Diabetics and health food: the personal and the planetary in the creation of cuisine

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Introduction

Earlier this year, the Journal of the American Medical Association published its first ever special issue devoted entirely to diabetes. In the preface, editor-in-chief Chris Saudek expressed concern over the rising incidence of type II diabetes. Among his list of topics that will require future research he posed two questions that involve the concept of ‘motivation’. These were: “how can individuals with diabetes be motivated to follow self-care patterns necessary to prevent complications” and second: “how can an entire society be motivated to decrease its food consumption”?

While the first question is not entirely confined to the question of food intake, studies which have examined U.S. diabetics’ compliance rates with pharmaceutical and nutritional therapy have found that such compliance, is, in fact, very low (Johnson 1992, Kurtz 1990). European research has provided similar data. The EURODIAB IDDM Complications study reported that of 2868 insulin diabetic from 30 study centres, only 14-15% of patients achieved the recommended dietary allowances for fat and carbohydrates (Toeller et.al. 1996). This study took pains to assure that the diabetics being studied, had, in fact, received dietary education and that what was being studied was actually patient compliance rather than the delivery of dietary education. Clearly, despite educational efforts, diabetics are eating in a pattern that fits Saudek’s definition of poor self-care, and Saudek concludes that the problem is one of motivation.

Saudek’s second question is even broader and is concerned with diabetes prevention. It’s premise, that Americans eat too much, is supported by statistics showing rising rates of obesity. The connection between obesity and diabetes has been elucidated by studies which examine the links between obesity, insulin resistance syndrome and Type II diabetes. Implicit in many of these risk studies, however, is the belief that risk is a personal attribute and that individuals can be empowered to change their own risk factors through actions such as dietary modification and exercise. Indeed, a U.S. diabetes prevention study based on just these assumptions did show that diet and exercise regimens can prevent the development of diabetes (Larkin 2001) and a Finnish study quantified the risk reduction associated with a four year lifestyle intervention in patients
whose impaired glucose tolerance put them at particular risk of developing diabetes (Tuomilehto 2001). But other intensive intervention programs using well-developed behavior-modification approaches have shown high relapse rates (Mann 2000) and as a result, medical research is now focusing on the use of medications such as metformin to reduce diabetes risk. Such a willingness to use pharmaceutical means to reduce risk implies an associated unwillingness to deal with broader issues of social context which may be affect the ability of patients to act on diabetes prevention education.

Advocates of social epidemiology, on the other hand, have argued that the issue of empowerment must be reexamined (Krieger 1994), and that if the larger social context is taken into account, many so called “noncompliant” behaviors, in this case, overeating or ignoring admonishments to exercise, can be explained without implicitly or explicitly blaming the victim. Indeed, such social and political perspectives are gaining new recognition among public health researchers concerned with diabetes (McKinlay and Marceau 2000). Such a willingness to investigate the societal context of eating behaviors, for instance, has led to work such as Marion Nestle’s on the politics of food and health in the U.S. Nestle examines the efforts of the food industry, which she says, have consistently opposed public health efforts to get a clear message to “eat less” across to the American public. She concludes that these industry efforts have been largely successful due to the co-optation of professional health societies such as the American Dietetic Association as well as government agencies involved in health promotion, such as the U.S. Department of Agriculture (USDA) via food industry financial donations and political lobbying efforts. Individual efforts to oppose such influences she concludes, will have little effect until a change takes place in public and corporate policy. In this light, the recent decision by the Los Angeles School District to remove soft drink vending from school premises can be seen as a step forward in efforts to prevent diabetes.

Still, a focus on an empowered individual remains central to American culture, and Saudek’s question of ‘motivation’ remains pertinent. Indeed, much of social science at the end of the 20th century is concerned with the individual position in postmodern society. Bauman’s conception of the individual as being defined by a chaotic succession of consumption choices which are made without a firm support from authoritative
structures has also been applied to an analysis of the individual vis a vis the modern food system. The anthropologist Fischler maintains that the multiplicity of influences upon the modern eater, such as food industry advertisements, health authority pronouncements as well as proliferation in food choices results in a chaotic breakdown of the rules of food intake and the individual is left in a state for which he named ‘gastro-anomy’, as a play on the concepts of gastronomy and anomie. In this way, Saudek’s contention that diabetics lack motivation, or that Americans in general lack motivation in their eating could be called American ‘gastro-anomy’. Thus while psychologists might examine factors that affect ‘motivation’ or ‘compliance’, anthropology looks at the cultural setting and asks what it is about the culture that causes an individual to eat in such and such a way: ‘why’ does he choose to eat this? What influences or shapes his choices?

This viewpoint leads to a different terminology as well: structuralist anthropologists describe the creation of ‘cuisine’ in contrast to public health efforts to influence ‘diet’. The difference between the two terms speaks back to the issue of motivation: we eat a cuisine, but we follow or don’t follow a diet. Thus, by definition, there can be no compliance problem with cuisine. Cuisine is something that the eater creates. The anthropologist Mintz says that what makes a cuisine is a “a population that eats that cuisine with sufficient frequency to consider themselves expert on it. They all believe, and care that they believe, that they know what it consists of, how it is made, and how it should taste”. (Mintz 1996 p. 96). If viewed through the lens of the structuralist approach to cuisine, the problem of gastro-anomy is diminished.

Such an approach allows us to examine Americans who do eat in ways that Saudek might approve and ask why do they do this. Nestle, for instance, says that people who individually oppose the greater food culture (often described as a fast food culture) are “voting with the fork”. But while she remains pessimistic that their efforts will have a widespread effect, such individuals do, in fact, accomplish what much of what Saudek wishes. Their cuisine is, in fact, already well described: its foods are grouped under the banner of ‘natural foods’ or ‘health foods’, though in fact, membership in the grouping has not hinged on scientific studies on food and health and ‘health foods’ have had historically little to do with what Saudek and the American Dietetic Association might
recognise as medically defined healthy food. Nevertheless, 'health foods' now constitute a cuisine, eaten by a growing number of Americans.

Indeed, that today's health food movement, more than 20 years old, still has little connection with conventional western medicine is greatly ironic. While the American Dietetic Association and the United States Department of Agriculture (USDA)'s Food Pyramid and Guidelines have been struggling to propound "what's healthy to eat" to the American public, a completely separate group has created an entirely different cuisine which, for its adherents, defines what is healthy to eat. Indeed, social scientists have recognized that the 'health food movement' has been uniquely effective in inducing individuals to change their eating patterns. Kandel and Pelto, studying the movement in the 1970's, attributed such efficacy to the structure of the movement, as well as its somewhat spiritual nature, while more recently Belasco has focused on the group's attention to some of the same political issues with which Nestle is concerned.

Describing the details of the movement's opposition to the food industry, Belasco shows how this oppositional nature was instrumental in defining the structure of the cuisine. And while Belasco admits that the health food movement has, to some degree, been co-opted by the same food industry that it opposes, there is no doubt that its cuisine has gradually gained acceptance, and that in addition to gaining adherents, many of the foods which the movement espoused have now become a part of mainstream cuisine eaten by Americans who have never set foot in a 'health food store'. From either angle, we can say that the health food movement has been particularly good at changing cuisine.

It is a bit curious, then, that conventional medicine has not examined either the cuisine or its adherents in more detail. Partly, this may be due to the alliance which many of its adherents have with alternative (complementary) medical systems which western conventional medicine has viewed with suspicion. As well, conventional medicine has been leery of the scientific claims made by some of the movements' proponents. But it is also entirely possible that conventional medicine does not "see" such people: if, indeed, health food is 'healthy', then eaters of this cuisine may be, for instance, less obese and less often diabetic and therefore literally less visible to medical practitioners.

If conventional medicine is to learn something regarding how this movement produces cuisine change, one place to start is with individuals who have a foot in both camps: with
diabetics who eat health food. This is such a study. While it is not our intention to lose
sight of conventional medical goals and wisdom, the study is careful not to include any
scientific judgements on the health food beliefs illustrated. As difficult as this may be for
those who are steeped in the conventional medical tradition, the purpose of the study is
not to judge the "healthiness" of the cuisine, but to see how its eaters' beliefs about health
and eating are expressed through their cuisine. In a sense, this study allows us to see
how conventional medical teachings 'stack up' against health food movement teachings.
Examining how such diabetic health food believers blend the teachings of conventional
medicine and the health food movement, teachings which are by no means identical, can
tell us something about the relative strength of these teachings, and whether there is
something about health food cuisine and its construction that conventional medicine
might learn to its advantage. The study is not intended as a strict comparison of
methodologies. Rather it is an analysis of a particular type of cuisine, a cuisine which as
defined by our diabetic study members is largely rooted in the beliefs of the health food
movement, a movement which is recognized for its ability to induce change. It is our
hope that such an analysis may provide at least some answers to Saudek's question
concerning how to motivate Americans to eat in a way more mindful of their health.
Chapter 1: Methodology

This study is intended as an anthropologically based view of the cuisine of diabetics who are also adherents of the health food movement. As such, the study is qualitative and descriptive in nature. Semi-structured in-depth interviews with the study participants were carried out over a six week period during the early summer of 2002 in Portland, Oregon in the U.S. In an effort to assemble a reasonable picture of participants’ cuisine, the study supplemented these interviews with accompanied shopping trips with participants to health food stores. This technique provides several advantages. The first is that it at least partly avoids the memory related problems of dietary recall. In addition, it provides the chance for direct observation. Such observation also allows a wide latitude for discussion in a less formal, and more conversational manner. Indeed, the technique allows almost complete spontaneity in the conversation. Rather than relying on a defined structure, the interview progresses via a walk through the store, from produce section, to baked goods, to package goods, etc. Discussions of opinions on particular foodstuffs follow this progression through the aisles, with commentary on specific products, both as to their appearance, their qualities, their use, and issues such as branding, and price. The discussion is freewheeling and well designed to allow participants the chance to air a variety of opinions. In addition, the setting also allows the participant to “be the teacher”; while the interviewer was identified as a physician and medical anthropology student, her culinary expertise and food knowledge was an unknown to participants, and as the interviewer had already expressed an interest in learning their personal cuisines, participants were already acknowledged as experts. In this sense, the technique allows for an equalization of power issues between interviewer and participant which is often lacking in nutritional studies of diabetics. Finally, the technique, though more personal and more intrusive (and more requiring more time) than a normal interview, occurred on neutral and familiar ground, so to speak, in a store of the participants choosing. All shopping trips were taped and notated; transcriptions of the tapes were then made to correlate with written notations taken at the time of the trip. In addition to the accompanied shopping interviews, addition time was spent observing the products, their layout, and marketing at additional health food stores. Market
literature, bulletin boards, and other market based informational sources were examined. Conversations with employees and random shoppers at markets provided additional background material. Health food stores which are both privately, cooperatively, and corporately owned were included in the study. Participants were recruited via an advertisement in a local weekly 'alternative' newspaper. The advertisement headlined with the question “Diabetic?”, and then continued: if you are diabetic, or the family member of a diabetic, and shop at one of the following markets.....medical researcher would like to speak with you. Respondants to the ad were interviewed initially over the telephone, and were given a description of the study and information on the voluntary nature of participation. In addition, they were promised reasonable safeguards of their anonymity, and were offered the opportunity to view the study results.

What follows is a presentation and analysis of these results.
Chapter 2  General Results: The Raw Data

This chapter will provide an overview of the research results. We begin with a description of the study setting and concludes with a brief description of each of our four main respondents. Chapter 3 continues our presentation of results with an outline of our theoretical basis followed by analysis of three themes: health food concepts, voting with the food dollar, and the hierarchy of diets. These themes will then be demonstrated in more detail in Chapter 4 via a discussion of two specific food groups that are of special significance for diabetics: sweeteners and grains. Chapter 5 presents our concluding comments.

Our result material comes from a variety of sources, including many observational visits to a variety of health food stores, readings from the popular press (such as lifestyle magazines and popular diet books), lay and professional medical information sources (such as the American Dietetic Association), as well as informal conversations with health food store employees and shoppers, and in-depth semi-structured interviews with respondents to the newspaper advertisement. Of 8 respondents to the advertisement, 4 in depth interviews were completed, 3 of which also involved shopping trips to one or another of the health food stores. The remaining respondents were interviewed via telephone, and either did not participate more fully due to their own time constraints, or due to not fitting well with the profile that we were looking for. For instance, one respondent had just moved to the area from Scotland, and was generally unfamiliar with the products offered at the health food store that she was just beginning to explore. Another shopped at only mainstream grocery stores, and another, also relatively new to the area, had just moved back to her mother’s home, and had not really begun to do her own shopping. While these respondents did provide some general opinions on how and what they chose to eat, their information was not of a detailed nature as far as specific product selection, and mostly spoke to mainly to issues such as cooking styles, diabetes education, and food categories. Their choices of foods will thus not be discussed in detail, though in so far as they provide further demonstration of general trends, their contribution is acknowledged.
The remaining four interviewees provide a interesting diversity of opinion within a defined framework. As previously mentioned, the advertisement was placed in a newspaper that is considered an ‘alternative’ news weekly, with a readership demographic that is largely urban, under 50, and politically left of center. In addition to featuring newstories on local issues, the newspaper reports lifestyle topics, with reviews of restaurants and entertainment; it also carries an extensive advertisement section. An entire page is devoted to advertisements for alternative (or complementary) health care practitioners of holistic medicine, acupuncture, naturopathy, and the like. Finally, it should be mentioned that the newspaper is given away for free from newstands around the city and nearly all health food stores provide these papers via stands at their entries. It was for these reasons that we considered respondents to the advertisement to be likely to be good representatives of the ‘alternative’ stance of the health food community.

The study took place in Portland, Oregon and its surrounding suburbs. Located one hour’s drive from the west coast shoreline, Portland is a midsized American city with a population of about 750,000 (inside the city limits); 1.5 million live in the metropolitan area. It is the largest city in the state of Oregon, which otherwise is largely rural: the entire state population is 2.5 million. The city is situated at the junction of the Willamette and Columbia rivers. As the major waterway in the northwest, with a tributary system stretching through 4 states and into Canada, the Columbia river system was the major transportation route for the area’s timber industry and Portland, despite its inland location, remains a major west coast port. Situated to the north of California, Oregon, with its extensive forests, became a major gathering location for the environmental movement in the late 1960’s and 1970’s. It is still viewed by the rest of the nation as being something of a “leftover hippie” refuge and counterculture leaders such as poet and environmentalist Gary Snyder and writer Ken Kesey have contributed to local culture as Oregon residents.

Not surprisingly, then, health food stores have existed in Portland since the 1960’s. The earliest were in the form of food co-ops. Nature’s Foods and People’s Foods, their names chosen to demonstrate the commitment on the part of the co-op membership to
environmental and social causes were, first and foremost, cooperatives: an effort to develop a community that supported environmental causes through its choice of foods. Both stores still exist today, though Nature's is now a corporately owned chain with seven locations scattered throughout the city and suburbs, while People's remains at its sole original location. Other health food stores have followed since. Food Front co-op (also aptly named) has joined People's co-op in the fight against corporate marketing, while New Seasons, a privately owned health food store with 3 locations, was started by former Nature's employees who were unhappy with the corporate takeover (or, as they would bluntly put it: Nature's "sellout"). Other, more specialized 'health food' stores also exist: the Daily Grind, for instance, is operated by the 7th Day Adventist church, a religious group which espouses a vegetarian lifestyle. Most recently, another corporately owned store, Whole Foods Market, has located a very large store in the heart of the Pearl district, a neighborhood undergoing redevelopment with the conversion of mostly abandoned industrial warehouses into very expensive "loft" residences for the well to do. The Pearl district’s intermediate incarnation as a location for cheap and spacious artist studios (in the previously dilapidated warehouses) has added to the cache of the area’s redevelopment and many art galleries are now interspersed with high end restaurants and interior decorating stores. The location of the Whole Foods Market in this area, then, is also a commentary on its target clientele.

A walk through the Whole Foods Market is, itself, a fascinating experience. Indeed, the store is so large, so beautifully designed and decorated, and so full of enticing products that, while only one of our respondents chose to shop there (and she was, in fact, not a resident of the Pearl district), all of our respondents had visited it at least once and without exception, expressed amazed approval at both the size of the store and amount of merchandise. Several said things like "you can get lost in there", or "it can take hours to shop there". Indeed, with a store size of 26,000 sq. ft. (about 2900 sq. meters) and an average of 20,000 SKU’s¹, the store is by far the largest health food store in the area. Nevertheless, the marketing message remains the same. The company’s summarizes its

¹ SKU stands for "stock keeping unit". It is an identifying number given to a product by the store as part of an inventory control system. Each one lb. bag of pasta of a particular brand will have the same SKU, for instance, while a one lb. bag of pasta of a different brand will have a different SKU. Similarly, 1 lb and 2 lb. bags of the same brand will have different SKU’s.
philosophy on “whole foods, whole people and whole planet” with the following statement:

“We believe in a virtuous circle entwining the food chain, human beings and Mother Earth: each is reliant upon the others through a beautiful and delicate symbiosis.” (www.wholefoodsmarket.com)

Just how much our respondants concur with such philosophies, and how they view corporate attempts to participate in this “symbiosis” is a question to which we will return later in this chapter in the thematic section on “voting with the dollar”. Nevertheless, it is important to recognize that the basic environmental message is propounded in both the cooperative health food markets and the corporate markets, despite obvious differences in their size and appearance.

That such environmental health concerns are common in shoppers at such markets is further supported by the fact that all of our in depth participants abstain from eating meat. All cited either “sustainability” or “animal cruelty” as their reasons for this. Several had been readers of Frances Moore Lappe’s indictment of the U.S. beef industry, “Diet for a Small Planet”. Though meat eating was not mentioned at all in our advertisement, all of our in depth interviewees were either completely or partially vegetarian; one was vegan, and another was vegan “at times”.

This contrasts with the stores themselves: only one of the food stores in the study did not sell meat (the store called The Daily Grind, run by the 7th day Adventists). Whole Foods Markets, for instance, carries “Country Natural Beef”, and supplies a color pamphlet at its meat counter, which describes the supplier of this product as a “cooperative of sustainable Oregon family ranches, committed to bringing you a product that is delicious, wholesome and safe for your families”. Under the heading “sustainable ranching” the pamphlet details its definitions of good ecological practice: “from plant-diverse, high-mountain meadows to thick aspen groves and miles of sagebrush-filled flats-Country Natural Beef cattle live in beautiful places”, humane treatment: “Country Natural Beef cattle are tended by ranch families who love the land they live on. Depending on the ranch, while moving cattle they might see Sandhill cranes, bald eagles flying overhead, deer heading into the underbrush, or trout swimming for cover under a fallen pine tree in the river”, and lastly, sounding perhaps a bit more ominous, good
animal health: "our cattle's health depends on wide-open spaces with mother nature providing most of their diet. Ranchers in tune with their cattle's natural patterns add any missing ingredients as necessary".

Our respondents bought almost none of it. One respondent ate fish, mostly salmon, which is native to the area, and which she purchases from an outlet run by a Native American tribe, about 50 miles distant from the city (an area which she visits frequently for other reasons). This same respondent also eats chicken but did, actually, purchase some ground beef during our shopping excursion at a health food store, rather sheepishly stating: "I know it makes no sense, but it's for my dog". Otherwise, meat was not included in any of our respondents' cuisines. Other than this one area of agreement, our respondents are a diverse group. We will now describe them in turn, with some biographical data, but also with an overview of their food choices and philosophies, highlighting some of the themes that will be examined in more detail in later chapters.

"B" is a single parent in her mid 40's. Her son is now 7 years old. She is currently self-employed as a jewelry maker, but in the past has worked as a professional chef, and has studied food and nutrition a the college level. She grew up in a rural area in the Southwest of the U.S. and became vegetarian at the age of 16 when she observed her father slaughtering rabbits which he raised commercially. She began cooking for her family (of origin) in her late teens. After moving away from the family home to the Colorado area, she worked as a professional chef, initially devoting herself to pastries, but also doing general catering. She states that she was vegan throughout most of her 20's and early 30's but was forced off of this diet after becoming a mother, since at that time she was unemployed and existed on food subsidies such as the WIC program. Describing this period of her life, she says "I ate commodity foods because that's what I had to do to survive". It was during this period that she first became obese. This, combined with her family history of diabetes, is what she views as the cause of her own diabetes, which was just diagnosed within the last 12 months. She has also had additional health problems including uterine cancer, hypothyroidism, and Type III

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2 WIC is a USDA sponsored subsidy program; its acronym stands for Women, Infants and Children; it's focus is on improving perinatal nutrition for the poor.
hyperlipidemia (a disorder of excessive triglyceride fat in the blood, somewhat similar to high cholesterol).

At the time of her diagnosis of diabetes in the fall of 2001, she underwent nutrition counseling with a dietician but was also prescribed the medication metformin (taken 3 times daily) to help her control her blood sugar. In addition, her daily medication regimen at that time included a thyroid tablet, an estrogen tablet, and an antilipid medication: in all, a total of 6 tablets per day. Not surprisingly, her goal became to eat in such a way as to decrease her dependence on medication. She has so far been successful at this, and has lost 55 lbs in the 10 months since the diagnosis of diabetes, through strict adherence to a 1500 calorie diet, though she still remains slightly overweight. She no longer takes metformin, and is pleased to report that her most recent hemoglobin A1c (used by physicians as a measure of a diabetic’s sugar control) was “6.1”, an excellent score. She has also stopped her other medications (thyroid and estrogen); she continues to discuss the necessity of the antilipid tablet with her physician.

Her nutritionist, who advised her on the 1500 calorie diet, tutored her in the methodology of counting carbohydrate grams rather than counting calories. Using the terminology of carbohydrate grams, she describes what she eats as “30 at breakfast, 45 at lunch, 30 at 3:00 PM, 45 at dinner, and 15 at bedtime”. She has become a skilled food label reader in this process. Indeed, she often chooses between similar products based on the carbohydrate content of the food, as shown on the food label. She is also very knowledgeable about food labeling laws. She is aware, for instance, of the currently proposed labeling of genetically modified foods (she supports this), and is aware of the differences in labeling laws affecting locally processed foods intended for local sale, and labeling of processed foods which are marketed nationally: whereas the former do not need to show the gram content of servings, the latter do. On this matter, she is more ambivalent, recognizing that it would be burden for local bakeries, for instance, to have to have the contents of their food products analyzed chemically for labeling and in general she would like to be supportive of locally made foods and small food businesses. At the same time, as a carbohydrate counter, she clearly would prefer that carbohydrate

\footnote{In the U.S., nationally marketed packaged food products must show, among other things, the number of carbohydrate, fat, and protein grams per serving of the food.}
information be available on the label. Thus, she chooses Ezekial bread, a ‘flourless’ bread made from sprouted grain, because it has relatively fewer carbohydrate grams per slice than other breads; she buys it not from the bakery department, but from the freezer section in the store, where the company Food for Life provides a packaged/labelled version which lists ingredients and nutritional information.

In addition to defining her “diet” via carbohydrate content, however, she has also resumed eating as a vegan. She gives a partial explanation for this, saying that veganism makes it easier for her to count “carbs”, and it is also cheaper not to eat meat. This doesn’t quite address the difference between vegetarianism and veganism, however. Her son, for instance, has decided to be vegetarian: she says that he made this decision on his own through his concern for animals. He is not vegan, however, and she buys milk and other dairy products for him, though she takes care to buy organic versions. She also recognizes that what she chooses for herself as an adult with several illnesses to consider may not be entirely appropriate for a growing child. She sees that children may want (or need?) snacks between mealtimes and she buys trail mix (a mixture of raisins, other dried fruits, and peanuts) for him. She views this as an indulgence within limits: e.g. in her attempt to limit what she calls “crap” in the house, she buys a “healthy” snack for her son, rather than the more mainstream choice of potato chips. She will also buy sourdough bread for him (a white bread), rather than the Ezekial (sprouted, multigrain bread) which she eats herself.

As a former chef, with some educational background in nutrition, she also demonstrates considerable knowledge of food chemistry and the construction of foods. Partly, this is also related to her choice of veganism. For instance, she was able to explain that lecithin, a lipid (fat) used by food processors as an emulsifier, was problematic for vegans, since though it could be extracted from plants such as soybeans, it is more commonly made from cow’s milk and thus, when listed as an ingredient on a packaged food, is something vegans avoid, unless the label specifically reads “soy lecithin”.

She also makes many of her own foods, ‘from scratch’, either to save money or to make foods more appropriate for her diabetes and her personal taste. For instance, she goes to a local berry growing area, where several farms offer inexpensive “pick your
own” prices on strawberries, raspberries and blackberries; from these fruits she then makes her own low sugar, low pectin jam. She makes her own hummus as well, saying that she prefers to control the mix of garlic and lemon and the flavoring. She also makes her own seitan. This food, also called mock meat, is common in asian vegetarian cuisines, and is derived from the gluten protein of wheat. To make seitan, gluten flour is wetted to make a dough, kneaded, and then simmered for several hours in a broth containing soy sauce and other flavorings such as garlic and ginger. The resulting product is then used as a substitute for meat or chicken in dishes such as stirfries; it has a dense texture and “meaty” flavor. The product can be bought commercially at health food stores, though it is relatively expensive. “B” makes her own from wheat gluten powder, which not only saves her money, but allows her to adjust the flavoring to her own taste and to substitute ingredients. For instance, instead of using soy sauce in the broth she substitutes Bragg’s amino liquid, a product made by one of the early pioneers in the health food movement, which though derived from soybeans and similar in taste and appearance to soy sauce, has no added sodium and is not fermented or heated. The product is marketed as “liquid aminos” and is touted as containing all essential amino acids necessary for adequate protein nutrition. Such attention to the chemistry of foods is common in the health food community, and for “B” is part and parcel of healthy eating.

There are, however, foods that “B” includes or excludes from her cuisine on esthetic grounds. Though she enjoys both tofu and soy milk, she doesn’t like soy yogurt, which she says tastes “nasty”. Similarly, she is particular about her tempeh: she rejects nori tempeh, because the nori (a japanese seaweed) makes the tempeh look like it is “full of bugs”. She does eat vegetarian “bacon strips” (a texturized vegetable protein product, similar to seitan) as a treat, because she still loves the flavor of bacon though she doesn’t want to eat the animal. And, as we shall see in the chapter on sweeteners, she does still indulge in the taste of sweetness, occasionally using an “artificial” sweetener, even if this violates her general rule of avoiding “chemical” or “artificial” foods.

There is, of course, much more to say about “B”’s cuisine. The above is intended only as an introduction, and we will return to a discussion of more of her food choices in subsequent sections. To summarize briefly, however, we can say that “B” is an excellent example of someone with a foot in two worlds: while assiduously following a
scientifically defined "diabetic diet" via carbohydrate counting, she also follows protocols set out by a vegan philosophy of healthy nutrition. She is knowledgeable about food politics such as labelling issues, about food chemistry, and about cooking methods. She is also flexible in her own attitudes to foods, as evidenced by her own personal history of on and off veganism, and her attitude to the foods that her son eats. What is particularly interesting to those concerned with changing American attitudes toward healthy eating is the level of commitment which she demonstrates to creating and enjoying her own cuisine.

We turn now to our second respondent, "S", who answered our advertisement on the basis of the fact that she is the daughter of a diabetic. Her mother, a woman in her 50's, was diagnosed as diabetic about 2 years prior and has been severely affected, spending most of the first year in a wheelchair due to a painful diabetic neuropathy affecting her legs. "S" believes that her mother's diabetes was due to obesity and life stress: her mother is a 1st generation American, and is now divorced from "S"'s father. As "S" puts it, her mother "had difficulty being a good Greek woman". As a consequence of such life stress, "S" feels that her mother failed to take care of herself, ate poorly, became overweight, and this brought on her diabetes.

In contrast to her mother, "S" has always been very particular about the foods she eats. She became an "emotional" vegetarian in her teens "as part of my teenage rebellion" but was not very knowledgeable about foods until she obtained a job in a health food store in her early 20's. "I didn't even know what a beet looked like if it wasn't in a can", she says. Her food expertise expanded rapidly at the health food store, and she became an avid reader of diet books. Indeed, her interest in health matters has expanded generally, and she is now employed as a massage therapist at a chiropractic medical office, mostly treating victims of motor vehicle accidents with musculoskeletal complaints. She is just starting to provide her patients with nutritional advise, but has many colleagues who

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4 Indeed, in a discussion regarding flexibility she tells a story about a friend who is vegan and a type I diabetic. While teaching a class at which "B" was assisting, her friend began to have an insulin reaction; recognizing his own symptoms he asked if anyone in the class had some candy or something sweet as an antidote. He was offered a chocolate chip cookie by a student, but mumbled a worried aside to "B" that the cookie probably wasn't vegan. "Here he was about to pass out, and he was worried about the cookie having milk in the chocolate chips" she says. "I told him: just eat it!".
include nutrition therapy in their practices, and is herself a patient of an accupuncturist who gives her advise on eating.

“S” is also the mother of a 13 year old boy. She shares custody of her child with the boy’s father who lives separately. Consequently, her son is physically in her home only 3 or 4 days per week. This schedule dictates many of her food choices: she tends to shop for foods that her son will like just before he arrives, and otherwise, tends to “forage” more (by which she means she eats raw fruits and vegetables) when she is home alone. She is vegan “at times”; her son is not. Even before he was born, however, she found being vegan too inflexible socially. For instance, when visiting her mother’s home, she would refuse to eat food that wasn’t vegan, and would extoll the virtues of veganism to her mother and younger sister. But such attempts to persuade them to what she views as better nutrition were not successful and became a source of friction. Similarly, eating out at friends’ homes became difficult if she adhered strictly to veganism. She now eats more flexibly and will generally eat whatever she is offered, though she still views veganism as her ideal. And while she has not abandoned her beliefs in other defined diets such as “combining” and “eating for your blood type”, she follows such diets only at times. Indeed, as we shall see in our sections on diets, she views veganism as the highest in a stepped hierarchy of diet options.

“S” does not do much cooking. As mentioned above, she eats many fruits and vegetables raw, particularly when her son is absent. She prefers to buy organic produce. On our shopping excursion together she bought some kale (dark green leafy cabbage), and said that she’d probably just saute it simply in a bit of oil. Though her mother cooks many traditional Greek dishes, she does not. Partly this is because one of her favorite diet theories is that of food “combining”, in which, in an effort to improve digestion, foods which require an acid digestion are not eaten with foods that require an alkaline digestion. Meat and potatoes, for instance, would not be paired together in such a diet (though this particular example is of little concern to her as she is not a meat eater). In addition, she espouses the health food belief in eating macrobiotically so as to conserve as many food nutrients as possible. Such beliefs, for instance, lead her to do sprouting, a kitchen sink form of gardening which we will discuss further in our analysis of grains. Finally, we can also speculate that prior employment in a health food store, while it may
have provided much education in basic foodstuffs, did not encompass education in food preparation, and that this, combined with her rejection of her mother’s meat based cuisine in her teens, means that she has had little time in a kitchen learning cooking techniques.

Indeed, she often mentioned the issue of time. About her shopping, for instance, she said, “I shop frequently and I’m always in a rush”. And she describes eating in her car while driving to save time. She often keeps fruits, both dried and fresh, along with an occasional baked good in her car so that she won’t have to ‘stop’ for food when she is having a busy day. In fact, she views this usage of her car as an auxiliary pantry positively, since she provides herself with what she feels is a healthy version of “fast food”, rather than stopping, as do so many Americans, at the drive through window of a McDonald’s or Burger King. She believes that snacking (she doesn’t call it that) is a reasonable solution to a busy schedule, and feels that this is true for her son as well. She does, in fact, buy him snacks that she would not ordinarily buy for herself, such as flavored popcorn. On our shopping trip she bought organic dried mango strips from a bulk bin “to keep in the car” both for herself and her son.

As with “B”, there is much more to say about “S”’s food choices. We will return to a further discussion of her foodways in subsequent thematically organized sections. But we can conclude this introduction by noting several similarities between “B” and “S”. Both are very knowledgeable about basic foodstuffs and the relationship between food and health. They are, in a sense, both interested in this topic. Both are vegans to variable extents depending on circumstance (“B” economic circumstance, “S” social circumstance); both espouse many beliefs that are defined in American culture as “health food” beliefs, such as buying organic products. Also, they recognize that not everything that they believe in as far as healthy eating is practicable: whether due to financial constraints, time constraints, or social constraints, they select what works for them, and what works for their children. And the latter may be different from the former, just as their own choices were different from their parents.

Our next two respondents provide a contrast with our first two. While both “R” and “ST” are just as knowledgeable and interested in food matters, they are also both type I
diabetics, meaning that they were diagnosed with the illness prior to adulthood. They are by definition, insulin dependent for the rest of their lives and no amount of "eating right" will change this. In addition, obesity is uncommon at the time of diagnosis of type I diabetes, and a "blame the victim" ideology is less common regarding type I diabetics. In other words, unhealthful eating habits are generally not seen as causative for this illness. It is interesting, therefore, to discover that "ST" does in fact, view his childhood eating habits as contributory to his illness and he blames his mother for feeding him excessive sugar during his childhood, even after a sibling, his sister, became diabetic. And "R", while not concerned in general about her childhood eating habits, wonders if her childhood exposure to chemical groundwater contamination (a exposure for which she is currently a claimant in a class action lawsuit against a large public corporation in the state of California) caused her diabetes; she views her lack of any family history of type I diabetes as arguing against a genetic component in her case, and the possibility that pancreatic damage from a chemical exposure caused her illness thus looms large for her. Both respondents, therefore, have directly connected the need to define "what's healthy food" with their personal health concerns. For "ST" such concepts revolve particularly around issues of sugar, while for "R", they are more concerned with issues of chemical contamination, such as pesticides and additives.

We start with "ST", who was diagnosed with diabetes at the age of 15, 2 years after his sister's same diagnosis. As mentioned above, he speaks with abhorence about the diet that he ate as a child, and his current cuisine is far removed from that of his mother. Now in his 30's, he continues to struggle with diabetes control and at the time of the interview had recently required hospitalization for an episode of diabetic ketoacidosis\(^5\). He describes this illness episode with puzzlement. Apparently he had been feeling fine the day before, and on the day of the illness felt nauseous for no apparent reason, vomited several times, and then rather suddenly collapsed and was taken to the hospital. The reason for the episode remains mysterious to him and he wonders about "food poisoning" but cannot be more specific about what food in particular was problematic. He has

\(^5\)Diabetic ketoacidosis (called DKA), is a lifethreatening condition in which fluctuations in blood sugar (usually elevations) cause a rise in the acid level in the blood; the condition is treated in hospital with fluid rehydration and very precisely controlled insulin injections. The two most commonly cited reasons for DKA from the physician standpoint are acute infections such as flu or pneumonia, and "patient noncompliance" (ie overeating or skipping insulin injections).
concluded that he needs to pay more attention to his diabetes and is happy with the fact that his most recent hemoglobin A1c, done at the time of a hospital followup visit with his physician showed improvement. He is still, however, not a frequent checker of fingerstick blood sugars as would normally be advised for type I diabetics, particularly after an episode of diabetic ketoacidosis. He has been instructed by a nutritionist in the methodology of counting carbohydrates but the extent to which he does this is unknown: he answered evasively when asked directly.

Otherwise, his life is currently in a state of flux: at the time of our interview he was packing up his belongings for a move to join his life partner at a new residence in the U.K. He had no promise of employment in that country, but was moving so that the relationship could continue. His economic resources were, by his own description, lacking.

Regarding food choices, “ST” became a vegetarian approximately four years ago. He cites “sustainability” as his reason for choosing this. His partner is vegetarian as well. In addition, “ST” expresses a common health food community distrust of processed foods. Similarly, he emphasizes the difference between ‘natural’ and artificial’ foods; in his own cuisine, this opposition is particularly important with regards to sweetener choice. As we shall see in the chapter 4, “ST” chooses Sucanat, a sweetener that is natural, organic, and minimally processed; despite his distress over the “sugary” cereals of his childhood, the need for a sweetener to be natural overrides the potential problems with sugar that his diabetes entails.

Also in keeping with his antiprocessing preference, he does not enjoy “american style” vegetarian foods, such as veggie burgers or hot dogs made from soy: he views these products as a sort of food processing industry attempt to manipulate vegetarian cuisine. Instead, “ST” usually cooks ‘asian’ dishes, mostly either Indian or Thai in style. He does this, he says, because he and his partner enjoy the flavors of such dishes, but also because of the plethora of vegetarian recipes available in these cuisines. Because of this preference, rice is his core carbohydrate (a concept we will examine further in Chapter 4). While he will occasionally use tofu in a stir fry, and does drink soy milk, he doesn’t enjoy asian style meat substitutes such as tempeh or seitan. Though he buys fresh vegetables almost daily, when asked what he thinks of macrobiotic concepts, such as
eating vegetables raw, he stated that he has a friend who believes in this, but that he does not.

Like our previous respondents, “ST” was very aware of the politics of food shopping. He would have preferred to shop at one of the health food co-ops in the city, but none were within walking distance, and public transportation in his area was not adequate to make such shopping trips feasible. He does not own a car. Though one of the corporately owned health food stores was closer to his home, his shopping there was limited by cost, and he goes there to buy only the products, such as his sweetener, which he cannot find at mainstream groceries. Otherwise, he notes that the mainstream grocery store which is opposite his apartment is starting to carry more “health food” products, such as soy milk. He has noted, for example, that the same brand of soy milk carried by the corporate health food store costs less at the mainstream grocery. And while he would like to be able to buy organic rather than conventionally grown produce, he does not do so because of the added cost. Thus, despite his beliefs many of the themes of the health food movement, his ability to carry out such beliefs are tempered by issues such as convenience and cost.

Our fourth respondent, “R” is a psychologist in clinical practice. She is in her late 40’s and has been diabetic for 32 years. She considers that she has done well with managing her illness and in fact, views herself as a bit of a veteran. She has a close relationship with her physician, who is the leading diabetologist at the university medical school, and cites his opinions frequently. She is highly knowledgeable about new diabetic treatments such as new forms of insulin and knows the status of research on pancreatic transplantation. She is happy that she has not suffered any of the dreaded diabetes complications such as circulatory compromise, eye disease, kidney failure, or neuropathy. She has, however, had some immune system complications: in addition to dermatologic problems, she has required 4 surgeries to deal with immune mediated connective tissue difficulties, including bilateral carpal tunnel releases, and bilateral (open) shoulder surgeries. Overall, however, she reiterates that she has “done well” with her diabetes. Importantly, she is also a breast cancer survivor, and as we shall see, some of her food beliefs stem as much from her cancer experience as from her diabetes.
Her current diabetes treatment regimen involves 4 insulin injections per day, each one preceded by a fingerstick blood glucose check which enables her to adjust the short acting component of her insulin dose to accommodate fluctuations in the balance between her eating and exercise. In fact, she was the only respondent to mention exercise as part of a diabetes treatment (or prevention) regimen. She mostly does her exercise by walking several times a day with her two large dogs. Regarding professional nutrition advice, she remembers being taught the old “exchange” method of counting her food intake, but has transitioned to the more current techniques of counting grams and calories. In fact, she does relatively little of any of this, and is not a food label reader, relying instead on portion control and her long practice in noting the effects of food intake on her fingerstick checks. She is rather proud that she is able to eat “pretty much anything” if she pays adequate attention to portion size.

She currently cohabits with her partner of 16 years. While she does much of the food shopping, he tends to do nearly all of the cooking. Neither trust processed foods and her partner goes out of his way to make ‘homemade’ sauces and condiments like ketchup and barbecue sauce. She describes her partner’s cooking style as “pretty normal” though this description apparently encompasses the American trend of viewing Jamaican style jerked chicken, Mexican enchiladas, and Thai noodles as “normal”. They eat very little fried food, and while she is very conscious that her cholesterol level is low and doesn’t worry about fats in general, she takes care to avoid foods that contain hydrogenated oils. Neither she nor her partner are meat eaters, though they do enjoy seafood, fish, and occasionally, chicken. They are also avid gardeners, and grow much of their own produce in the summer. They frequent a local farmer’s market for additional produce, and, as noted previously, buy salmon, apparently almost a staple item for them, directly from a Native American tribal store.

Even with this cursory description, it is fairly clear that “R” eats perhaps the most “mainstream” cuisine of any of our respondents. And yet she does this with a firm commitment to many of the health food movement goals while at the same time preserving her own ability to control her diabetes and eat a wide diversity of foods. The apparent difference between “ST” and “R” is the degree of control which they exert via usage of fingerstick technique; while they are both interested in their foods, only “R” has

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the constant evidence of her fingerstick data to give her feedback on what she has eaten. And in contrast to "B", who counts her carbohydrate grams assiduously, neither "ST" nor "R" do so with any regularity.
Chapter 3 Results ‘al dente’

Having now performed our initial introductions to “B”, “S”, “ST”, and “R”, we will continue our description of their cuisine creation with a discussion and analysis of three of the central themes which play a role in determining their food choices and cuisines: health food concepts, voting with the dollar, and the hierarchy of diets. But in order to do this, we must first acknowledge our theoretical foundations.

As previously noted, the basis for this research lies in the fact that the term ‘health food’ in the U.S. is applied not to foods that medical caregivers define as healthy but to foods that are so defined by the health food movement. Often called ‘natural’ foods, the definitions of this food category arose out of particular political and environmental concerns in the late 1960’s. This section will give an overview of some of the concepts which underlie this food system. As we shall see, the countercultural nature of the movement’s origins has led to these concepts being described by binary oppositions or dichotomies.

Anthropologists have long been familiar with such oppositions, of course. Levi-Strauss noted the opposition of nature and culture in his book “The Raw and the Cooked”. Indeed, he held that the human tendency to think in binary oppositions was a basic rule of culture. And Mary Gordon, in her discussion of ritually unclean foods says “there must be a contrariness between holiness and abomination which will make over-all sense of the particular restrictions.” (Douglas p. 49). It is thus fitting that Warren Belasco, who writes about the political opposition of the counterculture to the food industry, uses binary oppositions to describe the way in which this “counterculture” constructed their cuisine. He noted seven such oppositions, including improvisation vs. specialization, process not product, brown vs. white, slow food vs. fast foods (also called craft vs. convenience), vegetable vs. animal, ethnic vs WASP (White Anglo-Saxon Protestant) and light vs. heavy. While all of these oppositions are present to some degree in our research results, we have selected instead three oppositions which provide a better illustration of the particular pertinence of the movement’s beliefs to the construction of a healthy cuisine, (or better put: the construction of a cuisine that impacts health in general
and diabetes specifically). These oppositions are: whole vs. processed, raw vs. cooked, and organic vs. conventional. In this chapter, we will use a structuralist framework to examine the way in which these themes direct our respondent's food choices and thus their cuisine. Claude Fischler, speaking about anthropologic theoretical schools has said "while the functionalists looked at food, the structuralists looked at cuisine" (quoted in Mennell et. al. 1992, p. 8). It is our purpose to analyze the construction of our participants' cuisine and we do so with this 'structuralist' underpinning.

We must also be careful to differentiate our binary oppositions from other classificatory systems. Helman's food classifications, for instance, which include food vs. nonfood, sacred vs profane, parallel classifications, food as medicine and social foods, could be applied to the foods espoused by the health food movement. And Warde's system, which includes care vs. convenience, health vs. indulgence, and economy vs extravagance, devised to describe modern British cuisine seems particularly apt. But such classificatory schemes do little to help us understand the underlying meaning of foods. Indeed, it is just such a classification which the medical community has used (healthy vs. unhealthy) in its attempt to impact American cuisine. As we have seen, such a classificatory scheme has been difficult to operationalize for Americans. Part of the reason, we suggest, is that the healthy vs. unhealthy classification system carries little symbolic weight. In contrast, the health food movement makes extensive use of the symbolic meanings of foods, which it then structures into a cuisine. Our analysis therefore, also includes commentary on this symbolic dimension.

The second and third sections of Part Two in which we describe how our respondents "vote with their dollars" and choose from "the hierarchy of diets" are more informed by transactionalist theory. Ideas of the self and embodiment are more to the fore, at the same time that issues of empowerment are recognized. In addition, the "diet" section is also informed by developmental anthropologic food theory which addresses "menu pluralism" via the construction of diets.
Three health food oppositions

The first of our health food movement oppositions, “whole vs. processed” is, perhaps, the easiest to illustrate. Indeed, the symbolic meaning of a “whole” food has been a previous topic of anthropologic discussion. As Mary Douglas points out, the idea of equating “whole” with “holy” is found in the Judaic Old Testament. Further, this concept of holy/wholeness was extended to species and categories with the result that “hybrids and other confusions are abominated” (Douglas p. 53) and her exploration of food taboos was based on the idea that foods that were not wholly in one category of thing or another were rejected as unfit to eat. For our respondents, today’s “abominations” are, among other things, genetically modified foods (GMO’s) for which they hope the federal government will mandate labelling so that such foods will be easier to avoid. But as a more general example, we can use the health food community’s valuation of ‘whole’ foods such as brown rice, which are appreciated not only for their nutritive qualities, but for their connection to Mother Earth via beliefs such as those expounded in the Whole Foods Market slogan: “wholefoods, wholepeople, wholeplanet”. Indeed, it is this extension of the concept of “holy/wholeness” to the planetary level which has led our respondents to reject meat altogether as a food which violates the health of the planet.

The other half of the opposition, ‘processed’, speaks more to a resistance to the industrialization of food, to agribusiness, and to food processors whose actions can be summed ‘against nature’. The concept also implies a need to fight against a quality of anonymity in processed foods. Processing not only distances the eater from the food’s original nature: it breaks down the connectedness between the eater and the earth. Such connectedness is what health food community members desire. Seeking such connectedness, they ought, in theory, to eat locally produced foods “in season”. In practice, such seasonal awareness remains something which eludes even our most macrobiotic eater, “S”, who commented that she hoped to find Brussel sprouts in her produce department in Portland in June. But we should also remember that “R” both gardens and shops farmer’s markets, and “B” picks her own berries for jam.

Perhaps the most important belief regarding processing and personal health is that the processing of food allows both contamination to enter in the form of additives, while
nutrition, in the form of vitamins and other micronutrients leave. It is due to the former concern that “R” and her partner make their own ketchup, while it the latter that “S” was expressing when she exclaimed that before she worked at a health food store she didn’t know what a beet looked like if it wasn’t in its canned form. Similarly it is no great stretch to connect “ST”’s disdain of veggie burgers and texturized vegetable protein hot dogs with this antiprocessing bias. Such beliefs would also explain why our respondants bought no canned goods at all during our three shopping trips. An antiprocessing bias also explains why, while ‘snacking’ isn’t itself on our respondent’s radar screens as a potentially unhealthful eating habit, snacking on potato chips is. Distrust of food processors can also be the basis for “do-it-yourself” processing: while “B” cited the ability to flavor seitan and hummus to her own taste as well as cost savings involved in making these foods herself, one wonders if she isn’t also happy to be able to control the ingredients.

Antiprocessing bias has resulted as well in exacting definitions of process, as in “ST”’s choice, the sugar Sucanat, whose label goes to great pains to distinguish its processing techniques from that of other sugars. Indeed, we shall return to this issue of processing definitions when we examine sweeteners in more detail in Chapter 4. But another example, similar to sugar in what might be viewed as its minimal degree of processing is that of flour. Yet, the health food movement rejects the commercial product, which is first ‘bleached’ and then ‘stabilized’ with preservatives. In our research, the largest assortment of “branded” flours (i.e. excluding flours sold unbranded, in bulk bins) stocked in all the health food stores visited came from “Bob’s Red Mill”, located in a suburb of Portland. While the range of various flours, which includes such things as whole grain teff, described as “the favored food of highland Ethiopians” is, itself rather astounding, our point is that despite the health food store tradition of selling bulk product in bins, Bob’s product is sold in packages with his name and picture prominently displayed. He is, in fact, trading on the value of his low technology (anti-processing) approach. His advertising includes the following statements:

“With all the sophisticated knowledge of recent times, no machinery has yet been developed that grinds grains into flour quite as well as our flint-hard quartz millstones quarried in France and used by discriminating
millers since early Roman times....These slow turning millstones grind the bran, endosperm, and germ (containing its nutritious wheat germ oil) into flour in a cool natural way, creating a more assimilable food.”

(www.bob’sredmill.com)

We can see from these statements that in a culture where processing is to be avoided, definitions of the degree of processing have meaning.

Our second opposition, raw versus cooked, is also familiar to anthropologists from Levi Strauss’ similarly entitled work about the opposition of nature versus culture in the construction of mythology. While we are dealing a bit more literally with the topic than did Levi Strauss, the nature versus culture meaning is none the less apt. For the health food movement in the 1960’s, “back to nature” was a rallying cry in their rejection of mainstream culture. Such a belief in the superiority of nature underlies the belief in eating macrobiotically, which “S” espouses. It is also what underlies her interest in “sprouting”, for instance. This technique, in which dried legumes are germinated in glass jars suspended over a sink or on a kitchen windowsill is, in fact, an excellent example of the power of the raw versus the cooked opposition. Sprouting allows a dried bean, or pea, which otherwise must be cooked to be edible, to be eaten without cooking. And while it theoretically wastes some of the food’s nutritional energy, since the process of germination uses up some of the seed’s energy stores in the same way that a chicken embryo consumes the egg yolk prior to hatching, the resulting food product is “cooked” only in a dousing of water using the warmth of the sun. Such minimal cooking is not even recognized as cooking per se: sprouts are considered a macrobiotic (raw) food.

In fact, there is a biblical claim for the healthiness of the sprouting technique. “B”, we have seen, chooses Ezekial sprouted bread. This bread is, according to its bakers, made according to the injunction to Ezekial, Chapter 4, Verse 9:

“Take thou also unto thee wheat and barley and beans and lentils and millet and fitches and put them in one vessel, and make thee bread thereof, according to the number of the days that thou shalt be upon thy side, three hundred and ninety days shalt thou eat thereof.”

And while “B” chose it for its low carbohydrate count, the bread makers additional claims that the method of sprouting the grains before grinding results in a “living” bread,
that the grains’ starches are converted in the sprouting process to complex sugars, that the mix of grains and beans and lentils provides complete nutrition and that its low baking temperature preserves these qualities did not escape her notice. “B”’s description was more succinct: “It’s a flourless bread, made from sprouts, has low carbs, and it tastes really sweet”. Whether its the grinding of flour which should be “cool”, or the preference for baking bread at a low temperature, the belief that less is more (healthful) in cooking and that raw is even better remains a theme for the health food movement. Such beliefs explain why, for instance, none of our respondents make casseroles or stews. “B” cooks using the “flash saute” technique, in which the cooking pan is heated to a very high temperature before the food is added to cause the food’s external surface to “sear”, thus sealing in the internal nutrition. This cooking technique also allows her to cook quickly, and leave the interior of her food relatively uncooked, i.e. “raw”.

Indeed, while a raw cuisine has previously been propounded under the heading “macrobiotic”, attempts to mainstream such concepts often do not refer to this name, apparently in an attempt to shed macrobiotic’s earlier radical political associations. And, as with the food processing opposition, even the meaning of the term ‘cooked’ can now be defined more precisely thanks to the belief in the value of ‘raw’. Witness California chef Roxanne Klein, a disciple of legendary whole foods proponent and chef Alice Waters, who has gone a step further than her mentor: she serves a raw cuisine which, says journalist Michael Bauer, also excludes meats, grains and dairy products. He does not describe her cuisine as “macrobiotic”. Instead, he notes that her chic new restaurant, situated in the countryside just north of San Francisco is luxurious, and “the blue hemp chenille slipcovers on the chairs are closed with four large buttons, reminiscent of a Chanel suit, and all the food is presented on Bernardaud china...[Yet] when diners spoon into Klein’s asparagus soup, creamy with avocado, they’d never guess that even the celery, onions, and garlic were raw.”(Bauer p.168) And, as we have seen with the attention to definitions of processing, Klein precisely defines the border between the raw and the cooked. “Nothing that comes out of the kitchen at the restaurant is heated above 118 degrees (fahrenheit)” reports Bauer, though apparently the restaurant frequently
warms it plates “to release the food aromas” (p. 168). It would seem a belief in the benefits of a raw cuisine allow for the cooking of the plate, if not the food.

Our third opposition is ‘conventional’ versus ‘organic’. Unlike the previous two oppositions, the difference between products on one side or the other is largely invisible. Indeed, such invisibility induces the health food stores to go to some lengths to describe just how the organic nature of their products has been verified. Even the federal government, via the USDA and labelling laws has joined in this discussion, and a new law that will take effect in October 2002 codifies the steps that must be taken before a product can legally claim to be “organic”. And, as with our other oppositions, a new definition of organic degree has been established, called “transitional”, which allows the farmer converting from conventional to organic agriculture to sell his product during the 2 years he must legally abstain from chemicals and pesticides, at a price intermediate between the cheaper conventional and more expensive organic categories.

But what does the term “organic” mean to our respondents? Clearly, all understood that the term “organic” referred to the agricultural method and that the general idea was the avoidance of poisons and toxins. But they differed with respect to their beliefs in the size of the impact that such avoidance techniques could have. While all believed that organic agriculture was generally good, “S” expressed this as something which she thought would be more likely help the environment, though perhaps not herself personally; i.e. she doubted that the “small difference” between the organic and conventional products would be likely to cause much change in her personal health. This contrasts with “B” and “R”, both of whom have had cancer: they clearly believe that eating organic rather than conventional foods will have an impact, not only on the health of the environment, but on their personal wellbeing. Indeed, both cite “chemicals” in their causative explanations for their own cancers, “B” citing artificial sweeteners, while “R”, as we have said, points to her childhood exposure to industrial chemical pollution. Avoiding further chemical exposure, they feel, will have a personal impact for their health, though not necessarily with respect to diabetes issues.

All four respondents voiced the desire to buy organic produce: interestingly, only “S” did so almost exclusively. In fact, her main reason for choosing The Daily Grind as her
store is that she finds their prices on organic produce to be much lower than other health food stores, and she often reiterated “I vote with my dollar” during our shopping trip, a theme we will return to later in this chapter. “R” buys some organic produce at the health food store, but also grows her own, and shops at farmer’s markets regularly, where organic produce is often cheaper. While on our shopping excursion, she bought fresh blue corn (on the cob), which, though not organically grown, caught her eye because of its color and the association of blue corn with traditional native american culture, an association whose ancient character also connotes simplicity and preindustrial agriculture. “ST”, the respondent with the most limited financial circumstances, did not buy any organic produce; neither did “B”.

Yet when buying milk, the choice was almost unanimous: all respondent’s milk purchases were organic. The only exception to this was “ST”, who uses only soy milk, rather than dairy milk, due to his lactose intolerance. But “S” and “B”, who do not themselves drink dairy milk due to their vegan beliefs, buy organic dairy milk for their sons, and “R” who does eat dairy products, does so organically. In the dairy category, buying organic was unanimously felt to be ‘worth it’. “R” expressed this using the analogy of a filter. Thus, an animal such as a dairy cow, through its eating, acts as a filter, concentrating some of the ingredients in the food it ingests and then passing them on in concentrated form, via milk production. Chemicals and pesticides are thus felt to be present in milk in a higher concentration than they would be present in the animal’s feed. Without commenting on the origins of such beliefs, it is obvious that though presented in a specialized form, the filter analogy makes use of the health food concept that one can be connected to the earth through what one eats, and that treatment of the earth with chemicals will ultimately treat the eater with chemicals.

In sum, we can say that our three oppositions provide a common focus on nature and the environment for our respondents. This is of course, not unexpected, given our understanding of the health movement’s origins. In addition, however, all three oppositions also focus attention on the way in which nature interacts with the body through eating and the general relationship of the person to the planet. We can also see that the three oppositions differ in the way in which the connection is made: for the whole
vs processed pair, the connection seems rather spiritual, while the organic vs conventional pair makes this connection seem, at least for two of our respondants, more concrete. And our second dichotomy, raw versus cooked, seems somewhere in between, in its ability to integrate personal nutrition and “raw nature”. As Pasi Falk says, in his introduction to “The Consuming Body”, “the role of the human body goes far beyond its concrete physical boundaries” (Falk p.1). Indeed, we will return to a discussion of various types of embodiment in our concluding comments. But for now we can say that regardless of the mechanism, what is most important for our thesis is that such bodily connections to nature and the earth are meaningful for our respondants and that such meanings are used to structure their eating.

Voting with the dollar

We should start by noting that a belief in ‘voting with the dollar’ was something that at least one of our respondants, “S”, stated explicitly. Our other respondants, however, are also aware that they use this methodology in the selection of their foods and believe, in to at least some degree, that such choices are effective. Indeed, it is now a rare American who does not recognize that his consumption choices not only distinguish him (in the Bourdieu sense) from his neighbors, but also provide support for particular manufacturers and particular products as opposed to others. In short, our respondants believe that they have an opportunity to influence corporate practices. Ideally, for the health food movement, such influence should focus on environmental practices, but overall a general sense of the social “good” has developed, summarized in the widely used injunction to be “socially responsible” in one’s consumption practices. The operation of this concept is easy to illustrate in the case of coffee. At Whole Food Markets, for instance, coffee beans are labelled not only with the country of origin, and the style of roasting (‘french’ roast, for instance, is considered a darker, “heavier” roast), but also whether or not the product is ‘organic’, whether it has been ‘shade grown’ (a technique wherein deforestation is halted by planting coffee bushes in the shade of a
naturally diverse overstory, rather than in monocultural open plantations), and finally, whether the coffee is ‘fair trade coffee’ (a new category which emphasizes that the price paid to the small scale coffee farmer in that distant third world country is “fair” according to some standard, thus assuring the consumer that he is not helping some large scale agribusiness victimize said farmer). Such detailed product marketing has helped shoppers recognize that they constitute a community of consumers and that as a community, e.g. en masse, they have some power, even outside the borders of their own country, at the ‘whole earth’ level. While urban sociologists like Satterthwaite may lament the changing landscape of American shopping districts and the loss of a physical sense of “community” that the switch to suburban shopping mall layouts and Walmart style retailers has caused, it can also be argued that shoppers themselves are more aware that what they purchase as individuals affects the collective arena. Indeed, Americans are bombarded with this message as each little swing in the health of the economy is accompanied by polling results of “consumer sentiment”, felt by Wall Street investors to be a leading economic indicator. Consumer spending is announced on a monthly basis, and Americans are urged by the President to be patriotic and “buy” the country out of economic slumps. No wonder our respondents feel empowered in their ability to affect the world through their shopping choices.

Nor are our respondents completely naive about this. They recognize that such socially desirable labels can be little more than marketing ploys with little actual effect and they are wary of such manipulation. But the amount of skepticism varies. Its range in our respondents is best illustrated by their opinions of the Newman’s Own brand. This food company, founded by movie star Paul Newman, produces salad dressings and other sauces such as mexican style tomato salsas. The label depicts Paul Newman’s visage, and states: “Over $125 million given to thousands of charities since 1982. Paul Newman donates all his profits, after taxes, from the sale of this product for educational and charitable purposes.” Another company slogan refers obliquely to questions that consumers might have as to exactly how much of the ‘corporate’ profit might be Paul Newman’s personal share, or whether, in fact, Newman has done little more than create a fancy tax writeoff for himself. It attempts to assuage with humor and calls its own marketing style “shameless exploitation in the pursuit of the common good”. All of our
respondants were familiar with the brand, though they were divided over the worth of the products, which they mostly saw as unduly expensive. “S” loved the whole idea, stating that she believed that Paul Newman was rich enough and famous enough to not be in the food business for any but the best motives. “B” however, didn’t buy this figuratively, or literally, and saw the products as pure marketing ploy. “R” was undecided: while she does buy guacamole, for instance, from another company because it says it donates 5% of its profits to charity, she was a bit perplexed by Newman’s use of his fame in this manner. And while aware that the Newman’s Own brand had no artificial ingredients and no preservatives, she generally eschewed buying prepared sauces because of her bias against food processing.

Overall, however, once our respondants have decided that they should purchase a particular type of processed food product rather than make it themselves, their choices are often guided by brand perceptions. “B” for instance, states that her son prefers a locally made yogurt brand, “Nancy’s”, because of the fact, (widely touted), that the owner and manager of the dairy is a woman. “He thinks that’s neat”, she says. In addition, she states that she often explores company websites on the internet, to get information on corporate policy on issues such as the environment and corporate treatment of employees. Her decision to shop at Whole Foods Market for instance, rather than its competitor Nature’s came down to a difference which she perceived between the two parent corporations’ treatment of employees.

Measuring the effectiveness of such consumption decisions, as well as the consistency with which such social criteria are applied to purchases is beyond the scope of this thesis. From an anthropologic standpoint, we are more interested in why our respondants choose foods, than in an ethically based assessment of the efficacy of such choices. However, it is fair to question how such shopping methodologies relate to respondant’s definitions of what’s healthy to eat. If choosing products for a social good or more particularly for “social health” is conceived of as impacting personal health, then we must conclude that our respondants are expanding the boundaries of the self from the personal to the social. To turn a frequently used phrase regarding corporate social responsibility on its head: our

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6 In the interest of full disclosure, it must be said that the author has also been a long time consumer of “Nancy’s” yogurt, partly because of such “feminist” marketing, but also because of the name concordance!
respondants are attempting to do well by doing good. Indeed, an emphasis on the social body (as defined in Scheper Hughes’ essay, The Mindful Body) rather than on the individual body has been a consistent aspect of the health food movement and is in keeping with its holistic philosophy. Indeed, one of the much cited phrases in the movement’s literature, also quoted by “S” was to eat “mindfully”: in holistic philosophy, in which there is no mind/body dualism, and the body extends beyond its physical boundaries, eating ‘mindfully’ includes eating for good of the social body.

The hierarchy of diets

To begin this section, we must say a few words about the use of the term “diet”. While it is the goal of this research to examine the creation of a diabetic “cuisine”, we cannot avoid the fact that the medical community has used the term “diet” rather than cuisine. As stated in the introduction, a diet, which is defined not by the eater, but by some other creator, has the inherent problem of eater compliance. One eats a cuisine, but follows a diet. Moreover, the term diet generally implies restriction or abstinence. Frances Moore Lappe used the term for instance, in her “Diet for a Small Planet”; it was her intention to promote vegetarianism and the restriction of meat eating.

Yet at the same time that we are leery of the potential for problems of compliance in such negatively defined foodways, we see that our respondants are actively involved with defined ‘diets’. “B”s 1500 calorie diet, defined for her in carbohydrate grams by her nutritionist seems astounding in the singlemindedness of its mathematics. And on top of this, she is vegan, at least when she can afford to be so. “S”s “combining” diet, while less mathematical, is still very time oriented despite the fact that taking time for meals is problematic for her. And “S” believes in the worthiness of other diets, such as the diet “eating for your blood type”, and, not least, eating as a vegan. She eats in these ways as well, when she can. “ST” is a vegetarian as well as a diabetic; he restricts dairy to some extent because of lactose intolerance, while “R” restricts herself from meat while at the same time exerting portion control for her diabetes. Thus, while we can’t avoid a
discussion of ‘diets’, we can, at least, shift our focus away from the individual diet rationales and regulations, and even more firmly away from judgements as to the scientific validity of such diets, and onto the issue of how our respondents manage these diets. How do they make sense of this plethora of diet methodologies, each with their own definition of what and how to restrict? Without an undue focus on the issue of compliance with the ‘right’ diet, we can investigate how it is possible for our respondents to juggle their diets, for “juggle” them they seemingly do.

Two overlapping methodologies are discernible in our respondents usage of their diets. We shall call them the diet hierarchy, and diets for shifting selves. They are related in the sense that they both require flexibility, allowing the eater to determine at any time what is practicable. Let us examine them each in turn.

The first, the hierarchy of diets, was mentioned, almost literally by “S”. She has already revealed that she enjoys reading diet books, and has followed many different diets over the years. But she has now concluded that she should allow circumstances to dictate which of her diets to follow on any given day. She says:

“I love to do raw food all the time, but if I can’t do raw food then I just go down to vegan, and if I can’t be vegan, then I’ll just step down to food combining; and you know, if I’m in a situation where I’m like having an emotional problem, or like, I’m at a potluck, then I’ll just try to eat less of everything.”

Such a vertical “stepdown” in diet methodologies implies that “S” recognizes that the restrictions which her diets impose, in the types of foods to be eaten and excluded, as well as in their method of preparation and the manner of their eating, are not feasible in all of her social circumstances. She ‘ranks’ her preferences, and feels no compunction in moving between the rankings. Fischler, whom we have already mentioned with regard to his concept of “gastro-anomic” felt that individuals attempt to impose order on the chaotic state of the modern food system through the use of diets and this could certainly be said of “S”. Other anthropologists, such as Mennell, have looked at the use of diets as a way that individuals impose self restraint in the absence of external restraints and this too, would apply here. But what interests us is the fact that “S” does not view her diet(s) rigidly: her ability to “maintain” one diet is not of concern to her. As a consequence, she
never “falls off the bandwagon”, so to speak and once again, the issue of compliance, so problematic from the medical standpoint, is avoided.

Another way to look at such flexibility is with the concept of the dietary “career”. This perspective fits “B”, who started her young adulthood as a vegetarian, moved on to being vegan, then ate ‘commodity foods’ as a new mother, and now is back to being a vegan as well as a diabetic. Again, she identifies social circumstances as being the determinant for these changes. But her overall flexibility bears some resemblance to “S”’s and one is reminded of the “shifting selves” as described by Ewing in her essay “The Illusion of Wholeness”. Again, what is remarkably absent is a sense of transgression, which we might expect to find when, for instance, a vegan must, for whatever reason, drink milk, or more pertinent to “B”’s current circumstance: when a health food adherent consumes an artificial sweetener. Recognizing that her circumstances are conflicting, she shifts without guilt between cuisines without disavowing the worth of either.
Chapter 5 Foods of Significance: Sweets and Grains

In the previous chapter we reviewed some of the concepts which give structure to our respondent’s diabetic cuisines as well as some of the concepts of the self that underlie them. We have seen how these concepts as used by the health food movement, provide an underlying coherence to specific food choices. In this chapter we narrow the focus further by examining two specific food choices to see how these concepts can result in a variety of food choices. As previously noted, an anthropologic focus on foods and foodstuffs, rather than cuisine, has historically been considered an interest of the functionalist theoretical school. Marvin Harris, who combined functionalism with other ecological and political perspectives called his approach “cultural materialism”. Whatever it is called, we feel that it is important to provide this perspective in our analysis, since this perspective is, in fact, that which is used by much of medical nutrition therapy. Indeed, though nutritionists teach counting methodologies to provide structure to their diets, they are also involved in teaching more specifically about foods themselves. Foods are scientifically analyzed by their biochemical function: their energy contents, their metabolism, their micronutrient effects, and so on. Such analyses are then compiled into a summary which nutritionists use in their teachings to patients. And while such teachings have often been simplified in the service of clarity, the underlying rational that foods can be labeled as ‘good’ or ‘bad’, or more usually, ‘better’ or ‘worse’ is based on their biochemical functioning within the body.

But for the health food movement, the ‘function’ of foods is not quite so biochemically based. Foods, with their symbolic and political meanings can literally ‘function’ as instruments of change. This quality of food as political tool is something on which the health food movement is based. We should mention that one of the criticisms of the functionalist theoretical school is that it provides a rather static view of the components of a system and provides little insight into why and how things change. To the contrary, our contention that the health food movement is particularly adept at producing change in cuisine relies on a broad interpretation of functionalist theory, in which a particular food’s position vis a vis the health food movements opposition to the food industry functions in addition to its function of connecting the individual eater spiritually to the
earth. We are therefore applying Harris' additional ecological and political perspectives to a functional analysis. Put more simply, it is a recognition that foods can function at the level of the political as well as the individual and social levels that promotes particular food choices by health food adherents. It is appropriate then, to see how such political definitions function to determine our respondent's food choices.

One area which we shall not touch on in this chapter is a more global political analysis of these foods. While sorely tempted, for instance, to comment on the politics of the sugar industry, the U.S. Tariff Rate Quota system, and whether our respondents' sugar choices are really having the impact that they desire, we have decided to exclude such commentary on the basis that it does not belong in our attempt to describe, from an emic standpoint, the basis for food choices and cuisine creation. Our discussion of politics is, therefore, limited to our respondents' views as they affect food choices. What is important for this thesis, is that our respondents believe that their food choices serve their political and personal goals.

We have selected our two foods (actually food groups), sugar and whole grains, for this discussion because both are of special significance to diabetics. While both are carbohydrates, and thus something to be 'counted' according to medical nutritional teaching, the goal with sugar is generally to reduce consumption, while with whole grains the goal is to increase consumption. Americans in general are doing very poorly at this and while we are not attempting a strict comparison between a 'general' American and our respondent group, we do think that our respondents' provide insight into the way in which their beliefs support particular choices. Nor are we going to quantify their intake of foods and grains. Rather, we will examine how their health food beliefs function with regard to these two food groups, or better stated: how their health food beliefs define the function of these foods and thus, the ways in which these foods are to be consumed.

Sweetness and Power Revisited

The concept of sugar and sweetness is, of course, central to diabetes. To begin with, the disease name "diabetes mellitus" derived from Greek, means sweet urine, a reference to the fact that the excessive sugar in the blood of those affected is "spilled" into the
urine, where it gives off a characteristic odor. And of course, the variety of meanings of sweetness in the general culture is vast. To name only a few metaphors we have sugar as endearment (as in “sugar baby”), sugar as the stuff of love (as in “give me some sugar, baby!”), and sugar as drug (as in the name for a form of heroin, “brown sugar”). Such symbolic meanings can explain why the diagnosis of diabetes is so affecting. If you ask most people what it means to be diabetic, they say “you can’t eat sweets”; it is the need for abstinence from sugar that gives the diagnosis its emotional weight. But abstinence from sweets is, in fact, no longer a central teaching of diabetic nutrition therapy and nutritionists now mostly reject teaching absolute abstinence in favor of concepts such as moderation and balance. Nevertheless, sugar remains arguably the most central food to any discussion of diabetic nutrition. It is, after all, blood sugar, that diabetics are asked to measure. Rozin, commenting on the symbolic dimension of sugar, suggests that sugar and sweetness are equated with sensuality and sin. He traces this connection back to American Puritan moral values, which he feels still operate, for instance in current moral judgements of obesity. In this way, overconsumption of sweets (e.g. sinful indulgence) lead to obesity, or, more pertinent to our discussion, to diabetes, or even to poorly controlled diabetes. The anthropologist Posner suggested that it was the inability of diabetics to give up the deeply embedded social meanings of sweetness that gave rise to the dietetic food industry, in which noncaloric (artificial) sweeteners are substituted for sugar. Indeed, most U.S. mainstream grocery stores now have a section devoted to such foods; health food stores, as we shall see, do not.

Two sugar concepts that are directly connected with the issue of health and which therefore have special import for our respondents are the idea that sugar can be “empty” and that is it “fast”. Both concepts are, in fact, shared to some extent by the health food and medical community. Neither concept is exactly new. Mintz notes that even in the 17th century, as sugar consumption began to rise with sugar’s role as a sweetener of tea, there was medical debate which centered around the idea that a less nutritious substance (sugared tea) was being substituted for a more nutritious substance (beer). This is strikingly similar to recent medical studies which have examined the health effects of sugared soft drinks in the diet of U.S. adolescents in which the substitution of soft drink calories for calories that were previously consumed as milk. (Pereira et.al.). Such views
emphasize that while sugar contains energy (calories), it contains little else. Sugary foods are therefore felt to be "empty" of nutrition. The health food movements recognition of this concept is similar and was popularized by the publication of William Dufty’s “Sugar Blues”, which preached the evils of sugar and the detrimental health consequences of sugar consumption. Indeed, Dufty’s concept of sugar as being “empty” of value as a food became widely accepted, not only in health food circles but in the mind of the general public, as witnessed by the widespread use of the term “empty calories”. For the medical community, the solution to this problem was the use of artificial sweeteners. Thus, the American Dietetic Association endorses the use of saccharin, aspartame, and most recently, sucralose, the three noncaloric sweeteners which have been approved for usage by the U.S. Food and Drug Administration. For the health food community, though, these substances are problematic, as we shall see in our discussion of our respondent’s sweetener choices.

The other concept, that of speed, is also not new. Mintz notes that sugar was extolled, at the dawn of the 20th century, as the perfect food substance for the factory work break since it gave a “quick” energy boost that increased worker productivity. Such concepts persist in advertising for candy bars. The Snickers brand, for instance, uses this concept in its advertising when it says “eating Snickers is a good way to get quick energy that will keep you kicking all day long” (Nestle p. 191).

In the medical world, this concept of quickness is described biochemically as the ‘glycemic index’. This time quantity is defined as the rapidity with which ingested substances cause a measurable rise in blood sugar. Refined sugar has, almost by definition, a high glycemic index, while more complex carbohydrates have a lower one. Proteins and fats, which are only indirectly converted to sugar in the process of metabolism also have very low glycemic indexes. For diabetics who measure blood sugar by the fingerstick technique, the concept works at the personal level and is directly observable. Indeed, through the practice of measuring blood sugar, diabetics become expert at the glycemic index of their foods choices. Many insulin users adjust the amount of the quicker acting insulin component of their insulin dose on a ‘sliding scale’ to compensate for the type of food eaten at any given meal. What they are doing, is in fact, ‘catching up’ with the quickness of high glycemic index foods.
Similarly, the health food movement sees the ‘quickness’ of sugar as problematic, though the incorporation of the time aspect in their conception is, not unexpectedly, less biochemically based. Indeed, the concept of speed is approached more spiritually, and more globally. Speed is seen as an attribute, not just of sugar, but of modern industrial society and something to be opposed on this basis. Thus we have, for instance, the opposition of the “slow food” movement to fast food and the idea that taking the time to cook one’s foods ‘from scratch’ rather than buying preprocessed, packaged ‘convenience’ foods is valued, not only for its environmental and political impacts, for its ability to slow us down to a more leisured and less frenetic pace. It is also with the goal of slowing personal time that health food users use less processed sugars: the physical effects of less processed sugars are conceived of as being slower. A related belief, for instance, is that foods which contain high amounts of refined sugar can cause attention deficit hyperactivity disorder, a belief which persists among many health food community members despite medical studies to the contrary. For these believers, the strength of the connection between sugar as “speedy” and hyperactivity as a disorder of time is strong.

We can say then, that the qualities of emptiness and quickness in sugar are seen as problematic by both the medical and health food communities, though each community provides its own emphasis and its own connection between such concepts and the question of health. Both concepts can be used to promote specific food choices within the sugar/sweetener category, i.e. both concepts describe a ‘function’ of sugar and sweeteners.

We turn now to a discussion of our respondents’ choices of sweeteners, starting with the caloric sweeteners, including cane and beet sugar (sucrose) in its various forms, and honey. There are, of course, other forms of sugars which are stocked in health food stores: in keeping with a goal of food and environmental diversity, health food stores routinely stock date and barley sugars as well as fructose, corn, and maple sugars. Brown sugars are stocked as molasses, as well as in various ‘light’ and ‘dark’ crystallized versions, and finally, in a “raw” version. Our respondents, 3 of whom used caloric sweeteners, did not choose these products, however, and we will pass over them with just
this acknowledgement of their presence. We must also say that none of our respondents actually bought bulk sugar during our shopping trips, though we did discuss which sweetener they kept stocked in their homes, and we were able to discuss ‘added sugars’ in the packaged and processed foods which they did buy during our shopping excursions.

We begin with “R”, whom, as we have previously stated, has been a Type I diabetic for more than 30 years and is proud of not only how well she has done in managing her disease, but also of the fact that she can eat pretty much anything. In keeping with this, “R” uses regular table sugar when she uses sugar at all. She does not buy ‘dietetic’ foods which contain saccharin, aspartame, or sucralose. This avoidance is driven by her belief in the cancer causing potential of such chemical foods, and she would rather adjust her insulin dose to accommodate the glycemic effects of sugars in her foods than to expose herself to potential cancer causing agents. She mostly, however, has learned to not add sugars to her foods, and for instance, does not sugar coffee or tea. On the other hand, she is not afraid to buy products which do contain sugar: she bought a sweetened lemonade drink whose label showed that after “filtered water”, the ingredient present in the highest amount, by weight, was “organic dehydrated cane juice”. Similarly, she did not avoid the pastry section of the store, though she chose a freshly baked scone, which is, arguably, likely to be less sweet than many other pastries. All in all, however, her focus on making her own (or actually, her partner’s making) of most of their meals “from scratch” means that the issue of added sugars in her diet is not a major focus for her.

Our next respondent, “S”, is not diabetic herself: she is the daughter of a diabetic. Nevertheless, her approach to sugar is rather different than we might expect. While maintaining a whole foods stance, and not buying much in the way of processed food to which sugar has been added, she has been advised by her acupuncturist to increase her intake of honey. She does this gladly, enjoying the taste and liking the concept and says that she sometimes eats honey, by itself, ‘by the spoonful’. With her usual attention to the issue of digestion, is she also aware of the laxative effect of eating sugar in this way, but puts up with this because of her belief that eating honey will act to strengthen her immune system. She also purchased pastry during our shopping excursion: after much time spent considering her options, and initially leaning toward some vegan brownies, she opted for baclava, perhaps in deference to our discussion of her ethnic heritage.
Indeed, baclava was the only food she says she still eats that connects her with Greek culinary traditions. With neither her honey consumption, nor her pastry consumption did she make any connection with the issue of diabetes. Indeed, sugar figured very little in our discussion of her varied ‘diets’ and food beliefs, despite my attempts to keep the issue of diabetes to the fore and despite her belief that it was her mother’s poor eating habits which brought on her diabetes.

Our third sugar consumer is “ST”, who chooses a product called “Sucanat” because, he says, it is less processed and thus will be absorbed into his body more slowly. In addition, the product’s makers describe their efforts at sustainable agriculture: they don’t burn their cane fields, and instead, plow under the residual plant material as mulch. They also go to some lengths on the package to describe the exact nature of their product’s processing, and provide authoritative references on its organic nature. Such methodology makes this “ST”’s preferred product, despite that fact that it is much more expensive than other forms of sugar, and thus a particular burden given his limited financial means.

“ST” also says that he is trying to ‘wean’ himself off of the taste of sugar, but still adds sugar to beverages, for instance. Indeed, the concept of ‘weaning’ implies an underlying belief in the addictiveness of sugar, a concept to which we alluded in our mention of the metaphor of sugar as a drug. “ST”, as we can recall, is a type I diabetic, but nevertheless, feels that the sugar ‘habit’ which he acquired as a child, eating sugary breakfast cereals, and other processed sugary snacks, led to not only his diabetes, but to his continued difficulty managing his diabetes. Unlike “R”, he does not adjust his insulin dose with fingersticks, and though he sees sugar intake as more of a problem than she does, he still opts for a caloric sweetener rather than subject himself to the health risks of noncaloric ‘chemical’ sweeteners. After more than 15 years as a diabetic, one could say that his belief that he will one day wean himself off of a taste for sugar shows considerable optimism. Remember as well that “ST” was recently hospitalized for an episode of diabetic ketoacidosis, whose cause he contends was “food poisoning”. With this in mind, and given his views on the dangerous effects of sugar on diabetes, it is interesting, then, that his health food beliefs still cause him to use natural sugar in preference to a
noncaloric ‘artificial’ sweetener. We can conclude that his health food beliefs override his belief in the dangers of (caloric) sugar.

We move on to a discussion of the noncaloric (or nonnutritive) sweeteners, often referred to as ‘artificial’ sweeteners. Only one of our respondents used these products, and, as we might expect from a member of the health food community, she did so with considerable ambivalence. At the same time that the concept of sugar as “empty” calories would seem to foster the usage of such products, the health food concept that foods must be ‘natural’ and not processed or manufactured makes these substances problematic. And while the American Dietetic Association endorses the use of such sweeteners, and cites the FDA’s ruling on their safety, health food community members have not forgotten the uproar over the delay in the withdrawal of one such sweetener, cyclamate, from the U.S. market after studies showed its carcinogenic properties years earlier. Similar battles over saccharin’s carcinogenic properties have not led to its removal, and aspartame, while not a proven carcinogen, has been accused of myriad other health effects, without effecting its status with the FDA. Indeed, “R” and “B” who have both had reproductive tract cancers, wondered aloud if their cancers might not have been at least partly caused by their prior usage of such sweeteners and FDA pronouncements do little to sway their opinion.

Despite such concerns, however, “B” chooses to use a product called sucralose, marketed under the brand name “Splenda”. She does so sparingly, and with some chagrin, recognizing that the product is relatively new to the market, and that the product’s health effects may not yet be fully known. In the product’s favor are the fact that she was introduced to it by her diabetic nutritionist, and also that the product is “made from sugar”, i.e., though altered by the manufacturing process, the underlying substance is ‘natural’. She is also aware that the manufacturing process renders the sugar indigestible, and thus that it theoretically, at least, passes through the gut without being absorbed into the bloodstream. This mechanism seems to imply that the potential for harm is lessened, as the substance is literally never quite ‘incorporated’. Despite such positive attributes, however, “B” recognizes that the product does not fit the health food
conception of what’s good to eat, and she attempts to use it only sparingly. Similarly, she
admits to drinking “an occasional” Diet Pepsi, a product which contains aspartame,
which she would prefer to avoid. But her desire for the taste of sweetness in a form that
will not ‘count’ in her daily tally of carbohydrates overrides her concern about these
products potential negative health effects. In contrast to “ST”, who feels that he will
some day be able to wean himself off of a taste for sweetness, “B” has no such future
hopes. Indeed, “B” fits better with the diabetic situation as described by Posner, in which
an unwillingness to give up the taste of sweetness leads diabetics to the use of artificial
sweeteners. For “B”, however, this decision is fraught with risk: as a health food believer
and cancer survivor, the chemical nature of artificial sweeteners is of concern to her.
She is, in a sense, between a rock and a hard place. Her choice to use sparing quantities
of a possibly safer artificial sweetener must be viewed in the context of her great desire
to free herself from the necessity of taking diabetes medication, and she sees that her
nutritionist’s emphasis on counting carbohydrates, (a methodology which favors the use
of artificial sweeteners) has so far enabled her to do this. She is, in a sense, trading an
occasional use of one chemical for a daily (actually three times a day) use of another.
Whole Foods Markets expresses similar ambivalence about sucralose. Its
informational website lists 3 categories which provide the basis for its rating of the
product. These are safety, the issue of minimal processing, and “ideological
compatibility”. With regard to the first two categories, they find no credible evidence of
ill health effects, though they caution their readers that little information exists outside of
safety studies commissioned by the products producers. In a similar vein, little weight is
given to the FDA approval process. Regarding definitions of ‘natural vs ‘artificial’ they
comment that, while derived from sugar, the product is a “highly processed additive
created from the manipulation of molecules.” (www.wholefoodsmarket.com). But
perhaps most interesting is the website’s comment on ‘ideological compatibility’:

“The question of the ideological compatibility of sucralose with other
WFM products may actually be more complex than concerns about safety
or processing. Despite its derivation from plain sugar (a feature which its
manufacturers repeatedly emphasize), sucralose is an artificial sweetener.
Historically, our company has avoided selling non-nutritive artificial
sweeteners because they are not in concordance with our philosophy of
promoting “real” food. However, providing food for special diets has also
been an important function of our stores. The biggest foreseeable challenge for WFM will be to market these products in a way that does not threaten the integrity of our quality standards/goals.”
(www.wholefoodsmarket.com)

Levi-Strauss’ dictum that a food must feed the mind before it can feed the stomach finds new application here: a “real” food, must, apparently be “nutritive” and foods which are not nutritive are “not real” and can threaten the integrity, not only of a person, but a marketer.

But Levi-Strauss was a structuralist, and we are interested in the function of sweeteners. What are we to conclude from our respondents diversity of choices? Do all of these choices function either to connect our respondents’ spiritually to a whole earth conception, or as a vote for environmental causes? Or, as in the case of “B”, do they function within a specific dietary regime? And what ever happened to the pleasure of the taste of sweetness, which only “ST” actually mentioned, and which he is trying to give up?

It is rather hard, in fact, to make sense of this diversity, but one thing does stand out. That is, that the whole foods movement approach to sweeteners is not a unified approach; in fact, the issue of sweeteners seems to be, if anything, a topic that is approached only marginally through other areas of concern: i.e. through a discussion of the extent of processing, or the categories natural vs. chemical. On the subject of sweetness itself, the movement has very little to say. Perhaps this is because the movement hasn’t had any impetus to do so: its preference for unprocessed foods, for instance, has meant that the issue of added sugars is largely something that is moot for its adherents. Perhaps, as we have said in our introduction to this thesis, adherents to this cuisine are, in fact, less often diabetic.

What we can say, however, is that the idea of food restriction is not central to the health foods movement, which, while it values simplicity in food choice, doesn’t advocate self-denial. Sugar, therefore, has no particular function in the whole foods schema, except to the extent that it should be consumed in proper form, unprocessed, and preferably organic. Beyond a belief that it should not be consumed in ‘fast and empty’ forms: i.e. one should consume it ‘mindfully’, the movement has very little to say about it. In sum, for the health food movement, sugar is not sinful. It is, perhaps, this lack of emphasis
which underlies the inconsistency in our respondent’s choices. While sugar is central to the medical concept of diabetes, it is not central to the concept of what’s healthy or not healthy to eat for our respondents, even when they are diabetic. Their disembarassed choice of pastries, indeed, their obvious relish in such choices, even when the topic under discussion is eating as a diabetic, is more understandable when viewed in this light. The function of sugar in their lives is de-emphasized by their membership in the health food community despite the fact that they are diabetic or at risk of diabetes. And while we have not quantitated their sugar intake, it seems entirely possible that at the same time that they pay less attention to the issue of sugar than do many American diabetics, their general reliance on unprocessed foods means that their consumption of sugar is, in fact, less.

**Whole Grains for the Whole Earth**

In contrast to sugars, the topic of whole grains is something on which the health food movement has always has much to say. We begin, as before, with some general concepts and then move on to a discussion of our respondents’ choices.

We should start, however, with a few definitions. Nutritionists tell us that there is really only one carbohydrate category, and that this category includes fruits and vegetables, as well as grains, tubers, and legumes. When they teach diabetics to “count carbohydrates”, all such foods are included, and in limiting carbohydrates to a certain number of grams per day, they seemingly attempt to limit food categories that might otherwise seem ‘healthy’. We must understand that they also limit the remaining food categories of ‘fat’ and ‘protein’. In addition, we note that carbohydrate counting is now further defined by calculating the ‘effective’ or ‘absolute’ carbohydrate count which involves subtracting a food’s ‘fiber’ grams, from its ‘total carbohydrate’ grams to derive ‘effective’ carbohydrate grams that should ‘count’ in one’s daily tally. Mostly what nutritionists currently are trying to effect is a move toward healthier forms of carbohydrates and in this move, the term ‘complex’ carbohydrates is often used to describe whole grains and legumes. In summary, while nutritionists limit their diabetic patient’s total number of carbohydrates, they would in general like their patients to
increase, relatively speaking, the percentage of such foods which are in the form of whole grains and legumes (such as peas and lentils). Such an emphasis on whole foods, is, of course, something that the health food movement has been touting since its inception, well before it became a focus of medical nutrition. Our point is that the two teachings, often at odds on other topics, are now in accord on this point.

Such teachings contrast with one of the current popular diet trends in the U.S., in which carbohydrates, taken as a general category, as seen as the cause of obesity. Popular weight loss diets such as the Adkins’ diet and the Carbohydrate Addict’s Lifespan Program advocate severe restrictions in the consumption of carbohydrates, often sacrificing fruits, starchy vegetables and dairy products in the process. In contrast the teachings of the ADA, such diets make no distinction between ‘healthy’ carbohydrate foods, and ‘unhealthy’ ones. Whatever the cause, researchers at the USDA’s Center for Nutrition Policy and Promotion have concluded that Americans, as a group, are eating fewer whole grain products than they should. (Gerrior and Bente 2002)

One carbohydrate concept of particular importance to the health food movement is that of the ‘core’ carbohydrate. This is an historically based idea, in which one carbohydrate, usually a starchy food, provided the basic nutritional requirements for a population, supplemented by a ‘fringe’ of additional foods which provided not only additional nutritive value, but also diversity in flavor and texture to what was often a monotonous base. For Asian cultures, this core carbohydrate is rice, for Europeans, either wheat or, since the importation of the new foods from the new world, the potato, and for 20th century North Americans, it has been both wheat and potatoes. While other carbohydrate sources are still available, such as the grains rye, barley, oats, and the indigenous corn, as well as yams and sweet potatoes, most Americans are mostly still wheat and potato eaters. It is this concept of a monocultural and monotonous carbohydrate core that the health food movement rejects in its adoption of a diversity of whole grains.

Whole grains fit the health food movements concept of a ‘whole food’. And they do this better than potatoes, which, though undeniably a whole food, have the disadvantage of soft white centers, which compete poorly with the esthetics of grains’ brown chewiness. In addition, the potato’s culinary associations with mom’s meat and potato
dishes, a culinary tradition which our respondents have rejected for its meat, has meant that potato’s previous incarnation as a staple food, bought in 15 lb bags at the grocery store, has largely disappeared: potatoes are now bought by the handful, on an as needed basis, since their less frequent usage results in spoilage if bought in bulk quantities. Potato growers have tried to counter this decline with new varieties of crossbred potatoes: Yukon Golds, for instance have had their moment in the spotlight. But the health food movement, while desirous of biodiversity, would rather see such diversity occur via the preservation of older varietals rather than via the creation of newer ‘industrial’ potatoes. Advocates of biodiversity thus talk about South American cousins of the potato such as the oca, mashua, and ulluco which have yet to find their way to first world markets. And health food stores, while they do stock a few potatoes, make sure to emphasize yams and sweet potatoes, rather than the mainstream Idaho russets.

With these background comments, we turn now to a review of our respondents’ grain choices. We begin with “ST”, who generally chooses rice as his core carbohydrate. He does this because, as previously stated, he tends to cook “Asian style”, due to the plethora of vegetarian recipes to be found in Asian cuisines. Also, he no longer consumes breakfast cereals, since he views the added sugar in the majority of these products as being at least partly responsible for his diabetic condition. In addition, his bread consumption is limited by the fact that he doesn’t enjoy “American style” vegetarian products: thus, since he doesn’t eat veggie burgers or vegetarian “hot dogs”, he doesn’t consume the breads and rolls on which these foods are normally consumed. Of our respondents, he is the one whose choices are the most determined by a choice of an entire, predefined “cuisine” (ie nonamerican vegetarian) though, in keeping with his health food beliefs, the rice that he chooses is often brown.

Our other rice eater is “R”. She chooses a partially polished, organic brown rice, from a bulk bin which is labelled with the name and location of the grower (in this case, a grower from the neighboring state of California). Buying from the bulk bin means that, in theory, she saves on wasteful packaging, and knowing the name of the farmer from whom she is buying fits with the idea that smaller scale agriculture is better than large industrial agribusiness. Of all of these details, the one which hold the most personal power for her is the ‘organic’ one, since, as we have mentioned, she is a breast cancer
survivor, eager to avoid further pesticide and chemical exposures. She is not the least concerned over the carbohydrate content of the product that she buys. The fact that the product that she buys is partially polished is a tradeoff between the issue of “wholeness” and convenience, since partial polishing reduces the cooking time of the rice.

Neither “ST” nor “R” express any concern over the need to foster agricultural diversity with their these choices. Neither buy the more unusual grains such as quinoa or spelt, for instance, “ST” because such grains are not called for in his recipes, and “R” apparently because such grains have not yet reached the point where they make sense to her generally speaking. She is, admittedly, shopping so that her partner can do the cooking, and is thus, perhaps, not in the position of someone who might be more quick to experiment with new products. But it is also true that she is more interested in pricing: as a frequenter of farmer’s markets and other local producer markets (such as the Native American salmon market) she may be less impressed by the value of diversity when it is outweighed by cost. She does not confine her ‘core’ carbohydrate choice to rice, however, but also buys occasional potatoes and pasta. The former she buys in smaller quantities, since, as we have seen, it is subject to storage issues when used only occasionally; the pasta she chooses again from the bulk bin, buying a wheat based product. Both of our rice eaters are closer in practice to the traditional “core” carbohydrate usage than our other two respondents, except that rather than the core being wheat and potatoes as with the American majority, they choose mostly rice. Neither are label readers or gram counters, and so their choice of carbohydrate is not affected by the calories or carbohydrate grams as defined in such ways.

Our third respondent, “S”, is, as we have previously mentioned, particularly interested in healthy digestion. She is aware of medical evidence, for instance, that says that high fiber foods such as whole grains are good for intestinal health and may reduce the risk of colon cancer. She is also interested in keeping her grain choices diverse: while she is not ‘wheat allergic’, she does try to avoid eating too many wheat based products, believing that it is not healthy to subject the gut to too much of one particular product. She feels similarly about corn. Unlike her statements regarding whether or not to buy organic produce (in which she felt that the difference to her personal health would be small to the
point of being doubtful, but that the beneficial effect of her organic purchase on the planet was more pronounced) her interest in grain diversity is more personal than ecological. She prefers grains such as quinoa, which is a mesoamerican grain, with a very small kernal which she can simply boil and eat plain. She likes it for the fact that it is ancient (ie has not been altered by modern agriculture), as well as the fact that it is ‘less processed’. She also likes the taste. But she emphasizes that it is easily digestible. In contrast, she never buys rice, because she feels that it is overused, and that it is less digestible. Indeed, she link these two issues: overuse seems to lead to a reduction in digestibility in her explanations. Similarly, while avoiding overuse of wheat products, she looks for products that use buckwheat or spelt, both older relatives of modern wheat varieties. As we have stated before, she is also an avid eater of beans and peas, in sprouted form; her health food store provides her with 8 bins of such dried legumes from which to choose.

Our fourth respondant, “B” is the carbohydrate counter, and her choices of grains are largely driven by this. Like “S”, “B” also avoids rice, but does so, not on the basis of concerns about digestion, but because of what she feels is the excessive number of carbohydrate grams in each serving. Similarly, she eschews wheat based pastas, preferring instead to buy pasta made from the grain ‘kamut’, another ancient relative of wheat, with a relatively lower carbohydrate content. She buys this pasta product despite the fact that it is significantly more expensive than other pastas. She is the consumer of the Ezekial sprouted bread, which, aside from its ‘living’ nature, is also lower in carbohydrate grams per slice than wheat breads but which also must be bought, prepackaged, from the freezer section of her health food store, since the producer is not local. She also avoids corn products such as tortillas on the basis of their high carbohydrate content. Thus, her choices are entirely driven by her need to count carbohydrate grams and while she is aware that the products which she is choosing are “alternative grains”, in that they are usually not sold in mainstream grocery stores, her personal desire to contribute to biodiversity is not what drives her choices. Further, we can say that her need for package labelling causes her to mostly bypass buying the unprocessed grain products from bulk bins. Whereas she is very accustomed to making
many vegetarian foods, such as seitan and hummus from scratch, she is less likely to do this with whole grains.

In summary, with respect to their whole grain consumption, our respondents are, once again, a diverse bunch. Two eat rice, two do not. Two prefer ancient grains, though one because of concerns over digestion, the other for reasons of carbohydrate content. They all, however, eat few, if any potatoes, a rejection of one of their parent’s core carbohydrates. And to the extent that they eat bread, none eat white bread, preferring multigrain, or at least ‘alternative’ grain breads. What is missing from their cuisine as well are the highly processed carbohydrates: none buy breakfast cereals, or snack foods such as potato chips. In this way, they accomplish much of what nutritionists advise: their carbohydrate choices are weighted toward whole grains, rather than processed ones. It is in this consistent avoidance of processed cereals, snack foods, and other processed grains that their health food beliefs are most manifest. As well, we might note that many of the products that they choose are only found in health food stores in the first place because of their environmental effects. Spelt, the ancient grain enjoyed by “S”, has a particularly tough hull, which makes it more resistant in insect infestation and thus ideal for pesticide free agriculture. And while our respondents may not always be aware of such details, they do understand that spelt can’t yet be found in mainstream grocery stores, that it is, as “S” says ‘alternative’, and that its presence in their health food store implies an opposition to the monoculture of wheat.
Chapter 5 Concluding Comments: the creation of personal cuisine

Our examination of personal cuisine creation by our diabetic (and diabetic family member) health food eaters now concludes. We have covered quite a bit of anthropologic theoretic ground. We have seen how health foods can have symbolic meaning, and how health food categories which are themselves symbolic of a political purpose can provide structure to cuisine. We have seen how foods can provide connections that go beyond the boundaries of the physical body. And we have noted that while the health food movement provides an entirely different rationale for the selection of its foods, in areas in which it concords with medical definitions of what's healthy to eat, its adherents by and large eat 'healthily'. We would agree, then, with previous assessments that the health food movement does promote change: at the same time that our respondents seem to eat healthily, it is also true that none of their cuisines resemble what might be considered a mainstream American diet or even their parent's cuisines.

Despite this, we have seen that our respondents are still a rather diverse group and while sharing common beliefs, they seem to pick and choose how they will apply their health food beliefs. They do this rather pragmatically, as if from a menu of options, influenced by logistics, finances, and the constraints of social circumstances, e.g. eating with partners, children, family and friends. Similarly, their use of additional predefined and sometimes even astounding "diet" categories is both pragmatic and flexible, allowing them to shift between dietary definitions as their circumstances allow, without occasioning a sense of failure or blame. They do what they can, according to their beliefs. And if two beliefs clash, as in the case of choosing sweeteners, the decision on which pathway to follow can go either way: one of our respondents chooses sugar despite difficulty controlling his diabetes; another chooses artificial sweetener despite her fears of chemical effects. The underlying thread, however, remains consistent: when able, they choose on the basis of their health food belief in promoting sustainable agriculture and environmental health. Sociologists Beardsworth and Keil call such efforts choosing from a 'moral menu' and contrast this choice with other menus options including the one which they term the 'rational menu', defined on a scientific basis.

One difference between the 'moral' menu and the 'rational' menu, which we would argue, has much to do with the level of commitment which our respondents show in their
choice of cuisine, is that whereas the ‘rational’ scientific menu is constantly changing, based on new and frequently contradictory scientific study findings or based on new interpretations of older findings, the ‘moral’ menu has stayed the same since its inception in the 1960’s. The two ‘menus’ recommendations on the relative values of butter and margarine are a case in point: whereas nutritionists since the 1960’s have touted margarine as being lower in saturated fats and cholesterol and thus healthier than butter, today they tell us that, (whoops), the process of making margarine, called hydrogenation, produces ‘trans’ fats which are also unhealthy. Instead, we are told to buy liquid forms of margarine which minimize the hydrogenation or use vegetable oils. But the health food movement never did approve of margarine, which it viewed as a more highly processed food than butter, and to the extent that many of its adherents are also vegan, even butter was bypassed in favor of those very same vegetable oils that the nutritionists are now touting. Its viewpoint has not changed on this, and is not likely to.

In addition to the potential confusion which arises from changing nutritional definitions of what’s healthy to eat, it is also becoming increasingly clear to Americans that the interpretation of scientific research is politically influenced. How else are we to explain the findings of a recent review of the health effects of sugar in a USDA sponsored publication, which stated that

“recent evidence shows that aside from dental caries, the intake of added sugars is not directly related to diabetes....Because high intake of sugars along with other factors can affect oral health and can displace important foods and nutrients in the diets of children when consumed as soft drinks, it seems prudent to limit excessive intake. But the focus on sugar as an independent risk factor for chronic disease...should be de-emphasized.” (Mardis 2001 p. 89)

While it may take an expert such as Marion Nestle to lay out the exact nature of the connection between the Sugar Association and the USDA’s nutritional recommendations, Americans, already skeptical of their government, are ready and willing to believe in such connections. In contrast, the political nature of the health food movement’s message has always been evident. Indeed, as we have seen, the politics of the movement are seen positively, and actually provide a function to food choices.
It is no surprise then, that our health food respondents are able to maintain a ‘mindfulness’ in their eating which nutritional professionals can only admire but not induce in their own clients. If medicine is to ‘motivate’ its patients, it must first improve the believability of its tenets by addressing the nature of scientific change upfront and without apology. If Americans are educated in the fact that the next scientific study to come down the proverbial pike may only give the truth ‘for now’, they will be less likely to be exhausted by the seemingly endless stream of contradictory pronouncements. As well, we share in Nestle’s call for medicine as a profession to divorce itself from the politics of the food business and the pharmaceutical industry by refusing industry sponsorship of professional organizations that purport to interpret the validity and findings of scientific studies. It should, in fact, be less ‘businesslike’. And we agree Krieger’s call for action and attention to social issues that affect individual empowerment. By doing so, we hope that we can induce medicine to abandon its concern with the power laden concept of ‘compliance’.

In a sense, we are advocating that medicine take a higher moral ground than it currently holds. And while its ‘rational’ menu may never be a ‘moral’ menu in the way that the health food movement’s menu is currently, it may gain at least some symbolic power. At the very least it will address the skepticism and ‘anomic’ which causes Saudek, our JAMA editor, and others looking for ways to stem the rising incidence of diabetes, such concern.
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Summary

Diabetes incidence is rising worldwide and studies which have looked at ways to prevent the disease have so far made little headway in altering the rise of predisposing factors such as obesity. The editor of a recent special issue of the Journal of the American Medical Association, Chris Saudek, wonders how Americans, as a population, can be motivated to make the necessary behavioral changes. At the same time, anthropologic study has identified the health food movement as being particularly effective at inducing dietary change in its adherents cuisines. While health food movement definitions of what is healthy to eat do not always concord with medical definitions, the ability to effectively induce change is considered of some interest.

This research study used anthropologic methodology and theory to examine the ways in which health food shoppers who are also diabetic or at risk of diabetes through their family history of the disease, create their own personal cuisine. Symbolic aspects of health food beliefs that structure cuisine were elaborated, and individual choice and flexibility were also examined. While the study showed that there was little consistency between individuals, the underlying political belief that food can symbolically connect an individual to the environment and that promotion of a healthy environment is a moral goal were beliefs that consistently informed food choices. In areas where health food movement beliefs concorded with medical diabetic nutritional recommendations, the study seemed to confirm previous studies which showed that the health food movement was effective in inducing change.