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The discordant pleasures of everyday eating: Reflections on the social gradient in obesity under neo-liberalism

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A B S T R A C T

Despite widespread epidemiological evidence of a social gradient in obesity, there has been less attention focused on understanding this from a sociological perspective. Furthermore, whilst pleasure is an obvious feature of contemporary cultural representations of food and eating, this has not figured prominently in sociological understandings of the social gradient. Using qualitative data from biographical interviews conducted with adults living in materially deprived parts of South Yorkshire (UK) we introduce the idea of discordant pleasure in relation to everyday eating as a way of shedding light on the social gradient in obesity. We highlight in particular, the ways in which materially deprived individuals who were defined as obese described the tensions between the pleasures of eating and the struggles for bodily control, alongside the affective dimensions – frustration and shame – that this process engendered. We draw on Berlant's work on lateral and interruptive agency to make sense of these accounts, suggesting that classed agency and discordant pleasure are important dimensions in understanding the social gradient in obesity under neoliberalism.

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1. Introduction

A central question facing medical sociology as it intersects with social epidemiology remains how to explain the enduring relationship between measures of social position and health. Obesity shows a well-established social gradient in its prevalence, with the most socio-economically disadvantaged having the highest rates (Wilkinson and Pickett, 2009; Pampel, 2012). This gradient is most apparent amongst affluent societies but is also the emerging pattern in middle and low income countries (McLaren, 2007). It has been suggested that this gradient may be flattening as, what has been termed the "obesogenic environment" - ready access to high fat/high sugar foods, increasingly sedentary lifestyles and a range of associated practices and factors – continues to shape the health outcomes of all social groups (Foresight, 2007; Ljungvall and Gerdtham, 2010). However, the evidence for a gradient (Ulijaszek, 2014; Wilkinson and Pickett, 2009) and for the health concerns unambiguously associated with it has become stronger (Public Health England, 2015).

2. Understanding the social gradient

Whilst the existence of a social gradient in health and obesity is unequivocal, what accounts for it has been hotly debated, most recently since the publication of *The Spirit Level* (Wilkinson and Pickett, 2009) and the Marmot Review (2010) with their emphasis on both material and psychosocial factors, showing that psychosocial factors account for around a third of the excess mortality and morbidity in cardio-vascular disease, for example. But the psychosocial does not refer to individual behaviour or aspects of culture – sociological interrogation of the factors underpinning the gradient by scholars such as Link and Phelan (1995), Pampel (2012) and others have shed light on a wealth of factors, practices, meta-mechanisms and political discourses that begin to explain the enduring presence of a socio-economic gradient in health. Factors such as gender, age and ethnicity also result in social gradients, but here we focus on the socio-economic and its relationship to obesity, given recent contributions on this theme (Pampel, 2012; Warin et al., 2015).

In this paper, we seek to make a contribution to the sociological literature which has addressed the reasons why we see this social gradient in obesity drawing on recent reformulations of psychosocial explanations for inequalities in health (Wilkinson and

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Pickett, 2009; Peacock et al., 2014) to make our argument. In particular, we address the issue of *relative* deprivation and disadvantage, pointing to some of the features of neoliberalism and social class which shape, in particular, orientations towards the pleasures of everyday eating.

3. Obesity: the wider context

A primary driver for societal concern about rising rates of obesity has, of course, been the much debated impacts on health and longevity (Lu et al., 2014), with some questioning the extent and basis for these (Gard and Wright, 2005). Within the social sciences, obesity has also been the focus of considerable critical attention (Kullick and Meneley, 2005; Guthman, 2011; Saguy, 2013). For example, the increase in obesity rates has been viewed through a political economy lens, highlighting heightened consumerism and the globalisation of food production and supply (Guthman, 2011). Key changes in our relationship to food, such as reductions in time spent producing and preparing meals, the propensity to consume greater quantities of pre-packaged and processed food have also been cited (Swinburn et al., 2011). For others, the role of supermarket chains in controlling food retailing, alongside the marketing of energy dense, calorie rich foods have been seen as factors driving obesity (Monteiro, 2009).

There have also been numerous critiques of obesity from sociologists and feminists adopting very different perspectives (Murray, 2008; Throsby, 2007; Monaghan, 2008, 2014; Rich et al., 2015). For example, contemporary Western discourses around femininity and beauty have been seen as privileging small and slender bodies. As Murray (2008, p2–3) points out, "*what underpins the current 'panic' over obesity in contemporary Western culture is a moral anxiety about the preservation of fixed gender identities and normative female sexuality and embodiment*". For others, obesity has been medicalised as a 'problem' of individual psychology, and it has been noted that this discourse has distinctly moralistic and victim-blaming tendencies (Kulnick and Meneley, 2005). Others point to the singularity of the medical discourse around obesity, which fails to recognise cultural differences in how body size may be evaluated, and the range of factors shaping eating practices (Dumas et al., 2013). Our point of departure in this paper, is that there is an urgent need to provide a sociologically informed reading of what underpins the social gradient in obesity, given steadily increasing rates and evidence of its impact on health (Lu et al., 2014), and also because the obese body is often a shamed and stigmatised body (Lupton, 2013; Warin, 2015).

4. Shame, stigma and classed obesity

A key characteristic of neoliberal societies is an increase in shaming discourses (Peacock et al., 2014; Shildrick and MacDonald, 2013), with the obese body associated with ideas of indolence and lack of control. Furthermore, the obese body is usually "classed", with poor and working class bodies embodying much that is problematic. Rich et al. (2015) argue:

> *"One of the most powerful forms of stigmatisation and discrimination circulating within contemporary health emerges when the social and cultural tensions of social class intersect with obesity discourse"* (2015: 1).

This stigmatisation is brought sharply into focus in the context of contemporary health policy in England, where personal responsibility represents *the* doxic narrative for addressing obesity (and other 'wicked problems'), despite increasing evidence of the shortcomings of individualistic models of 'behaviour' change to address health inequalities (Baum and Fisher, 2014). Official guidance notes:

> "*Overweight and obesity are a direct consequence of eating and drinking more calories and using up too few. We need to be honest with ourselves and recognise that we need to make some changes to control our weight*." (Department of Health 2011: 3).

The attractions of this socially undifferentiated message are obvious to policy makers, who may not want to consider the troubling issue that the unequal distribution of resources – material and agential may be implicated in obesity and other health conditions (Ulijaszek, 2014; Warin et al., 2015).

5. From precarity to discordant pleasure

Increasingly, evidence suggests that the gradient in obesity is due to material lack and precarity which are increasing features of daily life across many countries (Ulijaszek, 2014). In England, rising levels of material and financial hardship (Lansley and Mack, 2015) clearly impact the food decisions of many (Garthwaite et al., 2015). Here, we build on this work but aim to further detail factors which are germane to understanding the complex relationships between eating, obesity and socio-economic position (Warin et al., 2015; Ulijaszek, 2014). We focus on the dilemmatic temptations of food or what we refer to as discordant pleasure, considered alongside the classed body's capacity to resist the obesogenic environment in line with current health policy prescriptions. Our food culture is one where pleasure is writ large (Probyn, 2000) and pleasure plays a dominant role in food decision-making, but one this is, curiously, little reflected in medical sociology (Coveney and Bunton, 2003).

In placing discordant pleasure and its affective aspects at the heart of the debate about the social gradient in obesity, we start with Crawford's (2000) comments on what he sees as a core contradiction in modern capitalism; that between the ethics of production and consumption. His argument is that motivations considered optimal for maximising consumption – loosening the bonds of self-denial, acquiescing to pleasure – are not those required for production, which requires delayed gratification, self-control and the deployment of will-power. Focusing here on health promotion, Crawford argues:

> *"Consumer capitalism relies on a change in cultural psychology – from a modal personality premised on the virtues of denial, delayed gratification and sobriety to a personality disposed towards fun, immediate gratification, and a propensity to exceed limits."* (2000: 222).

The logic of pleasure – the propensity to immediately satisfy desires – is apparent in the accounts of participants in the study presented here, and it is the classed aspects of this which we seek to address in this paper. Our work shares similarities with Warin et al.'s (2015) study exploring how obese individuals oriented themselves towards a national anti-obesity campaign in Australia. Drawing on findings from an ethnographic study in disadvantaged communities, the authors use Bourdieu's (2000) insights about the temporal orientations to practice in order to advance the idea of 'short horizons' to conceptualise the ways in which future-oriented discourses around managing risk, which are features of public health campaigns, have only limited relevance to the immediacies of poverty, contingency and survival that mark disadvantaged individuals' lives. In particular, they suggest that in order to control the future, one needs to be able to control the present, and make the important point that time is an analytical category forming part

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