and appearing irresponsible with her nutritional health. This is interesting because, as we saw in the previous chapter, my participants have a more holistic view of health than any one health message promotes. However, this can cause problems

because the different notions they have incorporated into their ideas of 'health' may contradict each other. These contradictory messages are navigated between depending on the situation, and an appropriate amount of obligation, pleasure, control, and release can be judged and acted upon with regards to health and any other considerations a person may have.

Health campaigns that focus on food choice as a way to get or remain healthy and cure or avoid illness place the responsibility for health on consumers. This means that each one of us can be seen as responsible for our own health, and therefore, illness. This leads to a 'blame the victim' mentality (c.f. Davison, et al., 1991; O'Dea, 2005:262), not only because we now understand health to be influenced by choices, but because it makes us feel safer because we can therefore avoid 'bad' choices (i.e. those that may lead to bad health). Consequently, if one gets sick with an illness that is seen as being caused or influenced by personal choices, that person may be viewed as irresponsible, or even immoral, and be socially shunned. This can be seen in the treatment of clinically obese people - they are seen, even by health professionals, as responsible for their condition and are often viewed as "lazy, stupid, and worthless" and not someone who would make a good friend (Schwartz, Chambliss, Brownell, Blair, & Billington, 2003:1037; also O'Dea, 2005:261). In a less extreme way, the everyday foods we eat, through their connection to health, can act as a social signal to others about our morality, discipline, responsibility, and worth as a friend and human being (Counihan, 1999:113; Williams, 1997:151). In other words, socially healthy foods or eating behaviours are ones that a person feels promote a positive image of themselves to others.

In this vein, Peter explained that he controls his food intake differently depending on the social situation. He said that he was more controlled (ate what he felt was nutritionally healthier foods) at home with his wife, which he feels is socially healthy in that setting, while out, or with some of his friends he eats more unhealthy meals which are 'healthy' for that situation, even though he feels they may not be nutritionally good for him. Both settings are, of course, nuanced with both control and release but one or the other dominates, and the opposite behaviour in either setting would be quite unacceptable. This may be because different people have different ideas about health that Peter can pick up on and act accordingly, or different situations themselves may promote greater control or release, such as in Williams' (1997) research which found a greater release was acceptable while on holiday than while at home.

Different amounts of control and release are required by different social situations and Peter navigates food decisions with his social health (as well as other things he values) in mind.

I had thought, when planning this research, that KKP in different domestic situations would have different feelings of responsibility and would cook with different considerations in mind. The evidence above, that social situations affect control and release behaviours supports this, but I found little evidence of it within different home situations. I found that Evan, who was cooking for his male flatmate had similar health concerns and KKP feelings of responsibility to Marie, who was cooking for her husband. In the past, a woman cooking for her spouse would have felt much more responsible for his health (Charles and Kerr, 1988), and the KKP duties would have been quite different between flatmates and spouses. Now, it seems, co-habiting and KKP duties can be similar, regardless of the marital relationship. One exception to this rule was households with children.

Because my participants were Key Kitchen People, they were responsible for what their children ate, and had a number of things to take into account. T.J. explained how he restricts the buying of certain products (such as ice cream and fizzy drink), while still trying not to deny his children anything. He tries to cook things they like, even if he thinks they are not the healthiest, like roast pork. It is well documented in the literature that parents do this for their children, because they use favourite foods as a token of love and to show they know and care about their children (Bahr-Bugge & Almås, 2006:207; Herda & Banwell, 1988:85; Tumer, Kelly, & McKenna, 2006). Anna and Jo, on the other hand, did not cook their children things they did not think were healthy, but when I looked in their pantry, both women had bought multiple food items for their kids that they were not completely happy about, the main things being chips, instant foods, and sugary drinks, things T.J. had none of. This shows a different collection of ideas about when it is all right to indulge, either at main meal times or snack-times, and that allowing children nutritional release was important.

T.J. restricts snacks, while being more lenient about meals, and Anna and Jo carefully control meal times while being more lenient with snacks. We can see some evidence of this in Jo's pantry (figure 8) below, which contains both 'healthy' meal ingredients, and things she told me were snacks for her children, which were not (in her mind) as healthy. This is one of the ways in which control and release plays itself out. Being healthy and controlled in one area means you can relax and be more indulgent in

another. My participants connect food with bodily and mental health: they are trying to “grow healthy children”, as Anna told me, and this means giving them food that is healthy for their bodies (or withholding food that is not), but being lenient with food that is seen as not so good for their bodies but may be healthy socially and mentally.



**Figure 8: Jo’s pantry with ‘healthy’ meal ingredients on the top shelf, and snacks for the kids (corn chips, crackers, biscuits) on the bottom (June, 2010).**

Cooking a ‘healthy’ meal is more about KKP choosing to make a healthy choice for the main family meals, and thereby fulfilling KKP responsibility, whereas snacks are more about individual choice. T.J. is taking a wide view of health in his preparation of main family meals. He wants to make his family happy, not just keep them healthy. With both male and female KKP working hard towards the health of their children, it is no longer just a woman’s job to ‘look after the kids’. T.J. wholeheartedly tries to keep his children happy and healthy. It seems this is now a ‘parents’ job, rather than a ‘woman’s’.

## **Mental Health**

Jo, Anna, Elizabeth, Marie, Peter, and Cath all expressed that food has a mental dimension. They talked most about sitting down at the end of the day with their household and talking, sharing, and helping each other, which is a component in mental health. As KKP they were proud that they could bring the family together in this way. This is different from the nutritional way of connecting food and health. This means that nutritionism is not the only food ideology for my participants. It is, perhaps, the dominant one, but food as social connection and mental health is important to them also. Interestingly, this is one of the fears writers such as Pollan, and scholars such as Scrinis and Fieldhouse have about nutritionism, that people have taken it too far and forgotten some of the other important, and more holistic, ways of connecting food and health. This does not seem to be the case with my participants.

They all saw food as a way to nurture themselves and their families. Jo said, for example, that she feels the love a person puts into preparing a meal can be felt by those who eat it. She is saying that mental health is affected not only by the actual nutrient content of what we eat, but by feeling connected to each other and sharing. This is a different way that food can be linked to health: through food related activities, not just the direct impact of food on the body that consumes it. It is also a very good example of health being about values. Jo values close connections with her family, and sharing with them, so one way for her to get what she values is through food, thereby connecting food with health.

Another mental component to food is more personal. This is strongly related to the discussion above about control and release of food desires. Cath told me that food is connected with both bodily and mental health, with all three things having an effect on each other. Like Jo, she connects food with mental wellbeing, but her personal example has its base in nutritionism:

I know you're not supposed to eat unless you're hungry, but a special treat can really relieve stress for me, or make me feel good. Like if I'm stressed out and feeling a bit hopeless and I go and eat a gorgeous bit of cake or have an ice-cream sundae, in that moment I'm totally relaxed, totally free of whatever is bothering me. It's magic. It doesn't work all the time though; you've got to really need it.... Like some of those empty calorie foods, like say a chocolate bar, might not be super good for your body if you ate them all the time, but

once in a while they can be super good for your mind. Like, relaxing food, treat food. It makes you happy. Though nutritionally good food makes me happy too, but in a different way. When I eat food that's good for me, I feel like I'm taking care of myself and feel good. When I eat food that's a treat, I feel good because I'm looking after myself too, just differently. The difference is, the treat food feeling good can quickly turn to feeling bad or guilty if I treat myself too much. There's a balance.

The ideas at work here are: that nutritionally good food can make you feel good for looking after yourself, but nutritionally bad food can also make you feel good for looking after yourself (cf. Smith, 2002:204). Nutritionally good foods do not relieve stress, but bad foods can, so much so that Smith (2002) found that female prisoners in English institutions used food to exert some control over their lives and give themselves pleasure in an otherwise very bleak environment. Caplan (1997:20) explains that people are very aware that 'unhealthy' behaviour can be life enhancing, even if it is not 'healthy'. Like Cath, however, these female prisoners knew what they were eating was nutritionally unhealthy, and felt bad for eating too much of it. So, bad food can be relaxing or reduce stress mentally, but not be so good bodily, but can lead to reverse effects, negative emotions and increased stress if the correct balance is not maintained between 'good' and 'bad'.

Clearly, this connection between food and health is made within the nutritional paradigm because Cath knows that when she 'treats herself' she is going against nutritionism, and that can feel good, but too much rebellion does not. This has to do with keeping things within 'normal' limits. Excessive behaviour would be considered deviant, but small deviations like Cath's are acceptable, and even encouraged as a show of release, but even more, as a show of control within that release. Release is not a true abandonment of control, but merely another way to demonstrate it, to keep release within certain 'normal', 'acceptable' bounds, and to know when to stop. The control must be controlled also; too much control without the 'release' is seen as abnormal also.

### **Conclusion**

Clearly, there is the pleasure of eating and the moral rightness of health, and these things are often mutually exclusive (Lupton & Chapman, 1995:477). There is a contradiction between food that is enjoyable and food that is healthy. So,

simultaneously, people are socially expected to eat both pleurably and healthily, but these qualities are, more often than not, not represented by the same food. However, it is seen as healthy to occasionally display release, because this is seen to represent a balance between one's self control and one's enjoyment, one's intake of 'good' food and one's intake of 'bad'.

Choosing the 'right' food is often about self control (Counihan, 1999:119; Williams, 1997:167-168). The food one really wants to eat is the wrong type of food, while the morally right food is only chosen when one has enough willpower. In this way, food is self-validating if one chooses 'right' and guilt inducing if they do not. Tied up in this 'self control' discourse is control and release (Lupton & Chapman, 1995:487). Sometimes it is 'right' to show self control, while at other times a show of 'release' is socially appropriate. This social acceptability, or expectancy, may not stop moral feelings of guilt, however. Because this relationship between food and health can be viewed in such terms as control-release, guilt-virtue, pleasure-obligation, and sacrifice-reward it is understandably fraught with nuanced meanings and anxieties. Indeed, the common dialogue of 'everything in moderation' (which is akin to lay notions of 'balance') is a way of coping with the confusion of information, anxiety, and social pressure (Lupton & Chapman, 1995:477) surrounding food and eating.

## Chapter 5

# Anxiety and Coping

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“It’s like the gestalt thing, the whole is greater than the parts? Well, if we start messing with the parts, we can’t tell what the sum is.”

Cath

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Because of the tensions outlined in chapters three and four, my participants felt anxious over their food choices. Much of the literature around food anxiety is concentrated on ‘food security’, or concern about having enough food to survive, as well as a plethora of work done regarding eating disorders such as anorexia. My participants all had more than enough food to survive and thrive on, but still reported feeling anxious about food. Rather than feeling this anxiety over *when* their next meal might be, they felt it over *what* might be in their meal. Food choices in times of plenty can also create anxiety.

My participants often talked about how it was difficult to know what was healthy for them to eat; that experts’ advice was confusing or contradictory, or that they felt profits interfered with the giving of unbiased health advice. Eating, though, is a natural process; why should people feel they need advice about what to eat? While food practices and eating include biological processes, as we have seen in the preceding chapters, they are also a culturally and socially constructed process, as is the science used to investigate healthy eating (Fieldhouse, 1995:49; Morrall, 2009:71), and culture can, in fact, be more important to people than health (Mintz, 1997). This means that the whole area is subject to change based on a range of variables including things such as politics and economy (Fieldhouse, 1995:1; Pollan, 2006:2). Scientists, also, are continually investigating and discovering in the area of food, which can lead to changes in dietary guidelines and advice (Scrinis, 2007a, 2007b; Beardsworth & Keil, 1997:159). This can make consumers feel that healthy eating is a confusing subject and that even ‘experts’ do not know the answers (Beardsworth & Keil, 1997:159-60). This can lead to doubt and anxiety around what food choices to make.

The idea that my participants might feel anxious over their food choices did not occur to me until I started talking to them because I expected to find that KKP had less control in the kitchen than they did, so therefore would not have many choices to be anxious over. In 1988 Charles and Kerr made a point of telling the reader that while

women were the main kitchen person in a household, they had little to no power to choose what meals the family was going to eat (see also Pill & Parry, 1988). Charles and Kerr recount horrible stories of husbands raging at their wives for cooking the ‘wrong’ thing or for preparing it in the ‘wrong’ way. As far as my participants were concerned, this was a thing of the past. The women I interviewed certainly took into account family likes and dislikes, but ultimately, they felt they had the power to choose what they cooked. Anna, for example, when I asked her if her children and husband liked what she cooks, said “I’ve never given them much choice [in what I cook]. I’ve always made sure they’ve had a wide variety of things to eat, but I like what I make”. She then goes on to detail some of her family’s preferences, such as for organic meat, but said she still cooks what she likes. Jo is a vegetarian while the rest of her household is not. She acknowledges that they would probably like her to cook meat, but she refuses. Her family accepts this, and has found ways to compromise, such as cooking their own meat at meal times. This is drastically different from reports of female KKP from the 1980’s. What is even more interesting is that the male KKP I interviewed seemed more likely to defer to the preferences of the females in their household. Both T.J. and Peter, who live with their female partners, said they often cook according to their partners’ health ideas and food preferences.

This change has occurred for a couple of reasons. Firstly, the rise of female equality is now well known and a part of the culture in New Zealand (Hausmann, Tyson, Zahidi, 2008; Wirth, 2002). This has made both men and women more aware of gender equality issues and given women more power in the kitchen, whether they are the one working in the kitchen or not. Secondly, there is more food choice now than ever before (Caplan, 1996:218), which means that more thought must go into meals and choosing foods, and there is ever increasing public and media attention focussed on the topics of food and health, so the issues around food are more salient and well known. The fact that the men in my study defer to the women in their lives with regard to food and cooking is likely because women are recognised as being more aware of these things, in general, and of being more concerned about health (Wardle et al., 2004). If we combine a higher concern and knowledge with a greater equalisation in power, we get the current situation: women and men more equal in the kitchen than ever before.

Alongside this increased knowledge, concern, and power, however, comes an increased sense of risk. Because KKP now know more about food and food risks, and because they have the power to control what they cook, the responsibility is theirs to

choose safe, healthy food. As with responsibility though, my participants did not talk about risk, food choice and anxiety from a KKP perspective; they spoke about it from a personal perspective, with little mention of how risks might affect their family, or how they were anxious over foods they fed to their family. Food risk seems to be a much more personal thing and is most likely linked to health being an individual responsibility.

### **Risk**

In cultural terms, Beck (2002) believes we now live in what he terms a 'risk society'. Lash and Wynne explain in the introduction to Beck's book (Beck, 2002: 3) that "The axial principle of industrial society is the distribution of goods while that of a risk society is the distribution of both 'bads' and 'dangers'". Beck explains that we are actually living with these two societies side by side; that it is industry, along with science, that creates the risks felt and experienced in our 'risk society'. As we will see below, my participants felt there were risks involved in scientific knowledge, the food industry, and in food choice itself. Their feelings of anxiety and risk were more diffuse than Beck describes in his work (cf. Beck, 2002: 25-6), where he mainly concentrates on issues such as pollution and toxins in food, whereas my participants were anxious about the general 'health' of their food, nutritional content, and the state of food knowledge and controversy.

Biologically, another source of food anxiety is what Fischler (1988) terms the 'Omnivore's Paradox'. Stated basically, the paradox is: humans want a lot of variety in their diet, but are also afraid of new foods (Pollan, 2006:3). Because humans are omnivores (we eat a great variety of foods including meat and vegetables) we need a lot of variety to stay healthy (Beardsworth & Keil, 1997:50), however, each new food we eat is a source of threat. In today's world when we are faced with so many food choices, but also many food threats (not to mention the social ideas about control and release discussed in the previous chapter), Fischler believes we are all subject to a fundamental anxiety over food. In other words, we are afraid that what we eat might make us sick, and as Rozin (1976:23) explains, "Omnivores... faced with an enormous number of potential foods, must choose wisely".

There is a cultural side to this risk also. Fischler goes on to explain that "incorporation is the basis of identity" (Fischler, 1988:279); we feel we become what we eat (Caplan, 1997:9; Fischler, 1988:279), providing yet another level to the anxiety

surrounding food. As Beardsworth & Keil (1997:52) say: "...when humans eat, they eat with the mind as much as the mouth". So when we eat, we incorporate food both physically and mentally (Fischler, 1988:280), and it is no wonder that this causes anxiety. Lupton and Chapman (1995:478) explain, "Food occupies the dual and conflicting roles of potential pathogen, source of disease and death, versus those of giver of life, nourishment and emotional comfort", and carries information about who we are and where we situate ourselves within society (see chapter 4). Fieldhouse (1995:85), for example, says that humans' need to belong to a group is a very powerful motivator for their actions, and that "food readily becomes an expression of this search for belongingness". A wrong food choice has both physical health risks and social risks.

Despite these anxieties, people eat, KKP cook for their families, and most do not report feeling overly anxious or under threat (Chamberlain, 2004:474). Lupton and Chapman (1995:478) propose that health advice and beliefs can be seen as a way of dealing with the paradoxes in human eating and the anxiety they produce (see also Beardsworth & Keil, 1997:158). What Fischler's and Lupton and Chapman's work means is that the omnivore's paradox is why many people in the West, including New Zealand, are widely reported as feeling they do not know what to eat and why they are looking to be told. Health advice tries to resolve this anxiety by telling us what to eat, but ends up actually making things worse because the advice (which is based on science) is shifting, changing, and developing (as science is supposed to), but this gives people no firm base on which to situate their food choices. The anxiety caused by the omnivore's paradox is compounded by the very advice that is designed to help people cope.

People do deal with this though. Everyone (with few exceptions) continues eating, cooking, and even enjoying, their food. This is because both society and individuals have come up with ways of coping with this uncertainty. These range farther than health advice to include aspects of food such as its perceived naturalness, vitamin content, pleasure, and personal experience. To aid my discussion of food anxiety and coping strategies I will use Green et al.'s (2003) work to draw parallels and differences with my own research. Their article centres around food scares and the idea that people use coping strategies to make food decisions with little to no direct reference to the 'risk' or 'safety' of a food. Risk, in the case of Green et al. (similar to Beck, 2002), means the perceived risks, thanks to media scares, of food borne disease and illness (p. 33). The fact that their participants did not refer directly to food risk is similar to my

findings; none of my participants mentioned risk. They did, however, talk about anxiety, which is why my focus is slightly different from that of Green et al.. My focus is on food anxiety, of which perceptions of risk can play a part. I will begin this section by giving some examples of my participants' food anxieties, before examining the 'rules of thumb' they use to overcome these.

### **Anxiety**

All of my participants spoke of their personal food anxieties, explaining to me what worried them, what they bought, and the strategies they used to reduce their worry. As explained above, much of this concern was about their individual health; they did not discuss worries about food risk and the health of their household without being directly asked. It seemed to go without saying that their personal food anxieties and the resulting food choices as KKP, while personally focussed, would also keep their families safe. Many of my participants told me they 'just do the best they can'. Some, like Anna below, were worried about chemical ingredients, some about fats, sugar, and salt, others about country of origin. What they all had in common was that they felt there was risk associated with certain foods. When, for example, I asked Anna whether she thought there was much anxiety around food, she replied:

Oh absolutely. You see people, (and even I do it!) looking at the labels of everything. I do it because I want to know if there's chemicals in there, but they look for fat and sugar. There's just so much anxiety over food, I think that must be unhealthy.

Different people may have different concerns about their food. Anna is worried about chemicals, while some of my participants, such as Peter, are concerned about avoiding excess fat and salt in the foods they buy. Cath, for example, was concerned with nutritionism being too narrow a view as a basis for healthy advice: "I don't think the nutritionists have got it all right. It's a narrow view....It's like the gestalt thing, the sum is greater than the parts? Well, if we start messing with the parts, we can't tell what the sum is". By this she means that food is more than the individual nutrients that scientists have identified, and that if we start eating or producing food with too much of a focus on a particular nutrient, then the healthfulness of the whole may be lost or misunderstood (see Pollan, 2008 for a discussion of this).

When I asked T.J. about his food anxieties, like Anna he spoke of chemicals in his food, but went on to talk about the origin of his food, food hygiene, and pollution:

I think ‘how much [chemical] is in that processed stuff?’. And I’m careful where my food comes from now too. Like some of these Chinese products, I just am doubtful about their hygiene practices, I think it can’t be as good. And, like the quality of the water that’s gone into that product. Like, one time I bought a jar of curry and it was made in Thailand I was just wondering how clean the cannery is, and the water quality, because they don’t always have the best sanitation. Hopefully it’s ok.... Like I stopped buying the peanut butter that came from China, so I look for NZ made. There was something bad about it, but I can’t remember what it was.... I’m always worried about stuff that comes from China because of the air quality, and the pollution.

T.J. feels anxiety and uncertainty over the food he is buying, eating, and feeding to his family. While his worries are sometimes diffuse and uncertain, his anxiety manifests itself in his behaviour; he no longer buys peanut butter from China, for example, but because he wishes to eat certain foods he does buy some products made in Asian countries, such as curry paste and coconut milk. He resorts to ‘hoping’ the food is sanitary and safe, and concentrating on buying New Zealand made products as often as possible. This is strongly related to Beck’s (2002) ‘risk society’ work, especially with regards to pollution, food borne illness, and the risks associated with industry. This connection with the risk society can be made because imported foods (along with most other foods in our supermarkets) are a product of the industrial age, and now along with the importation and distribution of food from other countries, we also import and distribute new risks – diseases, contamination, and pollution. T.J. is very aware of these risks, so uses his perceptions of risky foods to choose foods he believes are more ‘safe’.

My participants are anxious about not knowing what is really healthy to eat, chemicals and additives in food, and the hygiene and preparation practices around the food they buy, as well as the social elements of what they choose to eat. They are also anxious about feeling anxious. However, as KKP, they all still buy, eat, cook, and give food to the people they love. They have strategies for coping with their food worries and the anxiety caused by living in a ‘risk society’, conflicting and changing health advice, and the omnivore’s paradox.

### **Strategies for coping**

Green et al. (2003) present the idea that people use rules of thumb as a strategy for coping with food anxiety which allow people some measure of feeling 'in control' of their food choices (p. 33). They explain that rules of thumb are discourses around food that make food choices routine and unremarkable (see also: 'Strategies of confidence' in Sallerberg, 1991; 'Unconscious culture' in Fieldhouse, 1995:15). This was certainly the case with my participants. Their perceptions of changing and/or conflicting food messages from advertisers and health professionals, 'risk', and social considerations, produce anxieties and uncertainties (as can be seen above) against which rules of thumb provide easy and accessible answers.

Strategies for coping with food anxiety differ between individuals. Beardsworth & Keil (1997) found that people develop their own rules of thumb when choosing foods, for instance adopting discourses such as 'natural foods are better for you'. Chamberlain (2004) and Green et al. (2003) found that:

Some reported rules of thumb were simple dualities that divided the 'good' from the 'bad' in terms of food choices. These included organic/non-organic; ready made/home made; fresh/ frozen; traditional/mass produced. Others were extended as scales of preference, with 'favoured' and 'denigrated' food stuffs at either end. One scale, referred to in most of the group discussions, was geographical distance, with home (garden or allotment) produce the most prized, through local produce, to imported as the most suspect and potentially risky (Green et al., 2003:39).

This reliance on simple dualities was very similar to what I found with my participants.

One of the main ways that 'rules of thumb' were talked about by my participants was in terms of 'common-sense'. Referring to 'common-sense' was my participants' way of talking about 'rules of thumb' and these two terms will be used interchangeably below. Beardsworth & Keil (1997:143) believe that people rely on common-sense because some of the choices and behaviours recommended by science lack a feeling of logic, or 'intuitive comprehensibility', so people resort to these 'common-senses' to reshape nutritional ideas.

For example, one such aspect of common-sense is 'balance'. Balance has both 'scientific' and 'common-sense' meanings. Scientifically, it has to do with nutritional

notions of balancing nutrients and vitamins, whereas it may be ‘common-sense’ to balance sweet and savoury foods, meat and vegetables, ‘healthy’ food and ‘treat’ food. Lay people’s idea of balance seems to be somewhere between scientific and non-scientific meanings of balance (Beardsworth & Keil, 1997:145; Fischler, 1986:962), incorporating ideas of balance between control and release, good behaviour and rewards, and nutritional balance. This is not only because food is a very social object, but because while the public seems to want to trust scientific findings, "By its very nature, scientific knowledge is always provisional, subject to controversy, challenge, refutation, and replacement. In this sense, it is very unlike common-sense knowledge... whose elastic and slowly evolving nature makes [it] appear both homely and proverbial" (Beardsworth & Keil, 1997:159; see also Madden & Chamberlain, 2010:292). However, even in traditional societies, food classifications are not wholly agreed upon (Fieldhouse, 1995:47) and this seems to be the case in my participants’ discussion of common-sense food and health behaviour.

### **Common-sense**

Pollan (2008:13) situates common-sense in opposition to modern scientific knowledge or advice about food, not in content, but in ideological standpoint. Often common-sense is very similar in content to scientific knowledge, but people feel it is more stable. Pollan (2008) sees common-sense as tradition, and more a reflection of our ‘natural’ knowledge than that of science; natural knowledge that incorporates our own and our ancestors’ experience and culture. Similarly, Geertz (1975:para. 7) proposes that you can treat common-sense as “a relatively organised body of considered thought...”, but that this body of thought is often considered to be things ‘you just know’, or knowledge brought about by informal experience and reflection. The thing about common-sense is that it is just thought to be “life in a nutshell” (Geertz, 1975:para. 7), knowledge that is apart from science or academia; knowledge gained by living.

However, nowadays we get scientific knowledge just by living, we are being told it all the time, so this is incorporated gradually into knowledge that we think of as ‘common-sense’. Despite people’s reliance on common-sense for explaining how they know what they know about certain things (like diet and health as we will see below) common-sense is actually not very widely studied, and Geertz (1975:para. 11) proposes that it may be thought that it is common-sense to know what common-sense is. However, as you might expect, different cultures (and, as with my participants, different

people within the same culture) have different notions of what common-sense knowledge and behaviour is (cf. Fieldhouse, 1995:35; Ashkenazi and Jacob, 2003:175) .

The ‘common’ part of common-sense may not be so common. Is the ‘sense’ part sensible? Geertz (1975:para. 19) explains that people use common-sense to “plug the dikes of their most needed beliefs” (or to plug the dikes of their defences against anxiety and conflicting messages from ‘outside’), and I think this is really the core of the common-sense matter. Common-senses make sense to those using them, within the belief system and range of experiences of that person, but one person’s common-sense may be another’s stupidity. By telling someone something is ‘just common-sense’, you might really be saying, ‘I don’t want to analyse, question, or change this belief, it’s working for me and it should work for you, so don’t you question it’. It functions like a warning. If I say something is ‘common-sense’, you can not easily question it, because that would mean you do not have common-sense (which is bad thing). It is also saying, ‘How come you don’t know this? Do you not belong to our social group? *We* know it.’ (cf. Caplan, 1996:217; Lupton, 2000:95). It is a way of denoting social boundaries between insiders and outsiders and elevating insiders’ knowledge. Because belonging is so important, conforming to ‘common-sense’ becomes important. When I asked Marie how she knew what she does about a connection between diet and health, she said:

I used to read a lot of health stuff, but there’s so many conflicting opinions. It depends on who’s doing the research, and it’s always changing. I’ve found now that most of it is common sense. Like the darker or brighter the colour of the vegetable, then the more nutritional value it has. Unlike lettuce, which is almost white vs. spinach.... You need to know how basic food works and what your body needs, but once you know that you don’t need to know all the little details.

While Marie calls this knowledge ‘common-sense’, it is based on nutritionists’ messages, and shows that she has accepted and internalised these ideas to such an extent that they have become a sensible and easy way for her to make sense of food choices.

Marie feels she had developed a common-sense about food through her reading. Now that she feels she knows how the body and “basic food works”, she can develop a common-sense attitude towards it; it is about knowing the basics and being able to extrapolate out from them using logic and experience. This is not ‘common-sense’ in

the traditional knowledge sense of the term. Marie is using common-sense to mean ‘sensible’ and ‘balanced’, and sees this type of knowledge as a positive way to conceptualise her beliefs. Labelling her ideas as ‘common-sense’, even when they may actually be closer to scientific or academic findings, allows her to feel more comfortable with the ideas and makes the ideas more acceptable (or at least less questionable) to others.

In this quote we see a blending of ideas about colour and nutrient value. Jo also made this point, saying “...I think if you cover a broad range in colours then you’re probably covering things quite well”. This is something found both in nutritional advice and in the literature as well. Fieldhouse (1995:197) points out the aesthetic evaluation of a food is important to whether it is eaten, and Belasco (2008:22) explains that it is widespread in the West for consumers to look for “brightly colored” fruit and vegetables, and that this has to do with perceptions of freshness, sanitary conditions, and healthfulness (p. 71; see also Green et al., 2003:45). This is a rule of thumb employed to reduce anxiety about food risks and nutritional benefits presented as common-sense knowledge, making it more legitimate for the user.

Peter also used common-sense as an explanation for his actions and conclusions about eating and health. When I asked Peter how he knew what to eat, he said:

It’s just, I guess, a personal choice. Like, use your common sense and logic to think... like think about your food - do you need to eat a whole pizza, or just a few slices to feel full? I used to mindlessly eat a whole pizza, but now I look back and think ‘I really didn’t need to do that’. So, common sense and thinking about what your body actually needs to have in it.

Common-sense, personal choice, logic, and mindfulness are linked together, highlighting the fact that common-sense is formed through personal experience and reflection. Peter juxtaposes ‘mindless’ with thinking and ‘common-sense’. This actually negates the ‘common’ part of the common-sense, because he’s formed the ideas for himself, but obviously thinks it is the logical and common conclusion anyone sensible would come to. He is using a discourse of common-sense to legitimise the conclusions he has reached.

When I asked T.J. how he knows what is healthy to eat, yet again, the idea of common-sense was employed as part of the explanation. For him particular foods are

not intrinsically 'bad', but become unhealthy when eaten in certain (large) quantities. This suggests that food related health ideas are as much about food behaviour as about actual food. T.J. said:

Oh well, just common sense. Just keep down the sugar and the fats. Coconut cream, that's probably not good for you, but if you're only having it, say, once a month, then it's not that bad.

T.J. has used common-sense in conjunction with nutritionism. Because nutritionism, as we saw earlier, is an ideology it is not surprising that it has become incorporated into common-sense. If, as Geertz (1975:para. 7) says, common-sense is "life in a nutshell", then nutritionism ideas will certainly be contained within that nutshell. T.J. says that it is 'common-sense' to keep sugars and fats at a low intake. He also presents the idea that it is ok to have something in moderation - coconut milk only once a month, for example. This means that T.J. is focussed more on his behaviour than the food itself, meaning that he can reduce his food anxiety by monitoring his behaviour and worrying less about particular food choices.

In these examples, common-sense is being blended with other types of knowledge, such as nutrition, aesthetics, bodily feedback, logic, mindfulness, and habitual behaviour. 'Common-sense', therefore, is what people call their internalisations of other types of knowledge, especially scientific knowledge. This is because they see common-sense as more stable, reliable, and less questionable than scientific knowledge, or even self-deduced knowledge (like bodily-feedback or logic). By internalising messages and labelling them 'common-sense' they get an easily accessible, routine way to make food decisions and minimise food anxiety. In each of the above quotes, common-sense is used to internalise and bolster conclusions made through other ways of knowing or learning. Green et al. (2003:49) suggest in their work that common-sense can be used as a more socially acceptable explanation when people feel their ideas might be under threat or seem irrational. The example they give is religion-related food practices, but I think it is perfectly feasible that there is so much confusion over food and food information that all ways of knowing are controversial, under threat and can be seen by someone else with a different viewpoint as irrational. In this way, my participants employed notions of 'common-sense' to explain their beliefs about anxiety and food-health connection.

### **Rules of Thumb**

Stemming from ‘common-sense’ ideas about food are rule of thumb, the coping strategies that people use to make their food choices. Green et al. (2003:33) explain that rules of thumb are “Strategies for making food choices [that are], in general, characterised by confidence rather than anxiety”. In their study, participants did not report being worried about the safety of food per se, but instead used discourses such as “...naturalness, economy and convenience...” (p. 33) to talk about food choice. Green et al. call these discourses “‘short cuts’ or rules of thumb for establishing food choices as routine and unremarkable” (p. 33). They give examples of discourses such as organic, home made, fresh, and natural which their participants used to make easy decisions about which foods were healthy and which were not. My participants used these same rules of thumb to talk about food choice and what was healthy. By making these choices easier, rules of thumb also made the job of KKP easier. Their rules of thumb centred around ‘traditional’, ‘home-made’, and ‘natural’ because people felt they had some knowledge about these methods of food production, or if they lacked personal knowledge, then the fact that their ancestors ate food that was ‘traditional’, ‘home-made’, and ‘natural’ proved that it is safe. This passed-down knowledge is key to the survival of omnivores, so it is not surprising that the bulk of food suspicion falls on ‘new’, ‘processed’, or ‘manufactured’ goods.

### *Naturalness*

Green et al. (2003:48) found that “many participants... identify natural foods (those with least processing before they reach the kitchen) as healthiest, [and] there are also elements of faith in technology... as improving and ensuring [food] quality”. While I did not find explicit evidence for faith in technology among my participants, there was a marked preference for ‘natural’ products and foods. Both Anna and Cath stressed the idea that their food should be as close to how it has grown as possible, while Evan asserted that salad was the best food because it was eaten almost exactly in the state it was when it was growing. Elizabeth explained her distrust of processed food when asked if she thought processed was different from fresh:

I don’t know, but I suspect so. Yeah, I suspect that they have a lot of bits and bobs in there... but I don’t know that they do any harm either. You know, all those things you read, like you read that something that should have like four

ingredients, like milk, eggs, cheese, and pasta for macaroni cheese, but the packet has a list of like twenty ingredients... all these chemicals and stuff with numbers after them. Perhaps they don't do you any harm, I wouldn't have a clue. But then I also don't know if they're nutritionally giving you anything, either, or if it's just stopping you from being hungry.

Elizabeth is unsure about whether processed foods are bad, but she clearly distrusts them. She tries to make as much of her food at home as she can, such as pasta sauces and gravies, and even things like bread, pasta, ice-cream, and sausages when she can find the time. She says this is because these things taste better, and she knows what is in them.

Knowledge of what is in a food was very important to my participants (see also: Mackinson, Wriedent, & Anderson, 2009:570). The discourse of 'naturalness' they used to talk about what foods were healthy has a lot to do with really knowing what is in a food. As explained previously, omnivores, because they need to eat such a variety, must be careful about what they ingest in case it is poisonous, so knowing what a food is, especially if parts of it are not easily identifiable, is a key way a person can make their food choices less stressful. A person can, of course, read the ingredient label but some of the ingredients are not easily recognised, or are complicated chemical names. This causes anxiety, so they fall back on ideas of 'naturalness' to get them through. Jo illustrated this point when she said what she looks for in food is:

Lack of additives.... I compromise on butter because I don't like all the stuff in margarines, [but margarine is lower in fat] so we get a blend. I don't buy processed cheese, bread is wholemeal, yeah.

Sometimes coping strategies clash. Jo's desire for naturalness and her desire for low-fat result in her solving this problem by buying a blend. She feels that that way she is getting the best (and less of the worst) of both worlds: lower fat and fewer additives. She specifies she does not buy processed cheese (presumably because she does not know what is in it or how it has been treated) and when she does have to buy a processed food, such as bread, she buys 'wholemeal', which is advertised as being better for you and closer to nature because the grains are less processed (Baking Industry Research Trust, n.d.: para.4-5; Carr, 2007). Overly processed food is not

trusted, particularly because of concern about additives, but has to do with how much a food appears to have been handled by others outside the home. This, again, comes down to knowing what is in one's food and how it has been made/handled so that an informed decision can be made about the potential risks of that food.

Peter makes this point when talking about fish. He says:

Things like fish, we will almost never buy. I catch fresh fish and it's so much better. You never know how long the fish in the supermarket has been there. It's just not right, don't know how long it's been sitting there or what kind of nasty things could be happening to it.

This rule of thumb allows Peter to feel safe when eating his fish, and releases him from the worry of what others might have done to his food. Similarly, Marie spoke of wanting her own vegetable garden, because vegetables grown at home are better than those in the shop. When asked why this is, she replied:

Because they aren't imported, or injected, or dyed, or enhanced. And despite all that, the fruit [in the shop] can be really bland. So I think you know what's been done to them [if you grow your own], if they've been sprayed and what with. And you know how old they are. Plus, when it's growing, you can just take a little bit, and the rest stays fresh.

This matches with Green et al.'s finding outlined above; that people feel more confident about food grown in the home because they know what has been done to it. Once again, knowledge appears to remove some of the anxiety around a food.

My participants' concern about naturalness links in with the Omnivore's Paradox, and Beck's 'risk society'. People already have food uncertainty as a result of the Omnivore's Paradox and this is exacerbated by the perceived risks of modern food, so going back to a time when we envision food as being safer (to what we believe our ancestors ate safely) and by knowing what's in a food, we are in a better position to ascertain its safety. This reduces our feeling of anxiety. On the other hand, people do buy enhanced products, one main example being milk with added calcium or pre-biotics. I think this may be acceptable to people because those things are seen as being

present in foods anyway, so the risk is not as high as completely unknown food additives. This brings us to our next rule of thumb, nutrition.

### *Nutrition*

Green et al. (2003:41) point out that nutritional value is one way for a person to distinguish ‘safe’ food from ‘unsafe’ food, “especially the family food purchasers”. This makes sense because, being a dominant ideology, it is an easily accessible tool or way of thinking about food that people can use to minimise their anxiety when choosing what to cook and eat. Nutritional discourse is spread throughout other coping strategies, as we can see above in my participants’ discussion of vitamins, fat, and sugars to do with common-sense and naturalness. These coping strategies all blend together to form a person’s overall ideas about food and health. Anna is particularly interested in using nutrition to get the most out of her food and to choose her foods, especially when someone is ill:

I know a fair bit [about nutrition], probably not as much as I should.... I read. I have a real interest in that kind of thing. My brother got cancer a couple of years ago and the first thing I did was get some books out about how to eat for the immune system and things. So I am quite aware of things like that.... There’s a really nice book I’ve got called ‘The Food Doctor’, and it’s really good, when you’re unwell, to do something about it.

Green et al. found that for some people, and this is the case for Anna above, nutritional coping strategies can have less to do with food safety and risk and more to do with optimising the body through food (p. 42). While Anna spoke of foods that can help ‘boost’ the body or help make a person better from illness or discomfort, she did not mention any foods that could compromise the body or make it sick. However, it is fairly clear that the knowledge she feels she has about nutrition helps her reduce anxiety over what food to choose because she chooses the ones which will give the most benefits to her family.

Similarly, Cath spoke about getting benefits from food:

... seriously processed things, like that pasta you can cook from dry for a minute in the microwave... that stuff... well, ew for your body. I don’t reckon

you're going to get much out of it other than fat, salt, sugar, and empty calories.... [That means] calories that have no nutritional benefit. It's just energy and bad stuff: sweets, chips, fizzy drink. [Nutritional benefit] is important. It's what makes your body work.

In this quote, however, she does talk about some food being “just energy and bad stuff”, implying that foods with little nutritional benefit are not good for you. She uses these ideas to cope with food choice anxiety by choosing foods she feels will benefit her body and minimising those she feels will not. This gives her some solid guidelines to follow when choosing food and allows her to separate the ‘good’ from the ‘bad’ and make her shopping, cooking, and eating an easier process. As Green et al. (2003:42) found, nutritional coping strategies can be safety and risk based, as we can see from Cath’s explanation, or more focussed on bodily wellness and optimisation, as with Anna.

#### *Moderation, variety, and balance*

Moderation, variety, and balance are concepts mentioned again and again, not just by my participants, but within food-culture literature as well (along with other important related concepts such as aesthetics, pleasure, and sociability). All eight of my participants mentioned ‘moderation’ and ‘variety’ as being a key way that they work out what is ‘ok to eat’, and that within moderation there had to be variety and balance among foodstuffs. It was not just foods thought of as ‘healthy’ that were included in this discourse, either. An ‘everything in moderation’ approach seemed to be adopted as a way to eat things my participants loved but thought were not good for them. Peter made this point when he said “...it all comes back to moderation.... It’s a strategy to good health without giving up everything that you love”, and Anna said “[you can have] butter, fat, and cheese in moderation....You need to realise that a little bit of what is supposedly not good for you, is actually very good for you”. She is saying that the importance of variety overrides whatever notions of ‘good’ or ‘bad’ are attached to food, and that it is eating behaviour that is most important.

Not giving up food that is pleasurable was an important aspect to my participants’ ideas about eating healthily, and ideas about pleasure were apparent in their discourses to do with balance, variety and moderation. Elizabeth said that, for her, variety “is more in terms of boredom and taste for us”, and Evan felt that variety was important for both pleasure and nutritional health:

I'm not sure if it has a direct bodily impact, but it does on happiness. I mean, having the same thing day in and day out. I think variety is really important. You miss out on things your body needs. It has to be healthier; you cover all your bases.... Everything in moderation.

Nutritional ideas about “covering all your bases” nutrient wise are combined with ideas about happiness and pleasure. He also easily incorporates ‘moderation’ into his discussion of variety, which was common in my interviews.

Moderation, balance, and variety are very closely linked, with each idea incorporating the other two. Anna, for example, when asked about variety, said: “I kind of believe that we should eat a variety of things.... We tend to eat not a lot of one thing, like we eat a little of a lot of things. I think in that way we kind of balance out”. This links balance and variety, and in similar ways, many of my participants linked these three concepts. Elizabeth said: “I’ve always considered that we have a very balanced diet anyway. Very varied compared to a lot of people I’ve talked to, so it’s never been a concern”.

It may appear that the discourse of ‘variety’ is one that allows people release from the constraints of thinking about ‘good’ and ‘bad’ foods. To a certain extent, this appears to be true. My participants have used the idea of variety to make healthy eating an issue of eating behaviour rather than particular foods. A discourse about variety manages to combine both the pleasure people want and freedom from anxiety about eating ‘bad foods’. Bad foods are no longer ‘bad’ foods, they are all ‘good’ when built into a bigger discourse about ‘variety’. While this is partially true, and people do use variety (and the closely related notions of balance and moderation) to reduce the anxiety around their food choices by making many foods acceptable, *all* foods are not acceptable. T.J. finds foods from Asia unsafe, Jo steers clear of processed foods, and Anna sticks to home-grown (or as fresh as she can get). Many of my participants’ quotes show that they are anxious about foods themselves, not just their food behaviours, and class some foods as intrinsically ‘good’ and others as ‘bad’.

## **Conclusion**

Green et al. found that discourses of risk and safety were not points their participants made without being prompted. My interview schedule, on the other hand, did not

include any direct questions about the safety, risk, or anxiety over food. These themes and the ways my participants coped with them were all apparent in my interviews without my initial prompting. While food anxiety and coping strategies were not a key focus of this project when it was designed, these themes were so apparent that the research analysis had to be changed to accommodate them. This difference may partly be because I was asking Key Kitchen People about health, with a particular focus on the fact that they cooked for their families. Because of this highlighted responsibility, it may be that my participants felt food anxiety and risk more keenly because their attention had been focused on health issues, food, and loved ones.

The idea of common-sense as important to how people cope with food-choice anxiety was found by Green et al. to be a “last resort” way of coping, useful only when “more formal risk assessments contradict or fail to inform choice” (p. 51). This is, again, different from my findings. Using common-sense was one of the first and most talked about methods my participants identified as key to making food choices. Green et al. say that their participants identified common-sense as being in opposition to ‘expert’ advice. My participants, on the other hand, used and combined different types of knowledge, such as ‘expert’ scientific advice, knowledge gained through experience, and social knowledge to construct their common-senses – not in opposition to, but in tandem with, other ways of knowing. The ‘common-sense’ label was less about the origin or content or knowledge, and more of a rationalising or defence mechanism. This difference may be the result of the different cultures being studied. The research by Green et al. was based in England, while all my participants were New Zealand Pakeha. New Zealanders are known for their self-reliant, DIY attitude (King, 2003:509), and it may be that this has influenced how they make food choices. Perhaps, rather than relying on these ‘formal risk assessments’, which presumably come from ‘experts’, New Zealanders tend to prefer to integrate the knowledge with what they already know and make their own choices. So, for them, common-sense is a preferred framework and not a ‘last resort’. There is also the ‘Clean Green’ mantra which New Zealand is identified with. This may make New Zealanders, on the whole, more conscious of food chemicals, additives, and issues such as genetic modification, leading to them being more personally conscious of the state of their food.

## Chapter 6

# Conclusion

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“...food and eating are, like health, constructed and experienced as individual, personal responsibilities...”

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Food and health are complex cultural ideas and KKP construct and negotiate them with reference to a variety of received health messages and personal experiences and strategies for coping with food choice. In this thesis I have explored how and what a selection of Auckland Pakeha KKP think about ‘health’, how they construct and link concepts of food and health, and how they make food choices in light of these conceptions. In the preceding three chapters I have examined each of these areas in turn, and found that ‘health’ is a social construction and a constant negotiation between the barrage of messages KKP receive, their interpretations of these messages, and then their resulting actions. It became clear that personal values and life philosophies play a large part in how a person thinks about and acts on health.

Much scholarly work has been done regarding the situation where people report ‘knowing’ one thing about health, but act in a different way (Caplan, 1997:7; Duff, 2004; Medina, 2004). Many people, for example, ‘know’ that butter is ‘bad’ for them, but eat it anyway. That people have different, and personally relevant, ideas about health may help explain this; they may ‘know’ something, but it may not be deemed personally relevant or valued in their life, or it may be at odds with something else they already ‘know’. Some of my participants, for example, ‘knew’ that butter was classified as ‘bad’ by biomedical health discourses, but had other knowledge, such as butter being ‘natural’, that made it ‘healthy’ in their minds. This may contribute to the reason why mass health campaigns are widely reported as being somewhat ineffective and slow to create change (Duff, 2004; Keane, 1997).

There has been limited research into lay people’s understandings and constructions of ‘health’ (Shukla, 2001). The findings from the present research are significant because they not only highlight the social construction of health by illustrating how my participants use a variety of sources to create definitions of ‘health’, but, in their great variety and inclusion of sometimes contradictory discourses, point to how health is much more than the ‘lack of illness’ which is commonly presented by

biomedical discourses. 'Health' is not the same thing to everyone. It can mean similar things, or be constructed very differently. This has important social significance for mainstream health professionals, who may think of health only in narrow terms, such as an absence of illness, or the body functioning in a 'proper' way, whereas my participants also included ideas such as being happy with one's life, and being able to achieve their goals. By taking notice of findings such as those in this study, medical professionals may begin to understand that each patient has their own ideas about health, expectations about their treatment, and feelings of how illness and health are related. These findings suggest that professional and academic understandings of health need to be multifaceted and flexible, so as to foster a greater awareness of 'good health' and wellbeing.

The KKP I interviewed connected food strongly with their conceptions of health. This leads them into complicated negotiations of control and release behaviour. 'Control and release' discourses were often related to the moral dimensions food can have in Western culture, such as 'healthy' food being 'virtuous', while 'treat' foods are 'naughty'. Because food activities and eating are such highly regulated behaviours, the patterns of control and release found in this research are not altogether surprising. The concept of release (as long as it is a controlled release) was important to my participants' conceptions of health, especially their mental health, because it provided evidence that they felt in control of their own choices, and felt able to safely rebel against the 'health' discourses presented to them in mass-media campaigns. That this rebellion is built into the control-release framework, suggests how in control my participants are of their food and eating practices. Anderson (2005:66) points out that "...humans have a genuine biological need to feel in some control of their situation. Without it, they die". Because food is one of the key ways humans control their lives, their health, and their bodies (Fischler, 1988:80), these 'control-release' behaviours are important.

This finding mirrors Gluckman's (2004) theory of 'rituals of rebellion', which he explains are controlled and established systems of disputing power and control, which "in complex ways renews the unity of the system" (p.112). My participants, when engaging in 'release' behaviours, were disputing who had power over their eating choices and behaviour, and by rebelling they show themselves that they have a degree of power, but control the rebellion so as to not upset established and accepted food

behaviour systems. In other words: they rebel to feel in control, but do so in such a way as to still comply with the dominant practices and ideologies of those around them.

In this research, I found that ‘release’ as well as ‘control’ has strong links to emotional, mental, and social health. This, again, has important implications for health professionals and those who design public health messages. Smith (2002:211) points out that the more we are told something is bad for our health, and should control our behaviour regarding it, the more pleasure we get out of doing the opposite. If a discourse of ‘moderation’ and ‘variety’ were truly adopted, in which health professionals recommended release as well as control behaviours, then perhaps the dissonance between knowledge and behaviour so commonly observed might be reduced, as well as the moral judgements around food practices.

In part because of these control-release tensions and partly because of the other reasons detailed in chapter five, my participants felt anxiety over the health and safety of their food. However, they used notions of common-sense to create personally relevant coping strategies that let them choose foods with feelings of safety and confidence. They used these strategies in routine ways, to make the process of food choice straightforward and manageable, but the process of coping strategy production and application is anything but simple. This is because of the wide variety of factors my participants took into account, including many different types of, sometimes conflicting, information – which they used to create a cohesive set of ‘rules’ about food. This links with the important modern concept of ‘risk’ and ‘risk society’ (Beck, 2002), illustrating one important way in which people are coping with risk every day.

While exploring their strategies for coping, common sense, and the rules of thumb that make food choices easier and less ‘risky’, I noticed that many of the ideas my participants discussed as ways they cope with food choice, were also principles present in food advertising. Advertising claims such as ‘fresh’ and ‘low fat’, along with information such as ‘5% real fruit juice’, do not necessarily mean that a food product is safe or ‘healthy’, but play on, or help create, common rules of thumb. There is a common discourse between my participants and food advertisers. The key themes of this discourse include ‘naturalness’, ‘balance’, ‘variety’ ‘nutrition’, ‘freshness’, and ‘moderation’. While my participants employed these discourses as strategies for coping with food choice and anxiety, food advertisers may use them to make products seem a safe, ‘healthy’ choice, even when they may not be. The discourses include symbolic rhetoric, and advertising claims that play on this rhetoric come to suggest more than

may be strictly true about a product. For example, the claim of '5% real fruit juice' incorporates the concept of 'naturalness', even though 5% is a very small proportion of the overall product (indeed, 95% of the product is not 'real fruit juice'). Thus the rhetoric used may not match the health values of a product, but instead tap into an 'approved' health discourse, one which is also commonly employed in my participants' coping strategies.

Another interesting finding to emerge from this work is the paradox that while women have apparently been gradually released, over the last twenty or so years, from almost sole responsibility for food preparation, accompanied by little power over what was cooked for the main family meal (Charles & Kerr, 1988), presently, women may have rather less food preparation responsibility in the home but more power over what is cooked. This includes when they are not primarily responsible for meal preparation. We saw this in both T.J. and Peter's prioritising of their female partners' food preferences, despite the fact that they were male KKPs. In the past it seems that women had more responsibility but less power, while now they express feeling less responsibility and more power. In the last twenty or so years, based on the evidence from this small study, the balance of power and responsibility in the domestic kitchen has become somewhat reversed. There has not been a complete reversal, however. Women are still mostly responsible for kitchen duties, but the role of men in the kitchen is expanding (Kemmer et al., 1998). This is one form of evidence of the changing roles of women in Western society, and the values, responsibilities, and power associated with those roles. The changing role of women in regard to domestic meal preparation is a significant indicator of changing attitudes towards gender ascriptions because, previously, the KKP role was so integral to women's stereotypical place as 'nurturer', 'cook', and 'wife/mother'. Now, women can still be these things, but have more agency and power, and less responsibility than previously.

Putting these findings together, it becomes clear that food practices and eating are, like health, constructed and experienced as individual, personal responsibilities rather than household or KKP responsibilities. The surprising finding was that KKP are in fact a lot less 'key' than they appear to be, or were - they too work between often contradictory pushes and pulls, in which their own ideas of health and others' definitions are just one part. The life practices they construct result in range of more or less creative negotiations of the various tensions (control and release, anxiety and risk, personal experience and received health messages) that both effect and result from this.

What my participants' stories show is that they have created their own truths in the face of complex and often contradictory discourses. In a society supposedly controlled by corporations and the media, health, food practices, and eating are remarkably improvised and personal constructions.

### **Researcher expectations**

As with all research, there were parts of this project that worked well, and parts that did not. Luckily, the parts that did not work tended to relate to my own preconceived ideas about how KKP functioned and thought about themselves. One large area of information I expected to collect about KKPs' feelings of responsibility towards others' health did not eventuate. I began this project with the idea that KKP would feel very responsible for the ongoing good health of the people they cooked for, in line with works such as Charles and Kerr (1988), Pill and Parry (1988), and Cline (1990). My participants, however, volunteered almost no information directly about their feeling of responsibility to do with health, food choice and their families, nor about their identity as a Key Kitchen Person. It seems that this way of functioning within a family has changed, with health now being seen much more as an individual family member's responsibility, except in the case of young children. KKPs responsible for feeding young children were rather more concerned about providing healthy meals. Rather than seeing themselves as a 'Key Kitchen Person', or even as the 'cook' for the family, my participants saw themselves as mothers, fathers, spouses, electricians, and students, for example, who happened to do most of the cooking in their household. Many other roles preceded 'cook' in importance in their perceptions of themselves. While KKP is not a widely used term, my participants did not routinely identify themselves primarily as the family food provider. Some of the older literature (Charles & Kerr, 1988; Pill & Parry, 1988; Murcott, 1983) made the point that mothers identified strongly with their cooking and providing duties, whereas my participants saw shopping and cooking as just tasks alongside other tasks, rather than as constituting an identity.

As well as not being a large part of their identity, there was not as much focus on the role of 'KKP' in my participants' understanding and experiences of food and health as I had expected, either. The research, therefore, turned out to be more about their individual ideas about their own health and experiences, rather than as family food providers, because this is how they talked about themselves. They knew, when asked, that they were the 'main food providers and preparers' for their household, but it did not

seem to be a major point in their understandings of themselves, their families, food, or health. I do not know whether their ideas differed in any systematic way from people who are not KKP, however. It is possible that if they were compared to non-cooking, or non-KKP individuals, their role as KKP would seem more defined.

Like the role of women in the home, the role of KKP has changed over the past twenty years. Based on the limited findings of this study, KKP is now a much less meaningful term that it used to be. Instead of being a key factor in a married woman's identity, it is now just another task that either a man or a woman can do. Life, in general, has become busier for many people, women especially, who now juggle not only home life but, more often than not, work outside the home as well (Kemmer, 2000:329). Men in domestic roles are often in the same position. This means that there is a larger variety of roles that a person must fill, many of which are valued in our society more than 'Key Kitchen Person'. These other, more valued roles may have become more central to self-identity than relatively less-valued domestic roles. Alongside this, as the number of roles a person fills has grown, existing roles have changed. Roles inside the domestic sphere, such as KKP, used to be firmly a part of being a grown woman; there were clearly defined boundaries and duties related singularly to being a mother and/or a wife (Murcott, 1983). Now, these roles are less defined (Kemmer, 2000). Men may take them on, fully or in part, and people may choose to enact the roles differently than before (Kemmer et al., 1998). These changes mean that the role of 'Key Kitchen Person' is now less central to who my participants feel they are and how they understand the world.

These findings must be taken in context, however. Kemmer (2000) argues that older studies, such as those of Murcott (1983) and Charles and Kerr (1988), were conducted with a very defined group of participants: English mothers, or soon-to-be mothers from working-class areas. Kemmer found that middle-class participants in a different life stage (married without children, in her case) enacted and identified with domestic roles differently. On the other hand, Kemmer's (2000) work was conducted ten to twenty years after that of Murcott and Charles and Kerr, so the changes in society I suggest as possible sources of change to the domestic role are not necessarily negated. However it is important to note that my participant group was very different in class and domestic situation from the older studies to which I compare them. Kemmer (2000: 326) agrees, however, that time-based change is a significant factor in the differences found in the role of 'Key Kitchen Person' between these older studies and now.

The fact that these themes did not eventuate as I had originally thought changed the direction of my research, but did not hamper it. The fact that I was able to be flexible with the interview schedule was key. The interviews I had with my participants in their homes brought up numerous ideas that I had not originally considered, many of which went on to become key analytic themes in this thesis (food anxiety and coping, for example). In having such a flexible interview schedule, I was able to follow up on interesting ideas my participants brought up. However, in doing so I had to think quickly 'on my feet', which as a novice researcher could be difficult at times. I often had to email participants questions I should have thought to ask at the time. Because I did not know what was going to emerge as important in my participants' discussions, a broad interview schedule was a blessing.

### **Directions for future research**

Because of the small sample size utilised in this research, and the timeframe available to do it in, there were a number of variables I was not able to explore. Issues such as gender, ethnicity, and age, as they relate to health ideas and food choice have been explored elsewhere (Blaxter & Patterson, 1983; Coxton, 1983; Herda & Banwell, 1988; Williams, 1983) and do, in those studies, have an effect on food choice, health beliefs, and behaviour. What have not been researched as thoroughly, and I was unable to explore, are the effects of domestic situation on food-health connections. I interviewed people from a range of situations ranging from casual flatting, newlyweds, married for 30+ years, and divorced, but was not able to gather meaningful data on differences, because the sample size was too small. I could not attribute differences to domestic situation when they were just as likely to be the result of age, gender, personality, or inter-personal differences. This would be an interesting area to explore because, as I have shown in the previous chapters, food and health ideas have a very social element to their construction, and a person's domestic situation may well be a very important source of their social learning and experience about food, and different situations may promote different behaviours and understandings (see Lupton, 2000; Sidenvall et al., 2000; Sidenvall et al., 2001, though these studies do not explore domestic situations comparatively).

The findings from this study, and from Green et al.'s work, show that food choice is both simple and complex, and has many facets. More research into what affects food choice and what it means for those involved is a worthwhile avenue of

exploration. Wansink (1996; 2004) has investigated what immediate environmental factors play a part in food choice and how much a person eats in different situations, but the deeper social and cultural reasons and effects have not been widely studied. One very interesting idea linked to food choice, which I was mostly unable to explore because my participants only touched on it briefly, was the moral dimensions of food choice. Foods and eating behaviours that carry moral judgements such as ‘virtuous’, ‘good’, ‘bad’, or ‘naughty’ appear to be many and varied, and may have an impact on food choice and perceptions of health and wellness. It is a fascinating area of enquiry, and there have been some intriguing studies done (cf. Smith, 2002; Williams, 1997; Wood et al., 2010), but not a lot of work into where food morals come from or their function in people’s lives, health, or food choices.

At the beginning of this thesis, I set out to replicate parts of the study conducted by Herda and Banwell (1988) into the meaning of food to New Zealand women KKP. I updated this goal to include both males and the strong connection between health and food. It would appear, however, that the domestic role, and the values and definitions of that role, have changed significantly in recent decades. ‘Key Kitchen Person’ is now an elective role, something that can be swapped and changed, and not as clearly defined as it once was. Because of this, alongside creating their own meanings of health and how health connects to food practices, my participants were also constructing and re-shaping the role of ‘Key Kitchen Person’ to fit in with their other values, roles, lifestyles, experiences, and beliefs. My participants’ stories illustrate how they have built their own truths and practices out of what has come before and what is available now. They show that domestic kitchen roles, personal food practices, and health conceptions are contested, negotiated, improvised and individual constructions.



## Appendix A: Information Sheet

### **Health, eating, and ‘healthy eating’: How New Zealand Pakeha ‘Key Kitchen People’ relate food and wellbeing**

#### INFORMATION SHEET FOR INDIVIDUAL INTERVIEWEES

This is a student research project being conducted by Samantha Russell as part of the course requirements of a Master of Arts in Social Anthropology. The purpose of this project is to provide insight into how New Zealand Europeans/Pakeha think about health and relate it to food and eating.

Because of the growing importance of health and food issues in New Zealand, I wish to look at what 'healthy eating' means to people who are the main food providers/preparers (also known as the 'Key Kitchen Person') for their families. The areas I wish to focus on are:

1. What people believe 'health' means
2. How food and health may be related
3. What motivates people to provide and prepare the food they do
4. How what they cook and eat affects perceptions of their own and others' bodily and mental health
5. What social pressures people feel in relation to eating/healthy eating and how this affects them.

If these issues interest you, you would feel comfortable discussing them in an interview lasting approximately one hour, and going through and discussing the contents of your pantry/fridge, you are invited to take part in this research.

Only people who identify as New Zealand European/Pakeha and were born and raised in New Zealand, will be asked to take part in this study. Participants must also be 16 years of age or older and be the primary food purchasers and preparers for their household. This means you must buy and prepare at least four meals a week for at least one other person within your household. Ten people who fit these criteria will be selected to take part in one-to-one interviews and a discussion of the contents of their pantry and fridge. Names will be obtained through a ‘snowballing’ method, where existing contacts suggest people they think may be interested in taking part. If you wish to participate, you will be able to choose when the interview will take place so as to provide a minimum of disruption to your life. Interviews will need to take place in your home so that the contents of your pantry and fridge can be looked through and discussed.

Should you choose to take part, there is very little risk associated with the interview process, and care will be taken to ensure your anonymity throughout the research and in writing up the report. You will be asked to provide a pseudonym to be used instead of your name. This will ensure that any sensitive information you may choose to talk about during the interview will not lead to any individual. There is always a risk when taking part in an interview that you will feel uncomfortable or distressed, but there will be no pressure to continue the interview, or answer any question. After the interview has taken place, you will be given a chance to look over the transcript of our conversation and make any corrections or deletions, to ensure you are comfortable with the information. It is also completely within your rights to drop out of the study at any time before the 31<sup>st</sup> August, 2010, with no reason needing to be given.

### **Project Procedures**

If you wish to take part, you will be involved in a one-on-one interview with the researcher which will last for about an hour. These interviews will be voice recorded, and then transcribed. This transcript will then be available for you to view and edit.

During the interview, you will be asked to show the researcher around your pantry/fridge and talk about the process of choosing products, planning meals, being responsible for these things, and how this process relates to ideas about health. This will also be voice recorded and the transcript of this recording will be available for you to view and edit.

If you have any questions about these methods or your participation in them, please do not hesitate to contact me.

### **Data Management**

The data collected will be used to write a research report. Participants will be asked if they would like to be sent a copy of the finished project. Participants will be asked to provide a pseudonym. Names will not appear in the project, and pseudonyms will be used consistently.

### **Participant's Rights**

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;
- withdraw from the study at any time up until 31 August 2010;
- ask any questions about the study at any time during participation;
- provide information on the understanding that your real name will not be used;
- be given access to a summary of the project findings when it is concluded;
- ask for the recorder to be turned off at any time during the interview.

### **Project Contacts**

If you have any questions about the project, please don't hesitate to contact either:

Samantha Russell (student researcher)

Email: [samantha.russell@xtra.co.nz](mailto:samantha.russell@xtra.co.nz)

Post: P.O. Box 316, Warkworth

Ph: 027 6322459

Kathryn Rountree (supervisor)

Associate Professor of Social Anthropology

Email: [k.e.rountree@massey.ac.nz](mailto:k.e.rountree@massey.ac.nz)

Ph: 414 0800 ext. 9044

### **Committee Approval Statement**

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application 10/011. If you have any concerns about the conduct of this research, please contact Dr Denise Wilson, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x9070, email [humanethicsnorth@massey.ac.nz](mailto:humanethicsnorth@massey.ac.nz).

Appendix B: Consent Form

**Health, eating, and ‘healthy eating’:  
How New Zealand Pakeha ‘Key Kitchen People’ relate food and wellbeing**

**INTERVIEW CONSENT FORM - INDIVIDUAL**

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being sound recorded.

I agree to participate in this study under the conditions set out in the Information Sheet.

**Signature:**

**Date:**

.....

**Full Name - printed**

.....

## Appendix C: Interview Schedule

### **Interview Schedule:**

(Adapted from Hubert, 2004). Use as a guideline only.

#### **Cooking**

Who do you cook for?

What do you like to cook?

What are your preferred methods of cooking?

Why?

What does your household prefer?

If different, what gets done?

Do you spend much time in the kitchen?

What does cooking for your household mean to you?

What would you change?

How do you decide what to cook?

Do you use cookbooks/magazines/websites? What ones? Why?

**Health** (emphasis on participant's explanation of health, not necessarily nutritional health)

What does 'health' mean to you?

How did you develop this?

Where do you find information on health?

When you look at someone, what makes you think that they are 'healthy'?

Do you associate health with food? Discuss.

What is a healthy diet?

Is this different from tasty, or gourmet eating?

Do you link appearance and diet?

What are the characteristics of a healthy diet?

Do you take what you feel about health into consideration when shopping and preparing meals?

How do you feel what you cook affects your family's physical/mental/spiritual health?

Do you feel responsible for your family's health?

Do you feel any personal, moral, or social pressure to consider health/healthy eating?

#### **Food and Shopping**

Where do you shop?

Why?

What is important to you when shopping for food?

- Family habits
- Family preferences/demands
- Advertising
- Price
- Quality
- Health

Do you grow/produce/hunt/collect any of your own food?

Would you like to?

Who does this?

Why is it like this?

**Eating**

How would you describe the bulk of your household's meals?

Do you eat together?

Do you eat out often? Where? Why? Who chooses?

What is the most important meal of the day? Discuss.

What is your ideal meal, with no restrictions on budget?

Appendix D: Release Form

**Health, eating, and ‘healthy eating’:  
How New Zealand Pakeha ‘Key Kitchen People’ relate food and wellbeing**

**AUTHORITY FOR THE RELEASE OF TRANSCRIPTS**

I confirm that I have had the opportunity to read and amend the transcript of the interview(s) conducted with me.

I agree that the edited transcript and extracts from this may be used in reports and publications arising from the research.

**Signature:**

.....

**Date:**

.....

**Full Name - printed**

.....

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