"Good" Food as Family Medicine: Problems of Dualist and Absolutist Approaches to "Healthy" Family Foodways

Parsons, JM

Introduction

Foodways (the beliefs, behaviours and practices around the production, preparation, serving and eating of food) (Counihan 1999) are a powerful means of drawing boundaries between social groups and distinguishing the "self" from the "other". Further, "foodways" has a dual meaning; it highlights the significance of modes of practice or ways of doing food, as well as movement and direction across time (history) and space (culture). Hence, when exploring family foodways the emphasis is on embodied, affective, everyday food practices and temporal ways of doing food that connect past, present and future. Following the work of Morgan (1996, 2011) families are what families *do* and this is especially pertinent in an era of heightened anxiety about obesity, when family foodways become morally loaded activities that consolidate cultural boundaries. Indeed, family foodways inculcate a cultural habitus

(Bourdieu 1984) through the reproduction and reinforcement of values and tastes. Similarly, public health discourses reinforce divisions between appropriate and inappropriate family foodways, with "healthy" family foodways associated with "good" families and therefore being good.

Of course the association between food and morality has a long history. It emerged in the UK and other Christian based democratic countries in the West in response to a Christian ethic that developed out of the problems of the pleasures of the flesh (Coveney 2006). Or what Counihan (1998:108) refers to as "the Judeo-Christian orientation that is both dualistic and absolutist". This has distinct parallels with Cartesian mind/body dualism developed during the Enlightenment. Indeed, these connections between food and morality are well documented amongst cross-cultural anthropologists such as Counihan, (1999) and Counihan and Kaplan, (1998). Yet this dualistic and absolutist approach to foodways causes problems when negotiating the boundaries between good/bad, healthy/unhealthy food. What are the moral, social and personal implications of making the wrong food decisions and how might these be negotiated?

In an era of obesity, healthy foodways are correlated with "good" food and being good. Of course the notions of "good", "bad", "healthy", "unhealthy" are not easily defined. Indeed these are not fixed or stable categories. As Nettleton highlights (2006:170) "health is not a unitary phenomenon and is a highly elastic cultural notion". Similarly, Rousseau (2012:14) notes that "healthy is one of the most semantically unstable words in the English language". However, this did not stop respondents from engaging with popular

and public discourses regarding healthy family foodways. Their stories were liberally sprinkled with the term "healthy", although it was never expressly stated in most instances what this actually meant in practice. They were actively engaged in a kind of healthism, with health identified as feeling and being "good" (Bendelow, 2009:136).

In respondents' accounts transgressing the dualist and absolutist boundaries of appropriate family foodways sometimes resulted in guilt and moral approbation. This is evident when considering UK government dietary guidelines that advise "families to make healthy food choices" (DOH, 2010:39). Of course in reality it is mothers who are the "guardians of health" (Beardsworth and Keil, 1997:179) and therefore charged with "feeding the family" (DeVault, 1991) healthy food. Indeed in contemporary neo-liberal societies the pressure on mothers particularly to engage in healthy family foodways goes beyond the notion of providing a "proper dinner" of meat and two veg, identified by Murcott (1982, 1983) and Charles and Kerr (1988) around thirty years ago. Indeed, there is an intense moral imperative to feed children good "healthy" food and this is central to maintaining a "proper" maternal identity (Parsons 2014a, 2014b).

Thus, in the UK as in other westernized neo-liberal democracies, "healthy" family foodways are related to a middle class habitus (Bourdieu, 1984) with commitments to healthy eating and dietary restraint considered middle class[1] concerns and key markers of status (Naccarato and LeBesco, 2012). Further, notions of control are linked with aspirational and elite cultural capital. On the other hand lower class tastes are supposed to "lack", particularly in terms of lacking control, education and time (Skeggs

2004). Hence, practicing appropriate healthy family foodways becomes a way of reifying cultural difference. This raises questions with regards to the implications for maternal and class based identities. How do individuals manage their identities when engaging in what might be considered inappropriate family foodways, especially those that might be used to treat specific conditions or for health reasons?

The term "healthy" has also become part of a "common vocabulary" (Mills, 1959) that positions certain foods as treats and/or treatment. Treats are a source of pleasure, but they can also lead to suffering and anguish on several levels. It can be a corporeal reaction or an emotional one, because of over eating and feeling out of control, or just eating "bad" foods (however comforting). Again, what might be considered good or bad is not fixed, and is influenced by wider social and cultural norms and values, but for respondents in this study bad food was associated with sugar, fat and convenience (Parsons 2014b). In this article I will be considering the consequences of transgressing the boundaries of what might be considered "good" family foodways by particular reference to food as a source of Complementary and Alternative Medicine (CAM). It is notable that CAM is a typically female activity and usually identified with higher educational attainment and socio-economic status (Bendelow, 2009:111). It also falls outside of the traditional biomedical model and can be treated with skepticism.

Theoretical Background

Healthy Family Foodways as Cultural Capital

The practicing of healthy family foodways has high social, cultural and symbolic value (Bourdieu 1984), and these ways of doing food can be used to position the self as a "good" morally responsible citizen, an active agent in the maintenance of health, for the self and/or others. Indeed, there is a connection between foodways and health as a form of (self) surveillance medicine, so that practicing appropriate "healthy" foodways is a means of practicing/displaying good health. Further, there is a long history of dichotomous thinking in relation to foodways, with food a source of gratification and displeasure and/or health and illness (Beardsworth and Keil 1997). This is highlighted in the four antinomies of taste used by advertisers in the marketing of food: "novelty and tradition", "health and indulgence", "economy and extravagance" and "convenience and care" as identified by Warde (1997:194).

Also, when considering the notion of diet within everyday foodways, it is notable that the term "dietetics" originated in early Greek civilization and was a concern with daily conduct and modes of living, health, medicine and philosophy (Coveney 2006). Thus, the notion of "dietetics" is not just about food, but a way of life that incorporates exercise, food, drink, sleep, and sex as part of living a "good" life. Further, Coveney (2006) argues that the connection between food and health developed in Britain in response to food shortages in the 17th and 18th centuries. In order to ration food, there was a focus on nutrition, healthy habits and clean living. In contemporary westernized neo-liberal societies "healthy" foodways have therefore become a means of performing responsible individualism and displaying cultural capital.

The medicalization of everyday life, or the process whereby medicine has made inroads into the domain of "ordinary life", previously controlled or regulated "through moral, religious or legal jurisdiction" (Bendelow, 2009:11), has ensured that conforming to healthy dietary regimes has the potential to become "the" appropriate way of "doing health" (Moore, 2010). Hence, eating healthily and healthy foodways are moral practices and a means of demonstrating responsible citizenship. Yet, changes in dietary practices to treat specific conditions can be considered part of CAM. Paradoxically, when individuals practice CAM, (by treating conditions not sanctioned by professional medicine), they break the rules of the sick role and can be stigmatized and/or not considered legitimately sick (Parsons, 1951)[2]. Also, when following a dietary regime outside of what might be considered appropriate within the normalising discourses of health, individuals have to manage the presentation of the self, constantly adjusting their social identities and a spoiled (illness) identity[3] in social situations (Goffman, 1963).

Some food culture scholars argue that strict dietary regimes or food as CAM represents a means of imposing restraint in the face of increased normlessness around eating. Fischler (1980, 1988, 2011) for example has long insisted on a kind of gastro-anomy at work, with a decline in the social rules and rituals allied with commensality (eating together). In my study those forced to engage in dietary regimes for health reasons highlighted some of the problems of negotiating the social and cultural aspects of alternative foodways, which indicates the continued significance of social and cultural norms and values for individual and social identities. Hence, in terms of public policy a focus on individual

choice neglects the myriad ways in which individuals negotiate their social identities and these are important.

Methodology

This article draws on data from a qualitative study conducted over nine months in 2011 from seventy-five, self-selecting, mainly UK born, middle class respondents, who contributed auto/biographical narratives about relationships with food over the life-course. Their ages ranged from twenty-seven to eighty-five years of age, though most were born in the 1950s and 1960s. The scope of food memories therefore spans the 1930s to the present day. They presented their food histories as a type of transformation narrative or journey, expressing a shift in consciousness from unknowing child to all knowing adult with the memories of childhood explored through a modern day lens. So whilst respondents considered their narratives as highly individualized expressions of taste and/or distaste, they were also articulating wider social and cultural norms and values regarding "good" and "bad" foods. For women in the study this meant a commitment to "healthy" foodways[4] for themselves and/or their families that reflected current UK government food policies on the need for families to make "healthy" food choices.

The methodology followed a constructivist grounded theory approach; it was iterative with themes emerging as the project progressed, so data collection and analysis were concurrent (Charmaz, 2006). There were two interrelated purposes, firstly to explore the food memories of others, and secondly to critically examine the social and cultural milieu in which these were

articulated. In keeping with Mills' (1959) argument in favour of the "sociological imagination" personal troubles and public issues are interconnected. Indeed individual food memories have often been used by food researchers as this method illustrates the extent to which our memories of the everyday are socially constructed and simultaneously part of a shared socio-cultural history (Lupton 1996, Belasco 2008).

Therefore, the focus of my inquiry was food over the life-course and I invited potential respondents to write their own auto/biographical food narratives through a series of asynchronous in-depth online interviews, which is a form of computer mediated communication (Kozinets 2010). This entailed a series of written e-mail exchanges with respondents similar to correspondence techniques (Letherby and Zdrodowski 1995). I received full ethical approval from the University ethics committee but had to include an exclusion clause, "that strongly advised" potential participants "not to participate if they had suffered from an eating disorder" as it was ordinary, everyday foodways I was investigating. I used snowball sampling from my own social network, which is common in food research (Lupton 2000, 2005) and asked potential respondents if they would like to participate in a study to examine the role of food over the life course. Respondents in the study were therefore self-selecting. I sent out one hundred and ninety invitations, roughly ten per week. Once respondents agreed to participate I assigned them a pseudonym and replied:

> *What I'm really after is your 'food story'. Perhaps, this will include your earliest food memories, favourite foods,*

memorable food occasions, whether your eating habits have changed over time and why this may be. Also, absolutely anything food related that you'd like to share with me.

For some, if this proved difficult, I asked a series of questions instead. These centered on how respondents developed their own eating and cooking habits. I did not question respondents specifically about "healthy" or "unhealthy" foodways and did not mention these terms at all. It was very much an open invitation for them to tell their stories in their words and on their terms. It was the common vocabularies (Mills, 1959) across the narratives that I was looking to discover, rather than directing them in any particular way. Half of those invited to participate agreed to be involved, which resulted in seventy-five auto/biographical narratives by my self-imposed deadline. One third of these were male. Two thirds were parents at different stages in the life course, from those who were new to parenting to grandparents. There was also a range of family types including lone parents, co-habiting and married couples with children (and step-children).

The substantive analysis of the data focuses on four areas (i) maternal identity (family foodways), (ii) food as important for health and as a source of CAM, (iii) embodiment and (iv) a foodie identity. The focus of this article is (ii) and out of the seventy-five respondents, around a quarter identified strongly with this theme, with seven respondents directly discussing food as a source of CAM (see Table 1 below). Generally, most respondents considered that they had a "healthy" relationship with food, were concerned with eating healthily and also eating for health, for themselves and

their families. Overall, female respondents made a clear distinction between changing their diets for health reasons and dieting to lose weight[5].

I include a range of respondents but focus on Faye's account of her use of the ketogenic diet to treat her daughter's drug resistant epilepsy, because it could be argued that this particular diet breaks the rules of what might be considered a "healthy" diet for children. I would add, that whilst I identified four themes, there were common threads running through all of them, notably the intersectionalities of gender and class. Hence, in this theme knowledge of and participation in healthy eating discourses and CAM are sources of cultural capital. I am not suggesting that these were the only issues respondents were interested in, but the concern with food as a means of achieving health and CAM was enough to warrant consideration of this as an important source of capital within respondents' accounts.

Table 1: Demographics of Respondents Used in This Article

Pseudonym	Issue	A	Occupation	Qual	Living Arrangements
Annie	Wheat	50	Life Coach	A' level	Divorced +2 children
Chloe	Dairy/Eczema	46	Occ. Health Advisor	Degree	Co-habiting +2 children
Dalia	Ovarian Cyst	50	Painter	Degree	Co-habiting
Edith	IBS	54	Arts Coordinator	Degree	Divorced +1 child
Ellen	Comfort	61	Dance Teacher	A 'level	Divorced
Faye	DRE	46	Secretary	GCSE*	Married +1 child
Harriet	IBS	64	Housewife	SRN	Married +3 grown up children
Helen	Health	54	Publisher	Diploma	Married +2 children
Imogen	Wheat	36	Part Time Housekeeper	NVQ	Married + 4 children
Jade	Comfort	37	Architect	P/G	Single
Kelly	IBS	30	PhD Student	P/G	Single
Kevin	Dairy/Eczema	47	Consultant	Degree	Co-habiting +2 children
Magenta	Health	38	Academic	PhD	Single
Molly	Clean/Health	45	Housewife	GCSE*	Co-habiting +4 children
Nadia	Candida	40	Artist	Degree	Co-Habiting +1 child

Olivia	Sluggish	37	PR Manager	Degree	Co-habiting
Queenie	Wheat	62	Retired Hairdresser	GCSE*	Married
Ruth	M.E.	47	MD	Degree	Married +2 children
Willow	IBS	55	Senior Lecturer	Degree	Single +1 grown up child
Zoe	Sleepy/Rotten	44	Recruiter	Degree	Married +2 children

Key:

IBS = Irritable Bowel Syndrome DRE = Drug Resistant Epilepsy

M.E. = Chronic Fatigue Syndrome (*Myalgic Encephalomyelitis*)

A= Age

Quals = Highest Qualification GCSE* = GCSE Equivalent SRN = State Registered Nurse

NVQ = National Vocational Qualifications P/G = Post Graduate

Problems with Absolutist and Dualist Approaches

Treats and Treatments

Women's narratives were liberally sprinkled with the term healthy, although it was never expressly stated in most instances what this actually meant in practice. For many, food could be seen as a potential "treat" or reward for good behavior. It could also be conceptualized as a necessary "treatment" for illness. In the context of health discourses and the medicalization of the practices of everyday life, sometimes it was not necessarily that the food itself was "bad" but that certain foods caused "bad" physical and/or emotional reactions. The association of items such as bread or chocolate or sugar (sweets) for example with pleasure, childhood innocence and/ or comfort was common. Yet, excess consumption of these was considered sinful, as Nadia writes:

My general rule is if healthy at home then that is a good base to then have treats when out and about. If there is nothing too evil in the fridge then there is less chance of me eating badly. If I have chocolate at home I have little self-control, I would snack on it before an apple so it's best to not buy it.

Nadia's use of the word "evil" is notable; this is a strong word to use when describing food, especially something that maybe considered an innocent or a potentially comforting treat like chocolate. In this vein Ellen writes:

I already had a love of sweet things; cake, chocolate, cream cakes (a very special treat) and ice cream. (Comfort food?)

Ellen continues:

This is what I meant by being tempted back into eating chocolate. (There was always an event, a celebration, a reason to treat myself - or, of course, something upsetting that needed me to console myself by letting myself have... a treat.) It is now habit to want something sweet after a meal, almost every meal, and I sometimes try to get either a hot drink or a glass of wine to satisfy that craving. I wonder if having denied myself for several years has caused the longing to return, with a vengeance! Isn't that what an addiction is? A craving?

Ellen hints at treating herself as a form of comfort and consolation, similarly in Jade's narrative treats are related to what she also refers to as 'comfort food'.

> *Then, also sticking to life in London, work is hard, but food is good. So, it was a treat for me to get out of cramped office spaces and bite into a big sandwich, burrito or a rich soup for lunch… Other comfort food: I usually do not indulge on much candy during the day, but the occasional cookie with coffee is very tempting, especially if you are in an office that supplies them in abundance. And, after a hard days work I do like to sit down with a glass of wine (at home, yes) and some crisps, although those are destructive as well… A lot of the comfort food also has to do with being quick and easy. When you work 10 hours a day and want to go to the gym it is much easier to have a quick pizza or burger than to get some fresh vegetables.*

These narratives can be seen in terms one of Warde's (1997) four antinomies of taste, what he refers to as the health and indulgence antinomy. It is notable that comfort food (bad food), is often sweet and therefore has feminised associations. It is though importantly quick and easy to consume, and this has working class connotations, with its appeal to the need for instant gratification (Bourdieu, 1984). The notion of convenience food as 'bad' contributes to feelings of guilt if too much of it is consumed.

The level of agreement across narratives around what constituted a treat is notable as well as the consistency amongst

respondents about the types of food that needed to be avoided in order to be well. There was a general consensus that eating "healthily" was important in maintaining "health" and feeling "good". The "bad" or "unhealthy" food categories were alcohol, dairy, meat, sugar and wheat products. These categories incorporated specific food items such as cheese, chocolate and bread.

There were degrees of avoidance or acceptance of these foodstuffs and it was generally in the context of treating other ailments as a form of CAM that they took on particular significance. Respondents mentioned the following conditions/ailments that could be treated by using food as CAM; Acid reflux, Allergies, Asthma, Cancer, Candida, Depression, Drug Resistant Epilepsy, Eczema, High Blood Pressure, High Cholesterol, Intolerances, Irritable Bowel Syndrome (IBS), M.E., Ovarian Cysts and Rosacea.

Hence, Chloe and Kevin discuss having to avoid dairy products in their respective families, in order to treat childhood eczema. Dalia changes her diet in order to "avoid surgery on an ovarian cyst". Harriet, Edith, Willow and Kelly treat their IBS through a variety of dietary regimes. Others refer to the effects of certain foods such as wheat in making them feel "sluggish" (Olivia), "bloated" (Annie), "rotten" (Zoe) or leading to "stomach problems" (Imogen). Molly eliminates meat and dairy from her diet because: "I feel cleaner, that's it, cleaner, healthier". Queenie on the other hand avoids wheat because:

> *The memory of the unpleasant symptoms from eating wheat means that I don't ever lapse, it just isn't worth it; at the very worst I'd get stomachache.*

Likewise, Kelly claims:

Food is no longer the innocent pleasure it was when I was younger, I've grown to be a bit afraid of it, since it can cause me weeks of suffering if I'm not careful.

"Healthy" food and foodways, as noted previously, carries social, cultural and symbolic capital and can be used as a means of displaying a particular middle class habitus. Respondents engaged in the subjective monitoring and surveillance of the self and others through healthy foodways. It was through these "moral narratives" (Nettleton et al, 2010:296), that the individual gained or regained control over their food intake and therefore their health. These narrative food journeys outlined how relationships with food had developed from a state of innocence or ignorance to a well-developed sense of control over, or susceptibility to, certain types of food. Overall, respondents expressed an engagement with health discourses and knowledge of the correct food choices deemed beneficial for one's health. Thus, healthy eating is viewed as integral to being a responsible moral citizen and "Coveney (2006) reminds us, the discipline of nutrition informs the construction of notions such as responsibility and health" (cited in Nettleton et al 2010:746).

In Nadia's account her dietary concerns began because of issues to do with her health and she describes unhealthy food as:

> *…anything too 'plastic': food that has become too removed from its original natural source. I stay away from meats that I feel have not been humanely produced, I only eat free range and/or organic meats and in small quantities. I eat soy as an alternative to meats and dairy, and prefer organic dairy produce when possible. I check labels and avoid too many numbers, or even too many ingredients. I am wary of too much sugar so avoid lollies and soft drinks.*

Hence, unhealthy food is so alien as to be not even "food" but plastic. She attributes a "complicated" relationship to food to the problems of negotiating "a Western culture of plenty" in contrast to the spirituality and ascetic feelings she associates with her experience of other cultures:

> *I have experienced returning home from a ten-day silent retreat where I've enjoyed wonderful mindfulness choosing what to eat and slowly chewing each mouthful to finding myself at a dinner party mindlessly gorging myself.*

Nadia is conscious of her diet6 because of recurring bouts of candida, which she blames on an over consumption of sugar. Her health narrative food journey can be considered a response to Fischler's (1980, 2011) notion of gastro-anomy. Nadia's strong dislike of overly processed "plastic" junk food and commitment to healthy food could be interpreted as a means of countering the impact of an alienating and highly industrialized foodscape. Again, amongst respondents eating healthily was considered a means of

accumulating cultural capital, processed "junk" food was considered low status food. Hence, eating as much "healthy food as possible" as Helen claims becomes an important marker of appropriate mothering (Parsons 2014a, 2014b). These narratives also highlight a shift away from changing one's diet in order to lose weight to eating for health, as Magenta notes "[I] eat to maintain health rather than thinness" and Helen writes:

> *Currently I have been advised to cut out, sugar, alcohol, dairy, red meat and wheat as I my body is intolerant of all these... On top of that I have also been advised to stop eating tomatoes, potatoes, peppers and aubergines [egg-plants]... all members of the night shade family and reputed to be bad for arthritis. It is interesting that I can be very strong willed when it comes to my health but not when it concerns my weight!*

Food as CAM

Some foods that tend to be identified as "bad" within health discourses actually turned out to be "good" in the treatment of certain conditions. This is the case with the ketogenic diet as a treatment for drug resistant epilepsy in children, which relies on a high intake of fat and protein in order to send the body into ketosis. When the body is in this state, it is more likely to be free from seizures. This has implications for those involved in implementing a dietary regime outside of what might be considered "normal" and/or "healthy", because of the rigidity of the boundaries between good and bad food and the extent to which these are embedded within

moral discourses. Therefore any dietary regime however beneficial for health causes problems if it utilises food from the "bad food" category. It means individuals are forced to negotiate Warde's (1997:174) indulgence versus health antinomy. This contributes to feelings of anxiety and guilt and "these antinomies have powerful moral overtones that can compromise a persons' identity" (ibid: 193).

Although "good" food is conceptualized as significant for a healthy diet/lifestyle (way of life) the use of food as a treatment for certain conditions[7] is not wholly sanctioned by orthodox medicine. Nettleton *et al* (2010:297) note that the "avoidance of food because of food intolerances is associated with alternative and unconventional lifestyles, fashion and trends which in turn implicate the person who suffers". The question is how do those involved in using food as a treatment negotiate these contradictions? This has significant implications for those forced to adjust their dietary habits because of health or illness. In an era of responsible individualism there is a moral imperative to be well and to be unwell can be stigmatizing (Goffman, 1963).

Faye explained why she used "food" as a means of treatment and writes about the difficult and lengthy route through an alienating medical landscape in search of help for her daughter's drug resistant epilepsy. To begin with their daughter's neurologist told them that the ketogenic diet was:

> … *"a revolting diet that doesn't have a very good success rate" and "you have to eat packets and packets of butter and jars and jars of mayonnaise". I told her that I didn't care what*

you had to eat; we wanted to try the diet for [Name],
because it was our only hope. It took over a year to
persuade her to let us try the diet, and in the end she gave in.

In a similar vein, Ruth documents how she changes her own eating habits as a result of looking for a treatment for her daughter, she notes:

My daughter was really ill and diagnosed with M.E. – [I] took
her to an amazing kinesiologist in [City] who (through her
blood type) made changes to her diet… within 3 weeks she
was well and back at school (after the consultant had said to
face that she would probably never ever be able to go back
to school). I was so impressed and really heard what she
said about "it's like putting the wrong petrol in your car… it
can function… but it won't last as long or run as well…" so I
found out my blood type and more or less stick to a list … I
am not religious about it but aware….

In Faye's account she continues:

We came home with a menu plan from the hospital for
mackerel floating around in olive oil, whipped cream with
artificial sweetener with a few grams of kiwi fruit stirred into it.
Yes, we had a very creative dietitian - not! [Name] ate all
her food without hesitation and I cried buckets because of
what I was forced to feed her.

Eventually, Faye and her husband devise:

…new meals for [Name]; containing, amongst other things, healthy oils (safflower, sunflower, olive and grape seed), salmon, asparagus, avocado, swede and goats cream.

So, for Faye, whilst the introduction of the ketogenic diet alleviated all of her daughter's symptoms, it challenged the notion of what it was to be a good mother. It is notable that the:

…serving of food reflects Mauss's (1990) classic definition of the gift in that food creates and sustains caring relationships between people and displays an ethos of care… [as food is prepared it] reaffirms her concept of self and sense of identity as mother and wife (Warin et al, 2008: 104).

In her narrative, Faye cannot bring herself to describe the food she feeds her daughter as "bad" or "unhealthy" and in the end it becomes a diet of "healthy oils". This is despite the positive and life changing impact the diet had on her daughter's drug resistant epilepsy, as Faye declares:

…we noticed a positive difference in her seizures and overall well-being almost immediately. It was as if a veil had been lifted… We continued weaning [her off the] medication and as the days and weeks went by her seizures lessened in frequency and severity. We had won the lottery! No! It was better than winning the lottery! The diet quickly became part

of our daily lives and it was a real blessing because we got
to meet the daughter we had longed for - the little girl hiding
behind a huge array of medication and their side effects.

Following a ketogenic diet is potentially problematic in social situations and counters Warde's (1997:173) contention that "because people eat in social situations even the most self-disciplined will relax their abstemious personal regimes". And challenges his assertion that "people are not generally known for their eccentric eating habits" (Warde, 1997:182).

The notion that Faye might have compromised her daughter's diet in the interests of social interaction due to the "quasi-moral conflicts between the imperatives of asceticism and conviviality tomorrow and today control and abandon" (*ibid*) appears highly unlikely. To begin with the preparation of food was rigorous and immensely time consuming:

Each meal took us 2 hours to calculate, but we soon devised
a selection of healthy, appetizing menus. It took over an hour
a night to weigh up and label [Name] meals for the following
day.

Hence, Faye is occupied in the immensely time consuming act of mothering through the provision of such a highly specialised diet for her daughter and despite the rewards that this brings, she has the added pressure of managing her daughter's "spoiled" illness identity (Goffman, 1963). This would have been particularly

pertinent on social occasions such as birthdays. Faye concludes by commenting on how her daughter dealt with the diet, she says:

> *[Name] was a complete angel about it all and never once tried to eat anything that wasn't keto friendly. She would have friends around for tea and she would attend birthday parties, the whole time eating only her own ketogenic food we had prepared for her. I find it very difficult now, knowing that she never once had a slice of her own birthday cake. I don't know why I should find this so upsetting looking at the full scale of things, but I do. I suppose it's because it's such a simple pleasure, and one most parents take for granted.*

Thus, Faye's daughter would be excluded from the act of sharing the birthday cake her mother would have made especially for her birthday and this adds to the tragedy of the situation for Faye. It denies Faye the ultimate opportunity of being a good mother and sharing that intimacy with her daughter. However, when considering rigid dietary management practices Balfe (2007:138) notes:

> *…disciplinary practices are often not completely disciplined… people might fail in their ability to articulate the practices of one discourse because they are equally committed to the practices and ideals of another.*

It is difficult to imagine how Faye would not be completely disciplined regarding their dietary regimes, given the implications of

lapsing. The "social" aspects of eating and the pressures to belong and fit in contribute to Faye's anxiety about managing her daughter's diet. It marked her out as different and unable to participate in "normal" social activities, as unusual food regimes can be stigmatising (Goffman, 1963). So, whilst a disciplined approach to eating alleviates conditions for Faye's daughter, it does have repercussions for social interaction and the management of a stigmatised identity. In social situations the previously hidden dietary regime is made public and forces the individual to engage in the management of a "spoiled" (illness) identity (Goffman, 1963).

If food is considered within a moral discourse it can be difficult for individuals to negotiate alternative food identities when food rules are so rigid. So that even when supposedly "bad" foods, such as the high levels of fat needed in the ketogenic diet, have far reaching and remarkable health benefits the identity of those entrusted with carrying out the dietary regimes can be challenged by the act of feeding "bad" foods, particularly when feeding healthy food to children has such high social, symbolic and cultural capital. Indeed, feeding the family healthy food is a means of performing a middle class habitus (Parsons 2014a, 2014b). It is a way of displaying cultural capital; to be forced to transcend the boundaries in this field is risky. Of course, Faye was not engaging in these dietary practices lightly, or through lack of knowledge, but instead was highly engaged in practices of intensive mothering (Hays, 1996). Her dedication to her daughter's dietary requirements and the emotional work involved in her care was admirable. That she should need to justify her actions is testimony to the rigidity of the

symbolic and cultural division between what is considered good and bad food.

Of course, in terms of the limitations of the study, respondents were a self-selecting group of people. It is not a random or representative sample. However, their accounts do throw light upon contradictions inherent in current healthy eating discourses.

Conclusion

Generally, most respondents demonstrated a tacit awareness of health as capital (Bendelow, 2009). This had a symbolic value, as "healthy" eating was a moral act and a responsibility. Female respondents generally conveyed an understanding of and a commitment to disciplinary regimes of self-surveillance through the monitoring of their own dietary habits and by listening to the body's responses. However, whilst healthy eating as an aspect of responsible individualism fits with the social norms and values of a medicalised society and a middle class habitus, the use of food as a CAM did not fit quite so easily. Hence, those engaged in rigid adherence to food as CAM were more likely to need to justify their decisions to do so. They would be forced to manage a potentially stigmatised or spoiled (illness) identity, particularly in social situations. An adherence to dualist and absolutist approaches to everyday foodways has consequences for those forced to engage in what might be considered unhealthy eating. Faye was able to negotiate this contradiction by reference to forms of intensive mothering. She was a good mother despite having to feed her child unhealthy food.

This has implications beyond the individual case of one woman struggling to negotiate her maternal identity, within a cultural field that places a high value on healthy foodways and "good" healthy food. It illustrates the power of social and cultural norms and values and the desire to belong to a particular social group. The association between healthy foodways and elite cultural capital means that is difficult to swim against the tide, or change your eating habits if they fall outside of the cultural norm and you want to belong. This applies to all class groups whose everyday foodways are a means of distinction and taste. The stigmatization of "other" foodways is highlighted through this case study and this needs to be addressed on an individual case-by- case basis and by wider society.

NOTES:

1. I use the term middle class in a very broad sense, but in my study gathered details of marital status, occupation and highest educational attainments from respondents.

2. Parsons (1951) developed the "sick role" as part of a medical model in which individuals are assumed to have rights and obligations when ill. Most notably illness needs to be sanctioned by medical practitioners, which enables individuals to be excused from their usual obligations of work. They must obey the authority of doctors, take the prescribed medication and generally strive to get well in order to return to work. Breaking the "rules" of the sick role means that individuals are liable for punishment or at least stigmatized and not considered ill.

3. Goffman's (1963) theory on stigma, can relate to illness identities, which have to be managed in social situations, when the individuals "normal" identity has been "spoiled" by the association with stigma.

4. This was a particularly gendered concern, few of the men in the study made reference to healthy eating; they were more concerned with "good" food as an expression of elite cultural capital.

5. A female concern with embodiment and dieting was one of the four themes but not the subject of this article.

6. All respondents to a large extent were "conscious" of their diets and this is a thread that runs through all four themes. This sense of food consciousness, whether this was because of maternal identities, health/ CAM, embodiment or a foodie identity, is partly why they were able to participate in the study.

7. This is particularly significant when the medical profession has *not* sanctioned the condition or advised dietary change as treatment. In cases where dietary change is advised, conversely the individual may be liable to punishment (stigma) for non-compliance, as identified in the rules of the sick role (Parsons 1951).

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