

Moralities in food and health research

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Abstract Society has imposed strict rules about what constitutes a 'good' or a 'bad' food and 'right' or 'wrong' eating behaviour at least since antiquity. Today, the moral discourse of what we should and should not eat is perhaps stronger than ever, and it informs consumers, researchers and policy-makers about what we all should consume, research and regulate. We propose four types of moralities, underlying sets of moral assumptions, that orient the contemporary discourses of food and health: the 'good' and 'bad' nature of food items, the virtue of self-control and moderation, the management of body size and the actions of market agents. We demonstrate how these moralities influence consumer behaviour as well as transformative research of food and health and develop a critical discussion of the impact of the underlying morality in each domain. We conclude by providing a few guidelines for changes in research questions, designs and methodologies for future research and call for a general reflection on the consequences of the uncovered moralities in research on food and health towards an inclusive view of food well-being.

Keywords food; health; morality; governmentality; life quality

Introduction

The human being is an omnivore. In practice, however, the range of culturally defined edibles is always smaller than the biologically defined edibles. The human being is also, with Ernst Cassirer's (1944) expression, an *animal symbolicum*, and our practices, even the most natural ones, are always heavily imbued with cultural logics. Culture defines what can and what cannot be eaten. But not only that, culture also distinguishes between good and bad, correct and incorrect edibles, a distinction that is strung up between situations, roles, class, gender and so forth. The set of cultural rules and moral meanings constraining or advocating specific ways to eat are therefore at the core of the socialisation process (Fischler, 1990), and we can find accounts pointing to the morality of food in some of the earliest accounts of civilisation.

In his discussion of the moral history of food, Coveney (2006) underlines how a particular set of rules known as *dietetics* in antiquity established guidelines for eating and drinking through a set of cultural codifications. In more recent history authorities like the church, the state and the medical profession have become central in the control and the civilising of appetites (e.g. Mennell, 1997). The moralisation of food has become particularly prevalent in the past several decades as what constitutes a 'good' or a 'bad' food and 'right' or 'wrong' eating behaviour has taken on a whole new moral meaning. Society's fear of the potential consequences of 'bad' foods and 'wrong' eating habits on health and well-being has escalated to the degree that some experts have referred to the food industry as the 'tobacco industry of the new millennium' (Nestle, 2007). As a result, the policing of food has taken on new dimensions and reached new heights.

These developments can be attributed to several factors. First, there is a growing public and scientific interest in the relationship between eating habits and public health mainly inspired by growing concerns about the increase in obesity rates. Second, there is a growing public interest, although with less scientific effort, in various eating habits and regimes which should arguably improve the quality of life and lead to a healthier, happier physical and mental self. Food, in other words, has become one of the most significant lifestyle and life quality generators and markers. Finally, we have witnessed an increased focus on the body and on the techniques and practices that should improve the body's health condition and physical appearance. In sum, the moralities encompassing food and eating are stronger than ever in contemporary reflexive modernity.

This contemporary moralisation of food has influenced many discussions within the Transformative Consumer Research (TCR) movement and has sparked an interesting debate on food and health at the conference in Lille in 2013, from which this article originates. Business researchers and social scientists at large are claiming a strong voice in this debate in addition to traditional medical sources. However, as Latour (2004) reminds us, there is no epistemology that is not a political epistemology. Hence, it is surprising that to this date, given the increasingly moralised discussion of food and its relation to the body, there has been little reflection on what types of moralities drive TCR on food and health.

This is true not only of TCRs, but also of the social science of food and health, which has sometimes relied on heavy-handed assumptions about the impact of various food regimes on physiology. This paper attempts to address this gap. It represents a collective reflection on the moralities that drive our respective research interests in the domain of food and health. We hope our discourse will inspire consumer researchers to infuse self-reflexivity in their assumptions, goals and methods as they shift away from the restrictive paradigm of 'food as health' towards a holistic and inclusive view of 'food wellbeing' (Block et al., 2011).

Defining morality

Before we embark on our endeavour, it might be useful to go through a brief discussion of what we mean by morality in a food context, since there is a huge and diverging literature on this topic. Obviously, our discussion here can by no means be exhaustive. Nevertheless, we will highlight a few central approaches before producing what could be considered a working definition for the ensuing discussions. From a psychological perspective, Haidt (2007) summarises existing research by formulating three classic principles of morality, namely that 1. it is first and foremost intuitive and affective, but not independent from cognitive reasoning; 2. the primary purpose of a moral psychology is for orienting social action; and 3. morality is central for the creation of social bonds. Haidt adds a fourth principle of his own, namely that morality goes beyond harm (avoiding harm to others) and fairness to also include such dimensions as in-group loyalty, respect for authority and (pious) purity.

These considerations all take point of departure in the individual's conscious activities in relation to the community. Rozin (1999a), in his discussion of the moralisation process, underlines that beyond the individual, psychological level, there is also a historico-cultural level of moralisation which operates in a much less conscious manner through the process of socialisation rather than active decision-making. A similar distinction is drawn by Robbins (2007) in his discussion of an emergent anthropology of morality, in which he distinguishes between two broad trends. The first trend is, in consistence with a Durkheimian tradition, to consider all routine social action as bound to a scheme of normativity and thus as having a moral dimension. The other trend is to define 'an action as moral only when actors understand themselves to perform it on the basis of free choices they have made' (Robbins, 2007, p. 293).

We consider this dichotomy to be built on somewhat false premises, since, on the one hand, individuals cannot escape moralising, just as they cannot escape communicating. Doing nothing may be a highly communicative as well as a highly moralised act. All actions are potentially objects for moral interpretation, not just from the actor but also from other people. On the other hand, presupposing that there is a clear and distinct scheme of norms to which one can ascribe the morality of certain acts does not seem to be a very tenable hypothesis, especially in contemporary complex societies.

As Rozin (1999a, p. 218) notes, 'moralization frequently occurs in the health domain, because of a deep and pervasive link between health and moral status, a link that extends throughout history and across cultures'. Sociologically speaking, we cannot talk about moral status without considering power relations. As a result of this complexity and the existence of competing (moralising) expert systems and

countervailing discourses, moralisation of food and health in contemporary society is heavily embedded in systems of power that guide the choices of individuals, policy-makers and market agents.

Notably, these systems of power have become less obtrusive in the recent years as they have come to rely less on coercion and more on 'objective' guidance, which Sulkunen (2009) has referred to as 'epistolar power'. We therefore apply a Foucauldian perspective in this paper to assume that moralisation is embedded in a set of governmentality techniques. Foucault (2010) used the term 'governmentality' to describe the way in which modern states approach the double issue of problematisation and control of the population. Governmentality techniques thus encompass practices related to constructing knowledge about the population, problematising certain issues revealed in the course of knowledge generation and generating techniques for the management of the problematised issues. Food and health research is clearly one of the most important of such technologies of problematisation and control. Consequently, we view morality in the context of food and health research as the establishment of what Rozin called 'moral status' through various governmentality processes.

It is important to note that this paper predominantly looks at food and health research from a psychological perspective, reflecting the research profile of the majority of this paper's authors. While several authors subscribe to different conceptualisations, ontologies and epistemologies from the ones dominating here, the reflections on the issues of morality and moralisations tend to be shared across research backgrounds. Our broad purpose is therefore to map the moral politics of the current epistemology of food and health in the TCR context.

We tackle this goal by discussing the moralities underlying the social perceptions of four basic domains in the food and health debate: the nature of food items, the virtues of self-control and moderation, the management of body size and the actions of market agents. These domains constitute the four interlinked components of our theoretical framework. Inspired by the work of Holt (1995) on consumption practices, we build our framework on two basic dimensions. Our first dimension distinguishes between moralities that are tied to an object in and of itself and moralities that are tied to specific kinds of market and consumption actions. Our second dimension distinguishes between moralities that are tied to person-object relations and moralities that are tied to interpersonal relations. We thus construct a two-by-two matrix containing morality of the food item (a person-object relations/object morality), morality of self-control and restraint (a person-object relations/action morality), morality of body size (an interpersonal relations/object morality, since the fat body is both a person and an objectification), and morality of market agents (an interpersonal relations/action morality). The resulting matrix is depicted in Table 1 below.

For each of these four domains, we start out by covering a number of key findings in the food and health consumer psychology research. While our selection is by no means exhaustive, we would argue that it is quite representative of the kind of research done in the area and of the type of moralities that lie behind this research. For each of the four review sections, we extract some fundamental assumptions about what is qualified as 'good' and 'bad' in the research designs and research discussions, thereby revealing processes of moralisation (Rozin, 1999a) in each domain. We round off each section with a discussion of how a more reflexive awareness of the moralities underlying current food and health research might allow other research agendas to

Table 1 A framework for analysing morality in food and health research.

	Person-object relation	Interpersonal relation
Morality of object	<i>Morality of food items</i> Dichotomous classification of food into 'good' food and 'bad' food.	<i>Morality of the body</i> Stigmatisation of body size in social, economic and cultural domains.
Morality of action	<i>Morality of self-control</i> Idealisation of moderation and ability to resist temptation.	<i>Morality of market agents</i> Resentment of marketers' profit-orientation and of policy-makers' and marketers' reliance on consumers' ability and motivation to make an informed, sovereign choice.

emerge. Finally, we conclude with a discussion of the disclosed moralities in relation to a governmentality-based reflection on the contemporary discourses on food and health. It is our hope that this discussion will serve as a compass for future research on food and health and as a reminder of our responsibility as scientists for self-reflexivity.

Morality of food items

A dichotomous view of food is very pervasive (Rozin, Ashmore, & Markwith, 1996; Wertenbroch, 1998). In its simplest form, it is reflected in consumers' as well as researchers' tendency to qualify food items, including in experimental and survey designs, as 'healthy' and hence 'good' or 'unhealthy' and hence 'bad', although there is (or should be) much uncertainty in what constitutes 'good' food and 'bad' food, as will be evident from the ensuing discussion.

'Good' and 'bad' foods in consumer research

The dichotomous moral interpretation of food triggers a host of behaviours that do not always facilitate consumer well-being and health. First, consumers rely on their moral judgements of food quality at the expense of considering other critical factors such as food quantity. For example, consumers believe 'good' food items to be significantly healthier than 'bad' food items even when 'good' items contain ten times as many calories as 'bad' items (Rozin et al., 1996). As a result, consumers are more prone to underestimating the portion sizes of 'good' food items compared to 'bad' items, which in turn leads them to significantly overeat when a food is framed as 'good' (with the use of, for example, a 'low-fat' label, Wansink & Chandon, 2006).

Second, there is ambiguity in consumers' minds about what actually constitutes a 'good' or a 'bad' food. Although the health consequences of certain ingredients are established in the medical domain (e.g. the benefits of consuming whole grains for limiting the risk of diabetes, American Diabetes Association, 2006), the long-term health consequences of different nutrition regimes are lesser known (Adams, Lindell, Kohlmeier, & Zeisel, 2006), and many of these effects are interpreted by consumers and even medical doctors through the cultural lens of their social environment

(Leeman, Fischler, & Rozin, 2011). For example, in a large-scale survey conducted in France, Germany, Italy, the UK and the US, Leeman and colleagues (2011) found that there is a significant cross-cultural variation in the degree to which consumers as well as medical doctors endorse the healthiness of ingredients such as dairy, cereal and wine and of activities such as of fasting and exercise. Furthermore, while Americans hold a utilitarian view of food and associate food mostly with health, the French hold an epicurean view of food and associate food mostly with pleasure (Rozin, Fischler, Imada, Sarubin, & Wrzesniewski, 1999).

The moralised view of food is inherent not only to consumers but also to researchers who propagate this view in their research designs and interpretations. A great number of studies reinforce the moral food dichotomy by distinguishing between healthy and unhealthy food items. In these studies, participants' single choice between healthy and unhealthy foods (e.g. between a fruit salad and a chocolate cake) is used to measure indulgence and self-control (e.g. Krishnamurthy & Prokopec, 2010; Shiv & Fedorikhin, 1999).

This measure, however, provides limited insight because, first of all, it propagates a singularised nutritionist ingredient perspective on what is in fact a social pattern of foodways, meals and dishes. Consumers' food choices are correlated within meals and across meal occasions. Specifically, the choice of what is perceived as a healthy breakfast often licenses unhealthy choices at lunch or dinner, and the choice of a perceived healthy entrée licenses the choice of an indulgent side dish or dessert (Chandon & Wansink, 2007a; Ramanathan & Williams, 2007). Furthermore, choosing a 'healthy' food item does not always lead to 'healthy' consumption and vice versa. For example, individuals tend to consume more (although they believe they consumed less) at a restaurant positioned as healthy (vs. unhealthy) (Chandon & Wansink, 2007a). Therefore, moving forward, it would be important for researchers to expand the list of food decisions from dichotomous choices to more comprehensive measures such as choices of entire meals (menus), food diaries recorded over long time periods, shopping lists and consumption across multiple meal occasions (Cornil & Chandon, 2013; Patrick & Hagtvedt, 2012).

Finally, consumers translate 'good' and 'bad' food judgements into behavioural rules whereby choosing a 'good' (vs. a 'bad') food signals good (vs. bad) health, positive (vs. negative) body image, high (vs. low) self-control. Moreover, it implies being righteous (vs. sinful), moral (vs. immoral) and decent (vs. indecent) (Saguy & Almeling, 2008). For example, individuals intuitively judge healthy eaters to be more intelligent, active and financially secure than unhealthy eaters (Barker, Tandy, & Stookey, 1999). It is therefore not surprising that, when consumers make 'bad' food choices, they feel ashamed and stigmatised (Puhl & Brownell, 2003). The moral pressure to make the right food choice often works effectively in motivating healthy choices, but several studies show that it can also make consumers feel overwhelmed and lead them to abandon the goal of being healthy altogether (Crawford, 2006; Goode, Beardsworth, Haslam, Keil, & Sherratt, 1995). For example, restrained eaters who feel inherently motivated to eat right are more likely to overeat when a 'good' food item is present on the menu than when it is absent because the presence of a 'good' item vicariously fulfils their goal of being healthy (Wilcox, Vallen, Block, & Fitzsimons, 2009).

Defying the morality of nutritionally 'good' and 'bad' food

It should be obvious from the preceding paragraphs that the discourse in research and among consumers is heavily imbued with a moralising classification system based on predominantly nutritional criteria. It is also obvious that there is some degree of reflexivity within the domain pertaining to the limitations of the dichotomy, for example, in terms of the cross-cultural differentiation between what counts as 'good' and 'bad' as well as some reflections on potential negative effects of this dichotomisation, for example, in terms of compensatory behaviour.

None of these reflections, however, truly leave the realm of a nutritionist distinction between 'good' and 'bad' foods. For example, research efforts to design incentives that increase the consumption of 'good' foods assume that there is a linear relationship between the choice of 'good' foods and 'healthy' behaviour, which only perpetuates the fundamental dichotomy. Similarly, the call for considering meal (vs. ingredient) choices and for conducting longitudinal (vs. one-shot situational) studies may alleviate concerns about judging healthy behaviour based on single food choices, but it does not address the issue that the such studies remain invariably focused on promoting a healthier diet in nutritional terms. In other words, even within attempts to bring nuance to the research discussion, the dichotomy is still maintained and nutrition takes precedence over a broader array of food cultural quality criteria.

We admit that it is utopian to hope to find or establish a food culture that does not make dichotomous distinctions at all. In fact, such distinctions are at the heart of what defines a food culture. However, it should not discourage researchers from studying food practices that adopt other criteria of assessing what is 'good', 'bad' and in between. It is, for example, striking that a gastronomic perspective is generally absent in existing food and health research. While a nutritionist research agenda may be excused for neglecting gastronomy from its definitions of what constitutes 'good food', a social research programme may not. This is particularly true in view of the fact that the majority of consumers define food quality, also pertaining to health, in gastronomic rather than nutritional terms (Chrysochou, Askegaard, Grunert, & Kristensen, 2010). This tendency seems to also be consistent across cultures, if preliminary results from cross-cultural validations of this research are to be trusted (Chrysochou, Askegaard, & Grunert, *in press*).

Why would including a more gastronomically informed approach be relevant? The answer is that few people view food first and foremost as nutrients. Culinary traditions, socialisation, peer influence and the contemporary discourse on the relationship between food quality (in gastronomic terms) and life quality are some of the issues that shape daily consumer interpretations of what constitutes good and bad food. Therefore, the striking distinction between a gastronomic view and a nutritional view of food prevents researchers from developing a fuller understanding of how consumers qualify food and how they navigate through their daily food practices with various health claims from more or less institutionalised sources. If we can embrace the idea that people eat food, not ingredients or nutrients, we can then acknowledge the fact that food is inscribed in a food cultural system, which often supersedes a nutritional system.

Morality of self-control and moderation

The moralisation of self-control has roots in the mind–body duality prevalent in the Western culture: the mind is believed to be rational, privileged and obligated to use its knowledge in order to control and manage the undisciplined and desiring body (Thompson & Hirschman, 1995). This duality is clearly reflected in religious teachings and practices. For example, Christianity condemns gluttony as a bodily impulse and a deadly sin, and it propagates restraint and self-denial (in the form of, for example, fasting) as a gateway to eternal salvation (Rozin, 1999b). The ethic of restraint is thus very pervasive in Mediterranean and European cultural history, and it can be traced back to Ancient Greece and Rome, where moderation of one's pleasure was the key principle of appropriate daily management (Coveney, 2006). Consequently, even today pleasure-seeking has a dubious connotation in (parts of) society in spite of the rise of hedonism as a consumption principle towards the end of the twentieth century (Hirschman & Holbrook, 1982). While experiencing pleasure from food consumption is not considered to be wrong *per se*, deliberate and excessive pleasure-seeking is strongly denounced. In other words, it is believed that our pleasure-seeking impulses must be subject to restraint and moderation.

Self-control and moderation in consumer research

Self-control refers to one's ability to alter their states and responses; the capacity to override immediate, short-term, concrete impulses such as the desire to eat unhealthily in order to conform to abstract, long-term standards such as moral ideals (Baumeister & Exline, 2000). In other words, it refers to the ability to resist temptations (Dhar & Simonson, 1999; Dholakia, Gopinath, & Bagozzi, 2005). Self-control is considered to be an individual's moral obligation and key to virtuous behaviour (Baumeister, 2002; Dhar & Wertenbroch, 2000). Accordingly, the exercise of self-control is viewed as 'good' and rational, while the lack thereof is viewed as 'bad' and irrational (Conrad, 1994; Joy & Venkatesh, 1994; Marshall, 2010; Thompson & Hirschman, 1995). Similarly, individuals who resist (vs. yield to) temptation are considered by others to be substantially more righteous and moral (Steim & Nemeroff, 1995). In this light, the morality of self-control draws black and white judgements about both individuals and behaviours – high self-control is 'good' and low self-control is 'bad' (Marshall, 2010).

Concerned about the impact of self-control on issues like obesity, researchers have invested substantial resources in identifying factors – environmental conditions, personality traits, emotional and cognitive states – that may facilitate or hinder an individual's level of self-control (e.g. Baumeister, Gailliot, DeWall, & Oaten, 2006; Baumeister & Heatherton, 1996; Dhar & Simonson, 1999; Dholakia et al., 2005). Yet these insights have been limited in several ways.

First, most prior research has taken the link between self-control and long-term well-being for granted. As a result, many studies have overlooked the dynamics and long-term implications of self-control and instead have based their conclusions about such implications on observations of individuals' single decisions to resist or to give in to temptation. It would be important to adapt a long-term perspective of self-control by studying multiple decisions that take place over long periods of time (vs. one-shot

decisions) and appraisals of these decisions after a passage of time (vs. immediate appraisals). Doing so may relax and challenge the moral assumptions that have guided the self-control research to date. For example, some evidence suggests that failure to resist temptation on one occasion may motivate some individuals to reform and better control their intake on subsequent occasions, which may produce positive (rather than negative) implications for food consumption in the long run (Zemack-Rugar, Corus, & Brinberg, 2012). Similarly, appraisals of self-control success and failure may dramatically change with the passage of time. Although individuals feel guilty about giving in to temptation immediately after making a decision, they may regret resisting temptation after taking some time to reflect on the decision because they may feel that they have missed out on the pleasures of life (Kivetz & Keinan, 2006). Hence, adapting a long-term perspective of self-control will enhance our understanding of the link between self-control and long-term well-being.

The morality of self-control and moderation motivates consumers to restrict and moderate their food intake. Dieting is a common strategy that consumers use to keep their food cravings under control. It is endorsed by religion, which underlines the spiritual benefits of exercising restraint, and by medical institutions, which prescribe diet as a way to promote physical and psychological well-being (Turner, 1982).

Today the US alone is home to a 60-billion-dollar dieting industry with more than 70 million Americans trying to control their food intake (Krishnamurthy & Prokopec, 2010). Yet, as many as 95% of dieters fail to lose weight in the long run, and the rates of overweight and obesity are at an all-time high (Cummings, 2003; Olshansky et al., 2005). This happens partly because restricting and moderating food intake is difficult. Thanks to economic and technological progress, consumers (in developed countries) have unprecedented access to a wide variety and quantity of enticing food. Portion sizes of foods, especially those high in fat and sugar, have grown rapidly over the past decades and now invariably exceed the serving sizes recommended by the United States Department of Agriculture (Nestle, 2003; Schwartz & Byrd-Bredbenner, 2006). In this context, consumers need to withstand the escalating market norms and temptations in order to stick to their dietary goals, and it is not surprising that they often fail (Lake & Townshend, 2006).

There are many instances when consumers' attempts to restrict and moderate food consumption fail and even backfire. Self-control attempts break down when shifts in the environment ease the pressure to make healthy choices. For example, restrained eaters abandon their diets and overeat when unhealthy items are served in small unit packs, when unhealthy items have healthy labels (such as 'low-fat'), or when healthy items become available on the menu (e.g. Scott, Nowlis, Mandel, & Morales, 2008; Wansink & Chandon, 2006; Wilcox et al., 2009). Similar outcomes occur when consumers are in a 'hot' or visceral state (for example, when they are hungry or pre-loaded with a small amount of tempting food) and, as a result, focus all attention and motivation on satisfying the visceral need (Loewenstein, 1996; Wadhwa, Shiv, & Nowlis, 2008). Researchers have argued that visceral pleasure-seeking leads to self-control failure because of people's inability to predict future preferences when in a 'hot' state (Loewenstein, 1996; Van Boven & Loewenstein, 2003). This morality against pleasure has led to public policy interventions, which have sought to tame individuals' pleasure-seeking motives through cognitive moderation and restraint (Alba & Williams, 2013).

Finally, consistent with the moral view of self-control, individuals judge their own and other people's successful and failed attempts at exercising self-control through a moral lens. At the individual level, consumers experience guilt and regret when they fail to control their food intake (Ramanathan & Williams, 2007). Collectively, individuals blame self-control failure for the proliferation of social problems like overweight and obesity (Baumeister, Heatherton, & Tice, 1994).

These views are further propagated in research, as we have already seen. Research on food and health has relied on a limited view that pleasure is the bodily experience of enjoyable sensations when hunger, physical comfort or other visceral drives are satisfied (Dubé & Le Bel, 2003). This low-level physiological view of pleasure has contributed to the vilification of pleasure-seeking in food consumption and a popular hypothesis that food pleasure leads to overeating (Mol, 2010). Consequently, studies based on the principle of taming pleasure-seeking have overlooked the possibility that food pleasure may have multiple cognitive and emotional layers beyond just bodily sensations. Taking into account these symbolic and aesthetic dimensions of food pleasure may challenge the morality of self-control, because it could suggest that pleasure may in fact facilitate (vs. impede) moderation and well-being. This is consistent with the recent evidence that food rituals increase personal involvement and lead to more mindful and pleasurable eating experiences (Vohs, Wang, Gino, & Norton, 2013). Likewise, cultures that focus on food pleasure and eating rituals (e.g. France and Japan) are the ones where portion sizes are smaller and individuals are leaner (Rozin, 1999b, 2005; Rozin et al., 1999; Wansink, Payne, & Chandon, 2007).

Defying the morality of self-control and restraint

Summarising the general attitude behind food and health research on self-control and restraint, one might conclude from the discussion above that the individual has the moral obligation to resist (vs. give in to) immediate, short-term, concrete impulses in favour of abstract, long-term goals. While contested meanings concerning the moral code inherent in promoting the benefits of self-control and moderation do exist, as we have clearly demonstrated through our discussion in the preceding section, we see the same pattern emerge as we saw in the case of the morality of food items. For example, while the debate centres on long-term versus short-term benefits and costs of self-control, what it overlooks is the fact that the basic assumption underlying the research objective of promoting self-control – that sustainable long-term moderation and self-control may require allowance of some short-term transgressions – is defined by the very same morality that researchers should try to overcome.

What this does is to perpetuate the ideology of dieting, an ideology that has spread in contemporary consumer society. What varies across various dietary regimes is the exact way a diet should be carried out and which 'sins' are allowed during it. But the basic idea is unchanged: it is of life consisting of a more or less permanent dieting journey, where monitoring one's food intake (and exercise patterns) becomes a significant part of lifestyle for alleged short- or long-term effects on health and well-being. While the number of regular dieters has skyrocketed in contemporary society, the role of food as a creator of social bonds is increasingly endangered, and it is changing to accommodate gatherings of particular dieters rather than a common meeting and socialising ground (Fischler, 2013).

While they do not all explicitly focus on weight loss – newly emerging diets are defining a number of additional goals such as improving intelligence and improving

sleep patterns – losing weight remains by far the most significant goal that consumers try to pursue through dieting. As a result, a roughly estimated half of American women and one-third of the men are trying to lose weight (Gaesser, 2009). Not only does this in extreme cases lead to *anorexia* or to *orthorexia nervosa*, an obsession with healthy eating (Adamiec, 2013; Bratman, 2000), but it obviously in a much larger scale leads to the maintenance of a billion-dollar dieting market with an estimated long-term failure rate of 90% or more (Campos, 2005; Gaesser, 2009). Even more significant in this context is the observation that repeated failed dieting attempts and resulting weight fluctuations (so-called yo-yo dieting) may have more harmful consequences for personal health than a steady level of overweight (Campos, 2005).

The dieting ideology and the diet confusion due to competing expert systems and varying research results have spread through more or less (often less) reliable public channels of ‘knowledge’ dissemination in the form of research results, personal experiences and what most often turns out to be quick generalisations of partial findings on diet and nutrition. The consequence is a mediascape of divergent and often dubious dietary advice (Kristensen, Boye, & Askegaard, 2011). Consumer research on food and health also contributes to this picture, and while there is no denying of the fact that weight and health are to some extent correlated, this correlation is often overestimated, an issue we shall return to shortly, and dieting morality produces a considerable amount of what one could call ‘collateral damage’. This damage can be illustrated by the fact that 57% of French women within the normal weight range (BMI 18–25) want to lose weight (Lecerf, 2013). Furthermore, even for obese consumers, research has demonstrated that size acceptance and increased levels of self-worth may contribute more to consumer health than dieting (Bacon, Stern, Van Loan, & Keim, 2005).

While targeting people whose health might be at serious risk if they do not obey certain dietary principles, the general morality of health-related dieting reaches far beyond the target population, leading to sometimes profound deterioration of life quality and self-esteem in many consumer groups, women in particular. Food and health research which has not relied on the premise that self-control, as expressed through a variety of dieting behaviours, is the safest way to maintain health might not generate as much collateral damage. While restraint is still built into the dietary advice of the more sensible medical doctors to ‘eat anything one feels like, but not too much of it’, this advice is considerably less controlling than the plethora of dieting recommendations often given in the contemporary marketplace. To be fair, consumer researchers studying overeating generally subscribe to this logic. However, they generally fail to address the issue of making dieters out of individuals that needed not be – at least not for health reasons.

Morality of body size

Since the World Health Organization in 1997 called attention to what was considered an alarming obesity epidemic on a global scale (World Health Organization, 2000), the war on obesity has been one of the top medical priorities in many contexts. Hence, here we discuss the vast literature on the obesity epidemic, its origins – whether thought to be rooted in evolution (Power & Schulkin, 2009) or in the institutional functioning of the fast food industries (e.g. Nestle, 2007; Shell, 2003), as popularised by Morgan Spurlock’s blockbuster documentary film *Super Size Me* – and its consequences in the

form of various diseases and loss of life quantity and quality. Obesity as a contemporary social issue has framed a lot of the contemporary consumer research.

There are a number of countervailing discourses that seek to modify the definition of obesity as an alarming social problem and mitigate the stigmatisation of fat people. These discourses in science fall under 'fat studies' (e.g. Rothblum & Solovay, 2009) rather than obesity research. They do not, however, fundamentally shake the prevailing 'truth regime', that while thinness is associated with good health, success, smartness and worthiness, obesity is branded as a lifestyle disease, a social burden due to rising-associated medical costs and a sign of an individual's greed, immorality, laziness and lack of self-discipline (Campos, 2005; Gard & Wright, 2005; Murray, 2005, 2008).

Morality of body size in consumer research

The morality of body size shapes consumer behaviour and consumer research in several ways. Consumers, policy-makers and researchers moralise about individuals' physical appearance. Specifically, there is a widely held view that physical appearance – specifically, weight – is reflective of an individual's health and that low weight is 'good', while overweight is 'bad'. This view is prevalent in Western societies, particularly among women, and is often perpetuated by the media. It is so pervasive that even children as young as 7 years old have been shown to hold it (Ricciardelli & McCabe, 2001).

It is important to note, however, that overweight stereotypes and resulting behaviours are not as prevalent in contexts, where larger body sizes are acceptable and valued. For example, compared to women, the 'thin' ideal is not as strong among men (who place more emphasis on stature and muscularity, Ricciardelli & McCabe, 2001), African Americans (who often have heavier ideal body sizes than Caucasians, Lawrence & Thelen, 1995; Thompson, Corwin, & Sargent, 1997) and in the cultures of the South Pacific (where large bodies are associated with high status, power, authority and wealth, Pollock, 1995). As a result, individuals in such contexts experience less body dissatisfaction, feel attractive at higher weights and believe their size is considered satisfactory by important others (Kemper, Sargent, Drane, Valois, & Hussey, 1994; Odoms-Young, 2008). Together, these factors may account for fewer eating disorders and higher levels of body esteem observed among African Americans and among men compared to women (Field et al., 2005; Ricciardelli & McCabe, 2001; Striegel-Moore et al., 2003).

It is a well-known fact that obesity is more prevalent among consumers from low socio-economic strata than elsewhere in the social hierarchy (McLaren, 2007). In certain countries, this correlates with some of the above-mentioned ethnic groupings, making it difficult to separate the ethnic from the class factor. However, when addressing obesity within a social class framework, researchers tend to be less inclined to accept the same degree of cultural relativism, since these consumers are seen as inscribed not in a different culture but rather in a resource-deprived cultural context resulting in restricted access to education, goods and services that promote a healthy lifestyle or circumvent the problems of obesity. More research is therefore called for on the challenges that low SES consumers face to overcome the negative implications of overweight and obesity and on the institutional reality that perpetuates these conditions in the first place (Townend, 2009).

Moreover, when individuals fail to meet the weight norms, they can become subjected to stereotypes and discrimination, which feed a negative self-concept and self-stigmatisation and give rise to unhealthy emotions such as depression, guilt and shame (Goffman, 1963; Gracia-Arnaiz, 2010). This in turn can fuel further overeating and create a vicious cycle, which is why some researchers consider stigma to be one of the causes of the proliferation of obesity in society (Poulain, 2002).

Consequently, it is clear that health incorporates more than just objective measures of one's weight. The body is not just a symbol of health or illness, but it also represents a socially defined self that embodies diverse social and cultural meanings (Odoms-Young, 2008). Thus, when measuring and studying health, researchers must incorporate not just assessments of body mass index (BMI), dieting history and eating habits (Block et al., 2011; Bublitz et al., 2011), but take into account psychological assessments, such as the consequences of stigmatisation, which speak to the subjective measures of health (e.g. body esteem) (Bublitz et al., 2011).

The morality of body size spills over to the marketplace, where overweight consumers are treated as less legitimate and receive less attention. The resulting frustration motivates some consumers to mobilise for more inclusion by, for example, convincing marketers to target them, supporting companies that address their needs and identifying those that do not, and joining forces with institutional actors to get more resources to fuel this change (Scaraboto & Fischer, 2013). Other consumers seek inclusion by using market resources such as self-help groups in order to get spiritual and therapeutic assistance in overcoming overconsumption and losing the excess weight (Moisio & Beruchashvili, 2010). In fact, weight loss is the most common strategy endorsed by various market agents and adopted by overweight and obese individuals as an attempt to comply with social weight norms. However, engaging in weight control activities can induce negative feelings like anxiety (Sobal & Maurer, 1999).

Not all consumers adopt active strategies to cope with overweight stereotypes and stigma. This is because active stigma management strategies require consumer engagement and hence a high level of individual competence (Adkins & Ozanne, 2005). Instead, most individuals react through flight strategies (Kaiser & Miller, 2001). Thus, consumers who have internalised societal moralities end up feeling disempowered and forgo many consumption opportunities (Henry & Caldwell, 2006). For example, some avoid consumption practices like coupon redemption and thereby give up financial benefits (Argo & Main, 2008). Others restrain their shopping experience by limiting themselves to familiar products (Adkins & Ozanne, 2005). In sum, overweight and obese individuals not only carry the emotional burden of being stigmatised, but they also incur substantial financial costs in the marketplace.

Not only is overweight treated as an immediate sign of poor health, it is also considered to be the result of an individual's poor choices. As Kristensen and colleagues (2011, p. 197) point out, eating has become a notable site of individual responsibility: 'If you can do something about your consuming lifestyle and the alleged risks that follow from it, you should'. Together with perceptions of body size, this assumption of individual responsibility creates an impression that overweight individuals are solely responsible for their 'deteriorating' body, and hence that they are unwilling and unmotivated to exert self-control (Askegaard, Gertsen, & Langer, 2002; Puhl & Brownell, 2003). These beliefs are held by healthy weight, overweight and obese individuals (Crandall, 1994; Schwartz,

Vartanian, Nosek, & Brownell, 2006), and they feed the negative stereotypes of overweight and obese individuals in other domains of competence including professional, educational and justice (Crandall & Eshleman, 2003). In short, an individual's moral worth is assessed based on his or her appearance (Featherstone, 1982; Shilling, 2003; Thompson & Hirschman, 1995).

Defying the morality of body size

Considerable energy and resources are spent by consumer researchers on investigating the causes of obesity in terms of overeating, lack of self-control and sedentary lifestyles. When it comes to the dependent variables, prior research has primarily focused on decisions and behaviours related to weight loss and consumption regulation (Bradford, Grier, & Henderson, 2012; Moio & Beruchashvili, 2010; Wansink & Chandon, 2006). While these efforts do not endorse any particular beauty ideal, they still regard obesity as a 'problem' and thereby resonate with the body size morality that prevails in society in the form of mediated imagery and promotion of thinness that leads individuals to strive for slim and fit bodies.

Consumer research is far from alone in producing research that contributes to the overall stigmatisation of the fat body. A large number of health organisations at international and national levels have called for increased attention to the alarming obesity epidemic that is seen as a threat to global health on a level similar to tobacco (Nestle, 2007). As such, it is a process that is rooted in very general institutional and discursive processes in a society that has become largely lipophobic (Fischler, 1990). Even if the explanatory framework for the obesity epidemic is seen as complex, one standard explanation behind it remains the abundance of cheap and highly caloric (fast) food. Likewise, the process of stigmatisation is usually linked to the abundance of commercial imagery promoting the thin body as the overarching social ideal. Since consumption and commercial imagery are what consumer researchers seek to understand, it is not surprising that they engage in research that seeks to understand the processes behind the emergence of the obesity epidemic and factors that could contribute to the alleviation of the public and private stigmatisation.

If consumer researchers are trying to solve a serious health problem and, at the same time, also contribute to debase the social stigmatisation of overweight and obese people, what could then constitute a moral problem? If people are victims of their own choices as well as of luring presentation techniques, portion size manipulations and 'unhealthy' temptations of the marketplace, as well as victims of social exclusion and stereotyping, why should consumer researchers not give a hand in providing help to these victims?

The problem is that the general premise behind all of this is the notion that obesity is a health problem. Establishing it as such, to a certain extent, legitimises a degree of stigmatisation both in terms of personal responsibility (i.e. 'you should lose weight for your own good') and in terms of the alleged burden on the health care system that the overweight and obese population represents. Because obesity can be framed as modernity's scourge and being fat can be framed to symbolise poor physical, social and mental health (Gard & Wright, 2005), problematising the fat body becomes a positive moral stance, which contributes to solving personal, psychological and physical life quality issues.

However, medical and related fields of research have consistently pointed to sedentary lifestyles as a better predictor of poor health than obesity in and of itself. The fact that weight remains quite a poor indicator of a person's health (disregarding very extreme cases at both ends of the spectrum) is something that usually escapes the public mind (Campos, 2005; Egger & Swinburn, 1997; Friedman, 2003; Saguy & Almeling, 2008). The reason behind this is probably the fact that, while obesity is highly visible, sedentary lifestyles are not. As a result, the condition of obesity becomes medicalised – considered an illness rather than a particular bodily condition. This is despite the difficulty of finding evidence that can classify obesity as an illness, and the fact that, while obesity is correlated with a number of illnesses such as diabetes, the direction and strength of causes and effects are less certain. It also undermines the fact that attributing obesity to a simple equation of calories consumed versus spent ignores not only the social and existential complexities, but also the complexities of human metabolism (Gard & Wright, 2005).

The fat body is thus viewed as the much too visible sign of personal and social problems. The legitimacy of these interconnections, however, breaks down if the premise – that obesity in and of itself is not as a significant risk factor for health as many regard it to be – is proven to be false. This premise can indeed be challenged by certain counter discourses, which critique obesity research for being caught in the race for limited research funds and, as a result, for having a vested interest in alarming the public about the risks attached to obesity. According to these discourses, obesity research represents a less than pretty mixture of science, morality and ideology (e.g. Campos, 2005; Gard & Wright, 2005).

One example of a discourse that challenges the legitimacy of body size morality is the work by Gard and Wright (2005). It specifically points to large-scale mortality research from countries such as Norway, USA and New Zealand, which indicates that mortality risk rises above average only beyond a BMI level of 30, and the risk curve is much steeper at the low end of the BMI range than at the high end. For example, the overall mortality risk for Norwegian women aged 50–64 years was similar for women with a BMI of 18 (which is the lowest level at which one would be considered normal weight) and those with a BMI of 37 (which is well beyond the level when one would be considered obese and close to the level of BMI of 40 when one would be considered morbidly obese) (Gard & Wright, 2005).

The war on fat has therefore been interpreted as a middle-class-value-based attack on certain ethnic groups and social classes (Campos, 2005). Likewise, the focus on obesity as a health issue is linked to the long-lasting debate about commercial messages that promote ideal body imagery, particularly for women. Fat, therefore, has also been discussed as a feminist issue (Orbach, 2010; see Murray, 2005, 2008 for an academic treatise and Johnston & Taylor, 2008 for a consumer-oriented discussion).

The critique of the war on obesity and of the fat body as an indicator of poor health occasionally finds its way into consumer psychology and food consumption publications (Egger & Swinburn, 1997; Friedman, 2003; Saguy & Almeling, 2008) as well as research on consumer cultural phenomena (Scaraboto & Fischer, 2013). But these are the exceptions, not the rule.

In sum, similar to the dieting issue, the focus on obesity as a problem may contribute to the perpetuation of a particular view on food and health that may not be as sustained by medical research as it is by popular belief (and by consumer research). This view contributes to the collateral damage to certain populations

including the overweight and obese, but also women as well as economically and socially challenged ethnic groups and social strata.

Moralities of market interaction

Several moralities underlie consumers' and researchers' perceptions of market actors and their interactions. These moralities pertain to three main groups of actors – public policy-makers, health care providers and the food industry – and they are based on assumptions that are in some ways contradictory.

Public policies that are designed to guide individuals' eating behaviours primarily promote education about healthy lifestyle. Guidelines such as 'Eat five fruits and vegetables a day', 'Exercise regularly', 'Limit the consumption of fatty and sugary foods' as well as anti-obesity campaigns all trust that, provided with sufficient information, individuals will be motivated, responsible and morally obligated to choose the right lifestyle (Chrysochou et al., 2010; Kristensen, Askegaard, Jeppesen, & Anker, 2010). Similarly, in the health care domain, a steady shift is in place towards a collaborative health promotion model that emphasises information, individual control and agency (Maes & Karoly, 2005). When it comes to the role of the food industry, there is some tension in how the public interprets this role in the food and health discourse. On the one hand, consumers and researchers agree that the function of the food industry is to innovate and to make profit. In a market-driven economy, the manufacturer is free to sell products and the consumer is free to reject them. On the other hand, the profit-maximising nature of food marketers' activities is often perceived to come at the expense of public health (Brownell & Battle Horgen, 2003; Brownell & Warner, 2009).

Market actor morality in consumer research

The moral assumptions about market actors have given rise to several important phenomena in the marketplace. The World Health Organization has documented the detrimental effects that certain industry practices such as the marketing of unhealthy foods to children have had on public health (Lewin, Lindstrom, & Nestle, 2006). Generally, the food industry has been under attack for its detrimental effect on public health (for some of the most well-known examples, see Schlosser, 2001; and Nestle, 2007). Consistent with this profit (im)morality, the public often casts the food industry as an 'evil' and greedy entity that is willing to produce and market foods that are unhealthy, obesity-inducing and, in some cases, even toxic (Nestle, 2007; Taubes, 2011). Furthermore, the food industry has been accused of contributing to 'industrial epidemics' such as alcohol misuse and obesity and to the escalation of lifestyle diseases such as cancer, heart disease, cirrhosis and diabetes, all of which constitute a large share of public health burden (Hastings, 2012). Counter examples, however, also exist in the form of initiatives that have been successful at encouraging healthy eating (see, e.g. Jones, Comfort, & Hillier, 2006).

Many public policies that rely on the assumptions of consumer involvement and willingness to change have not been very effective and have even at times backfired (Werle, Boesen-Mariani, Gavard-Perret, & Berthaud, 2012; Werle & Cuny, 2012; Wilson, 2011). For example, the calorie disclosure policy has been recently implemented in many restaurant chains in order to inform consumers about the

caloric content of unhealthy foods. Yet a number of studies have shown that this measure has had mixed results (Loewenstein, 2011). While posting the calorie information has reduced consumers' intake of food items at certain chains, it has not changed their intake of beverages or full menus, and in some cases, it has even increased consumption (Rosenwald, 2011). Similarly, studies have found that the inclusion of informative health sanitary messages in food advertisements may actually enhance the appeal of unhealthy foods and consumers' likelihood to choose these foods (Werle & Cuny, 2012). Finally, the content of different 'good' and 'bad' ingredients in foods is often inconsistent. For instance, in the recent push to reduce the amount of fat contained in snack foods, manufacturers compensated for lower fat content by boosting foods' sugar content. Such inconsistencies may lead to consumer confusion and inconsistent decisions (Chernev & Chandon, 2010).

Such findings challenge the basic assumptions of consumer involvement and intentional behavioural change. From a psychological perspective, a growing body of evidence suggests that consumers' eating decisions are subject to judgement biases and that subtle changes in the environment can nudge consumers towards healthier food choices (e.g. Aydinoglu & Krishna, 2011; Chandon & Ordabayeva, 2009; Chandon & Wansink, 2007a; Chernev & Gal, 2010; Irmak, Vallen, & Robinson, 2011; Wansink & Chandon, 2006). For example, studies have shown that shrinking the size of serving plates and utensils decreases consumption (Wansink, Van Ittersum, & Painter, 2006) and that making it difficult for consumers to reach for unhealthy alternatives but easy to reach for healthy alternatives through buffet reconfiguration can change eating patterns (Rozin et al., 2011). Similarly, simplifying nutritional guidelines through innovative nutritional scoring systems (e.g. NuVal) or traffic-light food labels (which designate unhealthy foods with a red label and healthy foods with a green label) can ease the processing of nutrition information and improve decision-making (Riis & Ratner, 2010). However, alongside their relative effectiveness, nudging techniques have raised questions about the ethicality of marketers' and policy-makers' actions to change consumer behaviour without consumers' awareness or consent from political sociological and health psychological points of view, generally questioning the libertarian character of nudging's 'libertarian paternalism' (Goodwin, 2012; Selinger & Whyte, 2011; Smith, Goldstein, & Johnson, 2013).

Furthermore, in response to consumers' scepticism and allegations about contributing to public health problems marketers such as McDonald's, Coca-Cola, Pepsi Co and Kraft have initiated corporate responsibility programmes targeted at improving public health (Ludwig & Nestle, 2008). However, some of these programmes have stumbled upon public criticism. For example, UK's Academy of Royal Medical Colleges has warned the UK government that it is failing to tackle the growing obesity epidemic due to its hesitation to punish the food industry for its irresponsible actions (Hastings, 2013). The public scepticism goes so far as to create an impression among some consumers that official dietary guidelines are controlled more by commercial than by public health interests. Certain alternative dietary movements such as paleo- or low-carb diets harbour distrust and in many cases even lead to the abandoning of nutritional recommendations given out by authorities (e.g. Kristensen et al., 2011; Mikkonen, Luukkonen & Koivisto, 2012).

Although much of the previous literature assumed that consumers make informed, effortful and rational choices, it has become clear that food decisions are often made with minimal involvement and are subject to various environmental influences (Shah,

Ubel, Bettman, Keller, & Edell, 2013; Thaler & Sunstein, 2008). Therefore, it is considered important to explore strategies that can increase consumer involvement in food decisions. Some recent studies have shown that this can be achieved by changing how consumers evaluate and feel about food items when ordering meals. For example, consumers are more mindful of food portion size and eat less when they are asked to pay attention to and to estimate the size of each meal component as opposed to the entire meal (Chandon & Wansink, 2007b). Similarly, drawing attention to the trade-off between food healthiness and tastiness can increase consumer involvement and accuracy in estimating portion size (Cornil, Ordabayeva, Kaiser, Weber, & Chandon, 2014).

Defying the morality of market agent interaction

The inherent morality behind all of the above-mentioned efforts is linked to the neoliberal ideal (some would say, illusion) of consumer sovereignty, free market and corporate agency. The basic assumption here is that the market will function best if market agents can exercise freedom with responsibility; if corporate and consumer agents can act autonomously combined with respect to the social and personal consequences of one's free choices. As Coveney (2006, p. 93) underlines, Modernity has produced a situation where 'having choices, making choices and not being able to make the right choice – always against an index of morality – are things that emanate from a particular understanding of freedom'. It is an understanding that tends to overlook that the personal is deeply intertwined with the political.

The morality of the sovereign consumer is at the heart of the critique of corporate strategies which produce food items with little to no nutritious (and/or gastronomic) value and apply various seduction and manipulation techniques in order to present their products as healthier than they actually are and to lure consumers into over-consumption. If such techniques were abolished and the corporate world enacted their freedom with responsibility, these would be non-issues because consumers would be able to make informed choices based on objective conditions. It takes little imagination to see how this model of thought does not hold to a closer scrutiny in view of how a capitalist economy functions. There seems therefore to be no way out of a political discussion about regulating corporate behaviour. Such political regulation, however, runs counter to current ideals of liberal market governance, and it is politically and culturally difficult to establish, practically difficult to define and justify in terms of scope, and difficult to enforce without a considerable control bureaucracy. These dilemmas, however, are usually not discussed by consumer researchers.

More importantly, consumers may not want to make 'the right choice' in terms of nutritional value. We have already argued for the possibility of a gastronomic register of moralisation. Many consumer researchers would agree that consumers' failure to make 'the right choice' often stems not from their inability to discern the dubious nutritional value of modern foods (very few consumers actually doubt it), but from the fact that these foods just taste 'grrreat', to paraphrase Tony the Tiger. Furthermore, a large majority of the population actually builds 'sinful indulgences' into their diets (Chrysochou et al., 2010). Consequently, blaming health issues solely on corporate fraud and seduction is an overly simplified approach, which neglects the significance of transgression and indulgence for the constitution of human social life.

Furthermore, reducing the issue to a problem of making the ‘right’ choice basically puts the responsibility back on consumers’ shoulders. Decades of informational campaigns have tried to equip consumers with the necessary cultural capital in order to make these ‘right’ choices. However, defining what the ‘right’ choices are has become increasingly difficult with the explosion of information about health practices from competing expert systems, and the rise of the Internet as a consumer-to-consumer mass communication platform has only contributed to this complexity (Kristensen et al., 2011). Hence, we experience a situation, where the problem seems to be one of the mixed information rather than misinformation (Coveney, 2006).

The limits of considering the consumer as a decision-maker are far from new and have been criticised by decades of consumer culture theorists (Arnould & Thompson, 2005). In our context, the morality of the sovereign consumer has some unfortunate consequences such as a relative neglect of the way food is inscribed in practices of daily routine and of the complexity of interests and goals in cultural (and not just nutritional) schemes of life quality.

Even more problematically, the morality of the sovereign consumer neglects its own role as a technique of domination, since its reference to sovereignty hides the fact that any kind of governmentality is taking place. This is nowhere more visible than in the contemporary embrace of nudging techniques, which are often believed to be more effective than information-based campaigns (Oliver, 2011) and traditional social marketing efforts (see, e.g. Rothschild, 1999). Nudging through environmental design is seen as a way to orient consumers towards desired behaviours without the use of force and without the uncertainty and cost-inefficiency of information campaigns. But it is also a technique of domination, which at the same time claims to respect the image of the sovereign consumer, but also undermines it. As such, this poses a number of ethical issues concerning the nudging mechanisms, which need to be addressed in the future (Blumenthal-Barby & Burroughs, 2012; Ménard, 2010).

We would thus like to point to the limits of attributing responsibility to producers for facilitating ‘bad’ food choices and also to the limits of the model of the empowered consumer (Shankar, Cherrier, & Canniford, 2006), especially if one does not question some of neoliberalism’s basic principles. Most of the existing research buys into these principles and thereby ignores some of the subtle social processes through which modern market systems and market agents are constituted. While we do not believe in the absence of moral registers or that moralisation is essentially bad, we believe that a more overt reflection on the techniques of governance of consumer choice might lead to a more balanced discussion of market agents and their interactions in consumer research.

General discussion

This paper has examined some of the major moral assumptions that underlie the discourse on food and health in contemporary society. Our intention is to raise awareness and self-reflection among members of the public and the research community so that future efforts are directed towards studying and formulating policies that are more reflexive of their own basis for moral judgement. This is important because the prevailing moral agenda on food and health constrains the goals, methods and conclusions of policy-makers and researchers in many ways (as detailed in the manuscript) and in a number of ways it produces consequences

that subtract from, rather than add to, general consumer well-being. This ultimately results in a limited understanding of the relationship between food and well-being. It is also important because moralities of food and health – as moral discussions prevailing in other domains – are forming our conclusions in many ways. In other words, we will say with Foucault that our point is not

that everything is bad. [Our] point is that everything is dangerous, which is not exactly the same thing as bad. If everything is dangerous, then we always have something to do. So, [our] position leads not to apathy or enervation but to a hyper and active pessimism.

(1983, p. 231–32).

We thus suggest an active pessimism in terms of reflection on these moralities.

First of all, moralities of food and health rely on unstable assumptions. The moral stance about what constitutes a ‘good’ or a ‘bad’ food and diet has changed dramatically since the 1960s: the current era of fat (which advocates limiting the intake of saturated and trans-fats) succeeded the earlier eras of vitamins (which advocated the consumption of vitamins) and meat (which advocated limiting the intake of meats) (Santich, 1995; Scrinis, 2013). Contemporary discussions for and against various types of carbohydrates, the dietary usefulness of low-fat or fat-free products and so forth witness the temporality of such moral condemnations. These assumptions also significantly vary across space. For example, the French and Belgians hold weaker (im)moral interpretations of ingredients such as fat and salt compared to Americans (Rozin et al., 1999). In other words, the moral guidelines about what we should and should not eat reflect socially constructed concerns at any given time and place more than they reflect a physiological reality.

Moreover, moral guidelines embody the public’s attempt to justify certain lifestyles. While we ostracise some behaviours on moral grounds (eating an ‘unhealthy’ Big Mac), we overlook other behaviours that could arguably yield similar outcomes (raising infants on carrot juice rather than milk based on misunderstood dietary recommendations, cf. Kristensen et al., 2011). In other words, our moral assumptions give rise to double standards.

Finally, as researchers, we should remain conscious of the multitude of moralities that guide food consumption. Moralities of food reach beyond health concerns and impact perceptions of the social and market structures surrounding food. Contemporary debates on vegetarianism with references to a variety of moral registers including health but also climate change and animal welfare is a good example. Thus, moral assumptions influence our judgements of foods, as well as eating behaviours, both as individuals and society as a whole.

To overcome the rigid norms and policies propagated by moralities of food and health, researchers should strive to broaden the understanding of the basic components and drivers of food well-being. Future research can move towards this goal by expanding beyond the traditional methods applied in prior studies. In the domain of consumer psychology studies on food and health, we will draw attention to the following observations.

First, we recommend that future studies extend the list of dependent measures beyond simple one-shot choices of healthy or unhealthy food items to include, among other measures, choices of entire menus, food decisions across multiple meal occasions, food consumption over extended time periods, the quantity of food that

people consume, the time of day that they consume, and changes in eating behaviours following shifts in health policies, eating regimes, and diets. Second, researchers should move beyond the traditional Western, affluent, undergraduate participant samples to examine broader samples of individuals with diverse demographic and socio-economic backgrounds. More attention should be particularly paid to the influence of such factors as gender and to the study of vulnerable populations such as children and low-income consumers. Furthermore, researchers should try to replicate and qualify the established findings with diverse samples in different geographic locations and in non-Western cultures. There is quite a bit of knowledge about how food culture and socialisation influence eating habits and consumption, but this knowledge usually does not find its ways into consumer psychology, due to methodological individualism and lack of interdisciplinary interaction. Hence, it would be important for future studies to explore the various food rituals and social structuration of eating practices from a broader variety of perspectives. Finally, researchers should look beyond the traditional food manufacturers and policy-makers when studying the actions of market agents. They should also examine the actions of food retailers, caterers, health care providers and dieticians in order to fully understand the interplay of various policies and industry initiatives in the marketplace. Together, these research strategies will facilitate a rich discussion of the commonalities as well as the limitations, discrepancies and moralities adopted by researchers across different contexts, methods and paradigms, which in the long run should contribute to a more constructive, inclusive and self-reflective body of knowledge on food and health.

Beyond these reflections on how consumer researchers can try to remedy some of the evoked issues through a more reflexive design, we would like to reflect on the framework of moralities pertaining to food and health research presented here. Our first observation is the tacit interconnectedness of the various types of morality. 'Good' behaviour in terms of moralised action is considered leading to 'good' results in terms of object moralities: choice of inherently 'good' products and cultivation of inherently 'good' (=lean) bodies. A universe of predominantly 'good' products in turn facilitates the morality of the 'informed' choices and the exercise of restraint and moderation, just like the lean (=healthy) body is the ultimate sign of ability to exercise the other moralities in the scheme.

Our second note is that we are not trying to argue that consumers' relation to food can be free of socially moralised schemes. Nor are we arguing that there is no relation between what is deemed 'poor' eating habits and general health condition, or that there is no connection between obesity and health (although, as we have argued, this particular relationship tends to be presented in an oversimplified form), or that judgements of contemporary bodies can be free of the unhealthy (pun very much intended) confounding of aesthetics and health. What we are arguing instead is that contemporary societies are all to some degree permeated by the contemporary ideology of healthism (Crawford, 1980) and are therefore subject to the collective and individual exercise of the imperative of health (Lupton, 1995). This imperative of health, with its strategies of governance and its health technologies, is what creates the backdrop for the highly discursive and political presence of health in public and private lives. And it is this imperative that ultimately legitimises the inherent moralities in consumer behaviour and consumer research that we have tried to unpack.

The moral classification of 'allowed' and 'not allowed' food items, the establishment of dieting as a normal and, for many, constant consumer practice, the

reliance on informed and sovereign consumer choice and the attempts to guide choice through strategies of governance without direct prescription or prohibition (cf. Sulkunen, 2009) as well as the stigmatisation of the fat body in social, economic and cultural domains can be considered the most significant moral aspects of that contemporary ideology of healthism. In Foucauldian terms, these practices form the core of governmentality of healthy eating in modern society. As governmentality in other domains, it embodies technologies of self and technologies of power, which are simultaneously liberating and dominating (Shankar et al., 2006).

Crawford (1980) argued that contemporary healthism is ideological in nature and scope: it contributes to the ascendancy of a neoliberal social order that rests on the notion of personal responsibility and privatised market solutions to public problems. Healthism furthermore establishes health as an overarching social value that cannot be challenged. If by a myth, we understand a social construction that is turned into a naturally given fact (Barthes, 1957), the governmentality of health forms becomes a myth. While consumers to some extent can be excused for being blind to their own inscription in mythologies (since it is part of the very definition of myth that it is invisible to those who are subject to it), it is the duty of social researchers to constantly reflect on and contribute to the debunking of the social constructions that are held as scientific and/or public truths. The contested question in food and health research and policy is the extent to which what Foucault (2010) called 'biopolitics' influences the establishment of nutritional and food- and health-oriented claims. While offering no ultimate answer to this question (since no such answer exists), we draw attention to the fact that biopolitics may be more significant in food and health than we are inclined to think as consumer researchers. We therefore call for reflexivity on the moral assumptions that guide our research and remind the readers about the underlying imagery of the relationship between mind and body that underpins much of this research – that the body is a locus of vice and excess which needs to be controlled and mechanised by techniques of the mind (self-control) or of the environment (nudging) (Chauvin & Bouchet, 2014).

Finally, we have reflected on the politics of research in this era of neoliberal market governance. As noted by Comaroff and Comaroff,

neoliberal capitalism, in its millennial moment, portends the death of politics by hiding its own ideological underpinnings in the dictates of economic efficiency: in the fetishism of the free market, in the inexorable, expanding 'needs' of business, in the imperatives of science and technology.

They continue

Or, if it does not conduce to the death of politics, it tends to reduce them to the pursuit of pure interest, individual or collective – or to struggle over issues [including health care] that are [...] dissociated from anything beyond themselves.

(2001, p. 31)

Researchers should continue to self-reflect on their moral assumptions, goals and methods by asking themselves, to what extent does our endeavour as researchers contribute to reducing politics to the 'pursuit of pure interests'? Whose interests do we promote, and in what sense are these interests pure? How do we isolate social problems

such as health from their socio-economic and cultural contexts, and how can we overcome this isolation?

Conclusion

The goal of this article has been to spark a discussion of the moral assumptions that underlie our research into behavioural and discursive patterns pertaining to food and health. We hope that this discussion will prompt researchers (as well as people in general) to be reflective of the values that they apply to understand, interpret and behave towards food and their social environment. We also hope that it will motivate researchers to be reflective of the assumptions that they adopt in their research questions, designs and conclusions. We recognise that the list of moral assumptions and their remedies outlined in the article is far from exhaustive. Future research should therefore continue to uncover the nature and implications of existing and emerging moralities of food and health in various contexts. It is only by collectively challenging our moralities that we can move away from the traditional paternalistic, normative model of health towards an inclusive model of food well-being (Block et al., 2011).

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