

TO DIET OR TO EAT (HEALTHY):
CULTURE, SELVES, AND EATING STRATEGIES

by

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(Under the Direction of James Dowd)

ABSTRACT

This dissertation investigates the relations of culture, self, and agency through the examination of women's decisions about eating strategies. Eating strategies are a form of bodywork that transforms and/or maintains the body through eating practices, such as dieting and healthy eating. To understand these eating strategies, the author interviewed forty Black and White women and analyzed the data using grounded theory methods and computer-aided qualitative data analysis software.

Chapter Three examines how women respond to the increasing focus on health in the risk society. In this context, the ambiguity and complexity of health advice encourages individuals to consider all experts as "dubious" and subject to evaluation, both in the content of the advice and the qualifications of the claims-maker. In this evaluation, individuals relay in three forms of local knowledge: Collective local knowledge, Personal knowledge, and Embodied knowledge.

Chapter Four considers a synthesis between the theory of Possible Selves developed by Markus and Nurius (1986) and the theory of types of agency developed by Hitlin and Elder (2007). The author argues for an adjustment of the theory of possible selves to distinguish between likely selves and hypothetical selves and describes two likely selves held by the women

interviewed: the healthy self and the overweight self. Likely selves such as these provide motivation to action, but differences in agentic capacity differentiate the types of agency enacted. While all actors can enact Existential Agency, only a select few can plan and carry out Life Course Agency.

Chapter Five describes four eating strategies enacted by the women interviewed and applies the theoretical framework developed in the previous chapter. The author observes four eating strategies observed among the women interviewed include the Standard American Eating Pattern, Dieting, and two types of Healthy Eating, which are distinguished by level of sophistication in the practice. Comprehensive Healthy Eating involves a well-rounded variety of healthy eating practices, while Simplistic Healthy Eating utilizes only one or two dimensions of healthy eating. Both Dieting and Simplistic Healthy Eating are examples of Existential Agency, whereas Comprehensive Healthy Eating is an example of Life Course Agency.

INDEX WORDS: Bodywork, Eating Strategy, Dieting, Healthy Eating, Women, Culture, Possible Selves, Agency, Qualitative Interviews, Life Course, Race

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CHAPTER 1

INTRODUCTION

We are witnessing a historically unprecedented growth in body size for the population as a whole. According to the National Center for Health Statistics (NCHS; 2005), a division of the Centers for Disease Control and Prevention, the average weight of women increased from 140 pounds to 164 pounds between 1960–62 and 1999–2002. In their analysis of these numbers, the NCHS argues that the increase in waistlines is actually an increase in obesity, rather than simply an increase in the number of those overweight. Their figures show that while there has been a 2.4% increase in the percentage of White women who are overweight but not obese, there has been a much greater increase of 15.9% in the percentage who are obese. This corresponds to a 17.0% decrease in the percentage of White women who are at a healthy weight, defined as a BMI¹ between 18.5 and 25. In absolute terms, 25.7% of White women are overweight, 31.3% are obese, and only 39.7% are at a healthy weight. Zablotsky and Mack reported that there has also been an increase in obesity among women over 50 years in age from 14.4% in 1990 to 21.7% in 2000.

Weight is not a neutral characteristic such as eye color. Medical research has linked quite a few health concerns with being overweight, including heart disease and diabetes. Carrying

¹ Body-Mass Index, is a metric of body size that combines weight and height. This metric is often used by the Centers for Disease Control and Prevention for determining health and overweight/obesity status. A larger Body-Mass Index is indicative of a larger body-size. Body-Mass Index is calculated by the formula: BMI= (weight in pounds/height in inches/height in inches)x703. For reference, a Body-Mass Index of 18.5 or less is considered underweight, above 25 is considered overweight, and above 30 is considered obese (World Health Organization 1995).

excess weight may also aggravate conditions like high blood pressure, arthritis, especially in the knees, and respiratory illnesses. Even for people not at risk for these conditions mentioned, many doctors recommend losing weight as a sort of preventive cure-all. Further, weight seems to be the most common measure used for body size. Measurement of weight and height are the usual first steps for any health check-up, and many schools have returned to recording height and weight on students' report cards.² The prevalence of weight as a common metric likely results from its quantifiable nature, making progress or change easy to mark. However, so much focus on weight can lead to negative social judgments about both the weight itself and individuals who carry it.

Socially, overweight and obese individuals face criticism and ostracism. Fat jokes have long been a staple of comedians' repertoires, but overweight people seem to be increasingly marked for derision, and movies such as *Shallow Hal* and *Norbit*³ have taken the issue to new levels. Reality television focuses relentlessly on the spectacle of weight, including shows such as *The Biggest Loser*, *Fat Actress*, and *The Half Ton Man*.⁴ Individuals shun obesity at the level of

² States who require schools to record the height and weight of elementary school students include Arkansas, Illinois, Maine, New York, Pennsylvania, Tennessee and West Virginia (Bury 2007). For each student, the height and weight are calculated into BMI scores and listed on report cards like grades. This has created a controversy among parents and educators over the importance of informing parents that their children are unhealthily overweight versus concerns about reinforcing an unhealthy focus on weight and damaging students' self-esteem.

³ *Shallow Hal* (2001) depicts the story of a appearance-focused man who (through hypnotism) falls in love with a 300 pound woman because of her "inner beauty," which no one else can see because she is so overweight. This movie sparked controversy in the blogosphere as Gwyneth Paltrow, a very svelte actress played the role of the obese woman in a "fat suit," leading some viewers to wonder whether the fat suit is akin to Blackface as a performance of implied degradation (cf. Queen of Violets blog 9/22/07). *Norbit* (2007) depicts the story of a life-long nerd who finds himself desperately unhappy in his marriage to a severely obese and controlling woman until he reconnects with a beautiful, thin childhood playmate. The fact that Eddie Murphy himself played the obese woman in the picture implicitly raises the issue of notions of gender ambiguity in obese individuals, as if so much weight leads people to view obese women as less feminine and obese men as feminized.

⁴ *The Biggest Loser* (2004-ongoing) is a NBC reality series in which overweight contestants compete to see who can lose the more weight. While the title of the show ostensibly refers to losing the most weight, the notion that someone would enter such a competition because they are "big losers" (colloquial use of the term denoting someone of little social value) cannot be ignored. *Fat Actress* (2005) stars Kirstie Alley as herself, making the most of her frustration with Hollywood's disrespect of her due to weight gain. Kirstie Alley has since become a spokesperson for the Jenny Craig diet program, yet again reinforcing the importance of losing weight. *The Half Ton Man* (2005) is a

social interaction as well. In her book *Body Wars*, Margo Maine (2000) reports that half of women aged 18-25 would rather be hit by a truck than be fat, and two-thirds would rather be mean or stupid than obese. While these figures may be a tad hyperbolic, their existence speaks to the deep-seated fear of fat common in American culture. Further, this fear begins early: Shapiro, Newcomb, and Loeb (1997) found that by age 8-10, 45% of girls thought it was important for women to be thin and 67% were either always or often afraid of being fat.

With obesity and overweight such a salient negative condition for both health and social reasons, many individuals are motivated to lose or avoid gaining weight. Given the many dieting plans and strategies available to consumers, in this society, it is not at all clear how individuals decide which dieting plan to follow (if any at all). How do they conceptualize these strategies, and why choose one over another? The answers to these questions are not purely psychological, but are heavily influenced by culture. This research will examine the role of culture, social characteristics, the sense of self, and agency in weight control strategies such as dieting and healthy eating. However, before catapulting directly into the analysis, I need first to probe more deeply into the concerns about obesity and more generally, into issues concerning the body itself.

Bodies in the Contemporary Society

In recent decades, there has been a growing awareness of the necessity to include our physical bodies in analyses of social interaction. Much sociological theory, along with other academic theories, focuses on interactions, decisions, and even identity as if they occur unaided or unimpeded by actual physical bodies. Recent explorations of embodied social theory have attempted to rectify this problem, as well as drawing greater attention to the importance of bodies

documentary about Patrick Deuel, who weighs nearly 1100 pounds, and his efforts to lose enough weight to qualify for gastric bypass surgery.

in political, occupational, and economic realms (Turner 1984; Featherstone, Hepworth, and Turner 1991; Turner 1992; Shilling 1993; Falk 1994; Williams and Bendelow 1998 Crossley 2001). This interest in the body was likely prompted by the writings of feminist, ethnicity, queer, and disability scholars and their efforts to highlight the role of the body in various discriminations and subjugations, and over the past two decades sociologists have sought to address these and other issues. While investigations of bodies have focused on a variety of aspects including sensory, ability, performance, reproduction, and more, I believe that appearance is a central aspect that plays a role in every sort of interaction in the modern world. While appearance is often trivialized, it sets the stage for all manner of interactions and stands in for many aspects of great interest as we organize much of social life on the basis of visual clues. Most stereotypes function on visual indicators of racial, gender, and even class attributes, non-verbal indicators influence the progress of dyadic and group interactions, and most generally, we categorize individuals into social groups on the basis of appearances: indeed, the appearance of health, appearance of identity, and appearance of normality are taken as evidence of health, identity, and normality in daily interactions. Further, appearance is closely connected to the self-concept in that individuals use their appearance to make indications about themselves to others.

As an example of a work that seriously considers appearance, Rose Weitz begins her discussion of hairstyles by arguing that hair is important to examine because hair is “simultaneously public (visible to everyone), personal (biologically linked to the body), and highly malleable to suit cultural and personal preferences” (2001 p. 667). This is also true of the body in contemporary American society. While bodies are not as malleable as hair, they are certainly viewed as malleable to some degree, indeed, so much so that Shilling (1993) describes the body-as-project as one of the most powerful expressions of the current era. In the literature,

the range of behaviors designed to modify the appearance of the body have been termed *bodywork*.

Bodywork represents one window into a time in which a negotiation must occur between the body, culture, and the self. At its most basic, Gimlin understands bodywork as the efforts that transform the “natural” body into a social entity (2002). Further, it is work preformed on the exterior of the body, which is also work on the self. The body serves as the visual expression of the self to others. Thus, modification of the body results in changes in how others view the individual, the responses received, and eventually one’s own sense of self.

Bodywork is not a new social practice. It is engaged in by all social actors at some point in their lives. For this reason alone, it is worthy of examination. As sociologists have come to recognize the importance of bodies for individuals, they have acknowledged that bodies represent both a constraint and an opportunity for action. The body may be seen as an opportunity for self-expression, a constraint on that expression due to its resistance to change, and a site for efficacy through successful change (or non-change). Bodywork practices are a fascinating site to examine the intersection of self, agency, and culture.

Following Giddens (1991), I focus on bodywork practices as an example of individuals engaged in the reflexive construction of the self using cultural resources both as tools and in the selection of important aspects of the self targeted for (re)construction. In this way, I identify agency in the actions of individuals, even if their actions appear to be conforming to social norms. As Sharon Hays (1994) explains, choice is the active aspect of agency, as in a choice among alternative courses of action, but agency does not necessarily imply intentionality, complete individual freedom, or random or incomprehensible possibilities. In this situation, culture serves two functions. On the one hand, culture operates as a constraining and enabling

social structure (Hays 1994), a guiding force demarcating comprehensible possibilities for action through identifying social values. On the other hand, culture acts as a toolkit containing practices and lifestyles to achieve those social values (Swidler 1986).

Bodywork is gendered in that the practices considered to be appropriate for each gender differ. This does not necessarily mean that men and women do not engage in the same practices, only that their practices are likely different. The practice of tattooing offers a convenient illustration. While it is commonplace these days to see both men and women with visible tattoos, the size, content, and placement tend to differ. Men tend to get larger tattoos consisting of fierce animals, tribal markings, or images of people. They usually place their tattoos on the upper arms, chest, or upper back. Women, in contrast tend to choose smaller, prettier tattoos like flowers, sea or mythical creatures, or delicate patterns. Popular tattoo locations for women are the ankle, bikini line, upper chest, or lower back. Similar comparisons can be made for other forms of bodywork. Because gender is clearly a factor in bodywork, I will restrict my investigation to women.

There are many forms of bodywork, including exercise, hair coloring, and (as mentioned above) tattooing. All seek to change the appearance of the body in an effort of self-expression. However, the types of bodywork of interest here are those related to eating and body-size, specifically the eating strategies of dieting and healthy eating. These forms of bodywork are of interest for two reasons. First, they are *continual* practices, that is, practices that must be pursued in a continual, intentional way.⁵ As such, they represent an ongoing investment of time and

⁵ Recently, there has been an increase in the availability of surgical options to reshape one's body. Beyond traditional forms of cosmetic surgery such as liposuction and surgical body part enhancements and reductions, a new technique reshapes the body from the inside. The various forms of Bariatric surgery involve surgical means of limiting the amount of food that enters the body, thus leading to significant weight loss. Although this is an interesting new development, it lies outside the scope of this project as focusing on the continual, intentional, self-directed bodywork accessible to any individual.

energy. Second, they are practices that must be negotiated. As living beings, we must eat, and therefore, cannot avoid some consideration of food options. Combined with a social context of plentiful food options and the knowledge of direct correlation between food intake and body size and health, strategic eating bodywork illuminates some of the challenges of living in our contemporary social world.

Type of Eating Strategies Under Investigation

My research will focus on those types of bodywork that can be characterized as *eating strategies*. I am using the term “strategic eating,” or eating strategy, to indicate an intentional adjustment of one’s eating pattern with some goal in mind. This term helps conceptualize dieting and healthy eating as linked, providing a basis for identifying ways that these practices are similar as well as distinct. It also implies the role of motivations in practices, which are often overlooked, allowing one to understand connections such as exist when similar practices are motivated by different goals. Finally, the concept of strategic eating is distinguished by the notion that one is eating differently from the “standard American” eating pattern (Singer and Mason 2006). Eating strategies are methods of bodywork intended to change the body through eating. Both *dieting* and *healthy eating* are eating strategies,⁶ and as the main forms of bodywork considered, these bear some further elaboration.

Dieting

The word *diet* can indicate a number of ideas: the usual foods consumed by an individual, an alteration in the usual consumption to increase or decrease the consumption of certain

⁶ This term could also describe other goal-oriented eating practices, such as eating for increased mass among body-builders, vegetarianism, or eating only organic foods.

nutrients, or a decrease in consumption as a way to lose weight⁷. Today, most people associate the word *diet* with the last definition, to lose weight. Thus, in this chapter, as through out this dissertation, the term “diet” is used to refer to a particular strategy of eating characterized by caloric restriction, often under the guidance of an outside organization or plan, and which is understood to be a temporary adjustment to one’s usual eating pattern. Utilizing the colloquial usage of the term more easily allows for the investigation of the practices grouped under the colloquial usage of the term by the participants and the general public without the continually recurring use of encumbered sentence structure such as “the practices generally associated with eating less to lose weight are defined by the participants as....” Thus, for clarity, this usage will remain consistent, that is, the term diet will refer to the practice of temporary caloric restriction rather than to the more general anthropological meaning of diet as simply a pattern of eating.

Dieting in this sense is a consciously chosen, short-term change/reduction in the intake of various nutrients in an individual’s regular eating pattern with the goal of losing weight. To *diet* is to change, sometimes drastically, one’s eating habits for a short period, during which some specific goal is accomplished. After the diet is over, one would presumably return to their normal eating habits, perhaps with some minor variations. For some people, dieting may be a health-related behavior. For others, dieting is an appearance-related behavior. For most, it likely is some combination of both.

Dieting is a form of body modification, but is qualitatively different from the forms of body modification we most often think about- tattooing, piercing, scarification, etc. Rather than a modification intended to proclaim difference, dieting is motivated often by a desire to bring

⁷ Diet is also used to describe a longer-term change associated with a health condition, i.e. a low salt diet used to control high blood pressure or a low-glycemic diet used to control diabetes. This represents a relatively recent return to this use of the term as our understanding of the role of diet in the prevention and maintenance of disease has grown. However, throughout this dissertation, the word diet will be used in the colloquial sense to indicate an alteration of eating with the goal of losing weight.

one's body back into line with mainstream aesthetic norms and standards. Further, dieting is an ongoing process rather than a single act. In this way, dieting is more like coloring one's hair than getting a tattoo. However, there is still some urge to stand out, within mainstream parameters. Just as the most common hair dye color is blonde, which occurs statistically less frequently in nature than brown hair, the majority of women who diet most likely have no desire to become anorexic but do want to become thinner and more attractive than the average overweight person.

Dieting is one practice ideally used to change and maintain the body and allows an individual to (re)gain control over their body. Dieting maintains popularity in spite of the fact that it is not always (or even usually) successful (Wadden 1993; Ogden 1992). Further, research shows that many people who actually lose weight on a diet gain it back after the diet is over (Crawford, Jeffery, and French 2000). Yet individuals consistently and repeatedly engage in dieting, even while knowing that dieting may not be the best course of action for permanent weight loss. Understanding this paradox is one of the goals of this project. One key to this puzzle may be that dieting is a complex process undertaken for a variety of reasons, situated in a specific socio-cultural location. Thus, the focus of this investigation is why people engage in dieting as the prevailing method of weight loss in American society today rather than whether or not diets are capable of creating weight loss is not the focus.

Dieting is not a new phenomenon, as Schwartz (1986) amply shows, nor is the connection of dieting and health new. Throughout history, people have adjusted their diet in an attempt to eat healthier foods. In the twentieth century, as social prosperity spread, dieting for thinness appeared. For the last half century, there has been entanglement of being healthy with losing weight, such that to lose weight was to become healthy. Over the last two decades or so, this association moved in the other direction, such that healthy eating became paramount, from

which, weight loss would proceed. This is not to say that dieting has disappeared. In fact, dieting has continued and even gained variety.

Judy Kruger and her colleagues (2004) reported that 38% of women and 24% of men were dieting at the time of the 1998 National Health Interview Survey (NHIS). Among the respondents, the prevalence of weight loss attempts was higher among people less than 65 years old, more educated people, and people with higher Body Mass Indexes. Eating fewer calories, eating less fat, and exercising more were the top three methods people were using to lose weight, but only a third of them were using the recommended combination of eating fewer calories and exercising more. It is interesting to note that 24% of the normal weight women in the NHIS sample were trying to lose weight, compared to only 6% of normal weight men. Bish and colleagues reported slightly higher but similar findings based on analysis of the 2000 Behavioral Risk Factor Surveillance System data (2005). Forty-six percent of women and 33% of men were trying to lose weight, over half were consuming fewer calories, and nearly 70% were exercising, but only 20% were using a combination of fewer calories and exercise. Significantly, the percentage of the population using this recommended combination has not increased since the 1996 survey using the same method (Serdula, Mokdad, Williamson, Galuska, Mendlein, and Heath 1999). In a similar study that same year, French, Jeffery and Murray (1999) found that a majority of their respondents had tried reducing fat or calories or increased exercise, but that individuals sustained the increased exercise for a shorter period of time than the reduction in fat intake. Overall, it is clear that dieting is far more common than a combination of eating less and exercising.

There has been previous social research on dieting. However, this research has looked at other aspects of dieting than those proposed here. Historical researchers (Schwartz 1986; Iggers

1996; Stearns 1997) have looked at the origins of various diets, the cyclical nature of diets, and socio-moral ideas about dieting. Psychological theorists have focused on the individual development of eating and dieting patterns, the relation of dieting to eating disorders, and psychological consequences of dieting (Gilbert 1989; Spitzack 1990; Ogden 1992). Feminist theorists have tended to focus on dieting as a way to oppress women, seeing the pressure to engage in dieting as a significant arm of the beauty myth (Freedman 1986; Wolf 1991; Bordo 1993). Medical studies have tended to examine diet as a route to health or a method to limit illness, or when studying weight loss have focused on the medical merits of individual diets on a small scale.

There have also been some sociological theorists who have tread close to these matters. The now established field of the sociology of the body has looked at the place and meaning of the body in society, recognized that some bodies are privileged over others, and has even discussed methods of attaining such bodies. (Featherstone 1982; Turner 1984, 1991; Shilling 1993) However, most of these theorists have kept their ideas on the theoretical level rather than interacting with real bodies.

All of these approaches are incomplete. Historical research can give clues about the present but falls short of identifying contemporary intentions. Psychological research highlights the individual, neglecting the social, and has a tendency to focus on the extreme of eating disorders rather than the common dieting. Medical science is also individualistic, centered on the individual body, biological processes, and controlled studies, which miss the big picture of daily life and interpersonal interactions. The sociology of the body reflects the opposite problem, operating at the level of theory and not incorporating embodied actors.

Feminist theorists, having a history of interdisciplinary activity and an explicit interest in recognizing the personal in the political, have solved many of these problems. However, they have tended to enact a different dichotomy. In their analyses, feminists' political concerns have encouraged them to overemphasize the structure of culture, unintentionally depicting women as without agency, mindlessly following the dictates of the beauty industry. This precludes agency on the part of women, and ignores the decision-making capability of individuals. It also sets up a problematic position for feminist women by constructing a politics in which she is expected to either completely remove herself from cultural valuations, or consider herself to be capitulating to the oppressive patriarchy. Esther Rothblum takes on this issue directly in her essay "I'll die for the revolution, but don't ask me not to diet" (1994).

What got the feminists, along with others, into trouble is the fact that fat is devalued in our culture, and dieting is one very common way to avoid it. In fact, a line of cultural discourse supports dieting as a preferred form of bodywork. This discourse centers on a few common presumptions. First, it is important for the body to look attractive. Second, it is possible to change the body. Third, this change can be easily accomplished through short-term food restriction or other short cuts. Another piece of the cultural discourse of diet is that change through diet extends beyond the body. Through dieting, one will become not only thin, but also more attractive, more successful, and happier. Although there is some evidence, as well as common sense, showing that many women do not enjoy dieting, other researchers have found evidence for these positive results of dieting. When dieting is successful, it may result in satisfaction with appearance, achievement of personal goals, feelings of pride from self-discipline, and social recognition (Orbach 1986; Chernin 1981).

Part of the cultural discourse is a morality applied to foods. In most diets, fat, calories, or carbohydrates are considered evil, but there is no corresponding positive figure. Bad foods are those with high levels of fat, calories, or carbohydrates, while good foods are those with low levels of the offending substance. Susan Bordo (1993) finds that food is indeed marketed in this way: high calorie items, especially sweets, are temptations to be resisted or guilty indulgences. Similarly, in focus group interviews, Germov and Williams (1996) found much consistency in respondents' characterizations of foods into two categories: on-diet/good foods and off-diet/bad foods. The respondents freely supplied these moralistic characterizations, along with discussing feelings of guilt for eating bad foods. The extended implication of this morality of food in the context of the discourse of dieting is a correlation with the "thin/fat dichotomy; where it is good to be thin and bad to be fat" (Germov and Williams 1996). This is an extension of the morality from foods to people. This thin/fat morality is clearly an important piece of the discourse of dieting: thinness is the prized category that is admired and emulated while fatness is the subjugated category that is denigrated.

As a health behavior, dieting takes on more importance and legitimation. In this case, dieting is motivated not solely by a desire to lose weight, but also by an interest in preventative (or curative) medicine. Germov and Williams (1996) found that respondents clearly distinguished between weight loss and health, and associated their motivations for weight loss with appearance concerns. Further, they recognized that dieting required a "trade-off" with health and that the two could not be pursued simultaneously. However, studies that are more recent have found that health was a common reason for wanting to lose weight. O'Brien and colleagues reported that the majority of individuals interested in participating in a weight loss program cited health reasons (50%), while only 35% cited appearance reasons and 15% cited

mood reasons (O'Brien, Venn, Perry, Green, Aitkin, Bradshaw, and Thompson 2007). Biener and Heaton (1995) reported that nearly two-thirds of their respondents were dieting for health reasons, compared to 37% dieting for appearance reasons. Further, these authors found that 47% of the White female dieters were within a normal weight range ($BMI < 25$), but perceived themselves as more healthy when compared to a small random sample of non-dieters.

In the context of contemporary American culture, to diet seems logical. A recent survey by the Harvard School of Public Health (2005) found that 32% of Americans are counting calories, 47% are watching fat, and 36% are keeping an eye on carbohydrates. A similar survey by the Pew Research Center (2006a) found that 25% of respondents are currently dieting and a little over half (52%) have dieted at some point.

On the surface, it would seem to be easy to diet today. There is so much focus on dieting that much information is readily available. The calorie, fat, and carbohydrate content are displayed on the labels of most foods in the grocery store, as well as contained in numerous dieting and cookbooks. In contrast, exercise information is less available, such as what type of exercise is best or the necessary amount needed to be healthy or lose weight. In addition, dieting provides a subject to discuss with others, particularly among women (Spitzack 1990).

However, problems do arise. First, calorie, fat, and carbohydrate information is not always available at restaurants or for home cooked meals without numerous tedious calculations. Second, the incredible number of diets to choose from today is confusing. A search of one of the major booksellers, Amazon.com, found 284 diet books for sale. Each diet has a particular philosophy and claims to be backed by scientific findings arguing that this diet is the best way to lose weight. Third, none of these commercial diets include a health analysis by a physician to determine if or how much weight needs to be lost, or to ensure that one takes in sufficient

nutrition while following the plan. Finally, there seems to be no good way of determining which diet might work best for an individual. Beyond trial and error, the individual can only guess which diet (if any) will work based on food preferences, daily schedule, and cost. For instance, I know from personal experience that it would be very difficult to choose a diet that forbids carbohydrates for someone who loves bread and pasta, a diet that requires cooking all one's own food for someone who has a busy and inconsistent schedule, or a diet that requires buying all pre-packaged food on a graduate student budget.

Healthy Eating

Healthy eating focuses on increasing the nutritional quality of the foods eaten and trimming excess fat and calories. There is a definite morality applied, such that “good” foods are those with high nutritional value, while “bad” foods are those with little nutritional value. For example, a salad containing many vitamins is a good food while soda, containing high levels of sugar and sodium is a bad food. The rhetoric of good and bad is also applied within food groupings. For example, there are good fats (monounsaturated fats) which are found in olive oil and peanut butter, and bad fats (saturated and trans-fats) which are found in butter and animal fat. However, this morality is not the focal point. Bad foods do not need to be eliminated. They only need monitoring. This eating pattern encourages eating a better *balance* of foods rather than restricting the overall caloric intake. Generally, healthy eating focuses on increasing both the amount and variety of fruits and vegetables; limiting overall fat intake, especially saturated fats; replacing White flours with whole wheat; replacing red meat with leaner chicken and fish, while also increasing protein intake from non-meat sources like beans and other legumes; and limiting or eliminating refined sugars. These foods provide the highest levels of nutrients and fiber, as

well as antioxidants and nutritional compounds that scientific research is only beginning to understand, but recognizes as having health-promoting effects (Havala 1998).

There has been far less research on healthy eating than there has been on dieting. Definitions of healthy eating held by various populations are one area of healthy eating research. BM Margetts and colleagues found that Europeans tended to think about increased fruit and vegetable intake, reduced fat, or balance and variety in their definitions of healthy eating (1997). On the other hand, Falk, Sobal, Bisogni, Connors, and Devine (2001) identified seven themes related to healthy eating: low fat, natural/unprocessed foods, balance, disease prevention, nutrient balance, disease management, and weight control. Other researchers have reported similar findings (Keane and Willetts 1996; Povey, Connor, Sparks, James, and Shepherd 1998; and House, Su, and Levy-Milne 2006). Despite the lack of a clear definition of healthy eating in the academic literature, the lay population seems to agree on the general ideas of healthy eating.

Another topic of interest in research on healthy eating focuses on perceived barriers. One recurring concern for people seems to be cost (Lloyd, Paisley, and Mela 1995; Lappalainen Saba, Holm, Mykkanen, and Gibney 1997; Drewnowski and Darmon 2005). In a survey in the European Union, R. Lappalain and colleagues found that people perceived a variety of barriers to eating healthy. The most commonly mentioned barrier was lack of time, and additional barriers included the notion of having to give up favorite foods and lack of willpower (Lappalainen et.al 1997). Other researchers have reported similar findings (House, Su, and Levy-Milne 2006). Many individuals do, however, overcome these perceive barriers and engage in healthy eating. In a study of the relation between intentions and behavior of healthy eating, Connor, Norman, and Bell (2002) found that intentions to healthy eating significantly predicted behavior six years later. This was truer of predicting fat intake and fruit and vegetable intake than fiber intake

(Conner et al. 2002) In general, most middle-class people seem much more educated about the relations of health and eating habits today than they were in the past, but there are still disjunctions between knowledge and behavior. Red meat and potatoes are no longer seen as the healthiest meal, but a mixed green salad with “lite” dressing is still seen by many as boring and unfulfilling. Part of the cultural discourse supporting dieting is the idea that healthy eating implies eating only boring, bland, and yucky foods, forever denying all the wonderful flavors of sweets, rich sauces, and anything fried (e.g. Charles and Kerr 1988; Murcott 1993). In comparison to the short-term diet, to adopt healthy eating patterns is to change eating habits for a long period, perhaps the lifetime. Many still see healthy eating as a chore whereas bad-for-you food seems more tasty, exciting, and fun. Yet, most also recognize the importance of trying to eat healthy in light of medical research linking obesity and chronic illness. The increasing priority placed on health is discussed further in the next chapter.

It is difficult to measure the prevalence of healthy eating. Not a single study could be found that measured the prevalence of healthy eating. No doubt, this reflects the inadequacy of definition of the term “healthy eating.” Healthy eating is a concept used by many, but not clearly defined by any. Part of the problem is the nature of the scientific model. The scientific model has a premise of testing and retesting, with a high likelihood that any one “fact” may be found untrue in the course of further testing. However, diet, weight, and health research seems to be particularly susceptible to contradicting claims. These ideas too, will be expanded in the next chapter.

Research Question

Thus far, no sociological theorist has examined these forms of strategic eating together. First, sociologists rarely consider dieting at all. Whether this is due to assumptions of triviality or more interest in spectacular body issues such as eating disorders, cosmetic surgery, or tattooing is debatable. When dieting is examined, usually by sociologists of medicine, researchers tend to ignore the cultural context in which dieting occurs and view it in isolation- separated from other contexts of women's lives (except for media expectations of thinness). Similarly, researchers also investigate healthy eating through a lens of medical or health sociology, primarily considering the health-oriented goals. However, these two practices, dieting and healthy eating, also exist in a complex relationship with each other, and with health and appearance concerns. New health research increasingly links chronic diseases to being overweight, making weight loss both an appearance and health goal. Similarly, a svelte physique is viewed as a sign of better internal health, and thus better character (Finkelstein 1991; Goodman 1995; Roehling 1999), encouraging individuals to pursue (the appearance of) health for appearance reasons as well as avoiding illness.

Thus, in this investigation, I am interested in the process by which women make decisions about eating strategies. My overarching research question is: How do women develop eating strategies? This interest actually leads to three interrelated research domains:

- The first domain examines the role of mediated information and local knowledge.

How do women process information about eating strategies? How do they negotiate all the various sorts of information out there? How do they decide who to listen to, who to trust, which bits of knowledge are worthwhile and which are junk, and then how to incorporate them into their personal eating strategy?

- The second domain examines the role of self-concept in eating strategy choice. How do ideas about the self influence one's decisions about eating strategy? In what ways does self-concept impact one's options for eating strategy enactment? How does self-concept and agentic capacity influence eating strategy?
- The third domain examines the meaning and enactment of eating strategies. How do women conceptualize and practice eating strategies? How do women define dieting and healthy eating? Are they seen as similar or different, and how do they each relate to what they consider normal eating?

The purpose of this study is not to validate one eating strategy or another. Rather the focus is on understanding what these strategies mean to the women who enact them. How are these meanings constructed in relation to their experiences and communities? How are these meanings similar and different and what effect does that have on both their practices and their sense of self? How are these meanings shaped by both local and media cultures?

Organization of the Study

This dissertation seeks to address these questions by examining media use, identity, and practice engagement. After a discussion of the methods of data collection (Chapter Two), Chapter Three will examine how women perceive and engage with mediated expert advice in comparison with local knowledge. This chapter uses healthy eating advice as a case study of the ways in which individuals engage with new information in a complex social world. Such knowledge forms a context in which to consider possible selves. The fourth chapter will address the relation of possible selves, motivation, and agency to eating strategies. Chapter Five integrates the themes from the previous chapters, exploring how the reliance on local knowledge

and concerns about possible selves result in four distinct eating strategies. The final chapter will draw together some conclusions about the choice of eating strategies, summarizing the findings of the three previous chapters and considering those findings in a wider social view.

CHAPTER TWO:

METHODS AND SAMPLE

Before embarking on a research investigation, it is necessary to clarify a number of issues, including the methods and parameters of inquiry. In this chapter, I lay out the theoretical perspective and population of interest. Next, I describe the method of data collection and analysis. Lastly, I describe the sample on which the following analysis chapters are based.

Theoretical Perspective

This research begins from a perspective of symbolic interactionism, a sociological theory that explores the creation, interpretation, and negotiation of meaning, identity, and interaction in everyday life (Mead 1934). In this perspective, meanings are created through social interaction and are “central in their own right” (Blumer 1969: 3) as they are what drives all social action. The meanings individuals construct and share about their bodies and selves mold their social worlds in an ongoing process. Through listening to people talk about their experiences with bodywork, and their lives in general, it is possible to gain an understanding of how this reality is constructed and how they think about their lives (Gubrium and Holstein 1997).

However, individuals do not usually create meanings out of nothing. Culture provides an abundance of material for meaning making and negotiation. Following Hays (1994) I consider culture to be a constraining and enabling structure. Culture also serves as a resource, a “tool kit” (Swidler 1986) from which strategies for action can be selected. By this, I do not mean that

culture is determining, as individuals often modify strategies to suit their needs. Rather, I believe that cultural ideas and values inform individuals' notions of what is important and what is possible. This interplay of culture and negotiation is precisely of interest in this investigation.

I am interested in the complex ways in which women experience their bodies and see the relation of the body to the self, engage with cultural discourses about bodies, and enact and interact with eating strategies in their daily lives. All these are issues that must be investigated through the use of qualitative methods, seeking the nuances and variety of experience among different individuals, rather than imposing the researcher's pre-conceived ideas and definitions. This straddles two of the categories in the typology constructed by Rubin and Rubin (1995). It engages in both concept clarification, in that it seeks to explore the meaning of certain shared terms (such as dieting and healthy eating), and theory elaboration in that it uses a particular case (eating strategies) to explore more about how people interact with culture and build identities.

Sociological research has often overlooked the development and enactment of body practices such as eating strategies, and they have often been conceptualized as a form of vanity. My purpose in this research is to investigate body practices from the perspective of the women engaged in them. Mirroring reality, I examine these practices in a social context that includes sexism, ageism, and weightism. Drawing from various sociological traditions, including the sociology of culture and the sociology of gender, I seek to develop an integrative theory about the relation between bodywork, culture, and identity.

Population

Gender remains an important aspect of social and cultural organization. A discussion of gender is especially apropos to this research because of the continued disparity in focus on

appearance between men and women. Although the last few decades have seen a rise in the importance of appearance for men, women continue to be judged predominantly on the basis of appearance more often than are men.

Ideas of the body are distinctly related to conceptions about gender. Many theorists argue that more cultural messages about the body are aimed at women (Orbach 1986; Glassner 1988; Valentine 1994). Further, culture puts more pressure on women to be attractive than it does on men. There is evidence that ordinary women do feel this pressure. A majority of women in America are dieting or unhappy with their bodies (Smolak, Levine, and Striegel-Moore 1996). In a preliminary survey,⁸ I found that 70% of the women were looking to lose weight and 27% were looking to maintain their weight. Attractiveness is defined for women by appearance- facial beauty, good skin, shiny long hair, and a thin body. Attractiveness is also defined by youth- no wrinkles, age spots, or sagging body parts. Therefore, as women age, they face increasing pressure to engage in bodywork to attain or maintain standards of attractiveness.

More generally, concern with appearance and weight is a gendered behavior (Wolf 1991). Gender identities are “the socially defined self-meanings of masculinity/femininity one has as a male or female member of society and are inherently derived from and tied to social structure” (Cash, Ancis, and Strachan 1997). For many people, “being feminine” is the same as “looking feminine” (Brownmiller 1984). Cash, Ancis, and Strachan (1997) found that gender identity was related to body image and that women who had conventional gender preferences and

⁸ This survey was gathered as preliminary data to this dissertation research. Survey data was gathered during the Thanksgiving School Break of 2006 and 2007. Students in various introductory sociology and women’s studies courses at a large, Southeastern flagship university were asked to have multiple generations of family members complete a total of three copies of a survey. One would be filled out by the student herself, a sister or a girlfriend. A second copy would be completed by a mother or aunt. The final copy would be completed by a grandmother or older family friend or neighbor. The surveys were anonymous, with the goal of getting representation of older women paramount to actual family relations. After eliminating incomplete, illegible, and ineligible (under 17) surveys, a sample of 491 surveys remained for analysis. Although few results are reported here, analysis was conducted using SPSS version 11.0. Additional findings will be published by the author in future papers.

expectations were more invested in their appearance and were more likely to have internalized societal standards of beauty.

Part of the reason for this may be that social comparison may occur more often for women than for men. Ricciardelli and associates (2000) found that girls used social comparison along the appearance dimension more often than boys and that those social comparisons are linked to body dissatisfaction for girls but positive body image for boys. Perceptions of being overweight are potentially more distressing for women than men, and women are more likely to take action to alter their shape (Rozin and Fallon 1988). Body image has been shown to have a greater impact on the self-concept of women than it does for men (Lerner and Sorell 1981). Women's self-concepts are more likely to be correlated with their own perceptions of their attractiveness while men's self-concepts are more likely to be closely related to their physical fitness or effectiveness (Lerner, Karabenick, and Stuart 1973). Men see themselves more accurately (as others see them) than do women (Fallon and Rozin 1985). In conjunction, there is evidence that women are more psychologically invested in their appearance (Cash and Hicks 1990; Muth and Cash 1997). Synnott (1993) argues that these differences are inherently political: applying Foucault's (1978, 1979) ideas of surveillance of the human body illuminates the gendered nature of discipline and the gaze. In this relationship, women are the recipients of control, watched and watching themselves (Bartky 1988), and the fact that they must "look good" is reinforced. While the previous discussions of this idea were theoretical, Germov and Williams (1996, 1999) found supporting evidence in focus group interviews with actual women.

Further, women experience more body dissatisfaction than men experience (Shisslak, Crago, and Estes 1995). There are two reasons why women are more likely to be dissatisfied with their bodies than are men. First, the media sends more, and more explicit, messages to

women than to men, indicating that appearance is more important than ability (Glassner 1988), and that conformity to the norms of appearance is paramount (Valentine 1994; Millman 1980). These messages imply, or explicitly state, that a woman's body is not satisfactory as it is, but must continually be acted upon in order to be pleasing or attractive (Orbach, 1986). The idea that thinner is better and more beautiful appears throughout contemporary media. Garner, Garfinkle, Schwartz, and Thompson (1980) have found that the ideal body shape has shifted to a thinner size in the second half of the last century as evidenced by both Miss America Pageant contestants and Playboy centerfold models. A follow-up study by Wiseman, Gray, Mosimann and Ahrens (1992) found that this trend continued into the 1990's. Thus, it becomes more and more unlikely (or even impossible) for any average woman to reach the goal of ideal beauty. This trend also coincided with an increase in eating disorders (Pyle, Halvorson, Neuman, and Mitchell 1986) and an increase in the number of dieting and exercise articles in major women's magazines (Garner et. al. 1980; Wiseman et. al. 1992). Other researchers have found that there are 10.5 times more advertisements and articles on shape change and dieting in women's magazines than in men's magazines (Andersen and DiDomenico 1992). Similarly, another group of researchers found that 86% of all "appearance enhancement advertisements" were directed towards young women (Ogletree, Williams, Raffeld, Mason, and Fricke 1990). Myers and Biocca (1992) found that a young woman might alter her perception of the shape of her body after watching only thirty minutes of television.

Supporting a second reason why women are more likely to feel body dissatisfaction, there is evidence that greater social control is exerted on women than on men (Glassner 1988), and social control for women often takes place with the body as the focal point (Valentine 1994). This suggests that how a woman uses or acts upon her body is a gauge of her social and moral

worth. Women are identified with their bodies and so a woman is seen as morally uncontrolled if she cannot or will not control her body. As discussed in the introduction, the rise in self-reflexivity implies that this happens for everyone, but likely occurs more often for women.

As the preceding discussion shows, the body, and the social meanings attached to it are still highly gendered. The body is gendered, bodywork is gendered, and the meanings, issues, and relationships surrounding bodywork are different for men and women. One gender difference is the desired gender dimorphism in our culture. In general, many people see it as desirable for men to be larger than women, both in terms of height and muscle mass. In the resulting bodywork to achieve this dimorphism, men seek to increase their muscle mass or “bulk up,” while women seek to slim down. Thus, while men do engage in bodywork, they likely do so in different ways, by different means, and may get information about it from different sources than women. For example, my husband gleans much of his knowledge about what to eat and what to avoid from magazines like *Men’s Health*, which is oriented to building (lean) muscles rather than to losing weight. I occasionally read the sister magazine, *Women’s Health*, which includes some of the same information, but includes decidedly more commentary about losing weight than building muscle. This difference reflects many of the subtle differences in the ways that men and women approach nutrition and food. Similarly, there may still be stereotypes about dieting being a woman’s activity whereas real men eat steak and potatoes, and the sentiment “real men don’t eat quiche” suggests that men who diet must do it in a more hidden manner or risk stigma and shame. The preceding examples highlight the significant gender differences in bodywork along with the social influences and patterns of appearance and weight. For these reasons, this study is limited to the eating strategies of women. This focus does not represent an

essentialist view of women or men, but merely represents the fact that the gender differences are sufficient to merit separate study.

Three other social characteristics are important to consider in this investigation. Social class, like gender, functions as a research parameter rather than a variable of interest. Race and age, however, are included to explore how these characteristics influence eating strategy choice. Some relevant research for each characteristic will be reviewed below.

Although there has been some research that finds differences in body dissatisfaction across socioeconomic groups (Wardle and Marsland 1990), these differences appear to be shrinking. Robinson and colleagues (1996) proposed that the pressures to be thin are apparent beyond the upper and middle-classes as American culture is becoming more homogeneous across social class. Further, grocery store chains have expanded to a sufficient point that most foods, including fresh fruits and vegetables can be afforded by most of the population.⁹ For this reason, social class is not a variable of interest in this research. However, as a conservative measure, respondents were limited to middle-class individuals.

On the other hand, the dynamic of racial differences in eating strategies may be changing. African American women may experience dieting, and the pressure to diet, in different ways from White women (Stevens Kuamanyika and Keil 1994). Other researchers have reported similar findings, such as Sharlene Hesse-Biber (1996), Kim Buchanan (1993), and Susan Bordo (1993). In quantitative research, some researchers have found White women are consistently more likely to engage in restrained eating patterns such as dieting (Ogden and Elder 1998;

⁹ However, there is clearly more selection of healthy foods available to wealthier individuals. While some researchers argue that eating healthy does not necessarily cost more (Raynor, Kilanowski, Esterlis, and Epstein 2002), the differences are clear by visiting a smattering of grocery stores. For example, the variety of fresh vegetables available, and the cost for those vegetables, increases as one moves from a low-budget store, such as FoodLion, to middle level store, such as Kroger, to a relatively high cost store, such as Earthfare.

Lovejoy 2001), while others have found only small differences in body dissatisfaction between White and Black women (Demarest and Allen 2000; Grabe and Hyde 2006). Looking at the dates of all these studies, it seems possible that the differences between White and Black women may be decreasing. For these reasons race is a factor that must be considered in this analysis. While holding gender and class constant, the racial differences in the meanings and enactments of body practices can be explored through differences in cultural participation.

I think it is important to note that I do not make comparisons between White and Black women with the implication that Black women are not “living up to” White women’s body practices. While concerns abound regarding the healthfulness of the Black community, with higher rates of obesity, high blood pressure, and diabetes, it is important to question the presentation of the White community as the standard. It is possible that White women’s obsession with thinness is just as psychologically and physically unhealthy as Black culture’s acceptance of a larger body size for women. While some social critics, including Susan Bordo (1988; 1993), Sharlene Hesse-Biber (1996), and Naomi Wolf (1991), have addressed the problematic nature of White women’s quest for thinness, many large surveys still imply that African Americans are failing to “get on the ball” and enact body practices to the same level as Caucasians. This ignores a variety of social structural constraints on African Americans, as well as ignoring the differential impact of cultural sources. Rather than blame African American women for not enacting body practices, this research will seek to explore how body practices are differently conceptualized and valued among African American women.

Lastly, age is important to consider: whereas once aging was viewed as inescapable, medical and technological advances have encouraged the possibility of delaying the aging process. Like the body project in general, the possibility of minimizing the appearance of aging may set

up the imperative to do so (Featherstone 1982). This situation especially affects women. Susan Sontag (1979) described the “double standard of aging” as the dual effects of sexism and ageism, which leads to a social exclusion of women. There is a tendency to see youth and beauty as synonymous, and aging can be devastating to a woman whose status is predicated on beauty (Chrisler and Ghiz 1993). Markers of aging, wrinkles and grey hair, are not considered beautiful (Abu-Laban and McDaniel 2001). Additionally, both Orbach (1986) and Chernin (1981) remark on the connection of a thin body as a symbol of youth. Barbara MacDonald (1984) highlighted the effects of this exclusion: women who fail to remain youthful and beautiful become socially “invisible.” Recent studies have found supporting evidence for this double standard. Halliwell and Dittmar (2003) found that women’s discussions of aging focused almost exclusively on appearance, leading them to characterize the entire process of aging as negative based on this association. In contrast, men’s discussions lacked this focus on appearance and they described aging as a neutral or even positive process.

Indeed, many older women seem to be concerned about their weight. Mary Serdula and her colleagues (1999) found that 80% of women between the ages of forty and sixty report that they are either trying to maintain their current weight or lose weight. Ann-Francoise Allaz and her colleagues (1998) found that 62% of women over the age of 65 wanted to lose weight, despite the fact that 65% of those women were already at a normal weight. Translating this desire into practice, 31% of the women over 65 had dieted within the previous 5 years. Sixty-two percent of these women who had dieted were of normal weight (Allaz, Bernstein, Rouget, Archinard, and Morabia 1998). In the preliminary survey mentioned earlier (p. 23), I found that while fewer women aged 60-80 wanted to lose weight than in the younger age groups, the figure (51%) was still quite high. Further, 34% of these older women were on a diet. O’Reilly,

Thomlinson, and Castrey (2003) found that women who were worried about aging were more likely to diet but were *not* more likely to exercise in an effort to lose weight.¹⁰ Clearly, even normal weight older women are immune to neither body dissatisfaction, nor the impulse to diet.

Bodywork is gendered, and, conventional wisdom holds, a practice organized by age. However, as aging becomes an issue of greater social concern in society, practices usually reserved for the young are increasingly taken up by older individuals in an effort to appear young. As detailed in the studies above, bodywork such as dieting is one such practice. Whether real or romanticized, slimness and good health are characteristics associated with youth. Thus, bodywork can serve a dual purpose of making one look more youthful when successful, as well as removing the health concerns of being overweight. Increasingly, older individuals may be engaging in bodywork, with motivations focused on aging and health. In this context, examining age differences in eating strategies is apropos.

Having considered the social characteristics above, each plays an important role in understanding the bodywork practices of eating strategies. Gender and social class differences are significant enough to warrant a separate study, and so operate as exclusionary parameters here. Race and age differences in bodywork however, have been given less attention in the literature. For this reason, I decided to develop my sample along these two dimensions in hopes of identifying differences. Thus, for the purposes of this study, I am interested in White and Black middle-class women between the age of 25-80.

Method of Data Collection

¹⁰ Other research disputes these findings. Oberg and Tornstam (1999), in a population survey of Swedes, found that women's body image became increasingly positive with age. However, these researchers represent a distinct minority among gerontologists.

Information about our world generally comes in two forms, qualitative and quantitative. Each type of information has positive and negative aspects, and each has adherents among social scientists. Quantitative methods cast a wide net, getting a little bit of information from lots of people. This type of method is good for investigating the variety and incidence of practices. Qualitative methods, on the other hand, seek more detailed, rich, in-depth information from fewer people. This type is good for understanding the complexities of practices as well as why individuals engage in them. Many researchers utilize just one type of method, but I believe that understanding bodywork calls for the utilization of both types of methods. This dissertation is only one stage in an ongoing research program committed to examining bodywork through both methodological avenues. As such, it is informed by previous quantitative research on the prevalence of dieting and healthy eating techniques.

For this project, I choose interviewing as the best method of inquire for three reasons. First, interviewing allows for greater rapport with respondents, encouraging them to open up and share both intimate details and more carefully considered responses. Second, by encouraging respondents to explain things in their own words, interviewing provides a better view on how individuals use concepts and meanings in their daily lives, rather than reflecting the notions of the researcher. Thirdly, interviewing allows for a deeper understanding of the relations between concepts, within the fabric of respondents daily lives. There are some problematic aspects of interviewing, one of which is that a researcher can only trust what respondents say, and there is no way to verify responses. A second issue is that this methodology, as well as the questions about personal characteristics, beliefs, and behaviors which form the topic of investigation, raises the specter of social desirability. Social desirability is the (potential) tendency of respondents to respond in ways that position themselves in a positive light. Indeed, social desirability has been

shown to effect responses in the self-reporting of weight (Larson 2000), exercise (Adams, Matthews, Ebbeling, Moore, Cunningham, Fulton, and Hebert 2005), and dietary practices, (Herbert, Ma, Clemow, Ockene, Saperia, Stanek, Merriam, and Ockene 1997). Other researchers, however, have found little evidence of social desirability in self-reports of health beliefs and health-related food choice (Sheeran and Orbell 1996; Armitage and Connor 1999). Further, Roberts, Jackle and Lynn found that telephone respondents were more likely to provide socially desirable responses than in face-to-face situations (2006). For this reason, note is made of the possibility of social desirability in interviewees answers, but not seen as detrimental to the spirit of the project. Overall, the problematical aspects of interviewing are minimal compared to the wealth of information this methodology provides.

This study utilizes in-depth interviews to explore the agency women exert over body practices. They are choosing to engage in bodywork, to engage with an eating strategy, seeking to change their body. These choices, however, occur within a culture that applies social valuations to these practices and their results. On the one hand, American culture values thinness and supports dieting as the popularly preferred method of weight loss. On the other hand, it values health, with healthy eating described as the best way to achieve good overall health. Through conversations with 40 women, I examine the meaning of bodywork in such a culture. Interviews are the best method for addressing this question because the goal is to explore how women think about bodies and how they integrate their eating strategies into their lives and their self.

Method of Recruitment

To understand the relations of body, self, eating, weight and health for women, I sought out women who described themselves as either dieting or eating healthy. However, it is insufficient to interview only women who are engaged with a specific eating strategy, so I also sought women who are not intentionally adjusting their eating. I recruited women through flyers with information about the study and contact information at grocery stores (general stores as well as the local health food store), coffee houses, and local gyms. The information on these flyers included the general area of interest of the study as well as the criteria for inclusion and the estimated length of the interview (1-2 hours). Each flyer contained tear-off tags with my contact information, encouraging readers to call or email to set up an interview. Flyers targeting women aged 60-80 were posted at local senior centers, such as the Athens Community Council on Aging, as well as at some grocery stores and gyms. I also attended and handed out fliers at a community event put on by the local community recreation organization at which blood pressure screening was a featured activity. Finally, I solicited interviewees on a number of listservs I belong to. The email to the listservs contained the same information as the flyer, and in effect, functioned as an electronic flyer.

I also recruited additional interviewees through personal contacts in the Sociology and Women's Studies departments of a large Southern University. From these initial contacts, as well as those recruited through flyers, I used snowball sampling to generate additional interview candidates. Using business cards with my personal information, I affixed stickers to the back with the same information about the study as the flyer. These "research cards" could then be easily handed out to friends and respondents alike. These individuals were encouraged to pass on these "research cards" to anyone else they know who would be willing to talk about body practices.

Challenges in Recruitment

Despite hanging flyers and handing out “research cards” constantly, I found very few respondents through traditional recruitment means. I found that recruitment through listservs was by far the best way of contacting people. Likely this is somewhat due to the ease of “forwarding” the electronic flyer, thus reaching a greater number of potential respondents. In addition, as this is a study about personal eating habits, perhaps potential respondents were more willing to read the flyer in the privacy of their home or office than standing in the grocery store.

I found that it was easier to locate younger women willing to talk about their diets, bodies, and selves. I also found that it was easier to locate White women willing to talk about these things. These problems may be an artifact of the study location in a college town, or it may reflect cultural differences in willingness to talk about personal topics to researchers. Another possibility is that older women and Black women may be less likely to frequent the locations where I put up flyers, and be less likely to have internet connections. A fourth possibility centers on the social norms with regard to talking about body practices. Many women said that they knew of other women who were dieting or eating healthy, and also said that they talked to these other women about such things, but to pass on information about a study, and imply that they had talked about her with a researcher, might stress the bonds of the relationship. I do not believe that my race *per se* was a factor in my inability to locate older Black women to interview, as flyers and emails do not include pictures of the researcher. However, it is highly likely that my

social network played a role in that I know and interact with few Black women, and thus do not have an entree into those social networks.

Construction of the Interview

Although I utilized a semi-structured interview to guide the women along a discussion of the relationships between their eating practices, weight, their appearance, aging, and culture, I also incorporated open-ended questions about eating, the body, and weight history. Through these discussions, I encouraged women to consider the place of the body, and related practices, in their lives. This methodological strategy was guided by a feminist perspective that places the participant's experiences at the center of inquiry, yet also allowed the women to be introduced to new ways of thinking about themselves¹¹. Participant-subjects must be conceptualized as competent actors, with their own subjective experiences, that may or may not coincide with that of the researcher. I see the women in my sample, as intelligent, thinking, self-reflexive beings. They have a strong sense of self, and are very conscious of what they do and why they do so.

Similarly, taking a life course approach demands that the researcher be especially attuned to important temporal aspects of the participant's stories. Rather than seeing age as a mechanical variable, this perspective encourages looking at the subjective importance of age, life situation, life goals, and so forth as context in which body practices are undertaken. Following this perspective, I encouraged women to describe their weight history, their family of orientation, and their weight-related ideas of the future.

¹¹ In many of the interviews, one question or another was greeted with a response similar to "Huh, I never thought about that before." One of the questions that garnered this response most often was "Do you think your body truly represents who you are on the inside?"

The interview was open ended to allow the interviewee to discuss the issues around dieting, the body, and the self in ways that are meaningful to them (Denzin 1989). The results of a previously conducted quantitative survey of Black and White women between the ages of 18 and 85 (n=491) were utilized in the construction of the qualitative interview guide. I also developed questions based on my research questions, for instance seeking to identify how the interviewee's experience of the body influenced her self-concept.

Although I used separate interview schedules for dieters, sometimes dieters, healthy eaters, and women who were not actively engaged in an eating strategy, each interview addressed the same issues phrased to make sense depending on the type of eating pattern the individual follows. The interviews included eight topics of conversation: general eating habits, conceptual meanings of body practices, current body practices, previous body practice experience, role of body in life, issues of aging, sources of information, and sense of cultural discourses. A copy of each interview schedule can be viewed in Appendix A.

These interview schedules provided a guide for our conversations, but our interaction did not always follow them word-for-word. If the participant made connections between topics that were meaningful to them, I encouraged that line of thought. At such times, I used the schedule as a checklist, and was sure to come back to any items that were missed once the participant had completed her tangent. "Tangent" is really incorrect in the sense that these alternative paths through the discussion were not immaterial, but were in fact important aspects of how the interviewee sees the world.

The Interview Interaction

During the initial contact phone call or email exchange, I inquired about any statuses that would exclude the individual from the study. These included being outside the age range, any medical conditions that impair the activities of daily living, and being pregnant or recently pregnant (within 2 years). Pregnancy requires weight gain and body distortion, but some research shows that this potentially negative weight gain is offset by other factors such as joy and excitement over the coming event. I believe that weight gain and body changes surrounding pregnancy and new motherhood is a topic sufficiently complex to warrant its own investigation, and is not addressed here.

Additional questions in the initial contact allowed me to restrict my respondents to women who consider themselves to be middle-class as well as categorize my respondents into dieters and healthy eaters based on their self-classifications. This is a self-selected group of women who voluntarily sought an interview and includes only women who self-define as middle-class and as either White or Black. As such, this research is not generalizable to all women. However, research shows that many or even most women do diet at some point(s) in their lives (Pew 2006a), and the current investigation will provide a more detailed characterization of this experience.

I interviewed each woman in-depth, following the method of intensive interviewing (Charmaz, 2003). Each interview lasted between 1 and 2.5 hours depending on the responses of the interviewee. The interviews occurred in the campus student center, the interviewee's office or home, coffee shops, or restaurants. If the interview occurred in the campus student center or a coffee shop, I attempted to purchase the interviewee's coffee, but all declined¹².

¹² I did conduct one group interview, with a group of two Black women aged 60-80. While I was unable to locate any Black women in this age group in the local area, I was able, through personal connections to arrange to meet with these women during a trip to Pennsylvania. It should also be noted that I paid for the meal consumed during this interview.

Before each interview, I asked the participants to complete two questionnaires. A Background Information Sheet provided information about the participant such as occupation, education level, number of children, household composition, and exercise participation. A copy of this questionnaire, along with the next can be found in Appendix B. A final questionnaire was the Eating Attitudes Test, developed by David Garner and Paul Garfinkel (1979). This test has been shown to reliably distinguish eating disordered individuals and was included in order to eliminate any interview participants who might have an undiagnosed eating disorder. I utilized the description of these questionnaires, along with the consent form, to build rapport with the participants. All interviews were conducted between January and September of 2007.

Each interview was audio recorded and transcribed. I obtained permission from the Institutional Review Board of the University of Georgia to audio record the interviews after securing informed consent from the participants. (See appendix C for the Informed Consent Form used in the interviews.) With financial assistance from the University of Georgia Dean's Award, I hired a transcriber for the majority of the interviews. I provided explicit transcription instructions, and met with the transcriber after the first transcription to discuss further instructions. I proofread each transcription while listening to the audio recording of the interview before coding and analysis. These transcriptions, along with the information from the questionnaires, form the basis for my analysis.

A Note about My Position in the Field

Dieting is a funny thing.¹³ There are two competing tensions in culture- to talk about dieting or not. On the one hand, diets are visible, even insistent, in the media. Much of this is advertisement of diet plans and products, but also magazine articles and shows about diets used by celebrities and the general admonition of a healthy diet in health news and research. In addition, on any given day, half the population is on a diet (Pew 2006a). However, on the other hand, talking about one's diet entails a sense of shame and confession (Spitzack 1990) since it brings up the fact that one *needs* to diet. Because of this, people are more likely to discuss dieting only with people very close to them or people with whom they feel they are similar.

As a White, middle-class woman myself, this social group is more readily accessible to me as a researcher. Dieting is something that women talk about often, but are also sometimes ashamed of- both for needing to diet and for fear of seeming vain. Thus, this topic is one in which women are more willing to talk about with someone that they perceive as somewhat similar to them (Baca Zinn 1979). The additional fact that I am approximately 15 pounds overweight likely further facilitates this perceived similarity. The fact of my being slightly overweight may have conveyed that I, too, need to engage in bodywork to gain the slim, healthy body that seems so desirable. They may have surmised that I have tried some of the same methods as themselves. In this assumption, they would be correct, as I have tried both dieting and healthy eating techniques. However, I have clearly not been perfectly successful, thus necessitating the need for continued bodywork. Countless women, most likely including at least some in my sample, experience this pattern. My shared experience of a problematic body may have helped make them feel more comfortable discussing the challenges of body practices. For obese or severely overweight respondents, I tried to refrain from drawing attention to my weight

¹³ My discussion here centers on dieting in this section because talking about healthy eating seems unproblematic. Talk about healthy eating is engaged freely as it is perceived to be a healthy activity, a positive behavior without implying the problematic negative state implied by dieting.

status to preclude the possibility of offending them through their potential misinterpretation of such talk as equating our experiences (Goodman 1995).

Additionally, I think that my youth was both a slight challenge but also a help with older participants. While I had to work to assure my interviewees I could understand what they were telling me about how aging affects their bodies, the fact that I have not yet experienced it may well have encouraged them to elaborate on the relationship of age, bodies, health, and appearance as they experience it.

While the women I interviewed often displayed a little hesitancy at first, they quickly warmed up to the topic. In fact, few noticed when the hour mark passed, as they were wrapped up in telling me about themselves. On reflection, they were extremely open about themselves, their families, and their desires. Among other things, the women were freely willing to admit that they felt unsure of their practices, or lacked knowledge to make better decisions. In keeping with feminist research methods, as well as their openness, I intend to share my findings with the participants before publication.

Method of Analysis

Even during the interviewing stage, while interviews were occurring at a rate of 2-3 per week, I began to notice patterns in participants' discussions. I continuously refined my interview schedules, and began to write research memos about these patterns. These patterns helped me identify the most essential aspects of interest to analyze.

Data analysis of the responses gained through qualitative interviews centers mostly on quotation analysis of the transcribed interviews. However, additional analysis was conducted through the written responses of interviewees on pre-interview paperwork and screening tools, as

well as basic quantitative data coded on positive and negative responses to some interview questions (such as “Are you on a diet” or “Do you consider that you eat healthy?”). I examined such data through the use of cross-tabulations in an effort to identify patterns. However, these do not come from a random sample, and I had too few respondents to support reliable quantitative analysis.

As might be imagined, the transcripts of 1-2.5 hour interviews with 40 women produced quite a lot of data. I utilized a modified grounded theory technique of analysis, reading, and re-reading the transcripts to identify important themes. The transcripts were coded using *Atlas.ti*, a computer aided coding and analysis program (Muhr 2004). Beyond the ability to easily assign and change codes to transcripts, an important component of this program includes a graphical interface in which a researcher can visually (re)structure codes and the relations between them.

During analysis, I first looked for major themes based on the research questions and major topics of the interview. I initially coded all the interviews with general (or generic) codes such as “weight,” “healthy eating,” “dieting,” “appearance,” etc. Quotes related to these major themes were then recoded looking for more specific themes, patterns of response, and salient topics across respondents (Gubrium and Sankar 1994). In this process, I noted topics that were commonly addressed across respondents, and examined these topics more closely, categorizing responses and relations to other topics. For example, within the general theme of “healthy eating,” more specific themes that emerged included “conceptions of healthy eating,” “healthy eating strategies,” “healthy eating challenges,” and so forth. These specific codes highlighted the prevalence of various topics, and examination of the comments contained within indicated the similarity of experiences among the women. Together, these general and specific themes form

the structure of the three following substantive chapters that explore the relation of culture, the self, and eating strategies.

Sample

My collection efforts resulted in a sample of 40 women, 23 White women and 17 African American women. Of the White women, eight are aged 25-39, nine are aged 40-59, and six are aged 60-77. Of the Black women, eight are aged 25-39, seven are aged 40-59 and two are aged 60-74. Sixty percent of the completed interview sample is White while forty percent of the sample is African American. At forty percent African American, this sample is not equal but represents an over-sampling of African Americans in an effort to more clearly hear their voices in an area in which they have been understudied.

These women live in a mid-sized southeastern city and its surrounds,¹⁴ and all consider themselves middle-class. Half the sample is currently married, just over one quarter (11 of 40) are never-married, six are divorced, and three are widowed. Equal numbers of women live either alone or with a spouse and child/ren. Another nine live with their spouse only, and five live only with their child/ren. The remaining four respondents live in other situations, such as with roommates or unmarried partners. The majority of women have either no children (15) or two children (10). Nine of the women have one child, four have three children, and two have four children. Eleven of the women have one or more grandchildren.

Thirteen of the women work in office or professional positions,¹⁵ eight are college professors or other educators, and eleven are students, including representatives of the undergraduate, graduate, and post-doctoral levels. Seven women are retired, having ended their

¹⁴ Except, as noted above, the two older Black women who live near Philadelphia. I do not believe that this geographic difference is significant in this investigation.

¹⁵ This category includes most office positions, including secretarial, administrative, and college advising positions.

careers in a variety of fields including education, real estate, library sciences, and wholesale food production. The remaining respondent is still employed in wholesale food production, which some might consider a working class occupation. However, her unionized pay scale guarantees that her income places her squarely within the middle-class.

This is also a highly educated sample. Eleven of the women hold doctoral degrees, and ten hold master's level degrees. Ten additional women currently hold masters degrees and are in the process of completing a doctoral degree. Three women hold bachelor's degrees and five of the women completed two or more years of college. One older woman has only a high school degree. Table 1, below, displays the sample, organized by education, but also indicating race and age.

Table 1. Educational Attainment of Sample, with Age and Race Indicated

Degree Held		Degree Held		Degree Held		Degree Held	
H.S.	<i>Betty- 74</i>	Master's	<i>Monica-32</i>	Master's	<i>Teresa-25</i>	Ph.D.	Stephanie-30
Two Years of College	<i>Deanna-44</i>		<i>Brenda-37</i>	(currently completing PhD)	Nancy-25		Allison-32
	<i>Charity-49</i>		Georgia-44		Kate-26		<i>Rhonda-35</i>
	<i>Margaret-68</i>		<i>Maxine-45</i>		Camilla-28		Brooke-40
	Dot-72		Carla-48		Rory- 29		Elizabeth-41
	Isobel-77		Heather-49		<i>Tamara-30</i>		Bridget-45
Four Years of College	<i>Dacia-27</i>		<i>Beverly-51</i>		<i>Angela-30</i>		Elise-47
	<i>Dominique-27</i>		<i>Pam-59</i>		Jill-38		<i>Quilter-55</i>
	Cleo-39		Arlene-61		<i>Annette-53</i>		Carol-59
			Marie-66		Linda-56		Janet-60
							Clara-68

Italics indicates African American Respondent

Most of the women were at least somewhat concerned about their appearance. While Twenty-six (65%) of my respondents felt that they were at least a little overweight. Fourteen of the women (35%) had a Body Mass Index¹⁶ that classified them as “normal weight,” nine would

¹⁶ Body-Mass Index, is a metric of body size that combines weight and height. This metric is often used by the Centers for Disease Control and Prevention for determining health and overweight/obesity status. A larger Body-Mass Index is indicative of a larger body-size. Body-Mass Index is calculated by the formula: BMI= (weight in

be classified as “overweight” (22%) and seventeen would be classified as “obese” (42%). In comparison, the National Center for Health Statistics (2005), reports that 40% of White women are at a healthy weight, 26% are overweight, and 31% are obese. My sample is more obese than the general population, and this is likely an artifact due to my seeking out women already engaged in an eating strategy. When asked where they would like to lose 10 lbs., seventeen of the women named the stomach region. An additional twelve named the hips, thighs, or rear. Only three women were uninterested in losing 10 lbs., highlighting the emphasis on weight in our culture.

Having described my research methods and sample, I next turn to my analysis. In each of the three following chapters, I examine a different facet of eating strategies. The story begins in Chapter Three, where I describe the ambiguity of advice concerning healthy eating and the ways women make sense of such advice. The narrative continues in Chapter Four as information about healthy eating along with other information about the body is processed in the context of the self-concept, resulting in a motivation to action. This chapter also explores the theoretical construct of possible selves and types of agency, seeking a synthesis to illuminate the choice of one eating strategy over another. Chapter Five represents the climax of the tale, in which I describe the eating strategies I identified among the women I interviewed. Also in this chapter, I examine the relation of eating strategy to race, age, and possible selves. Finally, the Conclusion Chapter draws together this narrative of knowledge, selves, and eating strategies by expounding the significance of preceding analysis.

pounds/height in inches/height in inches)³. For reference, a Body-Mass Index of 18.5 or less is considered underweight, above 25 is considered overweight, and above 30 is considered obese (WHO 1995). In this instance, I calculated the Body-Mass Index for my respondents using their self-reported height and weight.

CHAPTER THREE:

HEALTH CLAIMS, “DUBIOUS EXPERTS,” AND LOCAL KNOWLEDGE

For years, health experts have been warning that Americans are too fat, that we exercise too little and eat too much, that our health is in jeopardy.

---- New York Times, January 22, 2008 (Rabin 2008)

How do women, or men for that matter, make decisions about what to eat? Do they seek advice and, if so, whose advice do they take? This chapter will examine the cultural influences on eating strategies, briefly discussing the importance of health in the modern era, and explore how women view, evaluate, and utilize various sources of information to construct an eating strategy.

In 21st century America, both dieting and healthy eating are considered to be practices related to health. As almost all of the women I interviewed (36 of 40) stated that they were trying to eat healthy in some way, further investigation of this concept seems especially important. A perspective that examines the culture surrounding “health” may help understand how and why this concern is so prevalent. Given the complexity of culture, exploring a single concept is a large enough goal for a chapter such as this. The perception of health is often associated with thinness, a cultural ideal that has been thoroughly examined elsewhere,¹⁷ as well as with other facets of appearance, such as a tanned skin (Broadstock, Borland, and Gason 1992). Thus, this chapter will focus on aspects of the culture of healthy eating, and I will return to probing dieting as well as healthy eating in the next chapter.

¹⁷ See for example, Seid 1989; Wolf 1991; Bordo 1993; Hesse-Biber 1996

In Chapter Five, I will examine the ways the women I interviewed enacted healthy eating, but these practices do not appear randomly. How did they know what to eat or how much of certain foods to include in their healthy eating practices? There is much advice about healthy eating, but little clear agreement beyond the basics, like including protein, fruits and vegetables, grains, dairy, and a limited amount of fats and sugars. On this basic level, enacting healthy eating should be easy. However, there is new advice about healthy eating nearly every day. In the course of daily life, it is up to the individual to negotiate the variety of healthy eating advice.

Negotiation of healthy eating advice is the rational act of an agentic subject. In the context of a social world in which health is valued, deemed the responsibility of the individual, and presented as controllable by the individual, seeking ways to create or maintain health is increasingly seen as reasonable, and as a responsibility of the individual. However, eating practices are not solely individual matters but reflect deep-rooted social structural, cultural, familial, and regional factors. As such, individuals seek out health related advice, but interpret and enact that advice in the context of their local social world. This chapter explores this situation by identifying some of the ways individuals perceive, evaluate, and incorporate healthy eating discourse.

Examining how women perceive and consider healthy eating advice provides a case study of the ways in which individuals evaluate the ever-increasing amounts of information available in our society. Concern for health and awareness of health risks combine to create a context in which understanding and acting on healthy eating advice is paramount. However, the vast quantities of information and ambiguity about the legitimacy of experts make healthy eating decisions complex. I argue that individuals use three types of local knowledge to filter and organize information and avoid becoming overwhelmed. These types, *personal knowledge*,

embodied knowledge, and *collective knowledge*, provide a basis for the comparison and evaluation of new information. This base level is not perfect, and is sometimes at odds with recent research findings. Though incomplete, it forms a filter through which new information must pass. Over time, this base knowledge, and the other forms of knowledge which comprise it, changes as new information is confirmed and slowly seeps into the collective consciousness.

Cultural Change: Risk Society and Healthism

Certainly, one aspect of our approach to food involves information about what is “good” and “bad” to eat. This distinction is ever-present in both lay discourse and advertising, as well as being a matter of debate and argument among dietary specialists themselves. One of the most obvious connections is the work of Douglas (1966), but this distinction between good and bad food is much more complex than what is palatable and what is not. In the modern era, food choice takes on meanings along the dimensions of both morality and health. These dimensions intertwine into a moralistic imperative to be healthy through personal action. Crawford coined the term “healthism” for this situation, which he defined as “the preoccupation with personal health as a primary goal- often the primary focus for the definition and achievement of well-being; a goal which is to be attained primarily through the modification of lifestyles” (1980: p. 368). Crawford sees this as a cultural change, an expansion of health through medicalization into other domains of social life previously unconnected to conceptions of health.

The notion of healthism, or the concern for health more broadly, also operates on two additional principles- the notion of risk, and individual responsibility. Generally, Beck’s construction of “risk society” (1992) focuses on human-produced risks like pollution, nuclear contamination, terrorism, etc. In this construction, risk knowledge is the domain of experts

because of the magnitude of the outcomes and the invisibility of the risk to the senses. These risks are anxiety-producing through the nature of their unpredictability, and experts utilize technology unavailable to the public to understand and manage risks.

Health outcomes, such as obesity, heart disease, or diabetes, are both labeled as risks by experts and perceived as risks by the public, but are seen as “risks you can do something about.” In this way, the risks of certain chronic illnesses are different from nuclear contamination or terrorism in that the risk comes not from outside, uncontrollable sources, but from an individual’s own actions. As such, it is generally accepted that it is the individual’s responsibility to engage in behaviors deemed to promote health. Such behaviors include, for example, getting vaccinations and regular medical testing (i.e. pap smears, mammograms, and prostate cancer screenings), and avoiding behaviors deemed to endanger health like excessive drinking, smoking, or overeating.

The idea of “healthy” is not limited to medicine, but appears in everyday behaviors, such as snacking, exercise, smoking, sleeping, hygiene, and even sensual relationships. The consideration of one’s health is so prevalent that some theorists have described it as a goal throughout one’s “lifestyle” (O’Brien 1995, Burrows, Nettleton, and Bunton 1995). In 21st century America, most messages about health are channeled through the media. Peterson (1994) argues that the public draw from various media texts to develop understandings about health, illness, and disease, along with “medico-moral” ideas about what constitutes a “‘normal,’ ‘healthy’ subject. In this discourse, health is achievable by the individual through making better choices, often through consumption, with the implication that to not make these appropriate choices is to be irresponsible. Certainly, there are exhortations to engage in health related behaviors expressed through health promotions, general media, and advertising (Bunton,

Nettleton, and Burrows 1995; Lupton 1995; Austin 1999; Lyons 2000; Fullagar 2002; Madden and Chamberlain 2004; Crenshaw 2007). As Peterson states, “A strong underlying message in the discourses of health promotion is that the individual needs to take care of the self by adopting a certain kind of lifestyle ... and illness [results from] a failure to regulate oneself” (1994: 36). This discourse is presented to the public as commonsense (Geertz 1983), irrespective of socioeconomic position and ability to participate. Throughout these messages, the individual is positioned as the social actor best suited to initiate and monitor health-promoting behaviors in all aspects of his or her daily life. As Hodgetts, Bolam, and Stephens argue, “within the ideology of healthism, individual agency is accepted as the primary source of health and the prevention of illness is associated with personal choices and willpower (2005: 124). Health is presented as achievable through individual behavior (making the right choices), but also as an *individual responsibility*, with individual blame to go along with making the wrong choices (Crawford 1980). In this contradictory combination, the individual must always be on guard for the development of risk, and simultaneously always engage in practices to lessen that risk.

The cultural changes of healthism and the risk society, along with the increasing prevalence of mass media, combine to present health as a desirable good in the context of risk (many threats to health), which is the individual’s responsibility to manage and promote through an ever-wider array of personal choices. Numerous authors have commented on examples from the most obviously related to health, such as smoking cessation and frequent health testing, to more diffuse examples such as seat-belt wearing, fitness, moderate alcohol consumption, and condom use (e.g. Bunton, Nettleton and Burrows 1995; Peterson and Lupton 1996; Robertson 2001). Healthy eating is one more example in this line. The hazards that healthy eating seeks to avoid are still risks (as described in a risk society) in that they are results of the overabundance

and over-processing of cheap foods laced with chemical additives and high levels of sugar and salt. However, eating-related health risks differ from other risks in two crucial ways. First, they cannot be avoided through abstinence. Everyone must eat, and continue to eat in order to continue living, and so (secondly) these risks are not limited temporally. Unlike vaccines, or even food scares such as Bovine Spongiform Encephalopathy (BSE; “mad cow disease”), the risks connected to healthy eating are not time delineated. Once an individual has received the vaccine, or the governments have changed policies to eliminate BSE from the food chain, the risk virtually disappears. The risks associated with unhealthy eating, rather, are ceaseless and ongoing. In this context, the cultivation of a healthy body becomes a life-long project. The notion of the body as a project, as discussed by Shilling (1993), is helpful as it highlights both the ways in which the construction, maintenance, and modification of bodies is a long-term process and the role of agency in that individuals seek to affect bodily outcomes in terms of health, appearance, ability (fitness), and longevity. In this process, individuals adopt ‘technologies of the self’ (Foucault 1988), culturally prescribed discourses and practices about the body and self, in order to reach their body project goals. These beliefs and practices include ideas of the importance of various body project goals, the importance of self-regulation as a means of achieving such goals, and techniques to incorporate practices related to these beliefs into daily life. I will return to the role of the body as a visible display of the self in the next chapter.

Of course, engagement with the body as a project is not an automatic process and the degree to which individuals take up these technologies of the self vary. For instance, socioeconomic status or other structural concerns may constrain an individual from doing so. However, healthism, the risk society, and individualism work together to create a secular morality (Katz 1997) in which health is a means of salvation and, therefore, harming one’s

health, or failing to enact a health-oriented life project, is a testament to sinfulness. In her essay “Risk as a Moral Danger,” Lupton remarks: “Ironically, there has been an increasing emphasis upon apprising individuals of their own responsibility for engaging in risky behaviors at the same time as the control of individuals over the risks in their working and living environments has diminished” (1994, p. 429). Thus, individuals seek to gain agency in an aspect of their lives that seems controllable (food choice) when it seems like more and more arenas of life lie outside their control.¹⁸ Among the women interviewed, even those who did not claim to eat healthy currently expressed guilt or shame for their failure to “do what’s right.” In the context of the risk society, where one’s health is presented as a daily concern, the desire for control in general and seeking to eat healthy in particular, has become established as a reasonable goal for agentic individuals seeking to live better lives. I next turn to the ways individuals receive messages about health and healthy eating.

Role of Discourse and “Experts”

To this point, the concepts of healthism and the risk society are “disembodied” cultural themes. In this unattached state, they likely would have little impact on live bodies and the individuals who inhabit them. These themes become more tangible, however, as they become expressed in messages communicated to individuals through the discourses of “experts.” To explore the role of these messages I analyze how the women I interviewed perceive these discourses and “experts,” through their accounts of trust for health advice. Interestingly, there

¹⁸ There is an eerie similarity in this understanding of the situation to much theory about eating disorders in which one of the prevailing perspectives holds that girls, feeling pressured to live up to high expectations for success and perceiving that their lives are already mapped out for them by their parents, seek some measure of control over their lives by attempting to control what does seem to be in their control, i.e. food. In that situation, the irony is that as the dieting becomes an eating disorder, the disorder itself takes control, making it extremely difficult for the girl to eat normally again even when she desires to do so. Could an analogous change occur for healthy eating? Once one sees food choice as an important way to control her health/life, is it difficult to relinquish this view?

were no discernable differences by race or age group, nor were there significant differences by dieting status. These forty Black and White women between the ages of 25 and 80 showed a common pattern of skepticism of both health discourse and “experts” and a reliance on local forms of knowledge for evaluating both the claim and the authority of the claims-maker.

Health Discourses

Lupton defines discourse as “a group of ideas or patterned way of thinking which can both be identified in textual and verbal communications and located in wider social structures” (Lupton, 1992, p. 145). Discourse includes both information and cultural evaluation of, or ways of thinking about, that information. This evaluation may include additional implications about the source of the information, perceptions about the applicability of the information, and/or information about the relation of this to other information. Arguably, there are multiple, overlapping discourses in existence at any point in time (Foucault 1984), which could be heuristically divided in a myriad of ways.¹⁹ I consider that the most useful way to consider various discourses is to draw from people’s perceptions of it. In this investigation, both the content and the medium of expression emerged as significant in the way people think about discursive messages. Thus, I will comment on government and public health promotion discourse, medical/scientific discourse, and mass media health discourse.

Although numerous other studies (e.g. Fullagar 2002; Robertson 2001) examine the government as an important source of health-related information, the women I interviewed did not often mention government statements or policy. Generally, when mentioned, publications

¹⁹ I say heuristically because the complexity of modern society makes it nearly impossible to actually differentiate discourses, knowledges, cultures, messages, etc. in reality. For instance, the message that thinness is important and attractive is expressed in the media, in health promotion campaigns that exhort people to lose weight, and in daily social interactions.

and sites produced by the government (i.e. the Center for Disease Control) or recognizable organizations like the American Cancer Society, were considered along with medical or scientific research sources, which were seen as trustworthy because they were seen as official, reputable sources. Monica explains,

I think also other places that I would trust would be any kind of, um, government site. Um, any sites that are kind of run by the government because there're particular rules and things like that to go by. I'm not going to trust, um, I'm not going to trust pharmaceutical sites. ... And so I find that the government really, I mean, the government is not really kind of winning out anything, you know, it's the government so they're not in the business of, you know, selling diet food or pills or any of those, I mean, they're the government. And so, if it's something from the government agency. Things that, research that has been done on campus, on university campus, the reliable research on Research II campuses, um, whose funding comes from the government.

(Monica, 32, Black)

However, overall, there was a lack of consideration given to government publications and websites. This seems to be an indication that the women no longer see government as an important authority on health. Trust of the medical and scientific research fields has superseded the government, and the two seem to have little connection. For example, despite the recent highly publicized re-construction of the government's "Food Pyramid," only one woman mentioned it and she had no real knowledge of it.

Certainly, medical and scientific research is the discourse perceived as having the most authority. While "health" now includes many aspects of life, the connection with medicine is still central. The medical and scientific discourse holds the most force when expressed in health-oriented publications and websites. The women viewed as trustworthy those publications and sites with clear connections to the medical field like Prevention Magazine and WebMD.com. This connection to a medical field was important, because the women viewed such a connection as indicative of the quality of the advice given. For example, Camilla explains why she went to the University Health Center website when she was looking to begin a diet:

And [so] I was looking through the Health Center diet [site] because I figure, okay, these are doctors and dieticians that are putting stuff together and it's as close as me going to my doctor and saying, "Hey, I wanna' go on a diet," as I would probably do. So I went there and I actually found where they had talked about-had a link to several web sites on how to rate these diets by their usefulness and their cost and end product and all that stuff. And now I think about it, I think it was sponsored by a personal dietician web site so of course they came up number one. And I think Weight Watchers came up number two or something. There were some other group that I knew of, some weird Italian diet. And that's basically how it worked is I tried to find ones that seemed to have their stuff together and seemed to be something I can do and was recommended or somewhat at least available through the Health Center so I felt like there was something [supporting it].
(Camilla, 28, White)

Thus these women, while trusting the discourse on the sites selected, consciously evaluated which sites to trust based on their acceptance of the organization. Further, the women viewed the act of going to the internet to gather information as an example of their critical evaluation of the claims posted by other sources.

However, the trustworthiness of medical and scientific research weakens when reported through the mass media. The mass media are the most common sources of health information for the lay public. Robin Bunton, through an analysis of magazines, found that "media are sites of increasing importance to contemporary problematisations of health" (1997: 232). Further, Peterson (1994) argues that the public draw from various media texts to develop understandings about health, illness, and disease, along with "medico-moral" ideas about what constitutes a "'normal,' 'healthy' subject. The women I interviewed observed health-related content in a wide variety of sources, and reported that this information often did influence their eating strategy to some degree. The participants reported considering health advice in newspaper health columns, television and radio news shows, news magazines, women's magazines, and television shows like the *Today Show*, *Oprah*, and *Good Morning America*. For example, Dominique talks about the variety of sources to which she pays attention:

I like to read articles like I love *Woman's World*, the magazine, I guess from there. Also, I watch the Food Network Channel. They do prepare sometimes healthier versions of food it just depends on who you're watching. I get information from, sometimes they

have specials on TV about nutrition and sometimes you can find something in the paper or just any kind of magazine. *People* sometimes has special articles in it. Just a variety I guess. (Dominique, 27, Black)

Dominique shows the variety of places to find food-related health information. A similar pattern emerged for internet sources, with a slight difference. While several women stated that they trusted much of what they saw on the internet versions of general media sources like CNN.com, Yahoo.com, the majority articulated wariness about general internet content based on the lack of regulation and high incidence of marketing. More women expressed this skepticism with regard to internet sources than they did concerning print, magazine, or television sources.

However, compared to Dominique, most women were both more skeptical of discourses and more sophisticated in their evaluation. The women used multiple frames to evaluate health discourses and advice, as found by Nettleton, Burrows, and O'Malley (2005). Mirroring their results, I found that the women evaluated both websites and other mass media sources along the following dimensions: (1) whether the source was a recognizable organization; (2) whether the source was a non-commercial, professional source; (3) whether the source used factual information rather than personal opinions and experiences; and (4) whether the information was replicated across multiple sites. However, given the interweaving of sources in the modern information age, the source of information may not be the most sophisticated way to examine the way people perceive healthy eating advice. In other words, both the New York Times (a print newspaper) and CNN (a television news channel) report similar news, including reporting on health research, and both also operate websites with indistinguishable content from their traditional formats. As declining newspaper readership rates seem to indicate, the form of information seems to matter little. The women's talk about healthy eating advice reveals that the

real differences emerged when the lens of analysis shifts to a focus on the specific “experts” expressing the various messages. Analysis of these differences comprises the next sections.

“Experts”

Much advice about healthy eating comes from “experts,” and thus, this chapter focuses on the relation of “expert” and “lay” discourses and knowledge. Generally, these two terms are characterized as distinct and often opposed to one another. Furthermore, the position of “experts” on the subject of healthy eating is hardly sacrosanct. In the “information age,” the lay public is often extremely informed and feels both competent and justified in evaluating both the “experts” and the information they provide on the basis of the three types of everyday knowledge.

At this point, the concept of “experts” bears some further delineation. In the risk society, the concept of “expert” refers to those individuals who are knowledgeable about dangers (risks) unobservable or otherwise outside the scope of understanding to the lay public (Beck 1992; Rimke 2000). Qualifications depend on a combination of advanced education, research, and access to technology. Society turns to these individuals for help in understanding the existence and immediacy of risks as well as potential solutions. Thus, in both healthism and the risk society, “experts” occupy a formidable position. They are the agenda-setters, with access to knowledge and technology that they sometimes share with the public (depending on whether it solidifies and increases their power), and produce the major discourses about various subjects

Only an “expert” can correctly observe and provide strategies to manage risk. Many health-related concerns are just such risks, including the long-term effects of smoking on the lungs, the potential long-term effects of frequent cell phone use on the brain, and the long-term build-up of cholesterol in the arteries. All three of these are examples of situations in which a particular individual cannot see, feel, or otherwise identify the negative effects. This causes a

reliance on the “expert” to identify the damage through medical testing, seeing into the body through technology. These three examples also highlight a second similarity based on time and consciousness. As each risk builds up over long periods of time, the actual effect of each cigarette, phone call, or cheeseburger is unobservable, and thus unnoticed, to individuals.

Thus far, I have discussed risk as used by the medical and scientific community, in a realist sense. In other words, the underlying assumption is such risks *do exist* in reality and that “experts” can identify and manage them. Yet the invisible aspect of risk complicates matters. This peculiar feature of modern risks encourages the lay public to rely on the “experts” to alert them to risks but also requires the lay public to trust or take on faith the statements of the “experts.” People want to be able to trust “experts.” The very definition of “experts” implies that they know more than the average person knows and thus should be able to provide better advice. This may be a form of ignorance (or wishful thinking) about the role of science, but nonetheless indicates the thought process of the public. However, despite the assurances from the scientific and medical communities, because the lay public cannot actually see microbes, viruses, or fat plaques, they cannot confirm the statements of the “experts.” This opens the doors for skepticism and concern that the risks may be overstated. As sociologists, we might say that these risks are socially constructed. By this, I do not mean that the risks are completely imagined, but that issues of power play a role in the identification and evaluation of risks, which risks are deemed worrisome and how dangerous they are considered to be (Lupton 1999). Experts do provide much information, and agree on much. However, for various reasons discussed below, health discourse is confusing. As particular risks and their immediacy are not confirmable by the lay

public (or by sociologists²⁰) and the public's responses to such risk are the focus of this investigation, I will examine how individuals deal with this ambiguity.

In this perspective, the term “experts” must be understood to include a variety of claims-makers, including scientific and medical specialists, government public health figures, and media opinion makers. Despite the differences among these groups, which will be the focus of the next section, they all make pronouncements and provide advice regarding health from a position of socially imbued authority. Although I am refining the definition of the term “experts” to include claims-makers without traditional scientific or medical knowledge or expertise, “experts” remains the best term for two reasons. The first is that this term is applied by both the lay public and the mass media to a range of figures, including a “generalized (knowledgeable) other.” A recent Lexus-Nexus search for “health experts” turned up 235 articles in the last six months that used that exact phrase. The authors of the articles did not always provide any information about the position, qualifications, or research field of the particular “experts” in question, on in some cases, even a name! Secondly, the term “experts” carries the idea of authority, even when the authority rests only on media popularity. A common occurrence can show the result of this diffuse notion of “expert”: even if an individual does not remember exactly where he or she heard particular health advice, it likely has a similar level of authority when repeated to another individual in conversation.

An attempt to delineate groups within the category of claims-makers quickly raises difficulties. It is clear that there are “legitimate experts” and “illegitimate experts,” but the boundaries between these groups can be permeable. One may be tempted to separate cleanly scientific and medical specialists from media opinion makers and activists. However, food or

²⁰ Indeed, there is a line of sociological literature explicitly examining how claims about the “obesity epidemic” are framed as a moral panic rather than a legitimate health crisis (Saguy and Riley 2005; Campos, Saguy, Ernsberger, Oliver, and Gaesser 2006; Saguy and Almeling 2008).

pharmaceutical companies, lobbying groups, or other organizations fund much research on health, diet, and obesity, raising the specter of bias (Nestle 2002; Brownell 2004; Simon 2006). Diet industry companies regularly refer to “research reports” touting the claims of their products.²¹ Other scientific or medical specialists develop products through the course of their research, which they then seek to promote (i.e. *Dr. Atkins’ New Diet Revolution*: Atkins 1998). Further, some opinion makers provide health or diet advice, despite having no expertise in science or medicine. Dr. Phil, for example, has a diet book (McGraw 2003). Other members of the mass media, such as journalists, are presumed to report stories in a value-neutral, objective manner, yet include opinions through choice of story, language use, and drawing (editorial) conclusions (Saguy and Almeling 2008). There may be some unimpeachable experts, such as Surgeon General C. Everett Coop, but there are also many questionable “experts” who “spin” information to sell products. The point is that there is a complex array of experts, and we, both as public and as sociologists, have not yet identified clear ways to differentiate among them.

The uncertain nature of “experts” is mirrored in talk about such figures among the lay public. On the one hand, the women I interviewed spoke as if there are legitimate “experts” (specialists) and those who are “dubious experts” (illegitimate claims-makers). Yet on the other hand, they remained skeptical of all claims-makers (as if legitimacy was unstable)²². Further, the women did not necessarily agree on which experts they deemed legitimate and which they did not. For these reasons, this investigation must proceed considering all health advice to be “claims.” The next sections of this chapter will explore how these women negotiate this

²¹ Any web search returns dozens of these “research reports.” For example, the website “Weight Loss Research: Which Diet Pills Will Work for You?” describes the “clinically proven weight loss” which will result from using the site’s most highly ranked diet pill.

²² Generally, the women evaluated the claims-makers rather than the claims. Once a claims-maker was deemed legitimate, future claims made by the same individual or organization were generally accepted. Further, association with this individual or organization provided legitimacy even to questionable claims.

legitimacy tension. First, I will examine the critiques these women express of the “experts” (claims-makers), and then I will examine the basis on which they justify their evaluations.

Critique of the “Experts”

The ethos of healthism seems to imply that individuals should listen to the large numbers of variously differentiated claims-makers to find the best ways to eat healthy, as anticipated by Foucault’s notions about the diffusion of power leading to increased power in the hands of specialists to monitor, categorize, and evaluate individuals (1978). However, along with the construction of health as one’s own responsibility, the combination of concern about risk and individualism also encourages individuals to become knowledgeable in their own right (Rimke 2000). The evidence from these interviews indicates a situation along this second possibility. The amount and complexity of health information presented has two results. First, a distrust exists, which results in the creation of “dubious experts.” By this, I mean that all “experts” are met with doubt, no longer hold unquestioned authority, and are subject to evaluation by individuals. Second, there is a reliance on one’s own evaluation of information in light of previous information and local cultural practice experiences. This evaluation includes both evaluation of their information and evaluation of their credentials and affiliations. In both aspects of this situation, questions arise about the quality of advice given.

There is arguably more health information available at this point than at any other time in history. We know far more about how the body operates, how it processes food, and the role of nutrients in maintaining health. Yet the sheer volume of information may itself have negative effects on our capacity to act. There is so much information, from so many sources, that so often seems contradictory (or at least competitive), that people begin to question all information.

An overload of information may be part of the problem. Having so much health-related information presented in so many venues may result in a kind of information fatigue. Monica feels adrift in the wash of information without solid ground in sight:

- Monica: And I think sometimes it's just, it's so much information out there, you're inundated with so much information, you don't know what actually is truthful information and what's not. And so you kind of get stuck.
- I: Stuck how?
- Monica: It's like there's so much out there. Everything sounds good but I'm not sure if it's good for me. For an example, when you think about Atkins, that diet sounds good. You know, the low carb because you think about, you know, bread is going to pack the weight on me, pasta's going to pack the weight on me. So, you know, if I kind of reduce it or take that completely out of my diet and I can eat meat and I can eat vegetables that sounds really good for me. But, we know if we do it over the long haul it's not going to be great. So it's like, who do I trust, you got any researcher or expert who's out there to say, "Go with this." But it's like, who do I trust? Or, you know, what is good for me? And so I'm afraid to do anything to damage my body even more than I already have so I'm just kind of stuck. You know, where can I go as a, and find a neutral source to get information. And it's not necessary promoting one diet over the other, but it just says, "If you do X, Y, and Z, this may be the outcome." And then I can take that information and make a decision as to what I want to do.
- (Monica, 32, Black)

To some degree, this situation can be explained using the concept of the "cognitive miser" (Fiske and Taylor 1991) the idea that people are resistant to change their views because of the work involved in acclimating themselves to a new idea. However, this situation is not so simple. Most of these women are not resisting new information, and indeed, many seek it out. Rather, the problem arises through the speed, variety, and ambiguity of new information. Every week, every day, or even every time one checks email, there is a new health-oriented report that makes suggestions about what to eat or what to avoid. This relentless onslaught of information leaves many people, including Monica, confused and dispirited. Can one person actually eat in a day everything the reports say we should?

Further, these findings often seem contradictory. Many respondents were quick to recall situations in which the advice of one month seemed to contradict the advice of previous months.

For example, Arlene pays attention to research reports, but does not accept them uncritically:

Well, I read the paper. The *New York Times* has a section on science every week and they have articles that relate to health and I'll go out looking for, out of my way looking for what I hear on the news and in the newspaper and people who share information some with friends. Of course the caveat there is it changes all the time. What some say is good for you one year then becomes bad for you. I mean I think you have to take it with a certain amount of skepticism. All kinds of foods have been-coffee for example. It's terrible; you should never drink coffee. And then it's, it's good for you it has antioxidants in it whatever. I don't think there's a definitive answer to any of this. It's the same thing with, you know, you should take vitamin E; you shouldn't take vitamin E. You should take cornmeal; you shouldn't take cornmeal. It keeps changing and if you accept it all on blind faith then you have about a 50-50 chance that it's wrong anyway.

(Arlene, 61, White)

Arlene feels that all this advice is not really helpful because “if you follow everything that people have been suggesting in my lifetime you would have embraced any number of things that turn out to be not good for you and given up an equal number of things that turn out to be okay for you.” In taking a wider view, she sees much of the advice over the years to be just so much bunk. Her solution is to fall back on common sense, or everyday knowledge, as discussed below. This appears that it would indicate an age difference, if only because older individuals are more likely to have been aware of health advice reversals for more time. However, younger individuals also indicated an awareness of these reversals, especially recent reversals concerning eggs, dairy (specifically focused on the fat content), and carbohydrates (specifically the distinction between “good carbs” and “bad carbs;” Squires 2006) Thus, it is more of an “awareness” difference than an age difference.

Another issue visible in Arlene's comments is the growing awareness that even trusted advice can be “un-verified” over the course of time as new research emerges. This perception leads to the relativist perspective that scientific knowledge is transient and impermanent. In turn,

these ideas lead to a greater reliance on one's own store of knowledge (as discussed below) and traditional ideas about eating (what's tried and true), as found by Lupton (2005).

One major reason that so much health advice seems to be contradictory lays in the transformation of "research" into "news." This process often strips new health knowledge of nuance, caveats, and perspective. Reasons for this situation include the wide difference between the scientific jargon of research studies, the ordinary language of major news outlets, and the surface-oriented "headline" style of journalism that is widely evident. Ironically, despite having infinitely more air time and column inches (especially considering the infinite capacity of the internet), it is more common for news to be packaged into smaller space, resulting in the increasing prevalence of 15-30 second "sound bites" rather than in-depth or nuanced coverage of any particular issue. Further, in an effort to "translate" the research for the audience, the media tend to craft short, simplified, overly enthusiastic pieces that avoid caveats or other qualifying information. Rory was quite clear about how much this sort of reporting turned her off:

I do pay attention when I see something but I also always take it with a grain of salt because a lot of times where I'm running into it is on CNN.com or MSN or any of the popular news outlets, you know, Fox, they can't tell the truth to save their lives. They report partial truths. They'll take a non-significant finding and blow it up. I'm very careful about that.

(Rory, 29, White)

Rory believes that the major news outlets are more interested in sensational headlines than actually reporting useful information. In an analysis of media reporting about obesity, Saguy and Almeling (2008) found that the new media tended to dramatize language and to focus on individual responsibility when reporting on scientific studies. Other researchers have found that the simplistic and overly dramatic reporting of complex health research in the news and other popular media results in confusion, panic, and eventually avoidance (Nelkin 1987; Klaidman 1990; Stallings 1990). Weight is also moralized in other sections of "soft news," such as entertainment and celebrity news and lifestyle pieces. The "unfortunate" case of Kirstie Alley's

recent weight (re)gain is a good example. In addition to reporting on Alley's recent weight gain, *ABC News* detailed her weight history and discharge as spokesperson for the Jenny Craig Diet program (Friedman 2008). Like other social ills, the use of moralistic tones by the news media often associates weight gain with health, appearance, and social decline (Schudson 2003). Stories like this are often aired on morning talk shows or located in the Style or Living sections of the paper, separating them somewhat from "hard news" on politics and world events, but they contribute to the general view of obesity as a negative situation.

As women evaluate healthy eating advice because there are too many "experts" saying too many (contradictory) things, they also evaluate the credentials and affiliations of these "experts" as well. Although they do believe that there are legitimate and illegitimate "experts," the problem of identifying the category of any particular "dubious expert" becomes consciously problematic in many of the women's discussion of health advice. One concern is the intentional manipulation of data by the researchers or funding organizations to support a product fraudulently. Many women expressed concern about the influence of commercial interests on health-related information. Monica explains her distrust of studies funded by food or pharmaceutical companies:

...you know, you can take the numbers and make the numbers look any way you want them to. And I think if I'm giving you millions and millions and *millions* of dollars, thousands of millions of dollars, to do this research and I'm a company, whatever company, company A, B, C, or what have you, I want the results to kind of come out in my favor. [Laughs] (Monica, 32, Black)

So, if one can identify financial contributions, one can easily discount the information as biased. However, other women felt that it was not always so easy to identify these sorts of connections. One interesting example of this situation related to websites where one can "chat" with a doctor. While some of the women liked and trusted these sites, Brooke expressed some reservation:

I look at stuff on the American Cancer Society web site, WebMD. Those tend to be my main sources if I want to find something. I don't put any credence in a lot of the blogs and the online ask the doctor kinds of things. It's like, well, who's the doctor?
(Brooke, 40, White)

Brooke worries that the “doctor” in this situation may not be qualified to dispense health advice (at best) or might be trying to sell a product (at worst). In Brooke's lay-sociological analysis, she recognizes that people may present themselves as an “expert” despite a lack of credible credentials, potentially misleading viewers. In the contemporary media-sphere, there are many “experts” and there often is little way for casual viewers to evaluate them.

Although most women still trusted their personal doctors, mediated doctors can no longer be assumed completely trustworthy as many diets advertise assurances from or are sold by doctors. For example, Dr. Atkins, Dr. Agatston (*The South Beach Diet*), Dr. Ornish (*The Ornish Diet*), and Dr. Oz (television personality Oprah Winfrey's diet guru) are all actual medical doctors who have commercial interests in particular diets. Kate describes how she thinks about Dr. Oz and his book:

With that Oprah doctor, which I didn't know he was the Oprah doctor when I got the book ... With him, it's kind of like this realistic look at you and your body. If somebody is handing me a book and it says, “Dr. So and So,” um, and they say, “I can help you lose 10 pounds in five days.” No, you know, I would say, “What kind of doctor are you?” And you also have to think about that. I mean, if you got your PhD in higher education and that's why you're Dr. So and So that's different. It's like Dr. Phil, you know. What kind of doctor are you? That's something to take into consideration.
(Kate, 26, White)

So, while Kate (reluctantly) accepts Dr. Oz's advice, she is concerned about accepting advice on name-recognition only. Kate, along with many other women I interviewed, recognized that the appellation of “doctor” does not necessarily mean that one is a *medical* doctor, nor does it indicate extensive knowledge about particular health topics. In other words, these women are more likely to view non-medical doctors like Dr. Phil as illegitimate “experts” whose existence

raises awareness of the need to examine closely the qualifications of all those dispensing health advice.

This section has examined the critiques of “experts” based on both the content of healthy eating advice and the credentials of the “experts” providing it. Specifically, the women discussed the quantity, variability, and contradictory nature of healthy eating advice along with concerns about simplistic reporting and the potential commercial/industry biases or illegitimacy of “experts” as important concerns. These problems raise questions about the validity of any healthy eating or health advice and reduce the trust these women hold for “experts” in general. They are left with an impression that all “experts” are “dubious” and do not really trust any until their legitimacy can be sufficiently verified through personal evaluation. I now turn to an examination of the local forms of knowledge that these women activate in their evaluation and critiques of the “experts.”

Basis for the Evaluation of “Experts”: Local Knowledge

Another reason for the rise in “dubious experts” is that healthism,²³ along with the ethos of self-help, implies that individuals must become their own “experts” in their responsibility to know about and maintain their own health (Rimke 2006: 62). Overall, this is the most significant way individuals challenge the “experts.” The women felt it was their duty to evaluate the expertise of the claims-makers. As shown above, this evaluation measured the qualifications of the claims-maker, the validity of the research, and the significance of the claim. To make these evaluations, these women relied on their own knowledge and experiences and the collective wisdom of local culture, the knowledge and experiences of family and friends. While previous research found this tendency to trust oneself over the “experts” to exist among a minority of their

²³ As discussed above, healthism is defined by Crawford (1980) as the preoccupation with health as a primary goal.

samples (Lupton and Chapman 1995; Keane 1997; Green, Draper, and Dowler 2003; Lupton 2005), the *majority* of women I interviewed claimed to engage in a critical evaluation of the “experts.”²⁴ In fact, talk of this sort seems to play an important role in women’s construction of themselves as intelligent, reasoning, health-conscious individuals. The majority were very keen to explain just how they made their evaluations, stressing the fact that they did not simply accept any healthy eating advice presented. Instead, the women engaged in a conscious evaluative process, measuring the new healthy eating advice (and health advice in general) against previous knowledge and local cultural wisdom. Specifically the women utilized three types of local knowledge: personal knowledge, embodied knowledge, and collective knowledge. Collective knowledge includes shared local understandings of the way the world works. Personal knowledge is the stock of previously learned information accessible to an individual. Embodied knowledge is knowledge gained from and through the body, such as how one feels after eating certain foods.

Collective Knowledge

Collective knowledge is comprised of shared understandings of how the world works. Collective knowledge encompasses knowledge transmitted among members of the social group and “taken for granted” information, maxims, and folk wisdom. Examples include the saying “An apple a day keeps the doctor away” and the idea that carrots are good for the eyes. As described by Michael Gardiner, everyday knowledge is “ruled by emotion and affect rather than formal logic; [it tends] to be repetitive, prone to analogical forms of reasoning and over-generalization; and [it is] pragmatic, based upon immediate perceptions and experiences” (2006:

²⁴ It is difficult to determine the reasons for this difference. One potential reason may be different national contexts: Deborah Lupton conducts her research in Australia while Anne Keane and Judith Green and her colleagues are working in Great Britain.

205). These ideas persist despite medical research proof or disproof because the ideas have the weight of tradition behind them.

Teresa uses her everyday knowledge to resist the urge to change her eating strategy with every new study:

And sometimes I take it with a grain of salt because, you know, today it's like, "Eat this." And tomorrow there's a study refuting what that study said. So, sometimes, you know, you can't listen to everything because you're going to be spinning your wheels, wasting your money, and then, you know, two months later you find out that eating that particular food did not have the health benefits that it said before, so. Go with the tried and true. You know to eat the green stuff, vary the colors, textures. We all know that whole grains are better for you than refined foods. So, go with the basics, is what I say.

(Teresa, 25, Black)

Other common examples of this basic knowledge were ideas of moderation and balance as being guiding principles to use to construct a healthy eating strategy. Women also used everyday knowledge for evaluation in a second way. If the “expert” discourse contradicts everyday knowledge, it is likely to be rejected. When Kate’s dietician told her not to eat peas, she resisted on the grounds that peas were a vegetable, and therefore healthy:

From my understanding of nutrition, of what I understand what I need to consume. If you’re going to tell me, “Eat between 12 and 14 hundred calories.” And then I do that. And then you tell me, “Well, peas are a starch.” I’m sorry, you know, that doesn’t fit into my know-the way I’ve constructed this. So unless you can explain to my why I need to replace those 80 calories with some other form of 80 calories, if you can’t explain that to me then I have no basis for changing that behavior.

(Kate, 26, White)

It is not the fact that Kate doubts the qualifications of the dietician, but that the advice does not fit with Kate’s everyday knowledge evaluation of the value of eating (any) vegetables. Also in Kate’s comments, it is apparent that (as mentioned above) despite the fact that most of the women interviewed still held great trust for their personal doctor, “real life” doctors, dieticians, and nutritionists are not immune to the waning of the automatic assumption of expertise.

A second aspect of collective knowledge is information transmitted locally that is based on the experiences of other local lay individuals. Friends or family members in medical or

related fields, considered knowledgeable about health, were particularly trusted. Conversely, there is also recognition that friends and family who are *not* in these fields may not know any more than oneself. Carol had much more faith in the traditional specialists than other members of the lay public.

- I: just to make sure that I'm clear, you said the traditional sources you're supposed to trust.
 Carol: Well, like your doctor and your pharmacist, the trained people in medical field.
 I: Okay.
 Carol: As opposed to, you know, Aunt Bertha, [Laughs] or whatever. I don't put much stock in old wives' tales, um, necessarily or, uh, hearsay. You know, that people say, "Oh, uh, I heard that this is good for you," or "I heard this is bad for you. I usually check it out more."
 I: So you are perhaps likely to go and research it?
 Carol: Yeah.

(Carol, 59, White)

Primary relations of friends and family serve as agenda-setters (McCombs and Shaw 1972), bringing issues to the attention of the women I interviewed. As such, they are subject to the same evaluation as other sources of health advice. After hearing about something from a family or friend, my respondents claimed to²⁵ follow up later with their own research into the issue. Despite this caution, the opinions of friends and family are often given greater weight than general mediated information. For example, Pam told me about how her daughter influenced her choice of sugar-substitute:

When *Splenda* first came out I was using a lot of *Splenda* because it seemed like it was a really good substitute. And then my daughter told me about *Stevia*. I don't know if you heard about *Stevia*. And so I said-you know I didn't quite understand the difference until I read about *Stevia*. And have started using *Stevia* instead of *Splenda* because it is-it seems to have more benefits than the *Splenda*.

(Pam, 59, Black)

After Pam heard about *Stevia* from her daughter, she investigated it online, and concluded that it was a better sugar substitute than *Splenda*. This sort of positive outcome of the agenda setting

²⁵ Of course, I can only speak to what my participants reported to me. I cannot know for sure if they did, indeed, seek out additional information about topics brought to their attention from family and friends. However, they did describe the process, leading me to believe that they did so at least sometimes. Further, they described a similar process in this situation as when confirming information from mediated sources, indicating they sought confirmation for new information, regardless of the source.

function of collective knowledge was common among my participants, but the cartoon on the next page shows a humorous perspective on when well-meaning friends and family members may take things too far.

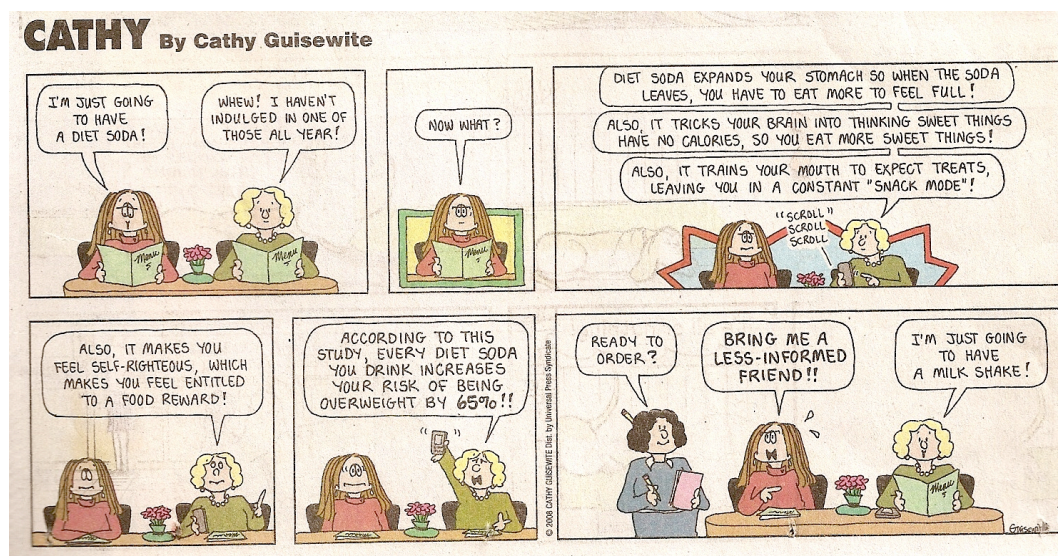


Figure 1: *Cathy* Cartoon related to Collective Knowledge.

The women viewed interaction with family and friends about health issues as free of the concerns about bias and marketing that are present in mediated discourse. They were considered more honest about what strategies worked and which did not. Further, their experiences with various strategies carried more weight because they were “like me.” Considered to have similar genetics and life situations, friends and family share aspects believed to have large effects on whether a particular strategy would work.

In an interesting twist, sometimes this trust for “people like me” can extend to media personalities as well. This situation is the inverse of the contradictory position of local doctors being generally trusted, yet not immune to evaluation with the blurring of “expert” and lay knowledge. Here, media personalities, who may not have any specialist expertise, are imbued with a positive evaluation and trust because they are deemed part of the local culture, despite mediated distance. This trust serves to further break down the barriers of authority between “experts” and collective local knowledge. In an effort to create intimacy through form of address magazines and daytime television shows embrace a “coffee klatch” format (Bunton 1997). Through a synthetic ethos of caring, this format seeks to provide new information with the recycling of old, comfortable ideas (everyday knowledge) that “increasingly blurs boundaries between lay and expert knowledge” (Bunton 1997: 232). This format combines with a perception of similar experiences, allowing the women to make personal connections with media personalities.

The best, and most common, example of the perception of similar experiences is the talk-show host, Oprah Winfrey. Oprah has very publicly lost and gained, and lost and gained, weight. This makes her a fellow traveler on the road to weight loss and health. Thus, when Oprah places her trust in someone, like Dr. Oz, other women followed suit.

I was looking at an Oprah the other day where she had Dr. Oz on and... Dr. Oz is wonderful at explaining. He's a great teacher. And he always gives you the why's and wherefores, which are always interesting for me, as opposed to just the bottom-line conclusion. Plus he brings things like fat and livers that have been from people who were drinking versus people who weren't and stuff like that so you can really see what it does to your body. And it's very-you know, we are a visual generation so it's very startling. So his information is incredible. And I have bought his books that do just a tremendous job of explaining the body to you. (Quilter, 55, Black,)

Oprah's television show not only provides a forum for Dr. Oz to talk about health issues, but it also lends him the weight of Oprah's seal of approval. Perception of similar characteristics was

important to many of the women I interviewed. Maxine told me that she would trust information from someone “more like her” because of the assumed similarities in situation:

it depends on who wrote it. It really does. I tend to like to read real-life stuff more than these guys that are in science, that are in the labs doing stuff. So if it's somebody who's really struggled with it that has a lifestyle almost like mine, I tend to value their insight more so than some guy that just went out and talked to 50 people. And I know that's bad to say because you're a researcher and I work in research but I tend to look at more real-life situations, people who are like me. That tends to draw me more. So a woman who's probably an African-American woman, her life's like me, single and is talking about her, I would probably value her, what she's saying more, because I figure she looks like me, she's like me, so she probably can give me better advice than some 55-, 60-year-old guy who's probably never has had the same problems, the same struggles that we've had.

(Maxine, 45, Black)

Having similar characteristics is seen as important because it is assumed that similar characteristics lead to similar experiences. By extrapolation, seeing something “work” for a similar person indicates that it will work for me.

Personal Knowledge

Personal knowledge is the store of knowledge an individual has accumulated over the course of his or her life. This knowledge is gathered from various sources, including formal and informal education and independent research. However, it only includes that knowledge that is retained and accessible to the individual.

The women viewed engaging in additional research as a way to accumulate personal health knowledge. Actively researching health and healthy-eating information was an important part of the women's talk about healthy eating advice. They resisted, through their talk, the possibility that they were uninformed about their health. The sources they used to engage in their further research were mostly online, but also included health-oriented magazines and books, and asking their doctors. Engaging in such additional research still shows a trust of “experts,” but individuals

evaluate the qualifications and claims made before it is trusted, as discussed above. As found by Nettleton, Burrows, and O'Malley (2005), the trusted sources tended to be real organizations, non-commercial, professional, non-experiential (personal opinions and experiences), and replicated across multiple sites. Analogous to seeing information replicated across multiple internet sites, the women often utilized multiple sources of information as a method to confirm or "triangulate" health information. Tamara explains:

... if they say something's bad for me though I would be inclined to look more into it and what else is out there and see if other people are saying it. Like, the little thing with trans fat. Once I heard that I didn't just go, "Oh, okay. Trans fat's bad." I really started to research other places to see if this was consistent.

(Tamara, 30, Black)

Rather than simply accepting new health information, Tamara seeks confirmation from other trusted sources. The knowledge gained, or supported by, this additional research then becomes part of the individuals own store of health-related knowledge that is accessible as needed and serves as a basis for evaluation of other healthy eating advice.

Another source of one's personal knowledge is formal education and work in academic research settings. For example, Nancy compares the knowledge she has gained through her own academic research to health reports when she says that she trusts

the magazines more than the TV shows because they dilute it *so* much on the TV shows that-and sometimes they say stuff that I just know is not right from what I know about. Or not necessarily a nutrition area; it's been in areas that I know a lot about the research, like maybe something psychological. So I realize that well if they're making an error here then they're probably making errors in stuff I don't know as much about. So I don't trust them as much. But a lot of times in those magazines they will actually kind of, they don't cite it, but say, "So-and-so from this university." And a lot of times it'll be somebody I've heard of. So I feel a little better about it.

(Nancy, 25, White)

Other women used their own education and academic experience to evaluate health reports in terms of sample size and in terms of statistical versus realistic significance. Comments from the women I interviewed indicate that people view media in sophisticated ways, identifying trusted

sources and useful information rather than just “soaking up” messages indiscriminately. Often research on the lay public conceptualizes it as an undifferentiated mass. However, the women I interviewed included a considerable range of occupation and education levels, and some of them used their education to evaluate the health reports they observed. Quite a few of them, like Rory (on page 63) and Nancy above, were very critical of the reporting of health research. When news agencies report academic studies equally regardless of sample size or methodological rigor, these women notice. For example, Elise says:

I trust it to a point. Um, but I mean I’m in research, evaluation, measurement, and statistics. And so when I look at the studies sometimes I go, you know, “They had 16 people. And I don’t know how that generalizes to everyone.” So I’m a bad consumer, or maybe I’m a good consumer, of research in that way. So I trust it to a point and then wait to see more.
(Elise, 47, White)

Other women used their own education and academic experience to evaluate reports that confused correlation with causality, that were methodologically suspect, or that may have an (financial) interest in, and the potential of manipulating, their data. It is important to note that trained researchers were not the only participants to notice these problems. When the women noticed these methodological mishaps, as many did, they cast an aura of doubt on media reports of studies in general.

Embodied Knowledge

Women also relied on embodied knowledge, gained through feelings and experience. By embodied knowledge, I mean experiential knowledge about the body, knowledge about what it can do, how it feels when it feels good or bad, healthy or ill, and how to give it what it needs. Although related to Bourdieu’s concept of Habitus (1977), embodied knowledge is more concrete and focuses only on the feelings from the body. In the last few years, the notion of embodied knowledge has seen a resurgence, with numerous self-help/therapy-oriented websites

and magazine articles encouraging individuals to “listen to your body.” The goal of such admonishments is to help individuals to recognize the body’s own messages about anxiety, energy levels, and other emotional states like depression. Especially with regard to eating, such advice encourages individuals to try to use the body’s signals of satiety rather than focusing on external cues such as an empty plate. Although it may seem silly, recent research has shown that external cues, such as the size of the food container, play a large role in the amount consumed (Wansink and Kim 2006).

Embodied knowledge also relates to how eating, exercise, or other activities make us feel. Grounded in one’s experience of the body through living in it over time rather than studying it from the outside, this knowledge is felt to be deeper and more personal. The “experts” may have science to back them up, but many of the women still felt that they know their own bodies the best. Maxine talked about how she does have some trust for what the “experts” say, but that her own embodied experience plays a larger role in her activities:

Whether I trust-I don’t say I trust as a strong word but I have enough common knowledge to know what works best for me. Because I mean I read these stories about, I mean I’m reading this information and I think-what was I reading? A fitness magazine. And they say, “This is what you need to be doing and this.” I’m looking at that saying, “Well, yeah. I do know you’re supposed to do certain cardio exercises to help your heart but I’m not gonna’ be doing an hour a day.” So whatever works for me. Because I do trust some of the information you’re giving me and you’re probably right. But for me I know what’s best for my body and what works well for me. So I just adapt things that’s gonna’ be comfortable. I mean I know if I had tried to adhere to some of their standards I would probably give up because their standards are way-I don’t have an hour and a half. I don’t have an hour to do cardio every day plus 30 minutes to do stretching plus incorporating a little yoga, a little Pilates. No, I don’t have time for all that. So I need to find what works best for me and still go within the guidelines to keep my body healthy. So that’s how I look at it.

(Maxine, 45, Black)

Maxine knows that if she tried to do as much exercise as they instruct her to do, she will quit soon, but if she only does what she feels comfortable doing, she will continue longer, and thus will have a better outcome.

Women also utilized experience in support for not changing their habits. When asked if she would eliminate something from her eating strategy once she had learned that it was unhealthy, Beverly said:

Probably not. The negative probably would, I probably would not jump on as fast as I would something that would be more on the healthier side because I feel like I've been doing this the way I've been doing it for as long as I am and I'm pretty healthy.

(Beverly, 51, Black)

Like many women, Beverly felt that people have eaten many of the things “experts” advised them to avoid for a long time with no discernable health effects. Only with proof of negative effects is she likely to take steps to remove them.

The three forms of local knowledge comprise a basis for the evaluation, rejection, or acceptance of new healthy eating advice. Personal knowledge is comprised of previously learned, accessible information about a topic. Embodied knowledge is information perceived about and through the body. Collective knowledge is comprised of information shared through family, friends, and others in the local group. These three types of knowledge are analytically distinct only and they are not always separated in daily use. For example, some of one's personal knowledge is comprised of the everyday collective knowledge shared amongst the local group. These forms of knowledge act as a set of filters through which new information must pass before being accepted. Information that differs from or contradicts the local knowledge is much more likely to be resisted. Relying on various combinations of these three forms of local knowledge, individuals become their own best “experts” with regard to their health in the context of their daily lives, as suggested by Rimke (2006), and are no longer dependent on the “dubious experts” dispensing advice.

However, this situation can cause problems. The concern is not that the local knowledge is incorrect or harmful in itself. However, if the process of resisting “expert” claims by relying on local knowledge operates too completely, the individual may be missing important new information that is actually helpful. In other words, they may be left with incomplete health knowledge. As I will show in Chapter Five, this may have ramifications in the construction of a concept and practice such as healthy eating.

Discussion

For various reasons, including the amount and contradictory nature of the advice, the potential influence of commercial interests, and the difficulty in identifying legitimate “experts,” women are engaging in evaluation of both healthy eating advice and the “experts” dispensing such advice. In this process, they consider all claims-makers as “dubious experts,” even those with the traditional authority of “Dr.” before their name. In their evaluations, the women utilize three forms of alternative local knowledge: personal knowledge, embodied knowledge, and collective knowledge.

In the case of healthy-eating, while there are more “experts,” in more differentiated fields, producing more health-related discourse, encompassing more and more aspects of life, the healthy eating advice produced by the general sources of scientific and medical research, government statements and policy, and the mass media seem to hold less sway with average people. Because of the amount and variety of messages, and the difficulty identifying legitimate “experts,” the lay population has become skeptical of health advice. As we have seen, individuals regularly engage in the evaluation of both claims and the “dubious experts” themselves. In this situation, power seems to be shifting from the hands of these “dubious experts” to the individuals evaluating them, but this shift exists at the same time as increasing

cultural anxiety over health. In understanding this conundrum, it is possible to identify three main factors in the development of “dubious experts:” the expansion of mass media, the convergence of rhetoric between discourses, and the cultural view of health as an individual responsibility.

First, in terms of health advice, the development of the mass media is a change of quantity rather than quality. As the power and knowledge about health increases, differentiation occurs, which results in more and more specialists²⁶ (this is not new). As there are more specialists, they begin to disagree (also not new). What may be new is that the legions of specialists now have relatively equal access to the public through the diversification of media and the internet. Whereas once major divisions between the specialists were confined to verbal interactions and various professional journals, the public now is often supplied with conflicting reports through various media outlets from a myriad of health experts. There are many, many individuals presenting themselves as “experts,” and individuals must find ways to differentiate. Contradictions, inapplicability, and questions about bias and legitimacy on the part of some “experts” give rise to a general questioning of all “experts.”

Second, many other claims-makers have picked up the rhetoric and ways of talking about health and the body processes that is common among of scientific and medical specialists.²⁷ Some examples of this are the use of the term “carbohydrates” rather than the older term “starches,” and the common use of phrases like “recommended daily allowances” and “body-mass index.” The use of this rhetoric imbues *any* claims with the aura of legitimacy implied by the scientific/medical discourse. Thus, even “dubious experts” may sound legitimate. For

²⁶ The term “specialist” might be used to refer to a traditional legitimate expert, an individual with socially defined legitimate expertise, through education, research, and access to technology. In contrast, the term “claims-maker” connotes any individual making a knowledge claim, without reference to legitimacy.

²⁷ Although this diffusion of terminology seems to occur with medical, scientific, psychological, sociological, and even political terms, I cannot find any research on this issue. This seems fertile ground for future research.

example, in 2005, the McDonald's Corporation began a new campaign, promoting its products as part of a healthy lifestyle. Changes include healthier food choices such as salads and yogurt parfaits, providing nutrition information on food packaging,²⁸ and a slimmer Ronald McDonald in advertising (Denz 2005; McDonald's 2007). While it may be hard to accept the McDonalds Corporation as promoting healthy living to its patrons as serious, this is indicative of a wider pattern. The focus on health and individual responsibility for it is so prevalent that even makers of ostensibly non-healthy products are attempting to utilize the rhetoric of healthy living.

Third, the increasing individualization entailed by healthism and the risk society includes the freedom to choose, but also the responsibility to make the right life choices, from among more complex options (Blaxter 1997; Williams 1998; Crawford 2006). This encourages individuals to seek out knowledge about risks, to accumulate their own store of health knowledge, and to make decisions based on this knowledge. So much focus on individual responsibility for risk, including health, virtually guarantees a lessened power in the hands of "experts." Technologies of the self (Foucault 1978 and 1979), including self-control, self-monitoring, and self (risk) assessment, and the preventative practices that go along with these, are increasingly developed and engaged in by individuals, resulting in less need for "experts" (Hodgetts, Bolam, and Stephens 2005).

Thus, the "experts" are not unquestioned authorities but "dubious experts." By this, I mean that all claims-makers are met with doubt and are subject to evaluation by individuals. This evaluation includes both evaluation of their information and evaluation of their credentials and affiliations. Individuals see it as their right and responsibility to develop their own store of health related knowledge, but the "experts" do retain (some) discursive control as agenda setters.

²⁸ However, this information is only accessible *after* one has purchased the food, and not necessarily available in the store prior to purchase.

Interestingly, the overarching narratives of the importance of health and the responsibility of the individual to maintain health generally carried in most of the scientific/medical and media discourses are severed from the specific content of any particular message and accepted whereas the specific content may be ignored. In this way, individuals utilize health discourse to organize their concerns, but not necessarily to dictate their specific practices (e.g. Hunter and O'Dea 1997). Before accepting any health advice, individuals seek to evaluate whether an individual "dubious expert" is worthy of trust. However, if a particular "expert" is deemed worthy of trust, they then regain the status of authority and advice is generally accepted. The situation of using the internet to conduct additional research into health related topics exemplifies this situation: the initial message from a "dubious expert" is not accepted outright, but the individual seeks out additional information from other, trusted, (previously evaluated) experts, and with confirmation, the advice is accepted.

The most important finding here is that individuals are evaluating health advice from all sources in light of their own knowledges and experiences. The "experts" still have the power to bring new health concerns to attention, but decisions about what to do about those concerns are much more likely to rely on alternative forms of knowledge to evaluate the advice. They are drawing on everyday knowledge, their own developing store of health-related knowledge, their own bodily experiences, and the experiences of other, similar, local actors. Used independently or in concert, these forms of alternative knowledge constitute a basis for the evaluation, rejection, or acceptance of new healthy eating advice. Although various researchers have identified some of these trends in their research (Lupton and Chapman 1995; Keane 1997; Green, Draper, and Dowler 2003; Lupton 2005), the degree to which this is happening has yet to be fully appreciated. The majority of women interviewed here engaged in such evaluations,

seeing it as part of both their responsibility and opportunity to determine the best way to live a healthy life.

These findings illuminate efforts of women to enact agency with regard to their health. In the context of individual responsibility for health risks, these women are enacting agency by maintaining a critical eye toward new healthy eating advice. It seems that many analyses of structure and agency within society focus on outcomes, attempting to classify whether engagement in a certain *behavior* is evidence of agency or conformity to some particular structure. The recent work by Hollander and Einwohner (2004) has begun an important conversation about the way sociologists conceptualize resistance and agency,²⁹ but they (perhaps unintentionally) reinforce in their analysis the assumption that all resistance is behavioral. However, symbolic interactionism has a long history of examining the ways individuals resist cultural and other social structures through the creation of (alternative) meanings. These findings show that healthy eating advice is one such example. It is clear that regardless of their ultimate behaviors, these women are exhibiting agency in evaluating the health discourse with their own knowledges. They are resisting the structure of discourse that automatically endows those presenting information as “experts,” and positioning themselves as local, embodied, knowledge holders.

These findings demonstrate that the public is becoming conscious (critical) consumers of media, exhibiting media literacy, and carefully evaluating health advice and the “experts” who are advising. They implicitly recognize the fallibility of mass media reporting of research studies

²⁹ Although agency and resistance are clearly related terms, perhaps even synonymous as implied by Hollander and Einwohner (2004), I utilize the term agency rather than resistance for two specific reasons. First, the term resistance seems to imply an act in response to a specific individual/group/organization/situation. In the case of healthy eating advice, individual may resist particular items of advice, or even the expectation that health is one’s own responsibility. However, the wider situation is better described as enacting agency in both evaluating advice and “experts” and seeking (dis)confirming advice to choose among various behaviors in the effort to be healthy.

and the construction of (illegitimate) authority in media personality. However, this should not be construed as an abandonment of the mass media as a source of information. The women in this study indicated that the mass media served an agenda-setting function in bringing important health issues to their attention. Then, some women used the internet or other mass media sources (along with evaluation of said sources) for confirmation in their individual knowledge accumulation. These findings also demonstrate the development among the lay public of a better understanding of how science really works, through the establishment of theories and continued testing rather than once-and-done facts.

In this chapter, I have examined some of the ways that women engage with healthy eating advice. This chapter began by examining cultural changes that explicitly position individuals as responsible for their own health, despite the invisibility of health risks contained in foods. In identifying three critiques of advice and “experts” and three forms of local knowledge used to justify these critiques, I sought to explore women’s response to these cultural changes. With these evaluations, women seem to be endeavoring to regain agency over this aspect of their lives. In the next chapter, I will examine how the self-concept contributes to eating strategy decisions.

CHAPTER FOUR:

POSSIBLE SELVES AND AGENCY

In the previous chapter, I discussed the role of mediated and local knowledge in understandings of health. In this chapter, I examine the relation of the body, the self-concept, and agency to provide additional explanation of eating strategy choice. Two theories that contribute to an understanding of the relationship between the self-concept and eating strategy are Hazel Markus' theory of possible selves and Steven Hitlin and Glen Elder's theory of types of agency. I review each of these theories and integrate them to illuminate the process through which division in the self-concept may lead to particular practices. I argue that probable selves are more motivating, and when endowed with agentic capacity, govern the choice of eating strategy. In this chapter, I provide the theoretical argument and discuss some example possible selves. In the next chapter, I describe the eating strategies and highlight their connections to possible selves and agency.

The Self in a Reflexive World

In the contemporary world, identity³⁰ is a reflexive project. As voiced by Giddens (1991), this project is one of the essential aspects of social life. In the context of high modernity, Giddens explains, the traditional sources of identity have become un-moored and fluid, with

³⁰ In social psychological literature, it has become common to use the terms "identity" and "self" interchangeably when the distinctions between the two are not central to the project at hand (Gecas 1982, Stryker 1987). I shall continue this practice in this chapter.

additional sources of identity available. The result of this situation leaves individuals with the project of “choosing” amongst a variety of identities in the construction of the self.

Giddens’s notion of the self as a reflexive project is not a unitary, single, or finite project. Rather, it is ongoing and multi-faceted, consisting not only of constructing identity, but also of interpreting and understanding identity. In other words, we are always interpreting our own actions as we enact them, placing them in context with other actions, and continuously reinterpreting them in light of further actions. While this sounds very complicated, it is in reality as basic to social life as the development of any interaction using gestures between Person A and Person B. As implicated by the basic nature of this situation, the notion of “choice” as used by Giddens can be misleading. In common parlance, the term “choice” is often used in opposition to terms like “necessity,” much like “desire” is paired with “needs” to imply that one is optional, perhaps even frivolous, while the other is essential. Rather, in the condition of high modernity Giddens describes, individuals must choose identities *of necessity*, because none are provided for them. This choice is not voluntaristic. Giddens describes a society in which traditional sources of identity are falling away and new opportunities, or more correctly, demands, exist for the self-fashioning of identity. More choices not only allow, but also necessitate choosing. The self, then, is a reflexive project that must be engaged in order to organize one’s life and actions within it. The reflexive self is no longer a choice one cannot make- it is simply a characteristic of our society. Inherent in the notion of the reflexive self is the aim of ongoing betterment, the notion that one can and should be interested in making ourselves *better*, whether through being happier, being a better person, being a better parent, being more attractive, and so forth.

Some criticisms of Giddens’ view of the self (e.g. May and Cooper 1995) claim that the reflexive project of the self requires unreasonable amounts of leisure and energy resources in this

(re)construction of the self. This critique fails to consider that the self as a reflexive project need not be total and immediate. Advice from experts about how one can become a better person (self) through large and small steps is common in the current period, thus offering engagement for the individual according to her abilities. In relation to the current topic of bodywork, a few examples will suffice. The Centers for Disease Control recommends 30 minutes of exercise five days a week. However, if one does not have the time or energy for that, the American Heart Association recommends at least getting some exercise through such methods as parking on the far side of the parking lot or taking the stairs rather than the elevator. Similar advice abounds for eating. Some experts advise abstaining from meat altogether, while others advocate reducing red meat to once or twice a week and eating fish two to three times a week.

The abundance of such advice does not necessarily result in successful self-change, however. Self-reflexivity is presented as a goal, or even a mundane fact of life, along with advice about how to better one's existing self; and yet a variety of factors including lack of resources may prevent such self-change from occurring. Further, the potential for change itself has a consequence. The created, 'fashioned' self (Dowd 1996) is not a unified, independent identity. Gergen discusses the replacement of the 'true' self with the pastiche, and later, the relational self (1991). Cognizant of one's self-construction, the incorporated aspects never congeal into an enduring formation. One is always reflexively aware about the choice of traits and the question of whether one should replace them with other potentially more gratifying traits. Self-improvement is unending: as soon as one "flaw" is uncovered, whether a feature of identity or appearance, it must then be worked on and fixed. However, the process of repair is never complete, as another flaw will soon present itself. Thus the reflexive self, and its corollary the body project, is never completed or satisfied.

In other words, self-reflexivity is not a unitary process. There are innumerable aspects of the self to (re)construct, with innumerable goals. Individuals might appeal to cultural ideologies, such as religion or fashion, for guidance about important self-goals. Further, as argued below, the salience of particular goals for the individual may influence whether one's energies are expended pursuing particular self-changes. In this context, agency appears as the decision how to engage in self/bodywork, if at all. This is similar to Giddens' (1991) concept of agency, in which any choice is agency because she could have chosen otherwise. Again, as mentioned in the section on theoretical perspective, trying to cast agency as resistance is misleading. For instance, one can resist traditional norms by, say, getting a tattoo, or one could resist a cultural trend by not getting one.

As already implied, one avenue of identity as a reflexive project runs through the body. The body is the self that is visible to the world. Shilling (1993) extends the concept of the reflexive project in his theory of the body-as-project. In Shilling's treatment, the body becomes the bearer of greater symbolic value in the contemporary world through increases in consumption, technology, and medicalization. However, these developments, especially increases in consumption and technology, allow for greater flexibility in the enactment of the body-as-self-project. Shilling sees (high) modernity as providing individuals with more tools through technology and consumption options, resulting in greater control over their bodies and the ability to (re)construct their own bodies to some extent (1993). While the ability to make drastic changes in the body through plastic surgery is increasingly available to the general public,³¹ it still involves significant cost. The notion of body change through diet and exercise,

³¹ Costs for plastic surgery generally range between one and five thousand dollars, depending on the procedure (American Society of Plastic Surgeons 2008). This is approximately the cost of a family vacation, and financing is often available. Less invasive procedures like chemical peels, laser hair removal, and Botox cost approximately \$500- \$1,000, putting them within reach of an even wider population (ibid).

however, is widely understood to be accessible to all. The potential of changing bodies implicates social meanings through values associated with various manifestations of the body, making some bodies more desirable than others.

Shilling (1993) employs the notions of physical capital from Bourdieu and the civilized body from Norbert Elias to explain the increased reflexivity of the body in high modern times. Physical capital refers to the idea that various bodies possess diverse values in social fields, with this variance distributed unequally (Bourdieu 1984, 1986). In *The Civilizing Process*, Elias explores the development of manners centered on the control and privatization of the body and its functions (Elias 2000). Shilling argues that both concepts place increasing weight on the body as symbolic of hidden aspects of identities related to class and status position. In a similar vein, Susan Andersen proposes that some of the ideas we have about the importance of control clarify the valuation of the body. As she explains,

In Western culture, self-direction and self-control are highly valued commodities. Because of this, the ways in which we attempt to control ourselves may be seen as importantly reflective of self because these efforts appear to be our 'truest' values, aspirations, and preferences. Hence, we may intentionally try to bring our personal reactions into harmony with our ideals about our selves, and the direction of these attempts at self-control, that is, the direction of our 'acts of will,' are seen as highly diagnostic of our own character and personality. (1987: 231)

Thus, as control is a valued good, individuals attempt to control whatever they may, especially the self. As the visible aspect of the self, the body may hold a special place as an object of control. In this cultural context, the body is a visible marker of one's ability and willingness to exert control. When the body appears to be out of control, these assumptions implicate the individual's ability to control other things.

In the theories of Bourdieu and Elias, and as described by Anderson, the appearance of the body is considered to implicate the individual: a neat, attractive, well-mannered, controlled body is taken to indicate a moral and upstanding member of society while a sloppy, unpleasant,

and out-of control body is taken to indicate an unsocialized and out-of-control person. Shilling argues that, combined with the increasing opportunities for bodily change available in high-modern society, these understandings motivate actions to change the body. Along these same lines, Turner states that modernity entails “a shift from an early emphasis on the interior regulation of the body... through such practices as diet, to a new view of the body in which the external presentation of ourselves within the consumer market-place puts special emphasis on the style and form of the external body” (Turner 1997). These cultural constructions provide the context for understanding the contemporary focus on bodies as visible indicators of the self.

Self Concept and the Body

One’s bodily appearance has such strong links to the self to encourage considering the body as the visible self, at least to outsiders. Living in the context previously described, people make judgments about intentions and character based on appearance. In turn, these judgments influence our self-concept. The self-concept is the internalized view we have of ourselves (Cooley 1964). It includes the combination of ideas and feelings we hold about ourselves: both how we think other people see and evaluate us, and social identity, which contains cultural ideas about the social statuses we occupy (Cooley 1964).

Body image is central to the self-concept (Markus and Smith 1981) and influences our experience of other aspects of ourselves. Body image is a subjective experience (Fisher 1986) consisting of the visual impression of the body in the mind. As a subjective experience, body image often connects only indirectly to objective reality, with individuals perceiving themselves as differently shaped or sized than objective measurements (Levinson, Powell, and Steelman

1986). For example, Bridget describes her realization that her bodily self-image was different from reality:

When I was the first year of graduate school, I somehow put on pounds without noticing and, um, probably didn't... My daughter was two or three and, uh, I went to some Christmas party and people were taking pictures with the Polaroid camera and passing them around and I kept thinking, "Who's that fat person?" [Laughs] I could not believe it was me. "Wow, that's funny. That picture makes me look kind of heavy. And that one does too. And that one does too." So that was when I realized I needed to lose some weight.
(Bridget, 45, White)

Bridget saw herself as smaller than she looked in the pictures, but other women frequently experience the inverse situation, in which they see themselves as heavier than they objectively are. Research shows that these (incorrect) perceptions can affect both self-esteem and behavior to an equal or greater degree as objective measures such as weight (Abrams, Allen, and Gray 1993). Mable and associates (1986) found a consistent association between low self-esteem and low body satisfaction. Self-esteem is the evaluative and affective aspect of the self-concept (Gecas 1982), and is a multidimensional construct that is influenced by ability in many domains of competence that combine in various ways to produce global self-esteem (Harter 1998). These domains may include appearance, ability, achievements, intelligence, and relationships. In other words, body image is only one domain of self-esteem, but one that research has repeatedly shown to have large effects. "Physical appearance self-esteem" is the part of self-esteem connected with the appearance of the body, and relates closely to global self-esteem (Cash, Winstead, and Janda 1986; Strauman and Glenberg 1994). Richman and Shaffer (2000) report that physical competence, body image, and self-esteem are all positively correlated. Further, Harter (1999) found that appearance was the domain most strongly related to self-esteem.

Poor body image can also be the result of discrepancy between different aspects of the self. Higgins (1987) defined three separate constructions of the self-concept that often conflict in self-discrepancy theory. These selves are the *actual*, *ideal*, and *ought* selves. The *actual* self is

the perception of what we are; the *ideal* self consists of ideas of who we want to be; and the *ought* self comprises ideas about who we should be. The *ought* self, like Freud's concept of the superego (Freud 1995), includes social norms of behavior and may heavily influence the ideal self. Higgins (1987) proposes that two possible discrepancies may affect how we feel about ourselves. Discrepancies between the *actual* self and the *ideal* self may lead to feelings of dissatisfaction and frustration. Similarly, discrepancies between the *actual* and *ought* self lead to anxieties and discontent. The reason discrepancies lead to negative affective states is that they are evaluations of the self. Discrepancies between the *actual* and *ideal* or *ought* self result in negative self-esteem. One example of this process is body image evaluations. Body image evaluations and emotions derive in part from discrepancies between the self-perceived actual body and internalized physical ideals (Szymanski and Cash 1995).

The social context described above is common among women in the United States today. Reactions to the common context do, of course, vary and not everyone engages in a project of self-improvement. Further, among those who do, strategies and commitment levels are not the same for everyone. Thus, women engage with different eating strategies despite this common context. To understand this enigma, I connect two theoretical domains: possible selves (Markus and Nurius 1986, 1987) and types of agency (Hitlin and Elder 2007a). In combining these theoretical constructs, I argue that possible selves play a role in motivating the individual to act, and differences in time horizon and agentic capacity result in different types of agency..

Self-Concept and Agency

In order to understand the connection between the self-concept and agency, it is useful to examine two theories independently. First, I will review Hazel Markus and Paula Nurius' theory

of possible selves. Second, I will review the relevant aspects of Seven Hitlin and Glen Elder's theory of types of agency. Finally, I will explore how these two theories can be integrated to provide a more comprehensive view of the relation between self-concept and agency.

Possible Selves

The theory of possible selves is similar to Higgins' (1987) ideas about the *actual*, *ideal*, and *ought* selves discussed above, but moves beyond Higgins' concept to explicitly argue that possible selves provide motivation for action through both attempting to achieve positive possible selves and avoidance of negative possible selves. As Markus and Nurius explain, "possible selves represent individuals' ideas of what they might become, what they would like to become, and what they are afraid of becoming" (1987). Possible selves provide a foundation for evaluating both the current self and actions past and present. More importantly, these possible selves offer a way to evaluate potential actions in light of achievement or avoidance.

Possible selves vary in their degree of elaboration (how complex and clearly imagined they are), valence (positive, negative, or neutral), and temporal sign (when the identity is located) (Markus and Nurius 1986). The concepts of "degree of elaboration" and "valence" are relatively self-explanatory, but "temporal sign" is not so forthcoming. The temporal sign, or time of an identity, can occur in the past, present, or future, but can also be located in multiple times. For example, a woman who has recently lost weight may still carry as a possible self a "fat self" that is located in the past (before she lost the weight), but may also carry that "fat self" as a future possible self that may occur if she does not continue to watch what she eats. Similarly, many women maintain past possible selves related to thinness, fitness, and beauty. For example, most women own at least one pair of pants which no longer fit, but which they hold onto as a physical

manifestation of their desire to regain that level of thinness, and ideally, be able to wear those pants again. This is an example of a past “thin self” that an individual might hope to regain (thus, a possible future self). Both these examples also highlight the connection to motivation through seeking to achieve or avoid a possible self. In this way, an individual’s past and present experiences provide a basis for possible selves.

In addition to an individual’s past and present experiences, cultural ideas inform possible future selves. As Markus and Nurius explain, “the pool of possible selves derives from the categories made salient by the individual’s particular sociocultural and historical context and from the models, images, and symbols provided by the media and by the individual’s immediate social experiences” (1986). In other words, these possible selves are dependent on cultural structures and evaluations. If someone views a “fat self” as negative, as is likely in the contemporary American culture, avoiding that outcome may well provide motivation to enact a controlled eating strategy.

The theory of possible selves does not require that all selves be consciously accessible at all times. In fact, it implies the opposite. While there are some identities that are nearly always immediately accessible, called the “core self,” the vast majority of possible selves are only salient depending on the situation, prompting, or other stimulus. However, there is a problem with this construction. A careful analysis of the concept of possible selves reveals that the theory is quite general. Besides the “core self,” all other possible selves are grouped together, and Markus and Nurius’s research applications indicate that some of these possible selves are marginal or even remote. It seems more reasonable to expect that one’s future selves include at least two levels, which are differentiated by their probability of being enacted. Besides the core self, which is ongoing and generally accessible, I argue that there are *likely* and *hypothetical*

selves. *Likely selves* are real potential identities, acknowledged by the individual as having some realistic chance of occurring in the near future. *Hypothetical selves*, in contrast, are more distant possibilities, either not probable to any great degree or not probable in the near future. Likely selves, conceptualized in this way, differentiate the possible selves Markus and Nurius found to be more elaborate and salient from those that were less so. For example, as a slightly overweight woman (one of my core selves), my likely selves include a lighter-weight self, a healthy self, and an obese self. These likely selves are achievable in the near future, with some effort (or in the last case, with an abandonment of effort). Three hypothetical selves are a fashion model, a morbidly obese self, and a tri-athlete. None of these hypothetical selves are likely to happen!

An individual's likely selves will vary with the context of current situations, experiences, and life stage expectations. Markus and Nurius argue that the selves salient in these contexts will depend on which "the individual believes to be possible and by the importance assigned to these possibilities" (1986). In other words, current and past identities and abilities, along with moral guidelines, career aspirations, and social acceptance concerns influence whether possible selves are likely, and thus are of concern to the individual. The salience of various selves/identities provides further insight into which selves are likely. Stryker (1987) proposes that multiple identities are hierarchically organized according to salience. Salience has been conceptualized as either level of commitment (Stryker 1987) or subjective importance (Rosenberg 1979). Where an identity is located in the hierarchy has consequences for behavior (Stryker 1980). The higher the salience of a particular identity, the more time and energy will be invested in identity enactment and the more one's self-esteem will be dependent on successful enactment (Thoits and Virshup

1977). Thus, identities or selves that occupy domains of concern to the individual are more salient, and influence whether the individual sees those selves as likely or hypothetical selves.

I argue that this distinction between likely selves and hypothetical selves is important. Likely selves are more salient, more immediate, and more realistic, while hypothetical selves are less important, more distant, and more implausible. For these reasons, likely selves influence motivations to a greater degree than hypothetical selves do. Thus, an individual has a greater likelihood of making changes to achieve or avoid a likely self than a hypothetical self.

The women I interviewed discussed both likely and hypothetical selves with respect to weight, health, appearance, and aging. Often in their responses, the women made implicit comparisons between various possible selves in a way that directly expresses the distinction between hypothetical selves and likely selves. Often they couched these implications in discussions of appropriate and inappropriate appearance changes. Most often these discussions centered on age because losing weight was always seen as appropriate. For example,

I don't want to look older than I am but I'm not concerned about looking my age at all. If someone thinks I'm 33 right now, that's fine. I don't care. If I'm 35 and someone thinks I'm 43, that would bother me. But I'm fine with looking the age I am. And I think there is a lot to be said for aging gracefully. And I think like Susan Sarandon and Diane Keaton have done it quite well. Other people who have everything lifted, nipped, tucked, yanked, grow up. You're 60. You're supposed to be a little wrinkly. You're supposed to have some laugh lines.
(Rory, 29, white)

Rory expresses the conflict women feel about appropriate aging. She does not want to seem older than she is, but also feels that aging should be accepted. She uses the trope of “aging gracefully” to highlight the ideal state of looking your age, but better, in a seemingly natural way. However, she points out, making it obvious that one is trying to look younger is inappropriate.

However, women do consider as appropriate looking younger by staying trim. This is often a delicate dance in terms of a resistance to seeming fake through the use of inappropriate methods of looking younger (hair dye or surgery) while actively considering their efforts to keep

their weight down as part of their effort to look younger. Georgia, a 44-year-old White woman, describes how she stays fit specifically to look younger:

I think that being energetic, being fit, physically fit, yeah, that's a large part of who I am. Well, particularly as a mom because for one thing I don't dye my hair so I look like everybody's mother. I might even look like my kids' grandmother. And so it helps me with my self image not to be too overweight because then I would start to feel really old. When my mom's hair started going gray with her first pregnancy. She had four kids by the time she was 30 and she was salt-and-pepper gray by the time she was 30. And I got all her genes. And so by the time I had my third baby, I had started, my hair just totally. And I don't want to bother with the other-I don't want to dye my hair. It's part of my resistance to the culture thing. But then I have to be real careful about my weight because if I start getting larger then I will look like their grandmother and not their mother. And it's really a self image tradeoff for me. I have to be very careful about my weight because of my hair.
(Georgia, 44, white).

Here the interplay between body and aging comes full circle. Rather than allow her weight to creep up due to aging, Georgia focuses on maintaining her weight to counteract the effect of aging. Later in the interview, Georgia more fully explained her problem with hair dyeing. In her view, this is a political issue: dyeing her hair would be submitting to a cultural obsession with appearance when other people are just struggling to survive. In this connection, Georgia says something interesting about cultural resistance: she opts out of the beauty standard with respect to hair color, but not with respect to weight. As a result, she explicitly sees this choice as reinforcing her desire to stay slim- by not conforming in one area, she feels more pressure to conform in another. This highlights the multivalence of appearance norms and negotiations individuals engage in with respect to them. In this process, the women utilize possible selves as reference points. Both Rory and Georgia are distinguishing between likely selves, such as a “gracefully aging self” and a “fit and trim self,” and hypothetical selves such as a “surgically altered self” and a “hair-dyed self” or “old looking self.”

Further, they linked their choice of eating strategy with these likely selves, indicating the likely selves acted as motivation for their choices. These individuals are using their likely future

selves as motivation to make changes in their lives, to change their current selves by embracing an eating strategy. However, this only provides half the picture. It is also important to look at how these likely selves interact with temporal orientation to understand how the women chose the strategies they did.

Types of Agency

Understanding agency and its relation to structure has occupied many prestigious sociological minds in the last two decades (c.f. Giddens 1984; Sewell 1992; Hays 1994; Emirbayer and Mische 1998; Hitlin and Elder 2007a). While each of these theorists have contributed important pieces to the puzzle, much remains to be illuminated. One important avenue of agency theory has centered on distinguishing types of agency. Emirbayer and Mische (1998) identified three dimensions of agency related to temporal perspective: the iterative, projective, and practical-evaluative element. The iterative element describes the process by which previously enacted patterns of action are habitually or selectively reenacted, providing stabilization over time. The projective element focuses on the future, as actors consider strategies of action to be engaged at some point in the future. The practical-evaluative element, in contrast, focuses on the present, as actors choose among strategies for action in response to current developments. This typology provides a more detailed understanding of agency, yet still fails to address differences in the enactment of agency.

Steven Hitlin and Glen Elder (2007a) expand Emirbayer and Mische's temporal aspects of agency by distinguishing types of agency through the temporal orientation of the agency itself. In other words, while Emirbayer and Mische described temporal aspects of thinking about agency, Hitlin and Elder describe different forms of agency engaged in at different times. Hitlin and

Elder use the term “time horizon” to describe an actor’s temporal focus for action (2007, p. 171). By considering an actor’s time horizon, it is possible to disaggregate different forms of agency, which allows understanding of finer distinctions than whether agency is present.³² Rather, examining agency in connection with the social contexts in which it occurs results in variations of agency attuned to the situation and social actors involved. Variations in time horizons implicate different forms of agency, and thus reasonable strategies of action. In their theory, Hitlin and Elder develop four constructions of agency including existential, pragmatic, identity and life course forms of agency. Of interest in this situation are existential and life course agency, and I will describe each of these more completely.³³

Existential agency is inherent and accessible to everyone. All intentional human action entails existential agency. Existential agency includes the choice to act, as well as the content, timing, mood, and style of the action, including inaction. This is the form of agency that most people enact on a daily basis, choosing to act in one way or another countless times throughout the day. Perry Anderson (1980) described a similar concept of universal agency in routine conduct. In this form, agency does include some self-efficacy, a belief in one’s capacity for initiating self-directed behavior, but this competence is generally limited to relatively short-term behaviors. The fact that most or all people are capable of enacting existential agency does not preclude the fact that some people are able to exert more existential agency than others (Hitlin and Elder 2007b)

³² In their paper, Hitlin and Elder (2007a) provide an exceptionally comprehensive review of the use of the term “agency” within the sociological literature. It would be redundant to rehash their assessment here.

³³ Both pragmatic and identity agency are more focused on agency within specific sorts of situations, such as interaction patterns and social roles, respectively. As the issues of interest here lie outside of these situations, these types of agency will not be discussed here. For a full discussion of these forms of agency, see Hitlin and Elder (2007a).

Life course agency describes choices and behaviors aimed at influencing the trajectory of one's life course. This form of agency consists of not only an extended time horizon, but also an enhanced notion of competence, a belief that one holds significant ability to organize and direct *lifelong choices* (Hitlin and Elder 2007a). While existential agency also employs some degree of self-efficacy, life course agency is distinguished by the magnitude of self-efficacy. In life course agency, the individual believes herself capable of sustaining her chosen path over long periods and in the face of adversity. As Hitlin and Elder state: "Some people have self-concept[ions] about the possible success of their efforts—which may be accurate or inaccurate—that allow them to endure setbacks or plan their lives with longer-term goals in mind" (2007a: 182). Although they never state it clearly, the implication is that few people are truly capable of successfully enacting life course agency. Decisions to complete graduate education before entering the workforce, planning the timing of pregnancies, and saving for retirement are examples of life course agency.

One form of life course agency is life planning. Jacqui Smith (1996) theorizes *life planning* as the process by which individuals think about and actively anticipate the future events, courses of action, and possible consequences of their actions in order to choose those actions best fitted to achieve their long-term goals. While her theory is aimed at understanding the creation of a single, revisable, overarching life plan, a similar process can be applied to particular domains of life, such as career, family, or, as in this case, health or weight. In this case, the process might be termed a "life project" (Giddens 1991). In an elaboration of her concept, Smith (1999) provides a clue to the uncommonness of life course agency and planning by developing the notion of life planning as a complex process that entails the management of all of the following: time, resources, self, and people/relationships (interpersonal resources). Such

skills require development often only available through innate ability/capacity, higher class position, intensive or focused training, or extended education. However, we should refrain from considering this sort of agency as class-determined: it does not simply map onto class position but can develop with age (and wisdom) or with continued success in smaller endeavors regardless of class position. Rather, we should think of life course agency as existing on a continuum. On one end of this continuum would be the capacity to make and carry out life plans of a smaller magnitude (making small changes or plans that focus on a few years at most) such as a middle-class person planning to go to college or saving for a vacation. On the other end of the continuum would be the capacity to make and carry out large magnitude life plans, such as becoming a nun or consistently saving for a comfortable retirement and inheritance for children.

Hitlin and Elder mostly divide their types of agency based on the situation in which the agency occurs. These types of agency are not mutually exclusive categories, and people can exercise both existential and life course agency at the same time. Hitlin and Elder developed this theory with the aim of returning people and social psychological concerns to the often-abstract discussion of agency. Yet their discussion remains relatively abstract, focusing on situations in isolation and failing to incorporate context. I hold that incorporating social psychological context (i.e. possible selves) returns the focus to the agents themselves and the complexity (and interaction) of agency in everyday life. Further, this differentiation of types of agency is, as yet, only theoretical. In this chapter, I propose an empirical application of these ideas.

Theoretical Integration

A synthesis of Markus and Nurius' theory of possible selves and Hitlin and Elder's theory of types of agency provides a clearer understanding of the factors involved in strategic

behavior. The notion of possible selves provides the idea that there are positive and negative identities, and that individuals consider these identities as potential self-identities to various degrees. Modifying the construct of possible selves to differentiate likely possible selves from remote hypothetical selves enhances the explanatory power of the theory of possible selves. Hitlin and Elder's construction of life course agency provides the notion of capacity and temporal orientations influencing agentic actions. Life planning is an example of life course agency, and is one process through which individuals act to achieve their valued future possible selves.

Together, these theories contribute to an understanding of how an individual chooses a course of action(s) based on their perception of possible future selves. Future possible selves that are both likely and salient are more likely to motivate change. Such change, to achieve likely selves, is an enactment of existential agency. However, achieving some likely selves is a more daunting task for some people than others. Likely selves that require long-term planning or substantiation necessitate life course agency, which includes the self-reflexive belief in one's capacity for such extended action. In addition, notions of capacity/self-efficacy influence which possible selves become likely selves in that an individual is not likely to invest much effort in a self they do not believe that they can achieve, especially if it requires long-term planning. To apply this theory, I begin by describing some possible selves below, after which I will link the possible selves with expected types of agency and courses of action. In the next chapter, I will describe the eating strategies observed and identify the possible selves salient to the individuals engaged in such strategies, along with the type of agency individuals are enacting therein.

Experiences of Likely Selves and Expectations of Agency

There were many shared ideas about possible selves among the women I interviewed. One of the most obvious points of agreement among the women concerned the valence of the overweight self and the healthy self as likely selves. These agreements rested on both social evaluations of these states and definitions of these concepts that they themselves hold.

First, a “healthy self” is a positive possible self. Every woman, even those not currently seeking to eat strategically, desired to be healthier. However, the healthy self was not very elaborate: talk about health was general, and usually described through negative comparisons. For example, women talked about avoiding health problems, not getting diabetes or high cholesterol. When discussing health in positive terms, they often talked about living a long life or being active a long time, rather than about specific health “achievements.” For example, Bridget says:

I want to live a long, long time and I think that this is my best bet. I really believe those studies that say that, uh, being actually slightly underweight will lengthen your lifespan. Because, since I have a tremendous amount of scientific evidence towards that. I don't know. I mean, if I wasn't really happy doing this, I wouldn't, because I think that that's more important than adding five years or whatever to your life. But I would like to have a long, active life. And I also think that, at this-I'm 45 now. And I think at 50, 55 is when, uh, sedentary people really start having a lot of health problems. And I want to be active, you know, way past 70. And I think the only way to do that is to get active and stay active and, um, [pauses] just have a healthy body. (Bridget, 45, White)

In this quote, Bridget had trouble defining “good health” and ended up simply relying on the tropes of “long life” and “active life.” This is consistent with Blaxter's findings about the difficulty in defining health compared to the ease in defining illness (2004). Despite this lack of elaboration, the healthy self may be highly salient due to the importance of health in American culture today (as described in Chapter Three).

In contrast to the “healthy self,” among the women I interviewed, “overweight” quickly emerged as a much-feared possible self. As in other research (Millman 1980; Goodman 1995;

Grover, Keel, and Mitchell 2003; Sobal 2004) overweight indicated a negative status. All groups of women held this opinion, regardless of age, race, weight status, or eating strategy. This view of overweight has much precedent. Certain body types have long been associated with certain personality characteristics and traits. For instance, Joanne Finkelstein describes the long history of physiognomy, the study of physical appearance to appraise character (Finkelstein 1991: 19-21). Markia Tiggmann and Esther Rothblum (1988) found several stereotypes of overweight people. Fat people were seen as less happy, more self-indulgent, lazier, less self-disciplined, and less attractive. Fat women are judged to have these characteristics more so than fat men, and even people who were themselves overweight shared these stereotypes. Similarly, W. Charisse Goodman details many of the stereotypes assigned to people who are overweight, such as being lazy, dirty, weak-willed, and incompetent (1995; for additional support see Rothblum 1992 and Roheling 1999). More recently, researchers have confirmed that overweight and obese people often internalize these stereotypes and agree with them (Wang, Brownell, and Wadden 2004). These stereotypes provide a social incentive to avoid being overweight and encourage feelings of shame if one already is overweight.

These stereotypes elide social evaluations on the basis of both social and health domains. As it is visible, weight serves as a proxy for (invisible) health status. This notion stems from the health discourse discussed in Chapter Three, and has been accepted by the general public. Researchers have linked quite a few health concerns with being overweight, including heart disease and diabetes. Being overweight may also aggravate conditions like high blood pressure, arthritis, especially in the knees, and respiratory illnesses. Even for people not at risk for these conditions mentioned, many doctors recommend losing weight as a sort of preventive cure-all. Although some analysts do seek to remind us that the links between weight and health factors are

correlations, rather than causal indications, and advocate focusing on other measures of health beyond weight (Miller 1999 and 2005), the majority of mediated health reports and general popular opinion often accept these claims unquestioningly. The uncritical acceptance of correlation studies as causal fact adds to the negative stereotypes of overweight individuals as automatically unhealthy. Weight has become a visual indicator of one's health status. Although not always accurate, weight is easily observable and classifiable, and so has come to stand in for other health characteristics that are not visible.

The women also viewed excess weight as a negative identity for social reasons. As a society, we have a tendency to individualize issues and so understand weight related problems to be individual problems. This ignores the social, political, and economic context of the issue as well as de-politicizing it and placing all the blame on the individual. Despite medical studies that suggest otherwise (Crawford, Jeffery, and French 2000), many people still maintain the belief that weight is wholly under voluntary control (Crandall 1994; Blaine and Williams 2004). Much bias, prejudice, and even discrimination on the basis of weight draws its power from this notion that weight is a matter of choice. If a person is overweight, others often perceive it as his or her own fault, assuming that the person has no willpower or concern for his or her health. For this reason, many consider overweight people as lazy and deserving of criticism.

Although obesity discrimination is illegal under the Americans with Disabilities Act (1990), an individual must either be severely obese (100% over the normal weight range is the standard use for legal cases) or prove an accompanying physiological disorder to qualify for an ADA claim (Staman 2007). In their literature review, Rebecca Puhl and Kelly Brownell (2001) highlight research findings documenting bias and discrimination against overweight individuals in employment, medical and health, and educational settings. Additionally, the researchers

describe a number of court cases over denial or extra charges for services because they were overweight.³⁴ Researchers have found that overweight women are especially susceptible to job discrimination (Pingitore, Dugoni, Tindale, and Spring 1994).

In the social realm, Crossrow, Jeffery, and McGuire (2001) used focus groups to document a range of stigmatization experiences towards overweight individuals from family, friends, potential dating partners, and the general public, as well as co-workers and service providers. Overweight women are also less likely to marry than their normal weight counterparts (Averett and Korenman 1996.) and overweight adolescents are more likely to be socially isolated and peripheral in social networks than normal-weight peers (Strauss and Pollack 2003). In such a climate, with powerful negative stereotypes, economic and political discrimination, and social bias, it is no wonder that being overweight is perceived as an undesirable status.

Twenty-six of my respondents saw themselves as overweight, including all who are obese (according to BMI figures), seven of nine women who are overweight, and two normal weight women who felt they were a little overweight. Almost uniformly, these women felt that being overweight was negative.

For many overweight women, the “overweight self” is a likely self. Even if one is currently objectively overweight or obese, the person may still not think of herself in this way. The overweight self may still be only a possible self because the individual resists integrating it as part of the self-concept. The individual woman may not think of overweight as part of her identity. She might instead consider it a short-term situation to be rectified. This situation might be compared to someone who gets a cold. The illness does not become part of one’s identity, but

³⁴ More recently, the case of *Hollowich v. Southwest Airlines* brought to light the fact that Southwest charges an overweight individual for an additional seat if they do not fit in the seat and are unable to lower the armrest, a practice that continues to this day. Last year, a court ruled that a Missouri man was too obese to adopt a child for whom he and his wife had been providing foster care. (Hohmann 2007).

rather is a temporary situation. However, repeated reminders of the overweight self make this a pressing issue. A coherent view of the self is necessary to function rationally (Gecas and Burke 1995), and when the outside (visible) self does not match the self-concept, we experience self-discrepancy (Higgins 1987). This self-discrepancy is uncomfortable and motivates action, as we can see in Deanna's comments below.

I just looked in the mirror in the other day and I used to didn't, you see this right here, when you [shakes her arm] look like turkey? I used to didn't have that. And we had a Fat Tuesday celebration here and they took pictures. So they emailed us the pictures and I almost cried when I saw my picture because I hadn't really looked at myself. In the mirror I've seen myself but I haven't really looked at pictures. And when I saw the pictures it was like, I was the biggest. And it's just depressing.

(Deanna, 44, Black)

A the time of our interview, Deanna had begun to see herself as overweight. She sees a difference when she looks in the mirror, and in pictures of herself with co-workers. This makes her unhappy, and is one of the reasons she decided to begin her diet.

In explaining why the overweight self is negative, the women described three negative effects of being overweight. First, it influences the wider self-concept. For example, when I asked Kate if there was a connection between her weight and how she thinks about herself, she said:

Yeah. You know, I hate that. I hate that. I feel so bad when I think about it, it's just like, you know, you see the number and that makes--you make a judgment about yourself. Or I do, I'm not going to say everybody does it. But, yeah, you get on the scale and you see 175 and it's like, "Man, what's wrong with you? You know? You're just an uncontrollable little, you know, cookie eater. What happened to you?" So, yeah, or it's, you know, you lost five pounds; it's like, "Way to go. You're a strong person." I hate that.

(Kate, 26, White)

For Kate, the number on the scale dictated how she felt about herself, her self-esteem, and her self-efficacy. When she gained weight, she denigrated herself and felt impotent. When she lost weight, she felt efficacious and competent. Later in the interview, she described how after weighing herself in the morning, these self-perceptions colored her outlook the whole day.

Second, being overweight impacts clothing choice options. Women's general preference for smaller sizes has been well documented in qualitative literature (Gutwill 1994a; Hesse-Biber 1996; Apeagyei 2008), and this was echoed by my respondents. Further, many women talked about not being able to find clothes they liked in larger sizes. Similar concerns about a lack of stylish clothing available in larger sizes has been found by other researchers (Millman 1980; Goodman 1995; Tiggemann, Gardiner and Slater 2000) There are two concerns about clothing: a lack of stylish clothes in large sizes and problems finding clothes that fit larger bodies correctly. For example, Brooke finds it very difficult to shop for clothing:

Brooke: I am a bit of a clothes horse and I miss wearing little, cute clothes. It's hard to buy stuff that I really, actually like when I'm my current size.

I: Is that because it doesn't fit right or?

Brooke: Both. Things don't fit right and I'm just not ready to go to elastic-waist, knit pants so it's pretty limited.

I: So the choices are limited.

Brooke: They are very limited, very limited. I even went to, kind of said, "Okay. I'm gonna' suck it up. I'm gonna' go to Catherine's," which is a plus-size store. And I walk in and just like, it's just huge; everything is really, really huge. And they really didn't have much in my size. And I thought, "Okay." So you go next door to Target and there's not much there either. So it's really limited when you're kind of in between the women's sizes and the highest, I guess, misses size. There's not a whole lot in that range. I go to TJ Maxx sometime and look at the 14s and up. They start to get really slim. You get to 16 or 18 and there's like three pair of pants. Very few choices that I would like.

(Brooke, 40, White)

Brooke finds that her clothing options are much reduced since she has gained weight, and that neither the "plus size" store nor the store implied to stock "normal sizes" carries clothes that actually fit her. Further, she is not prepared to give up style and buy pants with an elastic waist.

Many of the women I interviewed mentioned these clothing problems. These issues are not only practical issues, but emotional ones as well. A limited selection and ill fit challenge one's self-concept, implying that one is not "normal." The geographic layout of most department stores reinforces this implication as the most stylish clothes for adult women are found in the "Misses" sections of department stores. This section carries clothes in even sizes from 4 to 12 or

14.³⁵ Sizes above 12 or 14 are located in the “Women’s” section, and are generally considered to be “plus” sizes. The rhetorical significance of equating “women” with “plus” and smaller sizes with youth is self-evident, but unexamined in the literature. Overall, an inability to find clothes that fit and look attractive impinges on self-expression and self-esteem, and threatens one’s self-concept as a “normal,” desirable human being.

Third, there was a concern that being overweight impacts social interactions. Some women commented on an awareness of weight as a social focus of others. They felt that while overweight, people see the weight, not them as individuals. For example, Cleo describes her experience:

I did notice that once I gained, like, 20 pounds, you know, it’s like the shield of invisibility. And it’s not just attractiveness or being asked out or getting attention. You know, kind of, um, romantic attention or whatever. But people actually listen to you less....And, um, you know, and that I guess maybe anticipates some of the other questions you might ask. Um, being 38-years-old in a college town is, is also like the cloak of invisibility. But, um, but this was even when I was living in Atlanta. And I definitely noticed that, um, people seemed to see me less, including men.

(Cleo, 38, White)

Cleo felt that her weight made her invisible, or perhaps inconsequential, to other people in social settings. She felt that others paid her less attention, listened to her less, and dismissed her contributions to the social setting.

Overall, the women agreed that healthy selves were positive selves to achieve and that overweight selves were negative selves to avoid. The healthy self was viewed positively, despite the women’s difficulties in elaborating the concept. Being overweight is a negative possible self for a variety of reasons, including social stereotypes, links to health problems, and the limitations it sets on other avenues of social interaction and expression.

³⁵ Odd sizes are located in the “Juniors” section, which mostly holds teen fashions. The difference between odd and even sizes is based on width, in that even sizes generally allow for a curvier figure than odd sizes.

Aging and the Overweight Self

A second major point of agreement among these women was that aging causes the “overweight” self to become more likely. The women voiced two reasons for this: that weight loss is more difficult with age and that they expect weight gain to occur with increases in age. I will discuss each of these reasons, and the women’s interpretations of them.

One of the most predominant ideas expressed about the aging body relates to the slowing down of the metabolism and increasing difficulty of losing weight with age. As Kate explains,

as you age your metabolism backs off a little bit so if you were to gain weight it’s understandable. If you’re sticking with your regular pattern of diet and exercise, that as you age, just sticking with that pattern your metabolism’s going to counteract it. And yes, you will gain weight unless you change that. (Kate, 26, White)

Like Kate, nearly every woman conceded that people weigh more when they get older. Not every aspect of age-related weight gain is negative, at least according to one woman who stated that in comparison to ultra-thin, youthful models:

I think the models, role models, you see for older people are more the grandmotherly image that you might have a few pounds on you and that’s okay. You have a different, um, I guess there’s a different role that society sort of accepts of you at that point. It’s that you’re the more nurturing kind of person. That you gather them into your breast, kind of deal. (Arlene, 61, White)

Arlene was able to see a positive aspect in weighing more as an older woman as to her a (slightly) growing body indicated a different social status implying (grand) motherly love.

However, most women perceived the weight gain associated with aging in negative terms.

Although most women said that looking attractive for a significant other was *not* a major reason for their eating strategy, they did want to look attractive *for their own sense of self*. They saw gaining weight as unattractive and for this reason, felt that continued vigilance is necessary regardless of age.

Many women felt that it was harder to lose weight when one gets older and often utilized the trope of a slowing metabolism. Monica describes the concerns associated with this situation,

...but I also know, too, that I'm 32 and even though I've been blessed with wonderful genetics that that's gonna' run out soon. [Laughs] Because typically, you know, with women because we were built to carry children we have the extra shielding effect and things like that. Yeah, that kind of spreads as you get older. And, um, I want to make sure that I'm helping my body out to age gracefully. I'm not afraid of aging but, you know, I don't want to be 65 and weighing 300 pounds or 200 pounds and looking back on when I was 32 and I was a size 4.
(Monica, 32, Black)

In this comment, Monica also alludes to an idea shared by many other women, that even though it is acceptable for women to gain a little weight as they get older, they should not let it get out of hand. Over one third of the women voiced their belief that one should attempt to minimize the expected weight gain with age. Some of the women were critical of the idea that aging-related weight gain is natural because they felt that people used that as an excuse to let themselves go. One reason not to gain too much weight is health: when asked if it is more acceptable to gain weight when one gets older, Jill said,

I think it's more accepted for somebody at 40 to be a little overweight than someone at 20. I don't necessarily think that's good because that's when all the health problems start. You know, 20-year-olds don't usually have high blood pressure. Forty-year-olds do and gaining weight is part of the problem.
(Jill, 38, White)

The idea that women naturally gain weight as they get older is voiced with both determined optimism and resignation. Some women see this as a potential problem to combat through correct practices and vigilance, while others recognize that it will most likely happen regardless. There is no clear pattern by dietary status, race, or age to which women remain vigilant and which resign themselves to weight gain. Even women who admit resignation to weight gain work to minimize the gain for health or appearance reasons.

Rory, who links the situation with its societal implications, provides one reason for this situation.

...So with much less effort you can maintain a slimmer physique when you're younger. The amount of effort required as you get older-30s, 40s, 50s, and beyond-intensifies significantly and some people don't want to put that effort into it or don't know. Or even if you do your body is still gonna' change. Women's waists get thicker. Your breasts do droop. Your butt sags a little bit. That's all normal and natural. But it also makes you look-since we equate slim and healthy with your boobs are all way up and your butt's all you could bounce a quarter off your ass and there's never a roll on your stomach. I think broad based society absolutely equates being slim with being young.

(Rory, 29, White)

From the comments of Rory, Monica, and Jill, we can see that aging, and its associated bodily changes are of concern to women, notably because it becomes more difficult to keep a trim, fit physique. This is troublesome on both a personal (as expressed by Monica and Jill) and a social level (as expressed by Rory). The tendency to gain weight or for weight to settle differently as one ages, and thus lose the appropriate, approved body shape is something women worry about as they imagine their future selves.

The majority of the women held the idea that the "overweight self" is a negative self, the possibility of which only grows larger with age. This idea is part of the cultural, and perhaps biological, context that influences the pool of possible selves. In my adjustment to the theory of possible selves, this context helps push the "overweight self" closer to the status of likely than hypothetical self. However, the context also interacts with other aspects of the individuals' experiences and selves, which moderate the salience of this particular possible self. For example, while both Rory and Jill are concerned about gaining weight, they are more concerned about health, making the healthy self more salient to them.

Likely Selves Can be Influenced

Finally, the women agreed that strategic eating could be used to influence the achievement of likely selves. Generally, the women do not think of their eating strategies as part of their identities, but as a means to achieve possible selves. This is most clearly demonstrated by

dieters, who emphasize that they do not want to connect that practice to their identities because it indicates a negative self- the spoiled identity of “overweight” (Goffman 1959). In fact, while these women recognize that they are overweight, they actively resist incorporating an overweight self into their personal identity. Rather, they talk about “doing a good thing for themselves” and “being healthier,” both of which carry connotations of positive future selves. When pressed, healthy eaters are more accepting of a link between their eating strategy and identity because it indicates a positive identity. Healthy eating is seen as enhancing or maintaining a positive current self, whereas dieting is seen as having to climb out of a deficit, a negative current self.

Instead of incorporating their practices into their identities, the women viewed these practices as a means to an end. They viewed eating strategies as a method by which they could achieve, or avoid, their likely selves. They talked about intentionally eating in certain ways to achieve their goals. For example, Rory felt that enacting a healthy eating strategy made her feel:

More disciplined, more controlled, more positive and productive. Like I’ve got a plan and I’m working the plan. I tend to get upset with myself at any venue of life when I’ve got a plan that I know I should stick to and I don’t. Even if it wasn’t possible, I tend to feel as if it was a self-discipline issue even if it wasn’t. And sometimes it is. But generally it’s a big boost mentally and I feel much better physically as well.

(Rory, 29, White)

Rory finds that engaging with a healthy eating strategy makes her feel capable of achieving her positive possible selves, both related to health and to other areas of her life. Generally, negative likely selves were addressed before positive likely selves, but not always. For example, some women are overweight or even obese yet claim to enact healthy eating, rather than dieting as the argument would suggest. For these women, other likely selves are more salient than the “overweight self” is. For some the “healthy self” is more salient due to family health history.³⁶

³⁶ Family health history and genetics played a role in many women’s comments about weight and health. However, most of the women described genetics as only one part of the equation, and not necessarily a determining one at that. Most felt that even genetic predispositions towards obesity or health problems could be overcome through appropriate bodywork.

For others, other non-weight related selves occupy more attention, such as those related to career and family.

As we have seen, there is much agreement about the valence of likely selves, the tendency to gain weight with age, and that an individual can have an impact on the achievement or avoidance of possible selves through behavior change. However, this consensus does not necessarily explain why some women chose to diet and others to eat healthy. The key to understanding this puzzle is to consider likely selves, temporal orientations, and agentic capacity together.

Likely Selves, Temporal Orientations, and Agentic Capacity

As described above, individuals consider possible selves, motivating them to action. Selves that are more likely, immediate, and salient are more motivating than selves that are more hypothetical, temporally distant, or trivial. Choosing a course of action to achieve positive likely selves, or avoid negative likely selves, is an example of **existential agency**. Overall, these women do feel agentic. They feel that they can influence which likely selves will occur. In this case, they feel that strategic eating is one method by which they can achieve a “healthy self” or avoid an “overweight self.” An example of this existential agency would be going on a diet in order to avoid the overweight self.

Success, or even partial success, in such existential agency is very empowering. For example, Rory has recently lost weight, and found it had positive effects on her self-concept:

I know when I lost all the weight, when I lost the 40 pounds my second semester here, I was so relieved because at that point I had a lot of weight here [indicates stomach region], which I typically didn't gain weight there. Starting to get a little bit of a roll going here. I never had that. I was just so happy and relieved. I still feel astronomically better about myself that I did that. Not often, but probably once or twice a week I think back to that time and I am just so happy to not be there anymore. I just feel much more physically and psychologically comfortable.

(Rory, 29, White)

After losing the weight, Rory felt that she had succeeded in avoiding the negative overweight self that she had felt was immanent. Dieting is a short-term solution for an issue seen as a short-term problem. All of the women on diets planned to stop dieting once they lost the weight. Most of these women indicated that once they lost (some of) the excess weight, they would consider eating healthy as an eating strategy. However, at this point, they were unable to commit to the extended time frame required by healthy eating. For these women, the healthy self was a hypothetical self and temporally distant. At this point, they focus on losing the weight and avoiding that negative likely “overweight” self through existential agency by embracing the eating strategy of dieting.

However, some likely selves require extended time horizons due to the amount of planning required, long-term commitment, or extended time horizon of enactment. The healthy self, in contrast to the overweight self, is a positive self, but one which requires significant planning and commitment to truly achieve and maintain. As such, serious healthy eating is an ongoing strategy for living a long and vigorous life. This approach exemplifies Hitlin and Elders’ concept of **life course agency**. This form of agency involves both planning in an extended time horizon and a belief in one’s capacity to implement durable processes.

Healthy eating is a long-term process, which the women considered to be unending.

When asked how long she plans to continue eating healthy, Nancy said:

Oh, forever. I mean it’s not a diet or anything like that. You know you think, “It’s a lifestyle.” But I mean that is what it is. That is what we eat. And it’s not like we’re really restricting things and restricting stuff. It’s what we’ve found, you know, like really good goat cheese tastes better than fried chicken to me at least. I guess that’s fortunate. So it’s just learning what really does taste better a lot of times are things that are better for you or just fresh fruits. I mean I plan to do it forever. We plan for our children to eat this way.
(Nancy, 25, White)

Nancy saw no reason to stop eating healthy, and indeed planned to teach her future children to eat this way to ensure that they found a “healthy self” to be a likely self, or even a core self. Like Nancy, the other healthy eaters held a long-term perspective, and considered achieving this likely positive self as a life project (Giddens 1991). This is evidence of life course agency.

At this point, one final aspect of life course agency must be remarked upon. The healthy self also illustrates the issue of capacity in life course agency. Healthy Eating, which implies an extended time horizon, should automatically be life course agency. However, there are some women for whom the healthy self is motivating, but who lack the capacity for significant extended time horizon planning and commitment. These women want to be healthy selves, but fail in the commitment required to truly achieve the healthy self. This capacity difference will distinguish the two types of healthy eaters described in the next chapter.

The women I interviewed agreed on a number of things, including the status of “overweight” as a negative self and “healthy” as a positive self, that some selves are more likely than others, that age makes an “overweight self” more likely, and that they feel capable of some level of agency in enacting strategic eating. However, the key to understanding the differences in their choice of eating strategies lies in the combination of their likely selves and agentic capacity.

In this chapter, I make two theoretical contributions. I extend the understanding of Markus’ notion of possible selves by distinguishing likely and hypothetical possible selves. Further, by linking the idea of possible selves to Hitlin and Elder’s typology of agency, I extend both theories by linking motivation from possible selves with time horizons and agentic capacity. This contributes to the understanding of possible selves by explaining how one achieves those

selves and contributes to the understanding of agency by providing the motivational context of action.

In the next chapter, I will describe the meaning and practices of four types of eating strategies reported by the women in my sample. I will link these eating strategies to various combinations of likely selves, temporal orientations, and capacities for agency discussed in this chapter. In doing so, I provide an application of Hitlin and Elder's theoretical differentiation of types of agency, differentiating between existential and life course agency in women's eating strategy engagement.

CHAPTER FIVE:

EATING STRATEGIES

Stephanie: My impression [of dieting] is calorie restriction, fat intake restriction, maybe avoiding carbohydrates, and really eating high protein and lean protein, fish and vegetables, that sort of thing. That's what I think dieting is about. You know, cutting out all the bad stuff. No soda. No, you know, none of that kind of stuff. Water and green tea, I guess.

I: How is dieting, then, different from healthy eating?

Stephanie: Hmm. [laughs] You got me. I think that, well, I don't know if it is just a label. Because dieting to me implies restriction and not being allowed to have something where I think healthy eating is more about a lifestyle choice. And I think that there's no stigma attached to healthy eating. And I think the idea of dieting implies that there's some sort of a flaw that you're trying to correct rather than, I don't know. That's a good question. I guess they're really-I mean, other than connotation. Although to be honest I think for a healthy diet you can maintain a certain weight and so maybe you would, let's just say, aim for around whatever, 2000, 2500 calories a day. But I think if I was dieting the goal would be actually to burn more calories than I'm consuming and so therefore I would consume less and maybe I would shoot for again just maybe 1800 or 1500 calories or whatever, less calories a day than I would to maintain. So maybe that's the difference, is actually trying to lose weight. And so if you look at it like an equation.

(Stephanie, 30, White)

An outside observer might expect dieting and healthy eating to be separate phenomenon. However, as implied by Stephanie, the categories of “dieting” and “healthy eating” are not mutually exclusive, nor are they clearly distinguished. In fact, nearly all the women, including dieters, reported that they ate healthy in some way: only four did not claim to eat healthy. However, both definitions and reported enactment of “healthy eating” varied greatly among the respondents. Rather than argue that these women are “wrong” or misrepresenting themselves as eating healthy when they are not, or superficially categorizing them all as eating equally healthy, investigating the orientations and understandings that allow for such a range of activities to be labeled similarly is far more interesting. As we shall see, the devil is in the details and it is

exactly the meanings and goals, or “connotations” as Stephanie says, which distinguish the strategies.

In this chapter, I describe four eating strategies used by the women I interviewed. These four strategies, Standard American Eating Pattern, Dieting, Simplistic Healthy Eating, and Comprehensive Healthy Eating, display a range of commitment to change and healthiness. Dieters, as might be guessed, are oriented towards weight loss and maintenance. They also see themselves as engaging in some healthy eating techniques, but the concept and methods associated with dieting provide the main structure through which they organize eating. Healthy eaters, whether practicing what I refer to as “simple” or “comprehensive” healthy eating, in contrast, are oriented through the goals and methods of healthy eating rather than weight loss. Comprehensive Healthy Eating, as the name implies, involves a well-articulated and thorough conception of the healthful properties of foods throughout the overall eating pattern. On the other hand, Simplistic Healthy Eating, entails the use of only one or two aspects of healthy eating, and is characterized by a less sophisticated articulation of the principles behind eating choices. Table 2 (on the next page) provides a visual explanation of these categories, along with indicating which women comprise each category.

In order to understand one’s choice of eating practices, it is helpful to understand how individuals conceptualize and use those choices. This chapter will explore how dieting and healthy eating are defined, evaluated, and practiced by the participants. I will also examine the reasons they give for following these particular eating practices. The chapter will explore the differences between the four eating strategies, as well as the extent to which these practices differ by age and race. Finally, I will link these eating strategies with the possible selves and types of agency described in the previous chapter.

Table 2. Forms of Strategic Eating by Age, Race, and Weight Status

Age Group	Standard American Eating Pattern	Comprehensive Healthy Eating	Simple Healthy Eating	Dieters
25-39	<i>Monica-32</i>	Nancy-25 <i>Teresa-25</i> <i>Tamara-30</i>	<u>Kate-26</u> Camilla-28 <u>Rory-29^{†*}</u> Stephanie-30 Allison-32 Jill-38*	<i>Dominique-27</i> <u>Dacia-27</u> Angela-30 <u>Rhonda-35[‡]</u> Brenda-38 Cleo-38
40-59	<u>Beverly-51</u> Linda-56[†]	Bridget-45 <i>Annette-53</i>	<u>Elizabeth-41[†]</u> Georgia-44 Elise-47 Carla-48[†] Charity-49 Heather-49^{†*} Carol-59	Brooke-40[‡] <u>Deanna-44</u> Maxine-45[‡] Quilter-55 Pam-59
60-80	<u>Betty-74</u>	Arlene-61 Clara-68	Janet-60 Margaret-68^{†*} Dot-72 [†] Isobel-77	Marie-66

Italics indicates African American Respondent

Underline indicates overweight

Bold indicates obese

[†] indicates respondent also diets sometimes to lose weight.

* indicates respondent claims to use a simple form of eat healthy sometimes, but also describes repeated significant problems enacting it. In other words, practices revert nearly to the Standard American Eating Pattern.

[‡] indicates respondent articulates a comprehensive version of healthy eating, but also expresses a dieting mentality

The Standard American Eating Pattern

Although it is often unnoticed in scholarly writing, the decision to change one's habits to dieting or healthy eating rests on an unmentioned eating pattern *from which* an individual makes such changes. In seeking to fully understand the range of women's eating strategies, I will use the term Standard American Eating Pattern to describe this pattern. Alternative phrasing of this concept includes "the Western diet" (Pollan 2008) and the "Standard American Diet" (Singer

and Mason 2006), using the anthropological “diet” to mean eating pattern. I have rephrased this to avoid the confusion resulting from using both the anthropological usage of the term diet-as-eating-pattern and the lay term diet-as-weight-loss-technique. Although the terminology of “standard American” eating pattern is not currently in use in social theory, it is a recognizable term to the lay reading public, indicated by many internet articles, and even a forthcoming documentary movie scheduled to be released in December 2008.³⁷ One reference for this eating pattern can be found in Singer and Mason’s 2006 book, where the authors provide a rather complete, though unreferenced, description, along with some reasons for its frequency:

The Standard American Diet is high in meat, eggs, and dairy products. Carbohydrates such as bread, sugar, and rice are usually eaten in refined form, which, combined with a low intake of fruits and vegetables, means that the diet is low in fiber. Frequent consumption of fried foods contributes to a high intake of fat, with as much as 35 percent of calories coming from fat, most of it saturated and much of it animal fat. ... It’s a quick and easy way of putting enough food in your stomach to feel satisfied. With America’s low prices for meat, eggs, and dairy products, it’s not expensive either. (Singer and Mason 2006: p. 15)

Other theorists have investigated the historical, and political, development of this particularly American eating pattern. As Critser describes, environmental factors in the form of the fat and calorie content of American food have been a long time in the making (2003). The development of American eating habits occurred during time periods marked by food scarcity, when transportation of fresh produce and fish was difficult. As the country developed, the food processing industries also played a major role (Levenstein 1988). Supported by the establishment of “nutritional science,” advertising, and influence on the FDA and other food-oriented organizations, the products of the meat and dairy industry, along with White bread and flour, secured a central place for themselves on the diner tables of America (Havala 1998). Politics also played a major role in the institution of high fructose corn syrup, the introduction of palm oil and

³⁷ The film, titled *SAD (Standard American Diet)*, is slated to be a drama about the FDA “duping and doping Americans into living a chemical dependent way of life.” Whether this is meant to be an expose, a docu-drama, or fictional is unclear. The movie is directed by Tim Vogel and stars Carrie Anne Hunt and Michael Montero.

other highly saturated fats, and the laxity of physical fitness guidelines (Critser 2003). Even in the introduction to his history of the American table, Levenstein highlights both the taste for sweets and the “American attachment to the frying pan and the consequent greasiness of American foods” (1988: 8).

As America prospered, access to all types of foods increased, including healthier options of fresh produce and fish, but it is difficult to change ingrained habits or to challenge agribusiness monopolies (Nestle 2002). Although the consumption of vegetables and fruits has increased (Levenstein 1988), the cultural cuisine of America continues to center on large quantities of meat, high-fat dairy products such as milk and cheese, refined grain products such as White bread and pasta, and the starch of choice: potatoes. This menu of raw materials is buttressed considerably by the legions of commercial food processors that create the multitudes of prepared and packaged foods on supermarket shelves (Levenstein 1988). At this point, the majority of Americans face not scarcity but an overabundance of food. Four additional problematic aspects of contemporary American foodways join this overabundance of food: the complexity of food choices, busy lifestyles and snacking, increasing portion sizes, and the prominence of fast food.

Commentator Michael Pollan described the complexity in the current food choices in his books *An Omnivore's Dilemma* (2006) and *In Defense of Food* (2008). In these works, he discusses the common notion that there are good and bad foods. While in the abstract this is true, contemporary life is much more complicated. There are numerous categories in between good and bad, such as “good in small quantities” (alcohol) and “ok now, but might kill you in 30 years” (steak). This simple dichotomy is also complicated by multiple types of “good”: good for you (nutritious); tastes good; good for a specific thing (i.e. antioxidants might lower chance of

cancer); and even, as Pollan points out, good for the economy. Thus we have categories of food that taste good, but hold no nutritional values such as candy, and foods that are good for you but do not taste good such as Brussels sprouts. Pollan uses the case of corn and its many derivatives to show how the logics of production, industrialization and economy do not necessarily lead to food products that are nutritious and healthy for people to eat (even if they look pretty and taste good).

There are time constraints in contemporary American society that play a role in eating practices as well. Many people work long hours away from home, leaving little time for food preparation. They also shop less frequently, and thus choosing more frozen and otherwise processed foods over their fresh counterparts. Further, few families sit down to eat together on a regular basis, due to varied schedules of work, school, sports, and other hobbies. Varied schedules, time constraints, and the ease of pre-packaged foods also encourage snacking rather than the eating of real meals. Unfortunately, these snack foods usually contain great amounts of sugars and saturated fats, which have been clearly linked to the increasing rates of obesity (van Amelsvoort, van der Beek, Stam, and Houtsmuller 1988; McCrory, Fuss, McCallum, Yao, Vinken, Hays, and Roberts 1999; Ludwig, Peterson and Gortmaker 2001).

In addition to the types of food eaten is the issue of portion sizes. Although critique of large portion sizes has come in vogue recently when discussing restaurant meals, the American middle and upper classes have long been accustomed to large portions (Levenstein 1988). Despite a decline in the magnitude and complexity of American eating patterns in the early to middle 20th century, the general ingredients remain the same (Levenstein 1988). This is visible in the phenomenon of comfort foods- high carbohydrate, high fat, high calorie foods that are generally accepted to be bad for you, yet are routinely eaten in times of stress due to their

associations with home, family, and happier times, or perhaps just because of good “mouthfeel.”³⁸ Examples include mashed potatoes and gravy, macaroni and cheese, and spaghetti and meatballs, all of which are highly processed foods, especially in their pre-packaged, microwavable incarnations. Of course, these foods are not only eaten in times of stress, but also at family gatherings, holidays, and anytime one fancies a traditional, “home-cooked” type of meal.³⁹

Recognition must also be paid to the cultural institution of fast food. Since the McDonald brothers opened their first drive-through restaurant in 1937, the fast food industry has grown to more than 186,000 restaurants at which Americans spent over \$124 billion in 2004 (National Restaurant Association 2004, cf. Spurlock 2005). Fast food, “family” and “casual” restaurants are consistently criticized for serving highly processed, high fat, high calorie, nutrient poor foods in ever-increasing portion sizes (Schlosser 2002; Spurlock 2005), yet their presence on the cultural landscape continues to loom large. The staples of fast food, hamburgers, French fries, and sugary sodas clearly interlock with the central menu items of the Standard American Eating Pattern, and the agribusinesses that profit from it. A recent Pew Research Center poll (2006b) shows that approximately one third of Americans eat out once a week and an additional third eat at a restaurant two or more times a week. When asked specifically about fast food, 25% said they eat fast food, but less than once a week, 22% reported eating it once a week, and 19% said they

³⁸ “Mouthfeel” is a term used by the food industry to describe one aspect of the experience of eating, the feel of the food in the mouth. “Mouthfeel” also relates to the enjoyment of eating the food. Products are taste-tested for “mouthfeel”, and often sent back for further development, since poor “mouthfeel” can cause the product to fail in the marketplace. “Mouthfeel.” is usually dependent on the amount of starch in the food, and a poor “mouthfeel” can often be rectified by adding starch to the food.

³⁹ The irony of getting a “home-cooked” meal out of the microwave should be self-evident. However, comfort foods do change over time and most young people today have been raised on pre-packaged convenience foods and rarely experience the traditional incarnations. A good example is Macaroni and Cheese. When I was young, my paternal grandmother made macaroni and cheese from scratch with real cheese and milk for family gatherings. At home, the Mac & Cheese my mother made came in a blue box to which one added only milk and margarine. Now, when I make macaroni and cheese, I usually use Easy Mac®, a single service packet to which one only adds water.

eat fast food two or more times a week. While women and older people eat out less frequently, all age groups reported eating out at least once a week.

Combined with a consistent increase in the (sedentary) White-collar workforce and suburbanization, the high fat and high calorie foods that are staples of the Standard American Eating Pattern lead to increasing waistlines (Schlosser 2002). Increased medical knowledge and concern about the links of weight and chronic illness, as well as factors discussed above lead to an urgently weight conscious society. A recent Pew Center poll found that 67% of Americans consider the fact that more people are overweight to be a “major” problem (Pew 2006a). Yet little evidence exists to show that these concerns are having actual effects on the eating habits of the general population.

A few of the women I interviewed did not claim to eat healthy or diet, and described following this Standard American Eating Pattern. Although the presumption indicated by the terminology “standard” is that this eating pattern is likely most common pattern among Americans (and supported by evidence described above), they were a minority in my sample, numbering four in total.⁴⁰ These four women represented every age group, three of these women were Black, and one was White.

Monica is one woman who eats according to the Standard American Eating Pattern. She knows it is not the healthiest way to eat, and is somewhat concerned about her health in the future. However, at this point in time, she is young and still has a relatively small body size, and does not yet feel motivated enough to change her eating habits. Giving up potato chips for Lent last year is as close to healthy eating as she comes. On the other hand, she is somewhat bothered

⁴⁰ This may indicate that people are changing their eating habits, but it is more likely an artifact of my research methods. By advertising for women who are dieting or eating healthy along with women who are not doing anything particular to change their eating habits, self-selection bias likely operated, discouraging women who are not engaged in a particular eating strategy from volunteering.

by the notion that other people see her and think that she is healthy because she is trim, while she knows that health and thinness are not the same.

Other women who continue to enact the Standard American Eating Pattern echo Monica's perspective in knowing that they should eat differently for health or appearance reasons, but are just not motivated enough at this point to do so. Beverly and Linda, both middle aged women, feel that they have too many other things concerning them, such as returning to school for a higher degree and work/family concerns. Betty, an older woman, sees her age of 74 as an excuse, saying that she is "too old to worry about these things now."

Other women also used the Standard American Eating Pattern as the referent in their talk about dieting and healthy eating. Women engaged in strategic eating are making changes away from this pattern. The women also implicated this pattern when discussing times when they would "go off" their diet. As found by other researchers (Germov and Williams 1996), the women I interviewed applied moralistic language, equating falling into these patterns with being "bad" and envisioning maintaining their strategic eating as being "good." In focus group interviews, Germov and Williams (1996) found much consistency in respondents' characterizations of foods into two categories: on-diet/good foods and off-diet/bad foods. Their respondents, and mu own, freely supplied these moralistic characterizations, along with discussing feelings of guilt for eating bad foods.

Dieting: A Temporary Restriction for Weight Loss

The form an eating strategy takes is constrained by the cultural milieu, such as the characteristics of American foodways described above. For example, for a diet to be successful as a commodity, it must not only convince individuals that it works, but that it will fit into their

busy lifestyle. Hence, the increase in “meal replacement” bars and shakes packaged for easy eating on the go. However, the wider cultural climate can also be influenced by particularly successful diet plans: even many fast food restaurants now offer low-carbohydrate versions of their popular items, evidencing recognition of the Atkins diet. This relationship highlights not only the interconnectedness of the diet and food industries, but the sheer size and importance of the diet industry in our society. Each year, the diet industry sells approximately \$33 billion worth of tablets, supplements, bars, shakes, programs, recipes, and food labeled low sugar, low fat, low calorie, and low carbohydrate (Cleland, Graybill, Hubbard Khan, Stern, Wadden, Weinsier, and Yanovski 1998). The diet industry capitalizes on the same cultural conditions that made us fat in the first place. American culture privileges a fast-paced, jam-packed busy life, convenience, and immediate results. In order to sell its products, the dieting industry reminds us that we do not have time to exercise or cook, and are accustomed to quick success. For example, rather than encourage people to avoid potato chips, the diet industry has created Olestra, a form of fat indigestible by humans (and with significant side effects for many people) to make potato chips less fattening. Dieting represents a “have-your-cake-and-eat-it-too” mentality on two levels. First, there is the notion that one can eat whatever she wants, and then diet to lose the weight. Second, the appeals of many diet products, including Olestra, imply that one does not need to give up treats even while dieting.

No wonder dieting is so popular. A recent survey by the Harvard School of Public Health (2005), for example, found that 32% of Americans are counting calories, 47% are watching fat, and 36% are keeping an eye on carbohydrates. A similar survey by the Pew Research Center (2006a) found that 25% of respondents are currently dieting and a little over half (52%) have dieted at some point. French, Jeffery, and Murray (1999) found that a majority of their

respondents had tried reducing fat or calories or increased exercise, although individuals sustained the increased exercise for a shorter period of time than the reduction in fat intake. Overall, these studies and others (Kruger et. al. 2004; Bish et. al. 2005) indicate that a significant number of people are currently dieting, between 25% and 47% depending on the metric used, and over half the population has tried dieting. Further, they indicate that dieting is more popular than other methods of weight loss, such as exercise, and that people had more success in continuing dieting methods longer than exercise.

Among the women I interviewed, 19 reported that they were currently or sometimes engaged in practices related to dieting. They included 9 White women and 10 Black women, and included women of all ages. Twelve of these women are classified as Dieters, and seven of them are classified as Simple Healthy Eaters.⁴¹ Although these numbers are higher than in the general population due to the focus on dieting and healthy eating as the phenomena of study, surveys have consistently found that dieting is quite prevalent.

Meaning and Beliefs: Symbolic Aspects of Dieting

But what, exactly, is dieting? As described in the Introduction, the term “diet” is used to refer to a particular strategy of eating characterized by restriction, outside organization, and/or temporariness. This follows the colloquial usage of the term as the practice of temporary caloric restriction rather than the general anthropological meaning of diet as a generalized pattern of eating. However, such an imposed definition can only provide so much guidance. To understand how women chose dieting as an eating strategy, it is important to understand the conceptions of

⁴¹ Simple Healthy Eaters and the reasons why they might also diet are discussed in the next section, on healthy eating. However, as some do diet sometimes, I have included their views in the discussions of the concept of dieting.

diet they hold. Four major themes emerged from women's talk about dieting: restriction, regimentation, temporality, and the goal of weight loss.

The most common definition of dieting is "restriction." Nearly all the participants mentioned some form of restriction while explaining how they conceptualized dieting. The form of limitation varied, from a general limitation of food to limiting certain types of nutrients (calories, fats, carbohydrates), to even limiting certain times of eating (no snacks, no eating after 9 pm).

Nearly as common are definitions that center on "regimentation" or the following of a plan. In describing this theme, women mentioned having a set menu of foods, being told what to eat and when to eat it, or how to organize amounts or types of foods in a day. Alternatively, when using self-set dieting rules, the women describe keeping track of one's intake as much work. The women perceive a regimented plan as limiting in a different way, limiting the variety of one's food options, as boring. Rory provides a good example:

Dieting to me means following a regimented plan. And some are more regimented than others. For instance, some of the diets they put heart patients on to lose weight quickly that regular people use. That's extremely regimented. Not only do they tell you exactly what foods to eat, how much to eat, the order to eat them in, what you're gonna' eat each day for seven days. Less regimented would be things like Atkins where you're not supposed to eat all the eggs and steak you can could but that's what people do. But there the focus is the types of food you eat and less on quantity. Weight Watchers it's less about the types you eat but quantities that you're eating and how that all plays out. But you need to go and calculate the points and add up all your points and everything you eat you need to know the point value. So a lot of planning, a lot time involved not only in actually preparing food and eating food but also in shopping for food. So I see it as something that's very regimented and time consuming. And also after awhile you get really bored. Like when I had done Weight Watchers, technically you can eat whatever you want but you go for low-points food so I found that I just did the same things over and over because I knew they were low points or I knew how many points they were in general. So I didn't have to spend-I could start using that as a shorthand. I've never eaten so much fat-free bologna in my life.

(Rory, 29, White)

More dieters than non-dieters presented this definition, implying that this notion may develop through actual interaction with diets.⁴²

Women also conceptualized dieting as “temporary.” Dieting was not seen as a permanent way of eating, but rather as a period of deprivation, at the conclusion of which one returns to more “normal” eating patterns. Some participants stated that they would continue to practice some of the methods of a diet after the conclusion of the diet, but never all the practices of the diet. As Rhonda says,

...when I think of a diet, I think of a time limit on something. And I think of the Atkins diet or a Body for Life diet. I don't think Body for Life calls themselves a diet but there was another one where, I don't know if which this was, no carbs, I don't keep up with all the names, the South Beach diet. You know those are things that people go on for a small amount of time and they try and lose weight, to me, and then they go off of them and they gain that weight back. So to me a diet is a limited time period where you're losing weight but you may not keep it off.
(Rhonda, 35, Black)

Rhonda is skeptical of dieting because she views it as a temporary fix. She is critical of the fact that dieting presupposes “going off” the diet and returning to the (unhealthy) Standard American Eating Pattern.

Interestingly, for many women, the goal of dieting as “weight loss” was as much a part of the definition as the method. Thus dieting is limited in applicability to weight control, rather than being applicable to a wide variety of goals.

To me dieting means that you're putting your body on this system where you got to be accountable for everything that you eat. You going through this kind of like a program. I think a diet is like a program where you're trying to get your body to only eat a certain amount of food, to think about food in a certain way, and to set out these specific goals: This what I say I want to accomplish when I say I want to go on a diet. And so it's about sticking to the goals that you set out on: Oh, I want to lose weight to look better. Or I want to lose weight because I'm too heavy for my knees or something. I mean you've got to set out these goals and say, “Hey, this is what I'm gonna' do to accomplish my goal.” And I think that's what a diet is.
(Dominique, 27, Black)

⁴² Although the diets discussed here are undertaken by individuals independently, similar characteristics might also describe doctor-prescribed diets such as low-salt or diabetic diets as well.

In Dominique's view, along with many other women, dieting is the solution to solving weight loss goals. It is interesting that dieting maintains this association despite the fact that it is not always (or even usually) successful (Wadden 1993; Ogden 1992). Further, research shows that many people who actually lose weight on a diet gain it back after the diet is over (Crawford, Jeffery, and French 2000). Yet the women I interviewed, and popular opinion, continue to mentally link dieting as the eating strategy most appropriate as a method of weight loss. This idea, that dieting "works" to lose weight is part of the local knowledge discussed in Chapter Three, and the dieting industry is all too happy to capitalize on (and reinforce) this notion.

The preceding common definitions, and indeed all of the definitions of dieting provided by the participants, are neutral or negative. There were no positive definitions, and no women argued that dieting is a fun or enriching experience. The closest to a positive definition of dieting was that it entailed an increase in control or mindfulness of eating. Dieting did allow women to learn about themselves, usually by realizing how much bad-for-you food (as defined by the diet) that they eat. Thus, by carefully considering before putting anything in her mouth, a woman might gain a sense of self-control or self-confidence by choosing to eat good-for-you foods rather than bad-for-you foods.

I feel like on Weight Watchers you can really eat what you want to eat. If I want to go eat a piece of Cecilia's cake then I can eat that. There's nothing that says that I can't eat it. What I have to be mindful of is how that fits in with the rest of what I'm eating. So Weight Watchers, it takes into consideration the calories, the fat content, and the fiber content. So based on those things I do have a certain amount of food I'm allowed to eat per day. And I'm not supposed to go over that. So if I choose to go get Cecilia's cake then that's fine. That means I need to curb it down for the rest of the day. And then Weight Watchers also gives you-so you have your certain points for any given day on the flex plan. ... And then during the week you have 35 extra points and you can use them anyway you want. So I feel like that gives me-I don't feel restricted. I feel like there's nothing that I just can't indulge in. But being on Weight Watchers, even though I probably haven't been as true to it as I could be, as I should be, I don't feel like it's been restrictive for me. And I feel the freedom to-you know I enjoy eating; I enjoy cooking. But it does help me stay mindful. So I looked up a piece of Cheesecake Factory cheesecake in my little book. And I thought, "Mmmm." I mean that'd be worth it to me. So I'm more mindful of that and I'm more conscious about the decisions I make.

Honestly sometimes I just want a piece of caramel cake from Cecilia's and I'll go get it. And I'm okay with that. Now if I do that every day then I'm gonna' have some issues with that.
(Brenda, 38, Black)

Brenda sees her diet as helping her gain control of her eating habits by thinking about her eating in the context of the meal, the day, and sometimes even the week's worth of food. In this process, she gets to make her own decisions about where or when she wants to "spend" her calories. In this way, she gains self-efficacy by following through on her decisions. However, other women also discussed how this "food calculus" related to a sense of guilt or negativity if they did eat bad-for-you foods.

Describing diet as restrictive and regimented were commonly used to critique diets, arguing that this makes dieting difficult to maintain long enough to lose the desired amount of weight. Similarly, the fact that diets are temporary, with a return to "normal" eating, or even indulgence after the deprivation of the diet, led some women to believe that dieting "doesn't work." By this, they meant either that diets are too restrictive, causing people to break the diet, or that someone may lose the weight on a diet, but that they will gain the weight back after they go back to eating the way they had before the diet. Among many women, there is a sense that dieting at its very essence represents a problematic mindset.

I: Now you said, when I asked you, you said you didn't like the word diet mostly because, if I got this right, it implies something that you go off of.

Kate: Mm-hmm. Or it's like *not a normal way of eating*. I want to be in a place where I'm not thinking of that's on my diet and that's not. It's like, this is the way I eat every day to keep my body moving forward and that's the way I look at it. And I guess technically if you break it down, then there are things that aren't, you know, a part of that. But there's also a part of me that's wants to be able to integrate the chocolate chip cookie and not freak out about it.

(Kate, 26, White, emphasis added)

When dieting, Kate feels anxiety about eating, as if she must justify every bit of food. For her, this represents a focus on food that she feels borders on disordered eating, and she finds that

dieting in general encourages this sort of mentality. Although Kate no longer diets, and has since begun to eat healthy, even women who still diet express similar feelings.

This concern about a “normal way of eating” as voiced by Kate reflects a tension about food choices. On the one hand, both dieters and healthy eaters (discussed below) perceived the focus on food, the stringent rules, and especially the counting of calories, fat, or carbohydrates, as tedious and an unhealthy approach bordering on obsession. They desired an eating pattern that was not complicated or stringent, such that they could eat like (and with) their peers. In such comments, they referred to the Standard American Eating Pattern (SAEP) as normal. However, they also saw the SAEP as unhealthy, and desired a healthier version of it. Yet they perceived healthy eating to be just as or more effort than dieting and were unwilling to make such a commitment.

Related to this issue is the question of whether the women viewed dieting as healthy. There were three general responses to whether dieting is healthy- that it is healthy, that it is unhealthy, or that it is healthy only if an individual has a significant amount of weight to lose. The women’s responses to the healthiness of dieting were similar in terms of race, but differed by age. Half of each racial group felt that dieting was unhealthy, and an additional 25% felt that it depended on the circumstances. By age, however, the pattern is much different. No middle-aged woman said that dieting was healthy, whereas some young and older women felt that it was healthy. Young and middle aged women were more likely than older women to say that dieting could be healthy depending on the circumstances.

Only four women reported that they believed dieting to be healthy. Seven felt that dieting might be healthy in some situations, such as if someone is very overweight, or if someone is

dieting in a healthy way. For example, Stephanie, a 30-year-old, feels that dieting can be healthy under the following conditions:

- Stephanie: If you're doing it responsibly and if it's healthier than your previous lifestyle choices then it can be. I can also see how it can be unhealthy. I can see that if someone is like restricting caloric intake too much or denying themselves certain things or only eating vegetables or something like that I can see how it would be unhealthy. But if it's done responsibly, in general, I don't think it's unhealthy.
- I: And responsibly would be-
- Stephanie: Um, responsibly would be getting enough nutrients, um, not just surviving on Slim Fast shakes, eating real food, and a responsible amount. That sort of thing.

(Stephanie, 30, White)

Like Stephanie, most of the women considered dieting irresponsibly, by not getting enough nutrients, crash dieting, not eating at all, or yo-yo dieting, to be unhealthy.⁴³ As long as an individual does not engage in these practices, dieting can be healthy as a method to lose weight. Part of this perception relates to an implicit comparison of dieting to the Standard American Eating Pattern and the notion that in this comparison, dieting is the healthier option. However, the rest of the women I interviewed considered dieting unhealthy in every situation, as they believed that the restrictive nature of dieting was unhealthy in itself. Because of these health concerns about the nature of dieting, many women said that other methods of weight loss, such as exercise or healthy eating, are healthier or better to think about.

As might be expected, many of the views described above, that dieting is too restrictive, too temporary, or unhealthy, were held by women who now choose not to diet but to eat healthy. However, even dieters hold negative views of dieting. By far, the critique that “dieting doesn’t work” was the most common. Thirteen women overtly expressed this sentiment, including some

⁴³ Crash dieting is a lay term for a semi-starvation diet in which one reduces caloric intake by such a degree that it becomes dangerous. These diets are often successful in the very short term as one does lose weight (by not eating), but quickly regains the weight when they begin to eat again. Yo-yo dieting is also a lay term to describe a pattern of dieting, regaining weight, dieting again, and then regaining weight again. The term comes from a metaphor in which one’s weight bounces up and down like a yo-yo.

dieters. As might be expected, these negative evaluations of dieting act as barriers, perhaps steering women away from dieting or encouraging them to attempt to combine their dieting with healthy eating.

Dieting as an Eating Strategy

Twelve of the women I interviewed are currently engaged in the eating strategy of Dieting. They can be distinguished by their use of an organized dieting plan and a dieting mentality. I use the term “dieting mentality” (Gutwill 1994b) to indicate an experience in which the implications for weight loss (or gain) become the overriding aspect of decisions about food. Although they sometimes critiqued both their own diets and dieting in general, these women freely discussed their diets and were unapologetic about their choice of eating strategy. They viewed it as the best strategy for themselves at this point in time. Every woman in this category of dieting is overweight or obese. It is notable that the majority of women using Dieting are Black (9 Black vs. 3 White.) These women are also predominantly younger (6 women) and middle aged (5 women) rather than older (1 woman). I will elaborate on reasons for these race and age differences in the discussion section of this chapter.

As in any research, life is usually more complex than simple theoretical categorizations allow. This research is no exception and there are women who do not conform to expectations. One example of an exception is Simple Healthy Eaters who also diet sometimes. Although they do diet sometimes, their primary orientation is to healthy eating as they view it. I discuss these individuals, a subset of Simple Healthy Eaters, in that section. A second exception is Dieters who can articulate comprehensive version of healthy eating, but follow a commercial diet plan. There

were three such women in my sample, and I classified them as Dieters based on their use of the commercial dieting plan rather than their conception of healthy eating as their eating strategy.

To understand the phenomenon of dieting, it is helpful to separate a few varieties of dieting. At the most basic level, there are two main strategies of enacting a diet. The first is to participate in or join a commercial diet and the second is to engage in dieting practices on one's own. In the next sections, I will describe the meanings, evaluations, and practices associated with this form of strategic eating.

Commercial diets

Five women were currently using commercial dieting products. These included Weight Watchers, the Atkins diet, NutriSystem, and the Best Life diet. An additional three women were using commercial dieting tools, but not currently participating in the commercial aspect of the program. Most of these women had previously used the diet before, but did not feel that they needed the entire commercial program again. Rather, they felt they could use the tools independently and achieve similar results. For example, Maxine currently uses the Weight Watchers Point System to help regulate her eating, but does not attend meetings. She finds that the structure provided by the point system is enough to keep her on track without committing to the diet completely.

All of the women using commercial dieting products or tools fall into the category of Dieters. Among the eight women using commercial dieting products or tools were five Black women and three White women, four younger women, three middle aged women, and one older woman. Commercial diets are used by a wide range of individuals, with little discernable pattern by age or race. An additional 14 women had tried commercial diets before, and while there were

no racial differences, generational differences did emerge. Nearly all of the young women, twelve out of sixteen (75%), currently or previously engaged with commercial dieting products. In comparison, only 52% of middle-aged women and 25% of older women had engaged with commercial dieting. This implies an increase in the acceptability of commercial dieting products as a viable method of weight loss in our society. However, the fact that many of these women had quit these diets or practiced them without success, or despite previous success chosen alternative eating strategies at the present time, reinforces the notion that dieting is not a long-term solution.

Both in their current diet and in previous diets, women reported using commercial diets for a variety of reasons. One reason was that others (family members or peers) had had success with commercial diets before. Another reason was that the women felt that they needed something to “kick-start” their weight loss, and that the support of the commercial diet would help. Similarly, some women felt that they did not know how to start losing weight and that a commercial diet would provide the needed guidance. Finally, some women reported that they themselves had had success with a commercial diet before, and felt comfortable with the process.

There were also some critiques of commercial diets voiced. One critique is that commercial diets do not really provide any new information that reasonably informed people lack. Another critique is that many commercial diets require one to buy expensive, bad tasting, or overly processed food. Both dieters and healthy eaters voiced these critiques, but generally not women who were currently using commercial dieting products.

Dieting On One's Own

The remaining eleven women who are currently dieting or sometimes diet⁴⁴ do so independently. Dieting on one's own includes a variety of practices. While some discussed eating changes in terms of balance, portion size, increased consumption of fruits and vegetables, or mindful eating, the most common change was limiting things. In response to a question about how she was dieting, Deanna said:

Bread, I'm limiting bread. And no Kool-Aid or anything like that. No tea or anything like that at home. And just actually eating smaller portions. Because I was just reading something that said really when you, for your first 30 days, instead of just completely cutting out, that you should try smaller portions and then you go to the "Whites", and then you start limiting different categories of food out of your diet.

(Deanna, 44, Black)

Deanna, like many women, is attempting to limit foods that contain large amounts of carbohydrates and sugars so that she can lose weight.

Within this group, there were also a few women who reported using external tools as methods of support to help them with their weight loss. These tools included various forms of diet journals, nutrient calculators, and accountability to others. Diet journals are either websites or written journals in which one records all foods eaten along with nutrient information. The goals of these journals are two-fold. First, just keeping track of everything eaten brings to light the often unconscious amounts of food eaten. Second, tallying amounts of calories, fat, carbohydrates, or other nutrients helps one figure out how to limit "bad" nutrients or increase "good" nutrients.⁴⁵

⁴⁴ Six of the women who sometimes diet are categorized as Simple Healthy Eaters (discussed below), and one generally follows the Standard American Eating Pattern.

⁴⁵ Among the lay public, and even in certain medical reports, certain nutrients are considered "bad" in that they are less nutritious and potentially harmful in large quantities. Examples include calories, fat (especially trans fats and saturated fats), and carbohydrates (especially sugars and refined grains). Other nutrients are considered "good" in that they are more nutritious (or more nutrient dense), and generally perceived to be beneficial. Examples include proteins and vitamins. The use of "good" and "bad" terminology clearly indicates an applied morality, as discussed by Germov and Williams (1996).

Changing Notions of Diet

In dieting, the primary focus of the strategy is weight loss or weight maintenance. However, in light of the valuation of healthy eating and the devaluation of dieting, many women sought ways to combine their dieting with healthy eating practices. In fact, all the women who utilized dieting eating strategies reported enacting some form of healthy eating, usually a simplistic form of healthy eating.⁴⁶ However, in further discussion about their practices, it became clear that this was not true healthy eating, but an attempt to utilize the notions of healthy eating along with their diets. This accomplishes two things for the women. First, it neutralizes some of the negative meanings associated with dieting. Second, it bolsters the women's feelings that their dieting is a health behavior. In an amusing way, this desire to seem healthy even when dieting (even unsuccessfully) can be seen in this *Cathy* comic.



Figure 2: *Cathy* Cartoon related to “healthy diets.”

⁴⁶ As discussed below, in the Healthy Eating section, these simple forms of healthy eating conceptualize healthy eating through only one or two dimensions.

One way the women claimed to be eating healthy was by equated healthy eating with the directives of a particular diet, such as Weight Watchers or the South Beach Diet. Often, a diet chosen strictly for weight loss contains some aspects of healthy eating, which the Dieters embrace as their own understandings of healthy eating. The women in this category also use Simple versions of healthy eating to make better choices among diet-approved food choices and perhaps even to choose a diet that sounds like it is healthy. Many commercial diets, especially Weight Watchers, do describe themselves as “healthy living plans;” a conceptual move designed to avoid the negative perceptions of diets discussed above.

It is important to note that the diets these women follow might indeed represent “healthy diets.” None of the diets under discussion are crash diets or diets that require eating only certain foods, like “the grapefruit diet.” Further, if the comparison eating pattern is the Standard American Eating Pattern with no restrictions, then these diets are indeed healthier as they encourage consuming more fruits, vegetables, and lean meats; limiting refined grains, sugars, and excess calories; increasing balance and variety in meals, considering vitamin and mineral intake, and increasing exercise. However, even if particular diets do incorporate simple (or even comprehensive) versions of healthy eating, the diet is providing the healthy eating guidance, rather than the individual developing her own healthy eating practices.

Viewing the diet as a “lifestyle” was also an important theme that emerged through these women’s discussion about their practices. Many of the women, even though following a particular diet, talked about the negative connotations of dieting. For example, Rhonda, who is on Weight Watchers, explained how she thought about dieting in general and Weight Watchers in particular.

I don’t like to use the word “diet” because I think it’s a very negative term. I don’t think diets work. I think it’s a matter of changing the way you do things for good. And to me, when I think of a diet, I think of a time limit on something. And I think of the Atkins diet

or a Body for Life diet. I don't think Body for Life calls themselves a diet but there was another one where, I don't know if which this was, no carbs, I don't keep up with all the names, the South Beach diet. You know those are things that people go on for a small amount of time and they try and lose weight, to me, and then they go off of them and they gain that weight back. So to me a diet is a limited time period where you're losing weight but you may not keep it off. So I don't like the use the term diet at all and I struggle with it. I think on one of those papers you have there and also in the email that you sent me, because even though I follow Weight Watchers it doesn't mean it's not a diet. I've reframed the way I think about food and how I eat food for the rest of my life, not for a certain period of time. So I prefer not to use that term. (Rhonda, 35, Black)

In this quote, Rhonda articulates how short-term dieting is problematic and that a long-term change is necessary. She feels so strongly about this that the term "diet" no longer applies.

Rather she thinks about Weight Watchers as a "lifestyle." Rhonda goes on to explain other ways Weight Watchers has changed her lifestyle, encouraging healthier habits like not having a cookie jar on the counter, using pre-packaged 100-calorie portion controlled snacks, and eating more fresh vegetables (rather than canned). Lifestyle refers to one's combination of living practices, but beyond simply operating as a descriptor, the concept of "lifestyle" has come to indicate status through consumption. In our consumption-oriented culture, the promise of particular lifestyles (most often those of the wealthy, beautiful, and popular) is sold along with products, with marketing implying that the purchase of the product will lead to the glamorous life depicted (Featherstone 1987). Beyond advertising, lifestyles have come to indicate taste. By making the correct choices, one indicates his or her cultural capital (Bourdieu 1984). Further, the appeal to lifestyle indicates a connection with identity, implying that one's lifestyle constructs her identity or true self (Giddens 1991). In this situation, reconceptualizing their diet as a lifestyle signifies that they are aspiring to the status (and identity) of "healthy person." Further, by recasting the diet as a lifestyle, Rhonda sees this strategy as a positive change in her life rather than a period of restriction, thus increasing her self-efficacy. Most of the other women in this category also made similar claims, and considered their diet to be a lifestyle. By attempting to reconceptualize their

diets through appeals to the notion of healthy eating as a lifestyle, these women are displaying their cultural capital (Bourdieu 1984) in knowing the socially valued eating strategy.

Incentives to Dieting

Even though there is much agreement about the drawbacks of dieting, many women still engage in it. To understand why, it is helpful to return to the definitions of dieting discussed earlier. One common definitional theme was the notion that dieting is for weight loss. This conceptualization clearly links the practice of dieting with the goal of weight loss, while the women consider healthy eating not to “work” for weight loss. Thus, when an individual seeks weight loss, they naturally turn to the practice most clearly connected with that goal. For many women, this connection persists despite logical reasons not to diet. For example, Dominique, who is on the Atkins diet, explains why she continues to diet:

- I: What I’m hearing you say is that even though you’re not sure it’s that healthy-
- Dominique: Yeah. [Laughs]
- I: Even though you feel it’s kind of really restricted,
- Dominique: Yeah. [Laughs]
- I: Even though you’re not, you know, you kind of have some concerns about it, you’re still doing it.
- Dominique: Right. [Laughs]
- I: Because it works to lose weight?
- Dominique: Well, I’m still doing it for about two, three reasons. One, it does work and I haven’t been able to find anything else that has worked for me. Two, another reason I decided to do it was because I had my blood work done before I started back on it and everything came out good so that’s why I was thinking maybe I’m eating healthier than what I feel like I’m eating. And the third reason I’m doing it is because I feel that it really helps me stay in control because when I’m doing it it’s like I’m in control because I know exactly what-and even when I say I’m gonna’ take a break from for a month, it still helps me stay in control. This diet has taught me a lot about myself, a lot about my eating habits, which I thought well, I’m eating pretty good but I have this like, I’m gonna’ have a bag of pretzels they’re so nutritious. That’s what diet people want us to believe. That’s another reason do it. It has really helped me, I guess, really get to know me. What kind of things work for me, what kinds of things shouldn’t I eat, what kinds of things. I may be eating ramen tomorrow but some things probably should just be, you know, very, very

off limits. I can't tell you when the last time was I ate rice.
(Dominique, 27, Black)

Dominique has given this issue quite a bit of thought, but finds that the benefits of dieting outweigh her concerns about healthiness and restriction.

Another reason women continue to diet relates to the prevalence of the (unhealthy) Standard American Eating Pattern. Some Dieters view dieting as the only way to get to a position in which healthy eating would operate as a viable weight maintenance method. When asked if dieting was healthy, Brooke had this to say:

No, I don't. I really don't. I think that you really are talking about to have a healthy lifestyle period you just need to make good choices. And I think people have to diet because you have a cumulative effect of not making enough good choices. So, no. I don't think dieting is really-you know, it's a big industry in the US but it's necessary because we're making a lot of bad choices. And a lot of the foods that are produced that we consume, the packaging, whatever, they're really not good for you. And the portions you eat out. You know, you get a big plate and you eat it. And you don't need to eat it. It's not their fault that you're eating it all but we've gotten to this sort of over-consumption mentality. So I don't think dieting is a real healthy thing but I think a lot of us do it to try and get back into a healthier lifestyle.
(Brooke, 40, White)

Brooke feels that if she can just lose the extra 60 pounds she carries around, she could switch to healthy eating practices. However, she does not believe that healthy eating alone will enable her to lose the weight, necessitating a diet.

Despite negative connotations and beliefs about the unhealthiness of dieting, many women continue to diet. To feel better about themselves, many Dieters engage in meaning (re)construction. Quite a few utilize formalized diets and accept the directives of those diets as "healthy eating." Others sought to recast their dieting practices as lifestyle changes. Yet despite the negative views of dieting and the mental effort of meaning negotiation, dieting remains closely conceptually connected with weight loss, leading women to engage with dieting as the most appropriate method of weight loss.

HEALTHY EATING: A PROCESS OF CHANGE

The majority of women in the sample claimed to eat healthy to some degree. However, the descriptions of healthy eating provided by the women varied greatly. This variance likely results from the lack of unambiguous, applicable, and clearly legitimate guidance from “experts” as discussed in Chapter Three. I could not find a single academic study that measured the prevalence of healthy eating. This lack of research may well reflect the inadequacy of definition of the term “healthy eating.” As among the lay public, healthy eating is a concept used by many researchers, but not clearly defined by any. As discussed in Chapter Three, part of the problem is the nature of the scientific model. The scientific model has a premise of testing and retesting, with a high likelihood that any one “fact” may become untrue in the course of further testing. However, diet, weight, and health research seems to be particularly susceptible to contradicting claims. This issue leads to problems on two levels. First, there is a lack of definitive advice, which causes confusion about the “truth.” The second problem caused by this back-and-forth advice is that it makes implementation difficult. With little outside definitional influence, there is an extremely close correlation between the meanings women express about healthy eating, the evaluation of these strategies, and its practical enactment. However, it is useful to disaggregate these dimensions to see how meanings and evaluations influence the choice of practices

Among the women interviewed, the concept of *healthy eating* emerged as a commonly used concept, but one that was also often un(der)defined. This may indicate three possibilities: (a) healthy eating is a concept that is well defined in the popular consciousness to the extent that everyone knows what it means; (b) healthy eating is an undefined concept that individuals use without knowing its meaning; or (c) healthy eating is a generic term that individuals define for

their own use, but feel it unnecessary to define for others. I found evidence for all three possibilities.

The women had real difficulties differentiating the concept of healthy eating from the practices that comprise it due to the extremely close alignment of these dimensions in their understandings. Women used the term healthy eating as if I would know what it meant, but had difficulty articulating their meaning of the concept. When pressed, most women used one of three major themes to explain healthy eating: choosing the right foods, avoiding unhealthy foods, and balance. These themes, although undoubtedly healthier than the Standard American Eating Pattern, display a limited understanding of healthy eating. As women's talk about the concept mirrors the themes found in their talk about the practices of healthy eating, I shall discuss them together.

Healthy Eating Strategies

Despite nearly all of the interview participants claiming to eat healthy, the descriptions of healthy eating provided by the women varied greatly. Although there were similarities among the descriptions, a more detailed analysis yields a better understanding of how women are truly using healthy eating strategies. There are actually two forms of healthy eating expressed by the women I interviewed. Both the strategies of Comprehensive Healthy Eating and Simple Healthy Eating have the specific goal of eating healthy, but differ by level of complexity. A third sub-strategy is one of simplistic healthy eating with occasional use of dieting for weight loss. Despite this occasional dieting, the clear primary focus of this strategy is healthy eating. I will describe each type of healthy eating more fully below.

Comprehensive Healthy Eating

Comprehensive Healthy Eating is a version of healthy eating with an explicit all-inclusive focus. The goal is to increase one's health by considering all aspects of eating: gaining all required nutrients without overloading on any. This particular practice also seems to achieve a balance between pleasurable eating and the more onerous exclusion or limiting of certain problematic foods. As a result, Comprehensive Healthy Eating tends not to dominate one's thoughts as would be the case if one were exhorted to avoid over-indulgence. Of the seven women who practice Comprehensive Healthy Eating, four are White and three are Black, and every age group is equally represented.

Motivated by both health and appearance reasons, Arlene decided to enact a more comprehensive form of healthy eating.

Well, let me explain that two years ago I decided I needed to lose weight. And within the last two years about 40, 45 pounds. Up to that point I never really given it a great deal of thought. I'd gone to the doctor and my cholesterol was higher than it should have been. And I said I don't want to be on medicine so I would try to control it by eating. So I pretty much conscientiously changed eating at that point. Since then I mostly eat vegetables and fruit and a whole lot less meat although I still eat a lot of cheese and milk but I gave up ice cream-not gave it up-but drastically reduced the amount of sweets in my diet and starchy kinds of foods in my diet. I eat them all. There's nothing I've totally given up. I guess the quantities have changed and I'm more conscious of what I eat now. ... Um, because I used to eat more pasta, rice, potatoes, desserts, um, more meat, although I've never been a real big meat eater. I ate more than I do now. It's nothing really-I haven't given up any food but the emphasis is sort of switched. And trying to eat more fruit, more vegetables, green vegetables, red vegetables, those kinds of things. And a minimum amount of sugars and snack kinds of foods. Not cheeses, those kinds of foods, I just try to-not avoid them totally because then you feel deprived-but just not have them very often and when you have them, just have a little.

(Arlene, 61, White)

As indicated by Arlene, Comprehensive Healthy Eating incorporates multiple healthy practices in a variety of aspects of eating. Arlene thinks about what she eats, how much she eats, and the nutritional content of her food. She does not deny herself foods she likes, but does not over-indulge. She considers the overall proportions in her diet: lots of vegetables and fruits, reduced

meat, dairy, sweets, and starches, and considers fat and sodium contents. Only seven women, including Arlene, could both articulate and claim to enact a comprehensive version of healthy eating. It is important to note that there is no easy way to categorize healthy eaters. For example, three of the Comprehensive Healthy Eaters are also vegetarians, but three other vegetarians only expressed what I am referring to as “Simple Healthy Eating.” Three additional women described a comprehensive form of healthy eating, but as they drew their ideas and enactment from commercial diets, I categorized them as dieting-focused.

Simple Healthy Eating

The vast majority of women described both conceptualizations and enactments of simple versions of healthy eating. The descriptor “simple” is not a term used by the women I interviewed; rather it is a term I am applying to indicate that this is a more simplistic form of healthy eating than that discussed above. In comparison to Comprehensive Healthy Eating, Simplistic Healthy Eating utilizes only one or two aspects of healthy eating. Women utilizing this form of healthy eating often linked it to making lifestyle-type changes in their overall eating patterns, but these changes only focused on one or two aspects of healthy eating. The most common of these changes were choosing the right foods, avoiding bad foods, and balance.

Choosing the right foods included choosing foods that have clear manifest health properties, especially vegetables. Using fresh fruits and vegetables is one of the major descriptors of healthy eating practices among these women. Simple Healthy Eaters vocalize this strategy predominantly, whereas women who describe a comprehensive form of healthy eating rarely mention it. This indicates the banality of such concerns to Comprehensive Healthy Eaters, further evidence of the difference between the two groups.

A second common focus in Simple Healthy Eating is the idea of avoiding unhealthy foods. When asked what comprises healthy eating for her, Georgia described the following.

Staying away from sweets, staying away from doughnuts-I guess that counts as sweets-but heavy carbohydrates with no nutritional value. I just, for years, I've just been aware of what's good for your body and what's not. And even the good food you can eat too much of. Like bagels are great for you but you can eat too many bagels. Whole wheat bread is great for you but you can eat too much bread. So I've just worked at it for years and years and years to have, uh, trying to eat more vegetables. We don't do much with vegetables, a lot of salads and stuff but I know that's something we need to be eating more of. And I mean, is that kind of what you mean? ... Like fruit, when I fix the kids lunches, I don't do this for myself or [my husband] but I'll always put fruit in their lunches because I know that needs to be part of their lunch. Just always kind of trying to sneak stuff in like carrot bread or pumpkin bread, or something like that, trying to get the extra vegetables in there.
(Georgia, 44, White)

For Georgia, “healthy eating” means that she strives to limit her intake of sweets or carbohydrates, while trying to eat more fruits and vegetables. Georgia also maintains that the foods she avoids are not inherently unhealthy, but that they become unhealthy with over-indulgence. Other women talked about still eating unhealthy foods sometimes, but using portion control to limit the negative effects. In this way, they could still enjoy chocolate or cheese without feeling guilty for eating too much of it.

The third theme of healthy eating conceptions and practices was balance. Balance was discussed both with reference to balancing types of food eaten (balancing a fattening lunch with a salad for dinner) and balancing caloric intake with exercise. The women felt that this “food calculus” enabled healthy eating to allow for “mistakes”- they could correct any unhealthy eating relatively easily through portion adjustment at other meals or exercise.

On the surface, these individuals either seem to be new to healthy eating practices or were otherwise engaged in placing emphasis on the few changes they had made. An important theme that emerged in this group was the effort involved, while this theme was absent in the discussion of Comprehensive Healthy Eating. In discussing simple forms of healthy eating, many women described their efforts in terms of “trying” and described their efforts as varyingly

successful. For them, this was not an easy process. They described working very hard at enacting and maintaining these modest changes. Three factors combine to make healthy eating difficult for these women. A first factor may be that these are indeed significant changes for these women in comparison to their previous unhealthy patterns. A second factor is the continuing prevalence of the Standard American Eating Pattern, which is generally supported by our culture. A third factor may be the individual's knowledge of healthy eating. Recalling the points made in Chapter Three, many women were frustrated by the ambiguity of health mediated information and relied instead on local knowledge. This local knowledge, comprised of collective, embodied, and personal knowledge, may be incomplete, leading to an incomplete conception of healthy eating. The key here is that these practices may be healthy, but that they are viewed in isolation- with the notion that an individual can change one dimension of eating practices while leaving others unexamined.

Simple Healthy Eaters who diet sometimes (a subset)

A handful of the women who enact Simple Healthy Eating also occasionally diet to lose weight. When they did so, these women all devised their own diet rather than using commercial diet products. For example, Elizabeth (41, White) knows its time to go on a diet when her clothes get tight. When her clothes become so tight that they begin to annoy her, she knows she's about 20 pounds overweight. She begins a very regimented plan focused on controlling her intake of calories and fat. Her diet usually lasts one to two months, fizzling out as she approaches her normal size and her eating strategy takes a backseat to other more pressing concerns of family and career. She slides back into her usual pattern of Simple Healthy Eating, until her clothes begin to feel tight again.

These six women felt that the version of healthy eating that they were enacting did not consistently maintain their desired weight. Perhaps this situation stems from a greater inconsistency in their eating patterns than they reported (or realized), or the fact that they have not made enough changes to actually lose or maintain their weight. The fact that these six women used a simple rather than comprehensive form of healthy eating likely indicates that they had not made enough dietary changes to prevent weight gain.

Evaluations of Healthy Eating

In general, healthy eating was a positively valued term. The women perceived healthy eating as a system of positive practices, which would result in both a healthier body and a general sense of physical well-being. Nancy says that healthy eating is:

about eating what your body needs to function. I mean I kind of think of food as fuel. I mean it's also a pleasurable thing so sometimes you eat things you don't need like ice cream and stuff just because it's good and that's a good thing. So for me it's about both eating what you need for fuel purpose and then also having a healthy kind of psychological relationship with food. So it's not necessarily about being restrictive; it's more about making choices that are gonna' make your body run better and that are gonna' make you feel good to eat them. (Nancy, 25, White)

Overall, as Nancy indicates, this way of eating is an ongoing process with positive results throughout. In addition to making one's body feel better, numerous women talked about truly enjoying the taste and flavor of healthy foods. This is in contrast to previous research that found that individuals attempting to eat healthy did not enjoy it, but undertook these practices only for the healthy benefits (Charles and Kerr 1988; Murcott 1993). This may relate to increased availability of a greater variety of healthy foods in both restaurants and grocery stores.

The process aspect of healthy eating is significant as most women, including those practicing either Comprehensive Healthy Eating or Simple Healthy Eating, felt that they could be eating even healthier in some way or another. In other words, they were aware of steps they

could be taking to improve their eating practices further. One limitation, however, was the belief that the costs of increasing their commitment to healthier practices would outweigh the benefits that such a commitment would provide. Some vocalized structural issues, that it would take more time, energy, or money than they felt they either had or could devote to their plan of healthy eating. This is one of only two critiques of healthy eating that emerged. The notion that it costs more to eat healthier is common not only among the women I interviewed, but among the public as well. For example, this cartoon highlights this dilemma many women feel when trying to eat healthy.



Figure 3: On a Claire Day Cartoon related to Healthy Eating.

Other women vocalized taste and pleasure reasons when describing why they did not eat healthier than they did. For example, some said they just liked cheese or chocolate and felt that they compensated for those treats at other meals. Some felt satisfied with their current practices. They felt that their health was fine and that only additional diagnoses would push them to make more changes. Further, some felt that allowing themselves to have ice cream or chocolate occasionally was part of maintaining sound mental health. The notion that healthy eating, lacking

the focus on restriction characteristic of dieting, allows for such occasional treats was one of the attractions of healthy eating. As Jill says,

Healthy eating is being balanced. Not giving up ever eating chocolate again or ever eating something sweet again but balancing that with the knowledge that if all you eat is junk food then your body's going to fall apart. So it's more-at any point you have a choice whether you're going to pick up an apple or a Snickers bar. And if you have a Snickers bar once a week, that's fine. If you're having a Snickers bar every afternoon then that's something you need to address. ... Um, if you say, "I'm never going to eat chocolate again. Chocolate's off the list because it's bad for you. I can't have fat because it's bad for you. I can't have salt because it's bad for you" it's not going to be realistic. If you say, "Okay, I'll have a bag of chips now and have a salad at dinner instead of French fries or something like that." It's making those balances and knowing if I have something sweet now then I'd have to, you know, not have any bread with dinner tonight, that kind of thing.
(Jill, 38, White)

While this lack of structure is appealing to some women, like Jill, other women implied that such a lack of accountability that may lead to too many lapses in practice. Some women also critiqued healthy eating because it was not an efficient method for weight loss, especially for someone who is already eating somewhat healthy. For example, Carla said:

I think it's viable as a weight-loss strategy for an awful lot of people who don't eat healthy but probably not for the people that do. Does that make any sense? I mean if you were-and I work with people who do this. In fact one of the women I work with did lose weight. They take turns and they go buy what I would consider junk/fast food for lunch every day of the week. So one of the women I work with decided she wasn't gonna' do that for lunch every day of the week anymore and she did lose weight. She probably lost 10 or 15 pounds and kind of felt better. Got rid of the hamburgers and chicken. And they're Black women so there's a lot of greasy stuff in that culture's diet. So for them, yeah. If your thing is greasy, junky food, eat more vegetables would be a viable weight-loss strategy. But if you're already eating a lot of vegetables then eating more vegetables isn't gonna' make you get any skinnier.
(Carla, 48, White)

Switching to healthy eating may help one lose weight when it is a new pattern, or as other women indicated, when one has a great amount to lose. In these instances, the healthy eating is a major change for the body, and functions like a diet. However, when one already eats somewhat healthy, or is close to their appropriate weight, the women believed that healthy eating would not cause one to lose weight. Of course, also connected to this critique is the notion that weight loss through healthy eating is extremely slow, and therefore frustrating, in comparison with dieting.

Healthy Eating is generally understood by the women as the practices that comprise it, and they have few ways of describing it beyond those practices. The evaluation is generally positive, encouraging its enactment. Some women articulated and practiced a comprehensive version of Healthy Eating. However, most women hold simplistic understandings, equating healthy eating with one or two practices such as eating vegetables, avoiding unhealthy foods, and balancing one's meals. These findings echo previous attempts to understand people's conceptualizations of healthy eating (Keane and Willettes 1996; Charles and Kerr 1988). Most women also felt that they could eat healthier in various ways, but that the costs of doing so outweighed the benefits.

Eating Strategy Challenges

In addition to the challenges to specific strategies, including taste and cost of food, the women described a number of other factors that influence their success in changing their eating strategies in general. These factors cut across every eating strategy, and center on the difficulties of going against the grain of the Standard American Eating Pattern.

Many women felt that the health advice was not always practical to implement. Quilter, a middle aged African American woman, talks about the problems that arise with the attempt to implement healthy eating advice:

At some point you make choices because the truth is there's something wrong with virtually everything we do. So I think what you end up doing is picking and choosing what makes sense for you. And for me to say, "I will never eat another grilled hamburger," or hot dogs are my favorite. Just the hot dog itself is a problem because that's supposed to be full of crap. But to say that I would never eat another one just doesn't make sense to me. I mean it's not that significant. I don't do it every day. ... I try religiously to eat vegetables and put them in my life. And fruits. I religiously have at least two apples a day. Those kinds of things I am really likely to do. I am much less likely to, for instance, eat corn and carrots because of the high-sugar content. I'm much more likely to eat something like broccoli or blueberries because I know the value of those. So, yeah, I'm willing to do it. But we talked before-I mean I've learned that it really is such a

process because by not having that manual from the very beginning, the way we do when we get older, you're then talking about rewiring yourself. And food, because it has meant so much to us, so much more to us, than just nutrition, that hardwiring can be difficult. I mean if you think about how much food affects our lives. I mean you don't go to a party and there's no food. It just doesn't happen because [Laughs] food is part of what we consider to be a good time. ... And I think because of all of those connections that we have outside of just the nutritional value, the hardwiring gets reiterated sort of over and over and over again so when you try to take those things out it becomes much more than just, "I know this is bad for me. I shouldn't do it." (Quilter, 55, Black)

Clearly, enacting all these bits of advice makes for complicated eating! Given this long list of healthy eating prescriptions, one might be tempted to wonder about the litany of health problems experienced by this woman. However, Quilter does not have any particular ailments, but undertakes to enact these healthy eating prescriptions only with the aim of "being healthier" and accepting the advice that following such advice may forestall ailments down the road.

Quilter's quote above also highlights some of the difficulties of changing one's eating habits. Often healthy eating advice implies that the individual has complete and unambiguous control over her food life. In practice, however, some changes to eating strategy are difficult for practical reasons, emotional reasons, and social reasons. Other women talked about whether adding healthy items to one's strategy is practical with regard to cost, ease of access, taste, and ease of preparation. Often the women also had to consider the tastes and nutritional needs of other family members, social interactions over foods, and time constraints due to work schedules. Previous feminist social theorists have commented on the fact that women, as the primary caretakers of families, often place the needs of their families and other commitments before their own (DeVault 1991). Dieting and healthy eating is no exception. When women are responsible for the cooking of food for the family, as well as the shopping to keep the pantry stocked with foods the family enjoys (DeVault 1991), one might think that women could easily move their families into a more healthful mode of eating. However, the comments of the women I interviewed indicated the opposite pattern: the likes and dislikes of the family had a tendency to

keep the families, and the woman's, eating patterns in less healthy states. Among the women who engaged in Comprehensive or Simple Healthy Eating, those who had partners or other family members who also ate healthy reported more success. When the couple, or the whole family, ate healthy, there was both more support for the woman in question and a tendency to have only healthy foods around the house. Nicole Pallotta found a similar process of success or difficulties among young vegetarians: parental support played a large role in the ease of transition from eating meat to vegetarianism (Pallotta 2005).

Another potential problem is social eating. It might be argued that our American culture does not support dieting or healthy eating. Most people see dieting, healthy eating, and weight control as personal issues although this often overlooks the extent to which social factors profoundly influence them. For example, workplace norms of birthday celebrations, lunch meetings, or after-work happy hours may instigate eating strategy difficulties. Similarly, family dynamics can have an influence at holidays or when the rest of the family is not on a diet and tempting forbidden foods lurk around every corner. Kearney, Rosal, Ockene, and Churchill (2002) report that a majority (55%) of women dieters felt pressure to participate in social eating, while only 20% received social support for their diet. Kearney and colleagues (2002) also found that women who were unwilling to risk social disapproval and felt "unable to change their routines with work, family, or friends" were less likely to adhere to their diets.

The women I interviewed described facing these challenges. Black women in particular described the social pressures to break their diets or healthy eating patterns at family gatherings, barbeques, and even by work colleagues at lunch. Maxine describes her experiences:

Maxine: If I'm going somewhere with my non-African American friends. I mean, you go out, you have green salads and you have all these wonderful fruits. It's a balance. But when I'm out with my family that is nowhere on that plate. If you got salad, your choices are gonna' be either French or ranch and nothing has low-fat even though everybody is-I'm going

back to that cultural thing-even though everybody, the majority of the people there, have been diagnosed with diabetes and high blood pressure. So that makes it challenging when I like this weekend going to these different events which most of them will be with family members. It will not be presented and when I bring my own I'll be ridiculed. It won't be to the point where it's-it's just made fun of.

I: But you'll be teased.

Maxine: Yeah. Teased is more like it. So that makes it challenging when I want to spend time with my family, eating with them, to have those choices available to me. (Maxine, 45, Black)

Maxine feels that she is under scrutiny when with family, to the point that they overtly criticize her for her healthier behaviors. This teasing is a form of social sanctioning for not conforming to the same eating pattern as everyone else.⁴⁷ White women also felt these pressures, especially around the holidays, but described them as less intense than the Black women.

Possible Selves, Agency and Eating Strategy

At this point, I can connect the eating strategies observed with the possible selves and types of agency discussed in the last chapter. I argued there that a synthesis of possible selves and types of agency was most helpful in understanding the enactment of eating strategies. The first step is identifying likely selves, those possible selves that are more salient and immanent. In this situation, the overweight self and the healthy self are two such selves. For Dieters, the overweight self is a likely self, which they seek to avoid by dieting. Healthy eaters, on the other hand are attempting to achieve the likely self of the healthy self. While individuals in both groups may also hold the other self mentioned, the difference is in the priority accorded to it. For example, some Dieters talked about their diet as a way to be healthy, implying that they also held a healthy self as a possible self. However, their focus at this point is to lose weight, indicating

⁴⁷ Some might argue that African Americans have a distinct culinary tradition, but I would argue that these traditions are only a subset of the Standard American Eating Patterns. If anything, traditional Southern-style or Soul Food is likely even less healthy than the Standard Patterns as it is based on making the most out of the cheapest types of foods available, using much fat, salt, and sugar to make these less-desirable food stuffs more palatable.

that their overweight self is more salient. Similarly, some healthy eaters are overweight, yet achieving the healthy self is more salient to them than the overweight self.

Another thing that distinguishes healthy eaters from Dieters is a self-perceived capacity to develop an eating strategy on their own. Dieters, especially those on commercial plans, rely on the diet to tell them what to eat and what to avoid. Dieters felt that the structure (rules) and regimentation of the diet was necessary for them to achieve weight loss. Healthy eaters must develop their own eating strategy rules. They felt that they had the ability to develop and carry out a set of guidelines to achieve their goals. In this way, the healthy eaters exerted more agency than the Dieters did.

Thus far, I have not remarked upon the distinction between the Simple Healthy Eaters and the Comprehensive Healthy Eaters. This distinction relies on the second step, considering types of agency available to the individual. The two types of agency under consideration, existential agency and life course agency, are distinguished by time horizon of focus and capacity to make and follow through with long term planning. Both Dieters and Simple Healthy Eaters enact existential agency in that they are capable of embarking on an eating strategy and following it for some amount of time. However, they lack the confidence to make major changes in their eating patterns and the commitment to long-term significant change. Comprehensive Healthy Eaters display an ease of change not present among the other groups. For the Comprehensive Healthy Eaters, there is little “trying” to eat healthy, they just do. They have learned the multiple aspects of healthy eating and made this method part of their lives.

To sum up, what distinguished Dieters from healthy eaters is a priority on avoiding a likely overweight self. What distinguishes Comprehensive Healthy Eaters is the capacity of life course agency. The Simple Healthy Eaters exerted more agency than the Dieters did, but less

than the Comprehensive Healthy Eaters. Of course, what distinguishes those who continue in the Standard American Eating Pattern is that they have not yet made any significant changes to their eating strategy.

Discussion

In this chapter, I have outlined the meanings and practices of four eating strategies. I have also shown how these eating strategies relate to the possible selves and types of agency discussed in the previous chapter. The salience of possible selves provide direction and motivation for action, but it is an individual's agentic capacity determines the type of agency enacted. However, the racial disparity between Dieters and Simple Healthy Eaters cannot be ignored. In this section, I will address these differences.

Numerous theorists have proposed that African American women may experience dieting, and the pressure to diet, in different ways from White women. Stevens, Kuamanyika, and Keil (1994) found that older Black women had a more positive self-image of themselves than comparable White women did. However, my findings indicate a clustering of Black women in the dieting group. While I hesitate to draw definitive conclusions from such a small sample, my result suggest support for a different theory. A number of researchers (Gard and Freeman 1996; Robinson, Killen, Litt, Hammer, Wilson, Haydel, Hayward, and Taylor 1996; De Souza and Ciclitira 2005) have proposed that the pressures to be thin are apparent beyond the traditional focus on White, middle-class women as American culture is becoming more homogeneous across social class. Yet there are also racial differences within women's eating strategies. In contrast to Comprehensive Healthy Eating, which is equitably distributed, far more White women than Black women utilize Simple Healthy Eating. On the other hand, far more

Black women than White women diet. Two factors likely contribute to this situation: objective degree of obesity and differences in habitus.

First, while a majority of the interviewed women felt that they were overweight, more Black women than White women felt that they were overweight. More White women, on the other hand, felt they were not or only slightly overweight. When I calculated the BMI of the respondents, 50% of the White women were in the normal category, 10% were overweight, and 40% were classified as obese.⁴⁸ In comparison, 18% of the Black women were within the normal weight category, 32% were overweight, and 50% were classified as obese. Thus, Black women were likely to weigh objectively more than were White women, likely increasing the desire to lose weight. As found above, the eating strategy most connected with losing weight is dieting. For most White women, on the other hand, being healthier rather than losing weight seems to be the top priority (as there is less weight to lose) and (simple) healthy eating is the eating strategy perceived as the best method of achievement.⁴⁹

However, simply being overweight did not distinctly divide Dieters and Simple Healthy Eaters as there were overweight women in each group. Dieters see dieting as an appropriate response to being overweight. Simple Healthy Eaters, despite being overweight, see dieting as unhealthy and shortsighted. The differences between Dieters and healthy eaters cannot be explained by social class differences because all the respondents consider themselves to be middle-class. While there are far more Black women who diet and White women who use simple

⁴⁸ Body-Mass Index, is a metric of body size that combines weight and height. This metric is often used by the Centers for Disease Control and Prevention for determining health and overweight/obesity status. A larger Body-Mass Index is indicative of a larger body-size. Body-Mass Index is calculated by the formula: BMI= (weight in pounds/height in inches/height in inches)x703. For reference, a Body-Mass Index of 18.5 or less is considered underweight, above 25 is considered overweight, and above 30 is considered obese (WHO 1995).

⁴⁹ Some alternative findings do show that White women engage in dieting despite being objectively less overweight. Biener and Heaton (1995) found that among White women who were dieting, 47% were within a normal weight range (BMI < 25). The amount of time between Biener and Horton's study and my own may be at least partially responsibility for our different findings.

versions of healthy eating, this is not a pure effect of race. Rather, it indicates a difference in habitus among Black and White women. Habitus, as defined by Bourdieu (1977), is a culturally specific way of moving through the world, a set of predispositions of doing, speaking, and thinking. It includes ideas, values, and beliefs, including ideas about what forms of action are appropriate in which contexts. It develops based on previous experiences, especially during the formative years of childhood and adolescence. Although habitus tends to be "naturalized" in that it is taken for granted or assimilated into the unconscious, it forms a "worldview" that can distinguish individuals from various social groups.⁵⁰ In this case, habitus differences are visible in different norms of social interaction that the Black and White women I interviewed faced at family and social gatherings.

The Black women described frequent family and friend gatherings at which traditional southern African American food was served. In the course of our discussions, many Black women like Maxine described the problems they faced in attending these gatherings while attempting to eat better. The food available at these gatherings, which usually consisted of the same menu repeatedly, is rooted in traditional southern poor Black folk foods. This includes chicken fried in lard, barbequed meats with lots of sauce, cornbread, and greens cooked with ham for flavor. These foods contain high levels of both fat and salt. Further, additions to this traditional menu are not much healthier, consisting mainly of (non-diet) soda or alcoholic beverages, potato chips, and lettuce salad with (full fat) ranch salad dressing. The women I interviewed had tried various ways to minimize the impact of these gatherings on their eating strategies, with little success. Women in these communities take pride in their cooking, and not

⁵⁰ Bourdieu generally describes habitus with reference to socio-economic class, but does not preclude the possibility of habitus functioning based on other characteristics such as gender or race. Aaron Cicourel has argued that the notion of habitus needs to be expanded to include gender, ethnicity, and other social groups within a dominant culture (1993). Other theorists, including Katherine McClelland (1990), Diane Reay (1995), and Lo and Stacey (2008) have utilized habitus in its current form in discussions of gender and race.

eating is perceived as a social slight, as is bringing one's own food or condiments. The women I interviewed described all manner of teasing and cajoling encouraging them to partake of the food. In the end, many of the Black women felt that going on a diet provided them support and boundaries that their friends and family could understand. Saying that they were on a diet indicated that there were strict boundaries that could not be crossed, and so they could not eat the food. In contrast, saying that they were eating healthier implied permeable boundaries, and that they could eat a little (which often quickly turned into too much).

The White women I interviewed also described social eating as potentially problematic, but not to the extent expressed by the Black respondents. White women mostly discussed social eating as an opportunity of temptations for themselves, not as a situation in which they felt social pressure from others. In contrast to the Black women's descriptions, White women told of holiday parties which mostly consisted of "small bites (appetizers, finger foods, and desserts), potluck gatherings to which everyone always brought something different (with the expectation that attendees pick and choose among the offerings), or gatherings at which healthy food options were already at least part of the menu. In these settings, the women could more easily control their eating. Further, the phrase "I'm trying to eat healthier" may be met with something along the lines of "oh, its not that bad (for you)," but will generally be respected as a boundary line. Thus, White women may also use the concept of diet as an understandable demarcation of foods in social settings, but they feel less need of it as the concept of healthy eating carried equal weight.

Recent research on racial differences in diabetes treatment outcomes supports this argument. Thomas Sequist and his colleagues found that White patients were significantly more likely than Black patients to gain control of their diabetes symptoms (2008). While there were

some differences due to sociodemographic factors, the vast majority of the differences occurred between patients of the same doctors. In other words, this is an effect not of racial disparities in doctor treatment, but of racial differences in outcomes with the same treatments. The authors argued that these differences reflect racial-cultural differences in ability to enact doctor prescriptions (Sequest, Fitzmaurice, Marshall, Shaykevich, Gelb Safran, Ayanian 2008). Rather than attacking the patients' failure to "correctly adhere to prescriptions," the authors propose that a "one-size-fits-all" approach does not adequately satisfy racial-cultural differences in patients' daily lives.

Habitus differences (Bourdieu 1977) influence which eating strategies will work, in that differences exist in the social world in which an individual interacts. The Black women shared a habitus characterized by frequent food focused gatherings and a predominantly high-fat, high-salt, traditional food pattern. Overtime, they developed dieting eating strategies to allow themselves to gain control over their eating and maintain positive relations with their kin. The White women, on the other hand, experienced a world in which healthier options are present more often and the effort to eat healthier is more easily accepted.

Habitus (Bourdieu 1977) also organizes the content of the local cultural knowledge that women use to filter mediated health information as discussed in Chapter Three. Most obviously, the everyday and collective knowledge are influenced by habitus, but habitus also influences the observation and defining of experiences of the body that form embodied knowledge as well as the likelihood of developing a store of personal knowledge. This is illustrated by the fact that the White women in this sample were slightly more likely than the Black women to pay "some attention" to research about weight, dieting, and health. Further, they felt that they had more control (agency) over their food choices. For these reasons, they may feel more comfortable

using knowledge gained from various sources to construct Simple Healthy Eating patterns. The Black women in my sample, paying less attention to such research and feeling more pressure to eat traditional foods may feel more comfortable utilizing the structure provided by a diet to organize their eating strategies.

The racial habitus differences (Bourdieu 1977) identified in this chapter indicate that race remains a significant factor dividing social groups. Combining the theories of possible selves and types of agency provides the outline of a process by which eating strategies are chosen. However, it is also clear that habitus imparts conditions under which this process occurs. Only by considering these cultural differences can researchers fully understand the continuing racial disparities in research on health concerns.

In this chapter, I have described the meaning and practices of the four eating strategies represented among the women I interviewed, the Standard American Eating Plan, Comprehensive Healthy Eating, Simplistic Healthy Eating, and Dieting. First, the Standard American Eating Pattern, represented by only 4 women, is not viewed as an ideal. The women in this category felt that there were healthier ways to eat, and other respondents used this category as an unhealthy reference category. On the other end of the scale, a small group of women (7) enacted a Comprehensive version of Healthy Eating. These women have completely changed their eating habits, and healthy eating becomes “normal eating” for them. Comprehensive Healthy Eating is an example of life course agency. These women have both the extended time horizon perspective and capacity to carry out significant changes in their eating strategy.

Most women undertook a Simplistic version of Healthy Eating, utilizing one or two aspects of healthy eating. In this category, we can most clearly see the impact of the problematic

effects of the onslaught of health information. These women see health information as ambiguous and rely on local knowledge to guide healthy eating. Local knowledge is often incomplete, resulting in an incomplete version of healthy eating. Most of these women find enacting Simplistic Healthy Eating to be difficult (and some are even forced to diet occasionally). They do accept that such change is important, but they are unwilling or unable to change their eating habits completely. As such, Simple Healthy Eaters lack the capacity to enact life course agency and are only successful in enacting existential agency. However, they are enacting more agency than Dieters are, as they must construct their own healthy eating strategy.

The fourth eating strategy is dieting. Most of the women on diets are on commercial diets, and they accept the goals of the diet as “healthy eating.” They see dieting as a health behavior in the instance of large amounts of weight to lose, as losing weight would avoid the links of obesity with various chronic illnesses. However, both Dieters and non-dieters did not generally consider dieting healthy. Despite its unhealthiness, women dieted because they see it as “what works” to lose weight, their primary goal at the time. These women are enacting existential agency by choosing to diet.

CHAPTER SIX:

CONCLUSION

In this dissertation, I have investigated the way in which women chose an eating strategy. I use the term “strategic eating” to indicate intentionally adjusting ones eating pattern with some goal in mind. Both dieting and healthy eating are forms of strategic eating. Overall, my research suggests that this choice of eating strategy is neither trivial nor direct. Rather, this choice involves the evaluation of mediated information, local knowledge, consideration of possible selves, and agency. I have argued that in the face of the ambiguity of healthy eating advice, women to rely on three types of local knowledge to evaluate both claims and the “experts” making those claims. Likely possible selves, the time horizon considered, and agentic capacity also influence eating strategy outcomes. Together, women combine information, knowledge, possible self goals, and agency to enact one of four eating strategies: the Standard American Eating Pattern, Comprehensive Healthy Eating, Simplistic Healthy Eating, and Dieting.

Two major paradigms meet in this investigation. On the one hand, ideas of health imply a realist assumption, a practical concern with the physical realities of life. For example, the rise in obesity is likely related to changing American foodways and the increasing recognition of the unhealthful aspects of the Standard American Eating Pattern. Further, the current era has seen a growing ratio of older individuals in society and an increasing expectation of living longer. These issues increase attention to health as a means of extending life. On the other hand, notions about the body as a carrier of meaning rest on notions of social constructionism. In this

paradigm, changing ideas of the body and the rise of the reflexive self combine to provide a social context in which the body is perceived as an important indicator of the self. Both these paradigms inform our understanding of the body as the most intimate connection between the self and the world. Like many other things, the body is a physical object invested with meanings. However, as the “visible self,” the body is also deeply connected to an individual’s sense of self and identity, and all the meanings inherent within. The challenge of sociology of the body is to find ways to integrate these two paradigms. This dissertation is a step in this direction by examining the way women work to align their bodies with their self-concepts.

Summary of Chapter Findings

In the first substantive chapter (Chapter Three), I explore healthy eating advice as a case study of the ways women respond to mediated information. Together, concern about risk (Beck 1992) and the notions of healthism (Crawford 1980) encourage individuals to take responsibility for their own health, but also imply blame in the event of negative outcomes. I discovered that many women find the mediated onslaught of health information to be confusing and ambiguous. In light of this, they rely on three types of local knowledge to help make sense of the complexity and evaluate the “experts.” These three types are: a) personal knowledge, an individual’s accumulated store of learned and researched information; b) embodied knowledge, an individual’s sense of well-being and knowledge about how one’s own body operates; and c) collective knowledge, the combination of everyday knowledge and advice from family and friends. Together these forms of local knowledge form a set of filters through which new information must pass before acceptance. This situation is evidence that individuals are critical consumers of information and that they are exerting agency through this process of evaluation.

Chapter Four explores the role of the body in the self-concept, providing a basis for motivation. After presenting the theory of Possible Selves (Markus and Nurius 1986), I adjust the theory to distinguish likely selves from hypothetical selves and synthesize the theory with Hitlin and Elder's (2007a) theory of types of agency. The salience of likely selves, time horizons, and agentic capacity distinguish among the four eating strategies described in Chapter Five.

Chapter Five describes four types of eating strategies reported by the women I interviewed. These strategies included the Standard American Eating Pattern, Dieting, and two forms of healthy eating. Comprehensive Healthy Eating is a significant, well-rounded form of healthy eating that considers health in all aspects of the eating pattern. Simplistic Healthy Eating, on the other hand, incorporates only one or two aspects of healthy eating, and is often unsuccessful at maintaining desired weight levels. I examined the understandings the women held about these strategies along with the practices involved. Finally, I linked the eating strategies with the possible selves and types of agency described in Chapter Four.

Likely possible selves provide direction and motivation to action, separating those continuing to follow the Standard American Eating Pattern from those engaged in other strategies, and separated Dieters from both types of healthy eaters. However, enactment is limited by an actors' capacity for agency. Comprehensive Healthy Eaters are capable of planning and sustaining significant changes in their eating patterns over an extended time horizon, exhibiting life course agency. Simple Healthy Eaters, however, fail to commit fully to change and thus are only able to exert existential agency.

The Role of Age and Race

An initial expectation for this project was that one's choice of strategy would depend on whether one focused on health or appearance goals. However, connecting goals and practices reveals that the situation is not so simple. A majority of both White and Black interviewees reported that health was the ultimate goal of their strategic eating, but differences did emerge with regard to age group. Among the young women (25-39), the balance between eating strategically for health and for appearance was nearly equal. Among middle-aged women (40-59), slightly more women were interested in health. But in the oldest age group (60-80), almost all the women were interested in health exclusively. From this, one would expect dieting to cluster among the young women and the healthiest eating patterns to cluster among the older women. However, the practices described do not map onto this pattern. Other factors such as age and race are at work, and in this section, I will discuss the overall impact of these factors.

I did not find any age differences in eating strategies. Women of all age groups expressed an interest in losing or maintaining their weight, and did so through Dieting, Simple Healthy Eating and Comprehensive Healthy Eating. As mentioned above, almost all older women were interested in losing weight exclusively for health rather than appearance reasons. This finding coincides with other research on middle-aged women's weight concerns. Kate Bennett and Robin Stevens found that although women over 50 were heavier and had higher ideal weights, they had similar levels of weight anxiety as younger women (1996). This anxiety translates into practice. Renner, Knoll and Schwarzer (2000) found that individuals reported more intentions to eating healthier as they aged. Clearly, middle aged and older women are immune neither to body dissatisfaction, nor to the impulse to do something about it. Putterman and Linden (2004) found that there was an age difference with respect to reason for dieting: older women were more likely

to diet to improve their health while younger women were more likely to cite appearance reasons. In a qualitative study, Clarke (2002) found that older women viewed attempting to lose weight solely for appearance reasons indicative of vanity but loss for health reasons legitimate. However, they also recognized that appearance was in reality usually *at least one* of the reasons for losing weight. Tunaley and colleagues (1999) found that all the older women they interviewed wanted to lose weight, but also felt that the unavoidable nature of aging allowed them some release from personal responsibility for their weight gain. Interestingly, although they recognized the bias in sociocultural beauty ideas and resisted them by arguing that they “shouldn’t have to worry about such things at their age,” they still wanted to be slimmer, providing appearance reasons for this desire. These findings suggest that the concern with weight and appearance may be more closely tied to cultural values than it is to personal history. As such, the concern to be healthy and avoid being overweight does not end as one grows older. This suggests that age may be declining as an important variable, at least in this context.

Race also appeared to be less important than expected. Racial differences emerged only in distinguishing Dieters and Simple Healthy Eaters. In contrast to the category of Comprehensive Healthy Eaters, which was comprised equally of White and Black women, the category of Simple Healthy Eating was comprised predominantly of White women and mostly Black women populated the category of Dieting. I argue that in this situation race operates in conjunction with obesity and habitus (Bourdieu 1977). The Black women in the sample were objectively more overweight than were the White women, but there were also obese White women who enacted Simple Healthy Eating. I argue that this situation is a result of different habitus (Bourdieu 1977), including ethnic food traditions and styles of social interaction. I argue that the structure of a diet, especially a commercial diet, provides support to resist more

entrenched cultural food traditions like frequent social gatherings centered on (unhealthy) traditional Southern cooking. Having strict rules about what one can and cannot eat provides more support than “eating healthier,” which has permeable boundaries. Habitus differences, including those based on race, continue to be a significant factor in differences in the enactment of body work such as eating strategies.

Differences between the women did not appear by race or age as expected. Despite varying in age and race, the women I interviewed were all middle-class, college educated women who currently or previously had careers which provided them with independence and the skills to research information through their doctors or online. Further, they felt they could afford to purchase strategic foods relatively easily and incorporate them into their eating patterns. These findings indicate that cultural influences are more important in determining eating strategies than social categories of age and race. Appearance is still important at older ages. Individuals still want to look attractive not for vanity or even for the opposite sex *per se*, but for their own sense of self. Even position in the life course seemed to have little impact on health advice evaluation, consideration of possible selves, or strategy enactment. Race also did not play a significant role in health advice evaluation or possible self consideration. However, it did play a role in choice of eating strategy, reflecting a habitus difference.

Simple Healthy Eating: The New Norm?

Overall, I find the most significant finding of this investigation is the shift in eating strategy norms. In previous eras, there seemed to be two options- eat what everyone else ate, or go on a diet. Now, a middle ground of eating healthier exists, and it has become predominant. The Standard American Eating Pattern (SAEP) is now recognized as unhealthy. I believe that

eating healthier is the new normative ideal. It is what the majority of people now do, or aspire to do. While the data presented in this dissertation does not allow me to speak to whether a majority of the public is actually participating in this eating strategy, I can identify it as the eating strategy most valued by my respondents. Through their talk, they indicate that this strategy is viewed as the strategy in which people *should* engage. All of the women in the SAEP category felt they *should* eat healthier, but have not yet made the necessary changes. Similarly, many of the Dieters said they *would* eat healthier once they have lost the weight. The emphasis on “should” and “would” indicates a normative ideal.

I use the phrase “eating healthier” rather than healthy eating to distinguish the Simplistic version of Healthy Eating, which is recognized by all as healthier than the SAEP, but not as extreme as Comprehensive Healthy Eating. While Comprehensive Healthy eating may be objectively healthier than Simple Healthy Eating, it is still viewed as unattainable or undesirable by many people. Occasionally some still describe Comprehensive Healthy Eating as an extreme form of eating. In their comments about (Comprehensive) Healthy Eating, Isobel used the phrase “a health nut” and Bridget was keen to reassure me that she “wasn’t a saint.”

Inherent in the Simplistic version of Healthy Eating is the notion of an ongoing process of change in small steps, always eating healthier than you were before. It is important to separate this notion of process from the notion of life course agency discussed before. Life course agency involves an extended time horizon and capacity to sustain a course of action. Seeing Simple Healthy Eating as a process implies a series of small changes, which may not be part of an organized plan and any one of which may or may not be successful. However, the overall arc of small changes continues. In this way, individuals are likely doing some good for themselves.

While many people are not sure exactly what comprises eating healthier (because of all the conflicting information and new health research findings), there is a recognition that they need make the effort to eat healthier. As a process, nearly every woman felt that she could be eating healthier than she was currently, if the benefits outweighed the costs. As scientists conduct more research, healthy eating will continue to shift and so entails an acceptance of continual change. In such a situation, there is no rigid definition of “healthy eating” and a singular definition likely never will exist. So all there can be is *healthier*, an openness to the possibility of change. Simple Healthy Eaters embody a willingness to listen, evaluate, and change. They may not change completely, but they are trying to make changes, and are willing to continue to make changes, as they are convinced and able. This shift also reflects the increasing importance of health, both in a practical sense (we have more knowledge about ways to improve health) and in a sense of social meanings (visual aspects of health indicate things about one’s identity). The lack of any respondents who are willing to say that they diet without also having a concern to try to eat healthy is a testament to the pervasive nature of health.

Although many women found it difficult to articulate a meaning for healthy eating separate from the practices that comprise it, the women universally viewed it positively. The definition of healthy eating aligns with (purportedly) easily enacted strategies. However, when one’s conceptualization of healthy eating is limited, as in Simple Healthy Eating, it may not be as successful. Many women discussed the amount of effort they felt healthy eating required as stressful and an obstacle. Further, some women found that these barriers eventually necessitated a combination of dieting and healthy eating as they failed to lose weight.

Dieting was also a common practice, but the women viewed it far more negatively. The women described dieting as restriction, regimentation, and temporary, but also as effective for

weight loss. Multiple women characterized dieting as an unhealthy way to lose weight, as it often implies crash dieting or over-restriction. However, many (often the same women) also consider dieting to be an effective way to lose weight, at least in the short-term. This recognition that dieting is unhealthy, but may work for at least a little while, seems to lead women into attempts to combine dieting and healthy eating. Some women who use Simple Healthy Eating as their eating strategy also diet sometimes when they feel that their healthy eating strategy is failing to maintain their weight. Dieters attempt to utilize the notion of healthy eating to mitigate the negative connotations of dieting in two ways. First, by accepting the directives of a formalized diet as if they were healthy eating. A second approach, supported by the rhetoric of the diets themselves, is to recast these “diets” as “healthy lifestyles.” Both approaches allow dieters to feel as if they are making healthy choices, as encouraged by healthism in the risk society.

The fact that these Dieters appealed to notions of healthy eating is significant. A health discourse has become embedded in the culture. This finding indicates that the meaning and goals of dieting are also changing. The traditional understandings of dieting, as a restrictive, temporary method of weight loss, are losing favor, even among its adherents. In 1996, Germov and Williams found that respondents clearly distinguished between weight loss and health, and associated their motivations for weight loss with appearance concerns. Further, they recognized that dieting required a “trade-off” with health and that the two could not be pursued simultaneously. However, other studies have found that health was a common reason for wanting to lose weight. Biener and Heaton (1995) reported that nearly two-thirds of their respondents were dieting for health reasons, compared to 37% dieting for appearance reasons. More recently, O’Brien and colleagues (2007) reported that the majority of individuals interested in participating in a weight loss program cited health reasons (50%), while only 35% cited

appearance reasons and 15% cited mood reasons. As my findings and these studies suggest, many people now see dieting as a way to lose weight *in order to* become healthier.

One example of this shift is visible in a rhetorical change of commercial diets moving away from the language of “diet” toward the language of “healthy eating.” For example, Weight Watchers has a new marketing campaign that centers on the slogan “Diets don’t work- Weight Watchers does.” This slogan denies the fact that Weight Watchers is a diet, seeking to avoid the negative conceptions of dieting. Other programs accomplish the same rhetorical leap by calling themselves a lifestyle or a health program. By using these phrases, diet programs both distance themselves from the negative connotations of “diet” and appeal to people on the basis of bettering one’s health.

Both the shift in dieting rhetoric and the decrease in the acceptance of the Standard American Eating Pattern indicate a rise in Simple Healthy Eating as a new normative ideal. This is not a perfect situation, as Comprehensive Healthy Eating is undoubtedly healthier than the simplistic version, but it does represent steps in the right direction. The public is increasingly aware of the need to consider their own health as the notion of individual health risk responsibility also becomes ever more prevalent. Individuals learn ways to do so through mediated health advice, which must pass through a filter of local knowledge before it is eventually accepted as legitimate. Further, the body is assumed to be an indicator of the self. A trim figure is considered to indicate both social value and (invisible aspects of) health. On the other hand, obesity is equated with socially undesirable traits including negative stereotypes, social ostracism, and ill health. In this context, a trend toward healthy eating will likely continue. However, as few individuals are fully capable of sustaining long-term life projects (Smith 1996), most of these attempts result in Simplistic Healthy Eating.

Directions for Future Research

While social research answers some questions, others invariably arise in the process. First, this analysis privileges an understanding of healthy eating based on personal knowledge about the healthful properties of foods. This conceptualization avoids the issue of the truthfulness of Weight Watchers' claim to being a "healthy living plan" because it is a plan in which members are told what and how to eat. Alternative definitions of healthy eating may exist, although they seem to be extremely hard to find. In general, an alternative conception of healthy eating based more directly on practices rather than intention or beliefs may encourage different distinctions than I have drawn here. Certainly, a clear definition of healthy eating needs to be developed for use by both researchers and the public.

Second, this research is based on respondents' self-reports of their practices. This raises the issue of whether they were truthful or complete in their reports. Even more in-depth qualitative research involving respondent recorded food journals might provide more insight into the methods of eating choice and challenges therein. However, this sort of methodology would require a far greater time commitment on the part of respondents, an option unlikely without dedicated research funding for recompense of respondents.

It is possible that there are also class culture differences (Laureau 2003) at work here, providing women with different worldview in which they approach eating strategies with different perspectives and tools for enactment. Focusing on self-described middle-class women, I did not examine the role of class in this investigation. Future research that collects more information about individuals' family of orientation would be more suited to address such a theory. Further, it would be beneficial to examine the ways working class or poor women

attempt to incorporate healthy eating into their eating patterns, and how they conceptualize that effort.

This investigation has also raised some additional questions not organized around limitations in the current study. As mentioned above this research focused on middle-class White and Black women. Expanding the focus to include Hispanic individuals, men, and/or lower class individuals would be illuminating. Do they seem to experience the same processes? Do other factors come into play, such as different cultural norms that privilege unhealthy food in the name of masculinity or community identity? Answering these questions would require a series of comparative studies focusing on each of these under-studied groups.

Further, both the Simplistic Healthy Eaters and the Dieters stated that they would continue to try to eat healthier in the future. It would be interesting to follow up with these women ten years in the future to examine if they are in fact eating healthier than they are now. And if not, what other factors are preventing their intentions from becoming reality? Such a study could also more fully investigate the long-term implications and challenges of eating healthy on one's sense of self.

Conclusion

Eating Strategies are an example of how culture influences individual's behavioral practices to a greater degree than social categories. Cultural knowledge (both mediated and local) about health, healthy eating, and dieting constructs women's ideas of these concepts, and influences their choice of practices. Culture also influences women's eating strategies through the medium of ideas about the self, which reflect cultural ideas about health, weight, appearance, and aging.

This research analyzes the meanings and motivations of eating strategies as forms of bodywork among contemporary American women. Interviews with women reveal that these forms of bodywork are important to women's sense of self and identity as attractive, healthy women. These women develop their plans for bodywork action (or inaction) through an analysis of their current and possible selves as well as drawing on messages about the body and health from local and media cultures. The negotiation of these messages, local knowledge, and possible selves motivates women to choose various eating strategies, which are a type of agency. Differences in habitus and capacity for agency distinguish among types of eating strategies.

What is of broad interest to sociologists about this project is the contribution to understandings of the relationship between the individual and the social in the contemporary world and specifically the role of the body, and body modification practices, in the creation and maintenance of the self. The body, including both its function and appearance, is an important aspect individuals consider in their sense of self. This occurs not only in a nominal sense (i.e. whether one has a fully functioning body), but also in an evaluative sense (i.e. whether one had a "good body," an attractive body, a pleasing body, a healthy body, etc.). Obviously, the body is used in this evaluative way not only by the individual herself, but also by others. Thus, our perception of the body is not only interior, how it feels and how the individual thinks it looks. It is also a part of the criterion used by others in social judgments, and by extension, is a major aspect of the "looking-glass construction" of the self. This example of the looking-glass self is one of the simplest to use to explain Cooley's classic concept, yet somehow fails to be given much credence in actual sociological study.

Perhaps this is a lingering result of Cartesian dualism's privileging of the mind/self over the body, which also has the effect of encouraging a wide conceptual gulf between the two. This

gulf makes it difficult to think about the connections between the mind/self and the body, a challenge to which sociologists of the body have turned their attention along with scholars focusing on gender, race, and more recently, sexuality and disability. As their studies and the present research indicates, the body, as the vehicle of our mind/self, does indeed have important effects on experiences, outcomes, and yes, even the construction of the self.

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APPENDICIES

APPENDIX A:

INTERVIEW SCHEDULES

A1. INTERVIEW GUIDE FOR A “NORMAL EATER”

I. General Eating Habits

A. Tell me about what foods you regularly eat.

1. What are some of the foods you especially like?

B. How do you feel about eating?

1. Do you enjoy eating?

2. Do you ever feel guilty about the foods you eat?

C. Do you like to cook?

1. What types of food do you like to cook?

D. How often do you eat out?

1. What sorts of restaurants do you like, go to often, etc.

E. Describe for me some of your typical meals

a. (at home or eating out at a restaurant)

b. (also discuss timing of meals in context of daily schedule)

1. Breakfast; Lunch; Dinner; Snacks; Beverages

F. What sort of things have you eaten in the last few days?

1. Are they typical of what you usually eat?

II. Role of Weight Loss in Life

A. Concepts:

1. In the preliminary questions, I asked if you diet. You said no. What does the term “diet” mean to you?

2. In the preliminary questions, I asked if you incorporate healthy eating into your lifestyle. What does the term “healthy eating” mean to you?

a. Why don’t you eat healthy?

b. Are there things stopping you from eating healthy?

B. Do you have a strategy about eating? How do you decide what to eat?

C. Are you worried about your weight?

1. If yes, continue. If no, skip to B.

2. Why are you concerned about your weight?
 - a. What are some reasons you want to lose weight?
 - (i.) Are any of the reasons related to how you look to the opposite sex?
 - (ii.) Are any of the reasons related to your interest in clothing?
 - (iii.) Are any of the reasons related to physical discomfort?
 - (iv.) Are any of the reasons related to health issues?
 - (v.) Are there any other reasons we didn't mention?
 - (a) (probe any the are affirmative)
 - (b) Can we talk a little more about...
 - b. Do you think you're mostly motivated by appearance or health reasons?
 3. Are you actively doing anything to lose weight right now?
 - a. If yes, continue. If no, skip to 4.
 - b. Type
 - c. How long have you used it?
 - d. Goals
 - e. How much weight do you want to lose?
 - f. How long do you plan to continue this weight loss method?
 - (i.) If indefinitely: do you think you will continue to lose weight the whole time, or will you have a different type of goal then?
 - (a) Will you enter some type of maintenance stage at some point?
 - (b) What will this maintenance stage be like?
 - g. How's it going so far?
 - h. Why did you choose this weight loss method?
 - (i.) Did you consider other methods of weight loss? Like what?
 - (a) Did you consider dieting?
 - (b) Tell me about why you decided against dieting?
 - i. How will you know when the weight loss attempt has worked?
 - (i.) Is it only about losing weight, or is there more?
 - (ii.) Have you noticed other positive changes?
 - (iii.) Have you noticed any negative changes?
 - (iv.) How will you know when a diet doesn't work?
 - (v.) What will you do then? (when it no longer works)
 - j. Do most people close to you know about your weight loss attempt?
 - (i.) How about friends? Co-workers?
 - (ii.) What do they think about it?
 - k. How much time do you spend thinking about your weight loss attempt?
 - (i.) What are some times when you think about it?
 - (ii.) Do you talk to other people about weight loss?
 - l. If what they're doing sounds like a diet,
 - (i.) Why don't you consider what you do to be a diet?
 4. Why aren't you doing anything to lose weight?
- D. Why aren't you concerned about weight loss?
1. Do other people ever talk to you about weight loss? (theirs or yours)
 - a. Who talks to you? Can you give me an example?
 - b. How do you feel about these interactions?
- E. How much time do you spend thinking about your health?

1. What are some times when you think about it?
 2. Do you talk to other people about health?
 - F. Do you think health is more or less important, as you get older?
 - G. Next, I'm going to ask you your opinion about some specific weight loss practices
 1. Do you think dieting is healthy, in general?
 - a. What are some situations in which you think dieting is healthy or unhealthy?
 - b. Why would or wouldn't you diet?
 2. Probe about exercise answers from background info sheet
 - a. Why engage in exercise
 - b. Why do not engage in exercise
 3. What do you think is the best way to lose weight?
- III. Ideas about past, current and future selves (potential of self-change)
- A. Have you tried losing weight before?
 1. Tell me about your previous weight loss attempt(s).
 2. (If trying to lose) What is different this time?
 - B. Probe about visits to weight loss programs from the Background info sheet
 - C. Do other family members diet?
 1. Do any close family members diet now?
 - a. Spouse, daughters, sisters, mother, etc.
 2. Do you remember your mother or sisters dieting when you were young?
 - D. Do you believe that weight is completely under conscious control?
 1. are there things that sabotage good eating habits- even when the person in question has the best of intentions?
 2. Are there ways they might do it to themselves?
 - E. If attempting to lose weight:
 1. How do you feel about yourself now that you're attempting to lose weight?
 - a. How did you feel about yourself before you attempted to lose weight?
 - b. Do you feel different about yourself since starting the attempt to lose weight?
 - c. Do you feel guilty if you mess up once in a while?
 2. Does your weight loss attempt affect who you are?
 - a. Do you see attempting to lose weight as part of your identity in any way?
 3. What would happen if you lose the weight?
 - a. How would you be different then?
 - F. If not attempting to lose weight:
 1. How do you feel about your body and weight at this point in time?
- IV. Role of body and weight in life
- A. How much time to you spend thinking about your weight?
 - B. Do you see your body as an important part of who you are?
 - C. Do you think that there's a connection between your weight and how you think about yourself?
 - D. Do you think your body truly represents who you really are, on the inside?
 1. Has this changed as you have gotten older?
 - E. Do you think of yourself as overweight?
 1. What makes you think of yourself as overweight?
 - a. What defines "overweight" in your eyes?

2. Did you think about yourself as overweight before you started this weight loss attempt?
- F. Do you think other people think of you as overweight?
 1. Does it matter if they think you are overweight?
- V. Issues of Aging
 - A. First, let's talk about aging and weight. Then we'll broaden our focus to look at other effects of aging.
 - B. Has your weight changed much since you were younger?
 1. Has your concern about weight and your body increased or decreased as you have gotten older?
 2. Is the weight you want to be now close to the weight you were when you were younger?
 - C. Is it more acceptable to weigh more as you get older?
 1. Do you think that what is an appropriate body changes as one gets older? How so?
 2. Are there differences in what is acceptable for a 20-year-old vs. a 40-year-old vs. a 60-year-old woman?
 3. Why do you think there are these differences?
 - D. Is looking young related to being thin?
 1. Do you think being thin is an important part of looking young?
 - E. How has aging affected your body in ways other than weight?
 - F. Do you think that appearance is more or less important, as you get older?
 - G. Do you think health is more or less important, as you get older?
- VI. Sources of information and Discourse
 - A. How much attention do you pay to research about diet and nutrition?
 1. From which of the following sources do you pay attention to diet, nutrition, or health advice?
 - a. Doctors
 - b. Friends
 - c. Family
 - d. Spouse or Romantic partner
 - e. News Magazines
 - f. Health Magazines
 - g. Fashion/ Women's Magazines
 - h. Television
 - i. Websites
 - j. Advertisements
 - k. Newspapers
 - l. Diet books
 - m. Things you learned in school
 - n. (If they say they trust it sometimes, or some of it, probe for distinctions)
 2. Which of those sources we just discussed do you trust most? Why?
 3. How likely are you to actually follow advice that you get from the sources you trust?
 4. How likely are you to file away advice from sources you don't particularly trust, just in case you hear more about it?
 - B. If the federal government reported the results of a new study that said a particular food was not good for you, would you stop eating that food?

1. How about diets? If the same study determined that a particular diet was not especially healthy, would that cause you to select a different diet?
- C. Have you ever read a book on dieting?
 1. How much trust do you have in what they say in dieting books?
- D. What makes you more or less likely to follow health or dieting advice?
- E. Do you think our culture makes it difficult or easy to diet today?
 1. What are some things that make it easier to diet today?
 2. What are some things that make it harder to diet?
 3. Do you think our culture supports dieting?
- VII. Comparisons to others
 - A. What do you think of other people who attempt to lose weight?
 - B. What do you think about overweight people who don't diet or otherwise attempt to lose weight?
 - C. Would you agree with the statement that more Americans are overweight than they used to be?
 1. Why do you think that is?
 2. Why do you think that being overweight is such a problem in American society today?
 3. What would have to change so that fewer people were overweight and obese?
- VIII. Anything Else?
 - A. Is there anything else that seems important to you with regard to weight and your body that we haven't talked about?

A2. INTERVIEW GUIDE FOR A DIETER

I. General Eating Habits

- A. Tell me about what foods you regularly eat when you're not on a diet.
 - 1. What are some of the foods you especially like?
- B. How do you feel about eating?
 - 1. Do you enjoy eating?
 - 2. Do you ever feel guilty about the foods you eat?
 - 3. Do you think about eating differently now than before the diet?
- C. Do you like to cook?
 - 1. What types of food do you like to cook?
- D. How often do you eat out?
 - 1. What sorts of restaurants do you like, go to often, etc.
- E. Describe for me some of your typical meals
 - a. (at home or eating out at a restaurant)
 - b. (also discuss timing of meals in context of daily schedule)
 - 1. Breakfast
 - 2. Lunch
 - 3. Dinner
 - 4. Snacks
 - 5. Beverages
- F. What sort of things have you eaten in the last few days?
 - 1. Are they typical of what you usually eat?

II. Role of diet in life

- A. What does the term "diet" mean to you?
- B. Tell me about your current diet
 - 1. Type
 - 2. How long
 - 3. Goals
 - 4. How much weight do you want to lose?
 - 5. How long do you plan to continue this diet?
 - a. If indefinitely: do you think you will continue to lose weight the whole time, or will you have a different type of goal then?
 - b. Will you enter some type of maintenance stage at some point?
 - c. What will this maintenance stage be like?
 - 6. How is the diet going so far?
- C. Why did you go on a diet?
 - 1. The reasons you went on a diet:
 - a. Were any of the reasons related to how you look to the opposite sex?

- b. Were any of the reasons related to your interest in clothing?
 - c. Were any of the reasons related to physical discomfort?
 - d. Were any of the reasons related to health issues?
 - e. Were there any other reasons we didn't mention?
 - (i.) (probe any the are affirmative)
 - (ii.) Can we talk a little more about...
- 2. Do you think you're mostly motivated by appearance or health reasons?
- 3. Are there other reasons you went on a diet, other than to lose weight?
- 4. Are there other positive changes you've noticed?
- 5. Are there negative things you've noticed?
- D. Why did you choose this diet?
 - 1. Did you consider other diets?
 - 2. Are there diets you know wouldn't work? Why?
 - 3. Are there diets you haven't tried? Why not?
- E. How has this diet changed your life?
 - 1. Are there things you have quit doing because they interfered with your diet?
 - 2. Are there other things you have substituted for thing you quit?
 - 3. Has this diet, or any other, provided any eating rules you see yourself as permanently adopting?
- F. How much time do you spend thinking about your diet?
 - 1. What are some times when you think about it?
 - 2. Do you talk to other people about dieting?
 - 3. Do most people close to you know about your diet?
 - a. How about friends? Co-workers?
 - b. What do they think about it?
- G. How will you know when the diet has quit working?
 - 1. What will you do then? (when the diet no longer works)
- H. Why did you choose to go on a diet, as opposed to doing something else to lose weight?
 - 1. Do you think dieting is healthy, in general?
 - a. What are some situations in which you think dieting is healthy or unhealthy?
 - b. Do you think dieting is the *best* way to lose weight?
 - c. Is losing weight the same as being healthy?
 - (i.) Why do you think there is so much focus on losing weight?
 - 2. What other methods of weight loss did you consider?
 - 3. Probe about exercise answers from background info sheet
 - a. Why engage in exercise
 - b. Why do not engage in exercise
 - c. What makes exercising difficult?
 - 4. What do you think of the concept of healthy eating?
 - a. How would you define healthy eating?
 - b. Do you consider yourself to eat healthy?
 - c. Are there things stopping you from eating healthy all the time?
 - d. Is healthy eating viable as a weight loss strategy?
 - e. Do you think most people know *how* to eat healthy?

(i.) Why don't they?

III. Ideas about past, current, and future selves (potential of self-change)

- A. Have you tried losing weight before? Tell me about your "weight history"
 - 1. Has your weight changed much since you were younger?
 - a. Have you always dieted, or more or less as you got older?
 - b. Is the weight you want to be now close to the weight you were when you were younger?
 - 2. Tell me about your previous diet(s) or weight loss attempts.
 - a. Types
 - b. Experiences
 - c. Outcomes
 - d. How long did these diets last?
 - 3. What is different this time?
 - 4. Probe about visits to weight loss programs from the Background info sheet
- B. Do other family members diet?
 - 1. Do any close family members diet now?
 - a. Spouse, daughters, sisters, mother, etc.
 - 2. Do you remember your mother or sisters dieting when you were young?
- C. Do you believe that weight is completely under conscious control?
 - 1. Are there things the sabotage diets- even when the person in question has the best of intentions?
 - a. Are there ways they might do it to themselves?
- D. How do you feel about yourself now that you're dieting? Do you feel different about yourself since starting the diet?
 - 1. How did you feel about yourself before you went on the diet?
 - 2. Do you feel guilty if you mess up once in a while?
- E. Does your diet affect who you are? In what ways?
 - 1. Do you see dieting as part of your identity in any way?
- F. What would happen if you lose the weight?
 - 1. How would you be different then?
- G. How much time do you spend thinking about your health?
 - 1. What are some times when you think about it?
 - 2. Do you talk to other people about health?

IV. Role of body and weight in life

- A. How much time do you spend thinking about your weight?
 - 1. Do you think being on a diet makes you think about your weight more or less?
- B. Do you see your body as an important part of who you are?
- C. Do you think that there's a connection between your weight and how you think about yourself?
- D. Do you think your body truly represents who you really are, on the inside?

- E. Has this changed as you have gotten older?
- F. Do you think of yourself as overweight?
 - 1. What makes you think of yourself as overweight?
 - 2. To you, what defines “overweight”?
 - 3. Did you think about yourself as overweight before you started this diet?
 - 4. Do you think other people think of you as overweight?
 - 5. Does it matter if they think you are overweight?

V. Issues of Aging

- A. First, let's talk about aging and weight. Then we'll broaden our focus to look at other effects of aging.
- B. Is it more acceptable to weigh more as you get older?
 - 1. Do you think that what is an appropriate body changes as one gets older? How so?
 - 2. Are there differences in what is acceptable for a 20-year-old vs. a 40-year-old vs. a 60-year-old woman?
 - 3. Why do you think there are these differences?
- C. What things in your life have changed the way you feel about your body?
 - 1. marriage?
 - 2. childbirth?
 - 3. Specific birthdays? i.e. 30, 50, 60?
- D. Is it important to you to look young, or at least to look *younger*?
- E. Is being thin related to looking young?
 - 1. Do you think being thin is an important part of looking young?
- F. Do you feel that body expectations have changed over your lifetime?
 - 1. Do you feel that it is possible to meet these expectations?
- G. How has aging affected your body in ways other than weight?
- H. Do you think that appearance is more or less important, as you get older?
- I. Do you think that you will ever reach a point in your lifetime that you can stop worrying about the appearance of your body?
- J. Do you think that health is more or less important, as you get older?

VI. Sources of information and Discourse

- A. How much attention do you pay to research about diet and nutrition?
- B. Where do you hear about diet and health information?
 - 1. From which of the following sources do you pay attention to diet, nutrition, or health advice?
 - a. (If they say they trust it sometimes, or some of it, probe for distinctions)
 - 2. Which of those sources we just discussed do you trust most? Why?
 - 3. How likely are you to actually follow advice that you get from the sources you trust?
- C. If a study said something was good for you, how likely are you to incorporate it?

- D. If the federal government reported the results of a new study that said a particular food was not good for you, would you stop eating that food?
 - 1. How about diets? If the same study determined that a particular diet was not especially healthy, would that cause you to select a different diet?
- E. Have you ever read a book on dieting?
 - 1. How much trust do you have in what they say in dieting books?
- F. What makes you more or less likely to follow health or dieting advice?
- G. Do you think our culture makes it difficult or easy to lose weight today?
 - 1. What are some things that make it easier to lose weight today?
 - 2. What are some things that make it harder to lose weight?
 - 3. Do you think our culture supports dieting?
 - 4. What about healthy eating- does our culture support that?
 - 5. Let's compare dieting and healthy eating. Is it easier or more difficult to diet than to eat healthy?
- VII. Comparisons to others
 - A. What do you think of other people who diet?
 - 1. Do you think of yourself as "a dieter"?
 - 2. Is being "a dieter" a positive or negative thing?
 - B. What do you think about overweight people who don't diet?
 - C. Do you think most people know how to eat healthy?
 - 1. Why don't they do it?
 - D. Why do you think that being overweight is such a problem in American society today?
 - 1. What would have to change so that fewer people were overweight and obese?
- VIII. Anything Else?
 - A. Is there anything else that seems important to you with regard to dieting and your body that we haven't talked about?

A3. INTERVIEW GUIDE FOR A HEALTHY EATER

I. General Eating Habits

- A. Tell me about what foods you regularly eat.
 - 1. What are some of the foods you especially like?
- B. How do you feel about eating?
 - 1. Do you enjoy eating?
 - 2. Do you ever feel guilty about the foods you eat?
 - 3. Do you think about eating differently now than before you started eating healthy?
- C. Do you like to cook?
 - 1. What types of food do you like to cook?
- D. How often do you eat out?
 - 1. What sorts of restaurants do you like, go to often, etc.
- E. Describe for me some of your typical meals
 - a. (at home or eating out at a restaurant)
 - b. (also discuss timing of meals in context of daily schedule)
 - 1. Breakfast
 - 2. Lunch
 - 3. Dinner
 - 4. Snacks
 - 5. Beverages
 - 6. Are they typical of what you usually eat?
- F. What sort of things have you eaten in the last few days?

II. Role of healthy eating in life

- A. Tell me about your healthy eating
 - 1. Can you define healthy eating for me?
 - a. What is included/excluded, eaten more or avoided, etc.
 - b. How do you know what to eat?
 - 2. How long have you been eating healthy?
 - 3. How long do you plan to continue healthy eating?
 - 4. How's it going so far?
 - 5. What are some challenges to eating healthy?
 - 6. Why do you eat healthy?
 - a. Do you have a specific health goal?
- B. What are some reasons you eat healthy?
 - 1. Do any of the reasons you eat healthy include any of the following?

- a. Were any of the reasons related to health issues?
 - b. Were any of the reasons related to weight loss?
 - c. Were any of the reasons related to how you look to the opposite sex?
 - d. Were any of the reasons related to your interest in clothing?
 - e. Were there any other reasons we didn't mention?
 - (i.) (probe any the are affirmative)
 - (ii.) Can we talk a little more about...
 - f. If weight loss is a goal: How much weight do you want to lose?
 - (i.) What are some reasons you want to lose weight?
 - (ii.) Do you think healthy eating is the *best* way to lose weight?
2. Do you think you're motivated to eat healthy mostly by health reasons or appearance?
- C. How has healthy eating changed your life?
1. Are there things you have quit doing because they interfered with your healthy eating?
 2. Are there other things you have substituted for things you quit?
 3. Do you see yourself as permanently adopting healthy eating?
 4. Is there anything stopping you from eating healthy all the time?
- D. How much time do you spend thinking about your healthy eating?
1. What are some times when you think about it?
 2. Do you talk to other people about weight and health?
 3. Do most people close to you know about your healthy eating?
 - a. How about friends? Co-workers?
 - b. What do they think about it?
- E. Is there an end point to your healthy eating?
1. What do you consider measures of success?
 - a. What positive things have you noticed?
 - (i.) Is losing weight one of the positive things?
 - b. Are there any negative things that you've noticed?
 2. Can you envision a time in which healthy eating no longer "works" for you?
 - a. If you reach your specific health goal?
 - b. What will you do then? (when the diet no longer works)
- F. Why did you choose to eat healthy- as opposed to other eating strategies?
1. Did you consider dieting?
 - a. Tell me about why you decided against dieting?
 - b. What does the word "diet mean to you?
 - c. Do you think dieting is healthy, in general?
 - d. What are some situations in which you think dieting is healthy or unhealthy?
 2. Probe about exercise answers from background info sheet
 - a. Why engage in exercise
 - b. Why do not engage in exercise
- III. Ideas about past, current, and future selves (potential of self-change)
- A. Have you tried losing weight before? Tell me about your "weight history"

1. Has your weight changed much since you were younger?
 - a. Have you always dieted, or more or less as you got older?
 - b. Is the weight you want to be now close to the weight you were when you were younger?
 2. Tell me about your previous weight loss attempts(s).
 3. What is different this time?
 - B. Probe about visits to weight loss programs from the Background info sheet
 - C. Do other family members eat healthy, like you do?
 - D. Do other family members diet?
 1. Do any close family members diet now?
 - a. Spouse, daughters, sisters, mother, etc.
 2. Do you remember your mother or sisters dieting when you were young?
 - E. How do you feel about yourself now that you're eating healthy?
 1. How did you feel about yourself before you began to eat healthy?
 2. Do you feel different about yourself since starting?
 - a. Do you feel guilty if you mess up once in a while?
 - F. What would happen if you lose the weight?
 1. How would you be different then?
 - G. What would happen if you became healthier?
 1. How would you be different then?
 - H. Does your healthy eating affect who you are?
 1. Do you see healthy eating as part of your identity in any way?
- IV. Role of body and weight in life
- A. How much time do you spend thinking about your weight?
 - B. Do you see your body as an important part of who you are?
 - C. Do you think that there's a connection between your weight and how you think about yourself?
 - D. Do you think your body truly represents who you really are, on the inside?
 - E. Has this changed as you have gotten older?
 - F. Do you think of yourself as overweight?
 1. What makes you think of yourself as overweight?
 - a. What defines "overweight" in your eyes?
 2. Did you think about yourself as overweight before you started eating healthy?
 3. Do you think other people think of you as overweight?
 - a. Does it matter if they think you are overweight?
- V. Issues of Aging

- A. First, let's talk about aging and weight. Then we'll broaden our focus to look at other effects of aging.
- B. Is it more acceptable to weigh more as you get older?
 - 1. Do you think that what is an appropriate body changes as one gets older? How so?
 - 2. Are there differences in what is acceptable for a 20-year-old vs. a 40-year-old vs. a 60-year-old woman?
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- C. What do you think about people who diet?
 1. Is dieting a positive or negative thing?
- D. What do you think about overweight people who don't diet or eat healthy?
- E. Why do you think that being overweight is such a problem in American society today?
 1. What would have to change so that fewer people were overweight and obese?

VIII. Anything Else?

- A. Is there anything else that seems important to you with regard to healthy eating and your body that we haven't talked about?

Appendix B:

Interview Questionnaires

B1. Background Information Sheet

1. Age: _____
2. Height: _____
3. Weight: _____
4. Occupation: _____
5. Highest Degree Completed: _____
6. Marital Status & History: _____
7. Who lives in your household now? _____
8. Have you ever had children? How many? How old are they?

9. Have you ever had grandchildren? How many? How old are they?

10. Do you belong to a gym now? _____
11. Have you ever belonged to a gym? _____
When was that? _____
12. How often do you exercise? What sort of exercise? _____
13. Are you on a diet now? _____
14. Have you ever worked a job that required manual labor? _____
15. Have you ever played a sport seriously? _____
16. If you could lose 10 pounds, where would you lose it? _____
17. Have you ever been to a: (Please check all that apply)
_____ Weight loss Spa or Camp
_____ Health Spa Resort
_____ Personal Trainer
_____ Dietician or Nutritionist
_____ Diet or Weight loss Seminar
(Weight Watchers does not count)

Total Score (see below for scoring instructions)

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APPENDIX C:
INFORMED CONSENT FORM

Women's Dieting and Eating Strategies
Information and Consent Form

I, _____ agree to part in the research titled "Women's Dieting and Eating Strategies" conducted by Abigail Richardson from the Department of Sociology at the University of Georgia, under the direction of Dr. James Dowd, Department of Sociology, University of Georgia. I understand that I do not have to take part if I do not want to. I can stop taking part without giving any reason, and without penalty. I can ask to have all of the information about me returned to me, removed from the research records, or destroyed.

The purpose of this study is to gather information about women of different ages understand and experience dieting and other eating strategies. The findings from this project may provide information on how women think about themselves, eating, and dieting. There are no known risks associated with this research.

I should not continue with this interview if I am younger than 25 years old, am currently pregnant or have been pregnant within the last 2 years, or live in an assisted living facility. I should also not continue with this interview if I have been diagnosed with an eating disorder, have a medical condition that prevents me from performing normal daily chores, or a currently on a doctor-prescribed diet.

If I volunteer to take part in this study, I will be asked to answer questions about my dieting or eating habits, body image, and aging. This interview may last between one and two hours. I will also be asked to fill out two short questionnaires, each of which should take about 5 minutes to complete.

No risk is expected but I may be asked some personal questions. I can refuse to answer any question, or stop answering questions at any time. I may even decide later on that I no longer want the researcher to use my interview in this research, and she will respect my wishes.

This interview experience may benefit you by providing the opportunity to really think about your eating, diet, and exercise patterns and may encourage you to adopt more healthy practices, if necessary.

No individually identifying information about me, or provided by me during the research, will be shared with others without my written permission, except if it is necessary to protect my welfare (for example, if I were injured and need physician care) or if required by law.

This research is confidential. The results of the research study may be published, but my name will not be used. To ensure my confidentiality, I will be assigned a pseudonym, or code-name. This name will be known to no one but the researcher. This other name will be used in the transcripts of the interview, and in any other materials, including quotes in any published papers. Anything that identifies me as “me” will be removed or replaced with pseudonyms. This signed consent forms will be kept separately from transcripts or any other data.

This interview will be recorded with a digital voice recorder, which works just like a tape recorder. No one but the researcher will have access to the audio files. After the completion of this research, the digital audio files of the interview will be deleted.

The investigator will happy to answer any further questions about the research, now or during the course of the project (706-254-9429).

I understand that I am agreeing by my signature on this form to take part in this research project and understand that I will receive a signed copy of this consent form for my records.

 Abigail Richardson
 Primary Investigator
 Telephone: 706-254-9429
 Email: abigailr@uga.edu

 Signature

 Date

 Name of Participant

 Signature

 Date

Please sign both copies, keep one and return one to the researcher.

Additional questions or problems regarding your rights as a research participant should be addressed to The Chairperson, Institutional Review Board, University of Georgia, 612 Boyd Graduate Studies Research Center, Athens, Georgia 30602-7411; Telephone (706) 542-3199; E-Mail Address IRB@uga.edu