University of Chicago

Department of Sociology

MORE THAN JUST GOING THE DISTANCE: BODY IMAGE AND PERCEIVED ACCESS TO FOOD

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Abstract

This study seeks to answer the question: how can a person's access to food impact their relationship with food and their bodies. In the course of this study, ideas of access, health, and attractiveness are examined to ultimately conclude that people have two different definitions of health one that is based on societal conceptions of healthy food such as eating a certain amount of calories or limiting your diet to superfoods and exercising to lose weight and another that is more survival based and focused on a need to eat until one is full and exercise for the sake of moving one's body. These definitions are influenced by a shift in access to who is making a person's food as the participants transition from their parents providing their food to them providing their own food.

Introduction:

This paper seeks to understand the impact of people's access to food on how they form relationships with food and their bodies. The current literature and research that exists on this topic focuses more on access to food as solely physical distance from food resources and doesn't account for the way that people perceive and internalize their access. There is also a distinct research interest in how others socially perceive people's bodies and how that impacts the treatment that those people receive. Some of these studies also examine how individuals respond to this treatment and internalize it. There are very few studies that investigate how people feel about their bodies and food independent of their social treatment. I will examine literature that focuses on people's internal ideas of their own bodies based on larger societal ideas as well as literature that defines bodies in the public sphere. Missing from the literature is an understanding of how people understand their own relationship with food and their body outside of the lens of societal ideals. While most studies infer how people think about their relationship to food as it relates to geographical space, my study zooms into the people to ask them to reflect on their feelings and how their access to food affects their relationship with their bodies. It is important to understand these individual perspectives of access and understandings of food and the body to better interrogate how weight stigma is perpetuated from individual to individual. To that end, I will be combining areas of research to investigate how individuals have developed relationships with food and their body based on their changing access to food.

I interviewed 20 college aged students about these topics. In this paper I examine their answers through a mixed methods lens, relying both on qualitative examination as well as graphical representations of commonalities in their answers. This will be done in order to visually represent the overlap of individual perceptions of access, food, and the body. Ultimately, I come to the conclusion that college aged students have a rapidly changing definition and perception of their own access because they are moving from their parents providing their food to being responsible for providing their own food. Due to this shift, they are transitioning from one idea of health to another. These definitions of health are health 1, which is distinguished by eating a certain amount of macronutrients and exercising to lose weight, and health 2 which is distinguished by eating to feel full and exercising for the sake of moving one's body. I will show how this change from health 1 to health 2 can help us understand the process through which weight bias is continued in hopes of understanding how to best intervene in weight bias in order to reduce the stigma on a larger scale.

Theoretical Framework:

Food Access

The first step in understanding what literature exists that relates to this topic is by examining how researchers have created and explored definitions of food deserts through their studies. The standard definition of a food desert is a neighborhood or area that has "a low access to healthy foods and high access to unhealthy foods. Food deserts offer residents few, if any, high-quality, full-service supermarkets or grocery stores, but many corner stores and fast food restaurants" (Drew 2). This definition was formed based on a distance per population ratio.

According to the Department of Agriculture, the standardized numerical specifications for food deserts are as follows: “low access is characterized by at least 500 people and/or 33 percent of the tract population residing more than 1 mile from a supermarket or large grocery in urban areas, and more than 10 miles in rural areas” (Dutko 3). Other studies have sought to expand this definition and address the nuances of food deserts and discovered that there are gray areas within this definition that apply to “less dense, dispersed suburban areas” (Leete 5). According to Leete, these areas “lack the concentrated poverty and the empty shells of defunct grocery stores that are visible reminders of food access issues in food deserts.” (Leete 6) Essentially, these areas don’t have steady access to food but this lack of access isn’t as visible as it is in high poverty areas because there are fewer physical reminders of the lack of food resources such as abandoned grocery stores or buildings. Leete describes these areas as food hinterlands to represent the uncharted nature of their food access. Even with this new term in mind, this lens for research still focuses more on the numbers and geography of food deserts rather than on the perspectives of the people that live there.

Other studies have tried to address this difference by examining the role of social class in people’s perceptions of food. In the literature that discusses the sociology of consumption and class, the concepts of food deserts have been integrated into definitions of food as good and bad, healthy and unhealthy, and have impacted the way that people choose to buy and consume foods everywhere (Paddock 2016). People relate labels such as good and bad with food based on the class associations that they have with those foods, such as soda and chips being viewed as inherently bad and unhealthy versus other “superfoods” that are more expensive and classified as good and healthy foods. The way that these messages have been internalized by people has been investigated by researchers in the United Kingdom. These researchers conducted 20 in depth

interviews and discovered that "ideas about 'good', and in this case, 'alternative' food consumption are used as a means of drawing boundaries between social groups as distinctions are made in talk between foods that are for 'us' and those that are for 'them'." (Paddock 2016) The way that people form these ideas of food as it relates to food for them versus us directly correlates to how people interpret their own access to food, regardless of their status as a food desert. This shows how the standard definition based solely on distance doesn't account for the way that people view the food itself when they buy and consume it. My study seeks to address this gap by investigating how these concepts of access and the way that people relate to food combine within individuals in their everyday lives. In this study, access is defined more by a person's perception of the distance, time, and effort that goes into buying, creating, and consuming food. These layers of access impact the way that people view food in relation to their body and reveal how people's ideas of health, their own bodies, and the opinions on food that their communities have interact with each other.

Ideas of Health Related to Access

In addition to understanding how access has been written about in literature thus far, it is also necessary to investigate the way that researchers have approached the question of health as it relates to food access. Outside of the field of sociology, many medical researchers have tried to understand why the "obesity epidemic" and its related comorbidities in the United States are so heavily centered in low access food areas. These scientists examine weight as a health indicator in a system that operates under the assumption that as a person's weight increases, their quality of health decreases and thus their quality of life. From this, researchers have created a standard for healthy food and a healthy lifestyle, one that puts sole responsibility of health complications onto poor individuals, even health complications that aren't inherently tied to weight. This

narrative has allowed for doctors to standardize the theory that people eat unhealthy food because it is the only food available to them and if they were given the proper education and resources, they would eat healthier foods. (Pooler 2012) The United States has a standard for what is considered a healthy diet that is broken down into a measurement of different food groups. This model is known as the Healthy Eating Index and according to the United States Department of Agriculture, the United States general population has a score of 59 out of 100 for healthy eating. (agriculture website). Other researchers have approached this conversation by emphasizing that this focus on choice consumerism of poor people does not account for people who do not have time to think about food in terms of health, they only focus on being full. (Walker 2011) The idea that people would eat healthier if they had access to places that served healthier foods does not account for an individual's understanding of their health and how they relate to food. My study accounts for this gap by examining how people's internalized ideas of health shifted as their access to food shited. This investigation will allow for a deeper understanding of how higher access to healthier food actually impacts people's shopping patterns and how they classify their own health.

Obesity and Access

These conversations about health and access almost always converge on the marginalization of people based on weight, race, and class. While many researchers have examined the social construction of obesity and its relation to issues of class and race, the issue of fatphobia and weight bias is still incredibly prevalent in the healthcare system as well as in the general public. (Strings 2019, Panone 2013). This is important to consider when discussing a person's access to food because multiple studies have been done to investigate the relationship between poverty, access to food, and obesity. Researchers have concluded that the more

impoverished the area, the more likely it is that its members will be obese. [1] This trend has created an understanding of weight bias that is as much about food access and classism just as much as it is about fatphobia. Thus, we must now investigate the impacts and understanding of weight bias and obesity in order to understand why it is important to tie this conversation to one about access in order to reduce weight stigma.

One researcher Margo DeMello synthesizes many of these issues in her book Body Studies through a series of essays about the various interpretations and definitions of bodies in society. In reference to class, DeMello says that "growing up poor exposes us to vastly different foods, clothing choices, toxins, and illnesses than the rich, for example, might be exposed to. So not only would the rich and the poor embody those class differences in different ways, but those differences would be valued differently as well. Habitus carries symbolic power, just as eating hand crafted suchi is more symbolically valuable than eating at KFC or McDonald's" (DeMello 156). This is the trend that has been taken by most sociological researchers in this topic, they examine how people create and maintain a habitus through their diet and how they reinforce those concepts in their interactions with each other. There is a classed element to this lens that captures one of many facets of how people relate to food, and other researchers have expanded on this classed understanding to a racialized understanding.

Sabrina Strings wrote a book titled *Fearing the Black Body* that traces the historical development of the association between weight, health, and black bodies. She details how fatness became associated with "greedy Africans" and that overating was linked to ungodliness. This is an important relationship to track because poverty and race are closely linked, with black people

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3198075/

and other people of color accounting for the majority of poverty in the United States. [2] The association between negative moral values and weight in black people especially creates room for these groups to try and achieve a socially acceptable body through controlling their weight and their perceived healthiness.

These concepts that people have of themselves because of their diet and access to food lead to ideas of health that have created both an "inner body" and an "outer body", according to DeMello: the inner body, which we associate with health, and the outer body which we associate with appearance and social relationships. 'Within consumer culture, the inner and the outer body become conjoined: the prime purpose of the maintenance of the inner body becomes the enhancement of the appearance of the outer body" (169). This approach to body studies complicates the narrative of food access as it impacts people's relationship with their own bodies and health because it shows how much societal pressure there is to look a certain way. Fat people as well as black people exist outside of the social narrative of acceptable bodies and thus many of them do what they can to become socially acceptable, and if they can't it greatly impacts their opinions of themselves. We have established that the overlap between obesity and poverty is incredible and this means that people's internal relationships with their body's are based heavily on the narrative of trying to achieve an outer body that is socially acceptable in spite of a person's access to food. My study shows this trend through interviews and details how people link the idea of health and appearance become linked, the inner and the outer body become, and people's individual relationships with food suffers as a result.

[2] https://www.epi.org/blog/racial-disparities-in-income-and-poverty-remain-largely-unchanged-amid-strong-income-growth-in-2019/

Weight Stigma

In the Workforce

We have explored how food access relate to obesity, race, and perceived healthiness, but now we must zoom out from these concepts to look at how all of this combines to create systemic discrimination against obese people that further impacts their relationship with food and their own bodies. Researchers have looked into the way in which these ideas of weight and the bias that comes with it impact "obese" people in the larger world. A group of psychologists conducted a study that examined the role of weight bias in negotiations and determined that "negotiators made lower value offers to overweight counterparts relative to average-weight counterparts. In addition, overweight counterparts also received more negative messages over the course of their negotiation and were evaluated less favorably after the negotiation than average-weight counterparts" (Arnold 2021). DeMello also addresses this in another one of her essays and applies this weight bias and performance concept to the job sphere by saying "the heavier the job candidate, the more likely it is that they will not get a job. It's been estimated that each pound of fat costs 1,000 dollars per year lost in income. The diet products and programs purchased by the overweight and obese are also expensive, and since most overweight people will gain back the weight they lost on their diet, forcing them to diet again, the costs are spread over a person's entire lifetime. Not only, then, is poverty positively correlated with obesity- in part because of the costs associated with healthy foods, and the lack of education among the poor- but downward mobility is too." (Demello). Weight itself exacerbates issues of poverty that are found in these communities because it is one of the factors that keeps people in poverty. This makes it so that people's relationships with their bodies are in part determined by their inability to lose weight because of their limited access to food. This dynamic is only worsened as they try

to gain jobs that could change their access to food and any of the negative ideas that they have formed about their health and their bodies is socially reaffirmed.

Healthcare and Legal World

In addition to the realm of the job market, overweight and obese people suffer from discrimination in both health care and legal spheres. In terms of medical care, several studies have been done on the impact of weight bias on individual care of obese patients and one such study found a significant difference in the care given to overweight patients and that these "differences included specific diet and exercise advice, emphasis on pharmaceutical intervention, prominence of lifestyle modifications aimes toward weight loss, and the use of less empathetic discourse" (Seymour 2018). Similar studies have been done on the bias that exists in the medical care system towards obese people and these studies have taken the examination a step further to try and understand where intervention in the thought process of doctor's is possible (Phelan 2015). There is a consensus in these studies that "experiences of or expectations for poor treatment may cause stress and avoidance of care, mistrust of doctors, and poor adherence among patients with obesity" (Phelan 2015). The problem with these studies is that the people writing them still frame obesity as if it is a disease that has bias attached to it rather than the way that bodies can simply be and because of that their understanding of intervention varies wildly. It is this framework of thought that has resulted in the research effort to "evaluate the magnitude of weight on health care use patterns" (Musich 2016). In fact, even outside of the world of social sciences research, the emphasis in the news coverage about the obesity epidemic is on the ways

that obesity costs the healthcare system more money in comparison to taking care of people of "average weight." This understanding of weight and health makes it so that people with low food access who are living in poverty suffer from unnecessary health complications because their concerns are not taken seriously. They are automatically assumed to be unhealthy and suffer severe consequences because doctors have difficulty looking past their weight which can further exacerbate any existing health problems. As a result, people begin to internalize ideas of their health and weight in a way that has been societally tied to their access to food. In my study, I am trying to explore this shift between access levels of food in order to understand how this shift in access impacts people's ideas of their own health and thus their relationship to the food they eat.

Weight Bias Interference

The last set of literature that must be examined is the research that exists on how to effectively intervene with weight bias. The goal of my study is to examine how people's shift in access to food affects the way they relate to food in their body in order to understand how weight bias is developed and perpetuated generationally. In order to understand how my findings can be used to intervene in weight bias, we must look at how other researchers have attempted to shift views on weight. One researcher, Illiya Gutin, has conducted studies addressing the difference between BMI as an objective measure of health and a subjective label for various communities and in this research she ultimately proposes "an epistemological shift away from classifying BMI as a biomarker and toward a more flexible view of the measure as a holistic appraisal of health. In closing, I argue that researchers may continue to leverage BMI's ease of collection and interpretation, provided they are attuned to its definitional ambiguity across diverse research methods and contexts" (Gutin 2017). Other researchers have adopted this same mentality and tried to identify how to change the opinions and biases of medical professionals by examining

the effects of "a health elective that pre service health professionals were enrolled in. Attitudes to weight and knowledge of nutrition were targeted simultaneously" (Werkhoven 2020).

This manner of intervention in weight bias does not account for the way that ideas of health and body image are created first within the family and thus does not account for how the shift from familial access to food to personal access to food is an opportunity to unlearn weight bias. My research hopes to fill in this gap by tying together the ideas about food access, body image, and ideas health through examining the way that people's relationships with food shift as they enter college and become the sole providers of their foods. In doing so, I aim to add to the literature on weight bias intervention by creating a structure for identifying subtle weight biases that parent's pass onto their children and how their children unlearn those biases on their own. This structure can then hopefully be used in other scenarios to cause people to reflect on how their own individual understandings of food and their body have shifted based on their access and how they can unlearn the weight bias that they have inherited.

Data and Methods:

I conducted a total of 20 informal interviews with participants that were self-selected through the completion of a form that I posted in several Facebook groups for University of Chicago students asking for those who are still currently students at the college which resulted in participants in the age range of 18-30. In terms of data collection, my fieldsite was the campus of the University of Chicago for in person interviews, and a few of the interviews were performed using online video chatting services such as Zoom. Each interview lasted roughly 20 minutes. Half of the participants identified as using she/her pronouns, seven as using he/him pronouns, and three as using they/them pronouns. In these interviews I asked participants about their

grocery shopping and eating habits as well as how they perceived their own health and attractiveness.

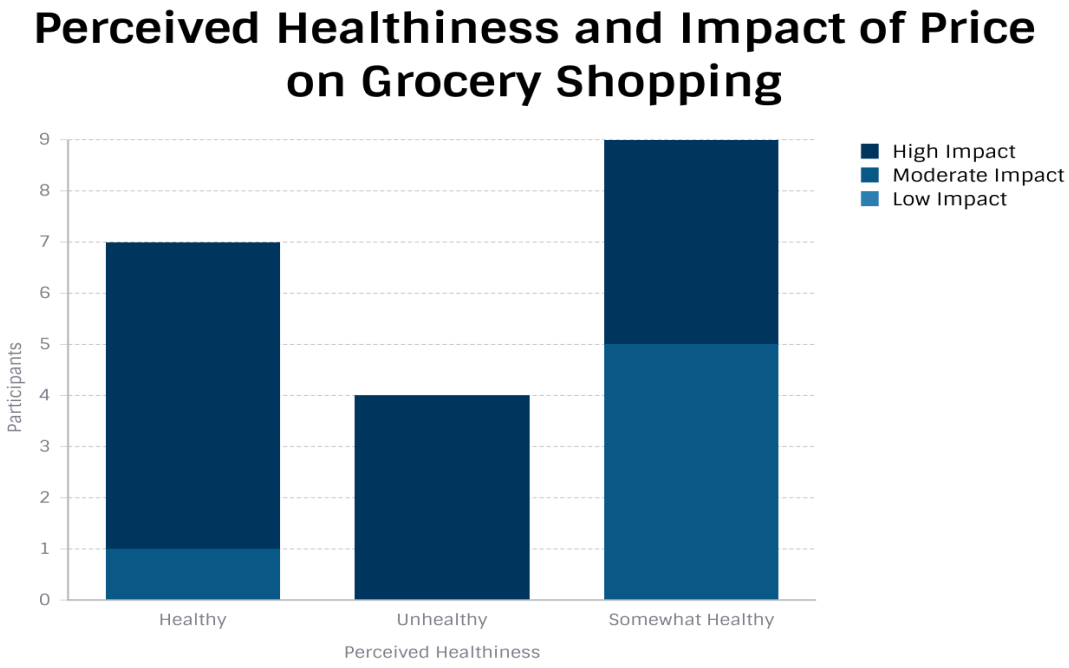
In this work I am interested in the process of how young adults in college shift from their parents being their main access to food to undertaking their own shopping and food preparation and examining how this change impacts their relationship with food and challenges concepts of understanding their body. Not all participants reported being directly impacted by their parents but more than half of them reflected on how their insecurity about their bodies and their relationship with food was based more on their interactions with their peers rather than their interactions with their parents. A noticeable correlation between these relationships can be seen in the graph "impact of parents and gender identity." This graph displays the correlation between the participants gender identity and the gender identity of the parent that impacted their relationship with food. A majority of those that identified as using she/her pronouns stated that their mother was the parent that impacted them the most and a majority of those that identified as using he/him pronouns stated that their dad impacted their relationship with food the most. This shows the way that these ideas about health, weight, and attractiveness are reproduced from parent to child as children try to relate to their parents. In these relationships, the parents put the ideas that they have about the health of their own bodies onto their children, and participants noted that their parents wanted to feed them "healthier foods" but did not have the funds to do so.

In the interviews, I discovered a relationship between a person's personal responsibility for buying and making their food and how much or how often they end up eating. Many participants also discussed how living in Chicago impacted their grocery shopping habits because walking to the store created a barrier to access that did not exist when they had the

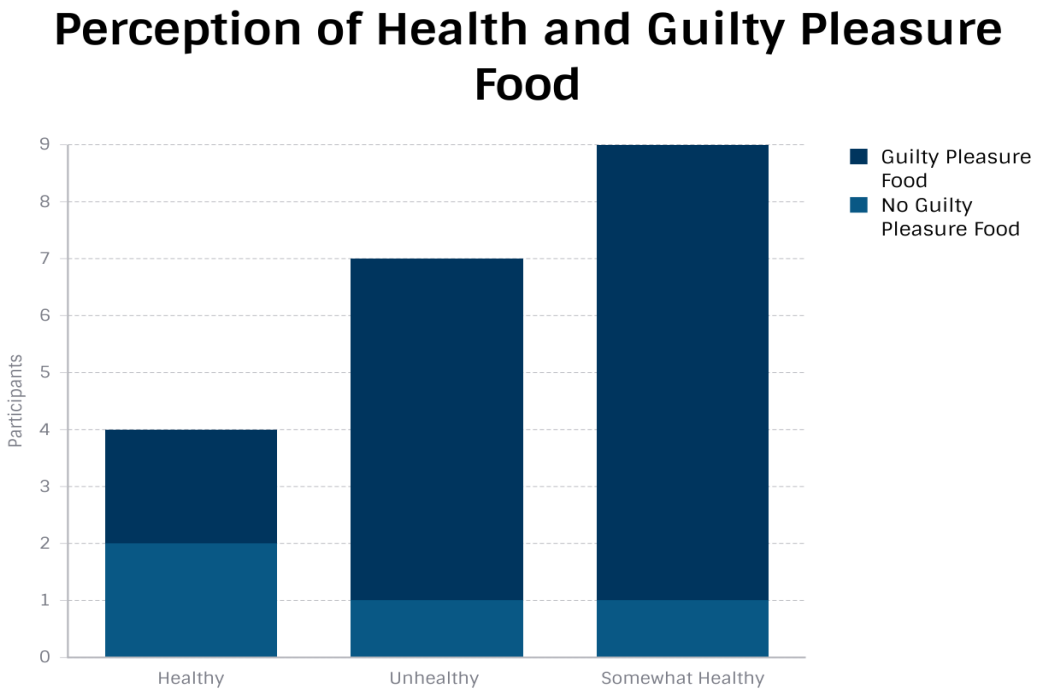
option to drive to the store. The participants that reported having cars also reported less hesitancy to make larger grocery trips. With these responses in mind, I am reconceptualizing how access exists as both a physical distance from food sources as well as access as it exists in who is having food made for them or mainly making food for themselves. I specifically focused on students in some form of secondary education. A majority of these students conceive their access to food in a different way than the standard for a food desert defines. For this group, conception of access is affected by who is making their food, what their walking distance from grocery stores is, and if they can afford the food that they want. This conception of access is largely based on a shift from living with their parents and then moving out of their parents house and having to reckon with food almost completely by themselves. This shift impacts how they view health, weight, dieting, and money as a struggle between what their own definitions of these ideas could be and what they learned from their parents. This focus on college students offers a unique perspective and opportunity to understand how to disrupt the perpetuation of weight bias. Their access to food is changing in that they are shifting from their parents providing their groceries and cooking their meals to them being the sole providers of those things and because of that they are shifting from their parents mentalities of health and attractiveness to their own. In this shift, they revealed how weight bias is perpetuated through inheritance and can be disrupted through a shift from understanding to what will be called health 1 to health 2. Health 1 is defined by socially accepted concepts of healthy foods and exercising in order to maintain an ideal attractive weight and health 2 is defined by eating for the sake of being full and exercising for the sake of moving your body. In examining how these college aged participants transitioned from one definition of health to the other this study offers up a new understanding of how to disrupt the cyclical perpetuation of weight bias

I made notes throughout the interviews and categorized my data set into groups of participants who self identified as healthy, unhealthy, and somewhat healthy. Using this baseline self categorization, I drew comparisons to how participants in those different groups viewed their own attractiveness and how they reported their shopping patterns. I also noted the relationship between the participants gender identity and which parent they reported as having the most impact on their relationship with food. In order to analyze this data set, I coded it for themes of body image and attraction, food as time, as well as money and food. I used a mixed methods approach to examine and represent this data. Using the categories that I previously mentioned, I made bar graphs to visually represent the relationship between participants' ideas of health, money, and attractiveness as well as bar graphs to map out the impact that parents had on participants' definitions of these ideas. These graphs give important context to the ideas discussed in the results section because they represent the larger trends and commonalities that I found in my participants' interviews as I looked over them.

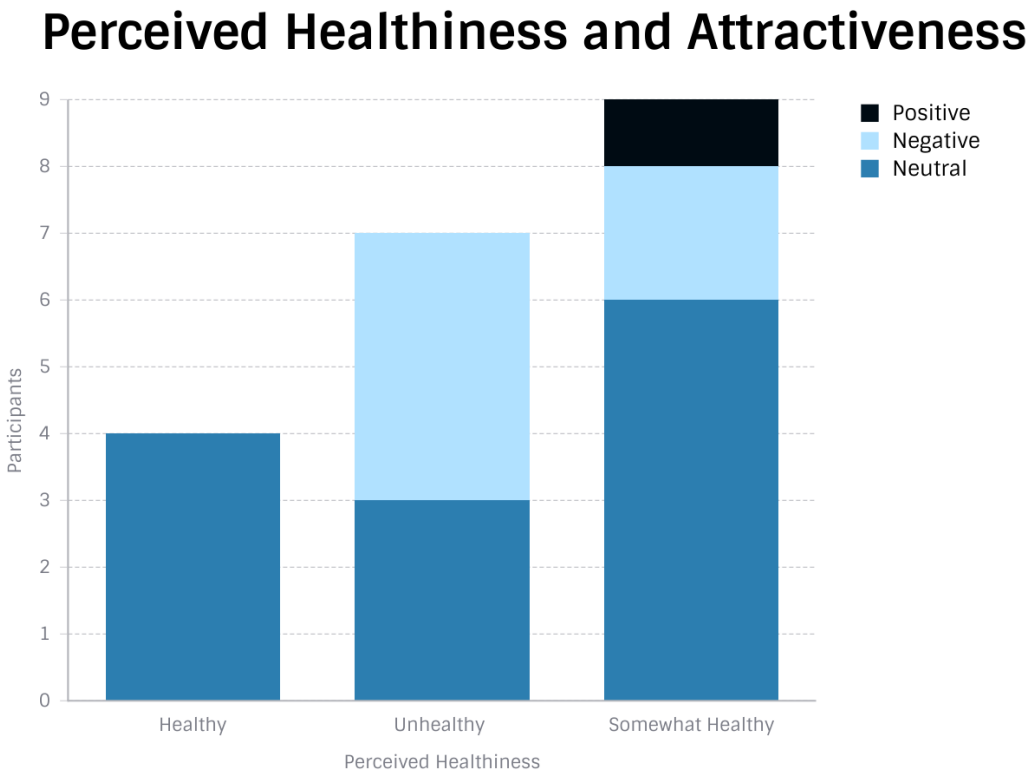
Graph A


Perceived Healthiness and Impact of Price on Grocery Shopping
High Impact
Moderate Impact
Low Impact
Participants
0
1
2
3
4
5
6
7
8
9
Healthy
Unhealthy
Somewhat Healthy
Perceived Healthiness

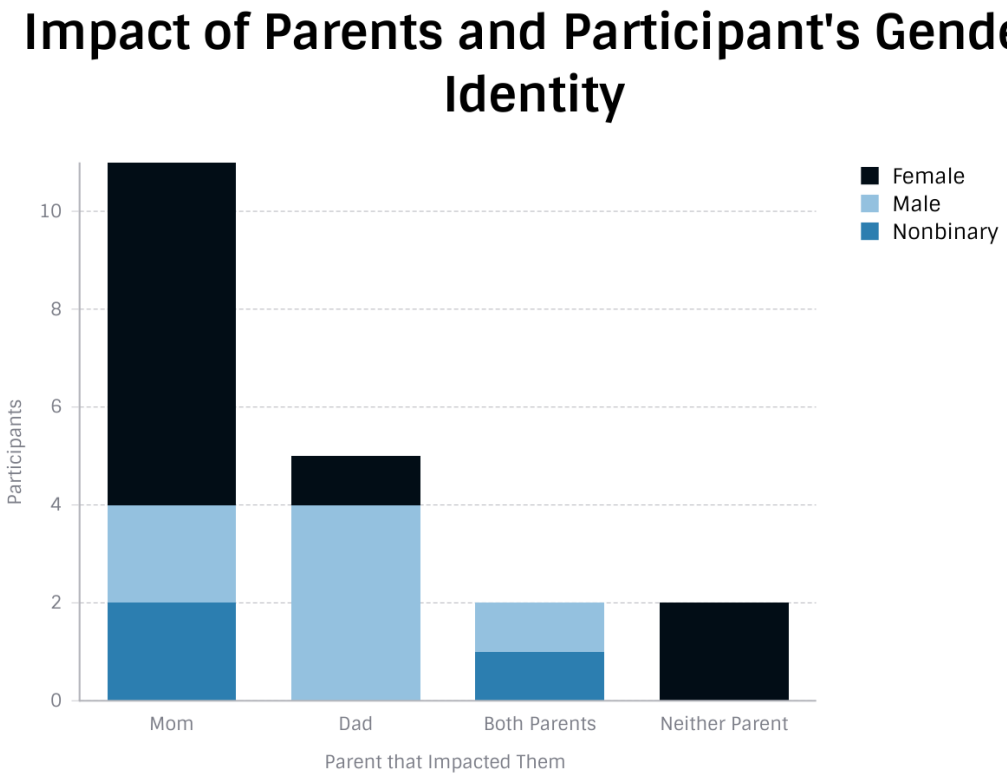
Graph B


Perception of Health and Guilty Pleasure Food
Participants
0
1
2
3
4
5
6
7
8
9
Healthy
Unhealthy
Somewhat Healthy
Guilty Pleasure Food
No Guilty Pleasure Food

Graph C


Perceived Healthiness and Attractiveness
Positive
Negative
Neutral
Participants
0
1
2
3
4
5
6
7
8
9
Healthy
Unhealthy
Somewhat Healthy
Perceived Healthiness

Graph D


Impact of Parents and Participant's Gender Identity
Female
Male
Nonbinary
Participants
0
2
4
6
8
10
Mom
Dad
Both Parents
Neither Parent
Parent that Impacted Them

Results:

Conceptions of Access

It is important to first understand how the participants viewed their own access to food in terms of distance before we can examine how this access impacts their relationship with food and their bodies. Understandings of access to food were largely dependent on whether or not the participants had access to a car. One participant stated: "Uhm, if my roommate has time and they have a car. So we go to Trader Joe's because that's feasible with the car 'cause like, that's like usually a big trip. And we'd only ever go to Trader Joe's if we were, like the Fridge was empty, yeah, and we can actually like physically take all that back in the car. Otherwise we just do all of our shopping at HPP except for a few things which are way too expensive at HPP because they're not really produce. So there's like a weird upsell, and then we just go to Target 'cause we live right there next to both of them." This participant mentions three grocery stores, all of which were mentioned by every other participant when discussing their shopping habits. They stated that they only ever went to Trader Joe's when they could carry a lot of things back and saved smaller trips for the other two grocery stores. This line of thinking was common among all participants who mentioned these grocery stores. There is also a dynamic at play where the grocery stores are good for different kinds of food in the minds of the participants. Food items that aren't produce are too expensive to buy at Hyde Park Produce, so participants reported going to Target for those items. Other participants talked about how they relied on Trader Joe's for their frozen items, saying that

> “I think the unfortunate thing with like Trader Joe's or like this since I started school again as I've been like eating a lot of like frozen food, you know things are often just for like convenience and timing, so I've been doing that a lot”

This shows that despite high geographical access to food, these participants viewed that access differently based on the food price and availability at individual stores.

The reliance on cars for large grocery trips is one of the first moments where we can see inherited ideas of food access impacting the participants. When asked about their parent’s shopping habits, all participants mentioned that their parents would do big weekly trips to the grocery store on their drive home from work. From this, it is clear that some of the participants still associate big grocery shops where they get everything they need with the usage of a car because that’s how their parents shopped. This can also be seen in the fact that, when asked, half of the participants said that having a car would change their shopping patterns and a fourth of them said that they already had a car. Those who said having a car wouldn't change anything were more removed from their parents' mentalities surrounding food as it relates to body image and healthiness. One participant states:

> “So that's interesting, I grew up in a city district so I walked everywhere in Pittsburgh and I also grew up in a very Jewish sect of the city. Like in comparison Hyde Park can feel very suburban.”

In this context, the participant uses suburban to describe the feeling of not being able to walk to your grocery store in the same way they could at home. They had access to many more food

options that they saw as easily reachable through walking whereas in Hyde Park, the food one can access depends on the car they have access to. We can see this transition from their before college mentality of their access to food to their in college mentality of their access to food in how they talk about the walkability and shoppability of Hyde Park. This geographical access in turn impacted the food that these participants found themselves able to buy on smaller grocery trips where they would have to carry everything back. Participants reported a shift in their mentality with grocery shopping upon having a car saying

> "So like when I didn't have a car when I was living in my old apartment like 3rd year Uhm, it was very like I had to be very planned about when I was going grocery shopping, but now it is a little easier to just like scoot over to somewhere and get what I need."

This participant felt as if they needed to plan their grocery trips to ensure that they could get everything that they needed. The fact that this pattern changed once they got a car indicates that this way of grocery shopping greatly impacts people's shopping habits because it requires more time to go to the grocery store and ensure that they have every item they need. This idea of food access and time is something that the participants discussed when they mentioned the time that it took for them to cook and how that impacted their relationship with food and ultimately their health.

Food Access as Time and Money

In addition to the time that it takes to go to the grocery store and physically carry everything back, there is also the layer of students transitioning into being responsible for cooking their own food. These participants talked about how this shift impacted their shopping

habits in that they tended to buy food items that were frozen or had preservatives rather than ingredients for making meals. In order to understand how this shift impacted their understanding of health we will now examine what exactly this shift was.

All but one of the participants said that their parents cooked for them in high school. The one whose parents did not cook said that the reason for that is that they became the only vegetarian in their family. Given this dynamic with their parents, we can track how they think about food as time through the way they speak about cooking and eating out and this examination can offer us further insight into how their ideas of food relate to their ideas of health. One of the largest factors that contributes to how participants view food as time spent cooking is how stressed they are about their school work at any given moment. One participant stated:

> "I feel like when people are stressed out, there's like sometimes there's just things that become too stressful to do and for some people that's like showering and for some people that's like exercising and for me it's cooking. And so whenever I get into the school year, I just have an aversion to spending time cooking. I think like last year we weren't in person and stuff and I cooked a little bit more. Because I think we just had so much more free time and when I'm not in school like when I'm at home or on break and stuff I love like baking and cooking. But when I'm here during the school year, I think it's like a time, It's definitely not logical. It's definitely like anxiety produced, but there's something about spending time and energy that I just- I can't do it. I don't want to do it."

For this participant, as well as many others, stress can create an idea of food that is based solely on how long it would take to make that food and how that time spent would take away time from their studies. It's important to note that food in this context is both time and energy; cooking becomes a chore in comparison to the list of tasks that students have every day. Other participants reported this stress about spending time cooking and their reaction to this stress was to change their shopping habits:

> "We've been moving towards snacky items. Easy to go grab stuff. Just 'cause we're going to classes"

This shift towards "snacky" items is important to consider as we move towards the exploration of how these participants thought about health as it relates to their food consumption. For some participants, buying food that they consider unhealthy is a sacrifice they are willing to make in order to save time on cooking. On the other hand, there were participants who talked about budgeting time with their meals and placing emphasis on carving out time for dinner by creating a time constrained routine for their other meals:

> " I spend a good amount of time prepping my dinners and I like to. Like I really enjoy cooking so I don't mind spending time on those, but I think if I just give myself permission to eat a super boring breakfast then I don't know. It makes planning lunches and dinners easier time wise."

For this participant, creating a routine of the same boring breakfast is what allows them to spend time cooking the things they want for other meals. This trade off approach to meals reveals that time is one of the largest deciding factors for students as they balance making and buying food with their school work. Another aspect that was considered by participants as they talked about time constraints was ordering food out. This layer of the conversation brings us back to parental

understandings of healthy food and how they interact with a student's shifting lifestyle as they manage their own food preparations. This relationship is seen in one participant's discussion on how their parents fed them as a child:

> "I think my mom tried to feed me in the best way she could and my dad didn't approve of it because he had more money than she did. They were divorced and so he looked at the food that she got me, which was like a lot of dollar meals at fast food restaurants or like cheap frozen foods from the grocery store that she could buy in bulk as being like bad foods and bad for me and unhealthy, and so he would criticize her and he would do it for me because he wouldn't do it to her face. He would be like, you can't eat that like that's bad. Your mom needs to not do that."

This quote reveals a common parental lesson the participants learned: frozen meals, fast food, and snack items are not good for your body. For some participants this also meant that eating those things created a negative self image. The issue is that when stressed, these are the foods that participants turn to when they are stressed about time or money because these are the foods that their parents turned to in moments when they were stressed. The issue seemed to be that their parents would turn to these foods while also acknowledging that they were bad foods and because of that, the guilt surrounding needing to buy these kinds of foods with some time or money as a college student persists as students form their own relationships with food and their bodies.

Additionally, some of them worried about making large amounts of food for cheap, and that buying individual and organic ingredients for meals is more money than just buying "a can

of beans and a box of pasta or something for like 2.00 and that's multiple meals." Another participant summed up the general mentality by saying:

> "I feel worse about spending money than eating 'unhealthy food' because I'm trying really hard to budget and not trying as hard to go along with the societal definition of healthy food."

These participants still have ideas about what constitutes bad food, and yet they still eat those foods because they feel they have to due to their lifestyle. This shared internal struggle is what reveals the process of how the participants shifted from their parents' ideas surrounding food to their own. They have to eat as college students, and some of them realized that they would rather eat the food that fit with their lifestyle and that meant needing to work through the guilt that their parents passed onto them in order to comfortably live their lives. This process is what I will call the shift from health 1 to health 2.

Health 1: The Sins of the Parents

Health one is the understanding of health that the participants inherited from their parents and it is predominantly defined by eating a certain amount of macronutrients and restricting intake of things like carbs as well as exercising for the purpose of losing weight. This idea of health was revealed as participants talked about how their parents have impacted their relationship with food. A key thing to note in the impact of the parents on these inherited ideas of health is that a majority of participants reported being most affected by the parent that they share a gender identity with. One such participant described this relationship as:

> "My mother is probably the predominant factor in my relationship with food because she's very judgmental. She's super skinny, super fit, she barely eats. So if

> I gain weight, she'll notice and she'll say something. She'll tell me to go on diets. She'll tell me to, you know, change my diet if I'm gaining too much weight."

This participant talks about how her mom is incredibly skinny and how she is able to stay that way because she doesn't eat, or cuts certain things out of her diet. In transitioning out of her mother's influence, this participant talked about how she was trying to learn how to eat food that she enjoyed and not care as much about weight and this transition was shared among many of the participants. Another person talked about how she no longer eats the way her mother does and has gained weight as a result and that her mom comments on that:

> "With eating I definitely, my mom definitely was like don't eat a lot of fats like you don't want to eat that much meat like, eat your vegetables would be something. Not only I think for cultural reasons but also, because I'd always been skinny my whole life, and that was considered pretty by a lot of people, like by general society. And so the way that they like even now when I talk to my parents and like I've grown bigger and like I eat a lot more or at least like I, I don't really care about how much I eat like my mom will make comments. And just be like, Oh my God, you're eating so much" or like don't you want to stay skinny like I could never."

Both of these participants reveal through their reflections on their mothers actions, that they are moving away from what their parents define as health as well as what exactly that definition is. There is an emphasis on staying a certain size, achieving some level of skinniness. This goal is sought after through the control of diet as well as increasing exercise. These participants talked about how their parents correlate being skinny with being attractive and because of that they are having a hard time understanding how they define beauty and attractiveness independent of the

skinny ideal. We must also note that this mentality was not exclusive to the mothers of the participants. One person talked about how their dad impacted their relationship with exercise:

> "My dad recently, as in the past five years, really went through his midlife crisis. Or I think he was doing everything he could to not age and a big part of that for him was like diet and exercise. So every time I call him on the phone, he's like, are you going to the gym like are you eating right? And it's like it's just one of his consistent questions that he asks and I know that he thinks he's doing it out of a place of care for me and wanting to know that I'm taking care of myself."

This quote reveals two major things, first that both parents can be responsible for inherited ideas of what makes a "good body", ideas that revolve around eating socially acceptable healthy foods and exercising to maintain a physical standard of "fitness" rather than solely about physical attractiveness. Second, this quote further reveals the temporal nature of the parental influence on ideas of health. Both of the participants that talked about their mothers mentioned that they dealt with current comments about their bodies as their bodies have changed in recent years and they have gained weight, but this person talks about how their dad only recently developed these ideals. No matter what age a person is, their parents can still have an impact on how they view food and their body because there are certain familial obligations that children feel to their parents, to ensure that they are living in a way that their parents would find acceptable. This is part of the reason that ideas of weight bias are so often inherited because children want to please their parents by being good in their eyes, and that includes having a so-called good body just as much as it does being a good person. For some participants, this inheritance was less of a worry and more of a downright fear due to the ways in which their parents have been treated poorly for their plus sized bodies:

> “Both my parents are, they weren't obese when they were younger. They're both definitely like obese now. I think my mom didn't want me to end up in the same situation as her and in her eyes, which I wasn't anywhere near there. Yeah, but it definitely had an effect there also like the food they would buy when I go home like I definitely notice it now more so than when I was just living there. I'm like, oh, that's just soda and like candy and I know it was hard for them 'cause also they don't have a lot of money, we're like low income, low income working. So they didn't have a lot of money to buy fresh produce.

This person starts off talking about how their parents gained weight as they got older, which indicates that the parental fear here is that it is an inevitability that their child will also end up fat. This participant displayed that same fear when later in the interview she mentions having conversations with her roommates about her insecurities and them reassuring her by saying “you’re not even fat.” It is clear that by looking at her parents she is looking at her future, not only with her body but with the treatment that body will receive. She also talks about how she notices how unhealthy the food that she used to eat at home is now that she has been away for college. In her case, her idea of health before college did rely on her parents' conceptions of health but focused less on eating certain foods and rather just exercising to maintain a body size and internalizing anxiety about gaining weight. This perception of healthy food based on what her parents ate impacted the way that she viewed healthy food access in Hyde Park:

> “There's definitely a lot more vegan healthy eating. More sit down restaurants than back home. I'm from Hannibal, MO. Actually I'm from New London, MO and it has like a population of 1000 and inside New London, Missouri there's no, like restaurants”

This is a key finding to examine because it contradicts everyone else's understanding of food in Hyde Park. Other participants responded to the question about restaurants in Hyde Park by saying that Hyde Park is "definitely mostly fast food." This participant views Hyde Park as having more access to healthy food in comparison to back home because of her lack of access in general back home. Regardless of this, her ideas of health before she came to college were still similar to those of the other participants: that exercising is about losing weight and limiting certain foods like candy can make you healthier. This shows that all of the participants came into college with a baseline understanding of health, health 1, that changed drastically as they began to develop a relationship with food that was more independent from their parents.

Health 2: Personalized and Intuitive Eating

As I continued the conversation with the participants, it became clear that there was a distinct shift in their opinions about health and their bodies as they developed their own relationships with food. All of them were shifting towards what I will call health 2 which is eating to feel full, exercising for the sake of moving, and aiming for body neutrality. While the participants were not actively aware of all of the ways that they had shifted from health 1 to health 2, the distinctions in the way they spoke about food and their bodies were clear. One participant noted this shift into health 2 when speaking of his mother's impact on his relationship with food:

> "We were just really, I feel like in some ways we were really normal like my mom wasn't very like calorie counting with us. It was definitely like you were supposed to be someone who looked quite thin but ate a lot which none of us genetically were designed for. Yeah, so when I was probably in middle school I

> was not severely underweight, but I just ate so much less. And then when I was in high school I gained so much weight 'cause I started eating basically not at home without my mom's supervision and now it's kind of balanced."

This participant notes that there was an incredible expectation to stay a certain weight as a child and the way that he maintained that weight was by cutting out foods. Notably, once he began to eat independent of his mother, he began his transition into eating whatever he wanted per health 2's definition, but he implies that this overeating was bad because it caused him to gain too much weight. The balancing out of his relationship would then mean that he no longer overeats or undereats but rather eats to feel full. There is still a concern about weight in this transition from one version of health to another, but the focus is more on developing a more considerate relationship with food.

Other participants also talked about the nuances of this considerate relationship with food that they began to develop as they grew away from their parents. One participant described this shift after I asked if they thought they were a healthy eater:

> "I don't know, I mean actually I would say yes. I don't know that everyone In the world would consider me to be a healthy eater. But I eat when I'm hungry and I eat- like the thing is like, I think how I would describe it as I try to eat balanced. So it's like I definitely eat cheez its and ice cream every day, but I also try to make sure that I have a fruit and a vegetable every day. So in my head I'm getting my body what it needs. And I feel full and have energy every day, so in that way I think I'm healthy. But I don't eat like salads and that's it. So if that's your definition of healthy, not yours, but like if that's like the definition of healthy, then I would say no."

This participant tracks the divide between health 1 and health 2 quite clearly. She is focused on balancing her meals overall rather than consistently eating healthy items. She also talks about the difference between social perception of health and her own personal definition of health, acknowledging that everyone in the world might not call her healthy but she thinks that the fact that she considers what her body needs above all else as healthy. She is also focused on making sure that she has the energy that she needs to get through the day, and centers her eating around that, but notably says that she doesn't eat salads, which is a shared idea among the participants of what qualifies as a healthy food. While this shift is not something that she notes as defined by breaking away from her parents ideas of health, it is a breaking away from some socially taught idea of health, which we can assume were taught by her parents as well as enforced by the environment she grew up in. While other participants expressed similar approaches to their relationship with food, they categorized it as unhealthy. Another participant responded to the same question of whether or not they considered themselves a healthy eater by saying:

> "I think in my mind when I think of healthy eaters, I think of the people who do look at nutrition labels and are much more conscious about the food that they select and purchase and make for themselves. I think for me food is just a way to stay nourished like to have energy. So I think I'm much less careful with what I'm putting in my body. Just making sure that I'm eating something."

They say the same thing as the previous participant does about making sure that they eat food to stay nourished and have energy but because that does not align with the socially accepted definition of health 1, they do not consider themselves a healthy eater. They specifically say that they are not careful about what they are putting in their body, which contradicts with the idea that they eat to stay energized. Health 2 is defined by nourishing your body and eating to feel full

and energized, but this is at war with health 1 in this participant because they feel that they need to eat foods that are socially accepted as good in order to consider themselves good. They don't think about food as much as other people in their lives around them do and because of that, they don't feel that they have earned the title of healthy.

This was a common struggle among the participants as they talked about ideas of their health and the way that they eat now. Another participant felt this exact same struggle but noted that he was trying to distinguish between healthy foods and foods that were health for him:

> "When I think about a healthy food I think about nutritionally dense for the number of calories but at the same time I've been trying to reframe for myself like labeling specific foods as healthy or unhealthy and trying to think about how the combination of foods that I eat like throughout a day or throughout a week or with a thread like a specific meal like just give me energy or like give me pleasure or just like add to my day, so I so I've been trying to I guess separate like nutritional health from like more, maybe health not the right word for it in. Like in the broader sense, but like good foods"

This is one of the clearest examples of an active shift from health 1 to health 2. Health 1 is focused on the specific labeling of foods as healthy or unhealthy, good or bad, and health 2 is focused on labeling things as good for you or healthy for you. It is an internalized focus that is aware of how your individual body responds to food and acts accordingly. This is the essence of health 2, it is focused on eating for nourishment as well as pleasure, and acknowledges that socially constructed ideas of health do not always align with what is best for individual health. It is important to recognize that this version of health does not entirely exclude the consideration of

calories. Under the definition of health 2, there is an attempt to deconstruct the restriction of calories for weight loss and rather focus on calories as a measure of energy.

The definition of health 2 is important but so is the way that people distinguish between health 1 and health 2 and journey between the 2. Several participants talked about their relationship with food by saying "I think that I don't have a healthy relationship with food. I think I do eat healthy food though. I think those are two different things." The journey from solely eating healthy things to eating food in a healthy way is one that many participants went on and now we have tracked the differences between health 1 and health 2 and how the participants developed their ideas of both. With this journey in mind, we can now look at the implications that going from health 1 to health 2 has for the participants' understanding of attractiveness and weight bias in order to look at how to best interfere in weight bias in individuals more broadly.

Health, Attractiveness, and Weight Bias

The way that these ideas of health are internalized and impact the idea of what people consider attractive directly correlates with weight. In the conversations that the participants had about their own health, they struggled in different ways with how they viewed their own weight as it relates to health. The journey from health 1 to health 2 is partially defined by the acceptance that weight and health do not have a direct relationship and that one can be healthy at any weight. I asked each of the participants whether or not they considered themselves attractive and followed up asking what they believed to be attractive and their answers revealed how they correlate attractiveness with weight. Given that the shift from health 1 to health 2 is one that is defined by shifting from believing that weight is indicative of health to the idea that you can be

healthy at any size, how internal ideas of attractiveness changes with that is where we can begin to understand how to mitigate weight bias in individuals.

One participant responded to the question of attractiveness by saying:

> "I wouldn't consider myself unattractive, but I wouldn't consider myself attractive if that makes sense. I would say that I'm average. Uh, yeah. Average, I think from what I consider attractive or beautiful or like other women I see like they're definitely a lot skinnier body wise, like my boobs are not there at all."

In her reflection on her own worth, she talked about how she wasn't skinny and that she didn't have big boobs, so she considers herself average. She is the same participant who talked about her mother fearing her gaining weight because of her own weight issues. The idea that she is average because of these factors is one that relies on a social understanding of beauty that is correlated with weight. This belief system is one that was inherited from her mother, and without intervention, could be passed down to her children or reaffirmed by her to the other people in her life, and she is not the only one who thinks this way. Another participant responded to the question by saying:

> "No, I'm not skinny. No, For the same reason, yeah, OK. I'm also not white, so. Uh, because that's I guess like that's what's valued in both of my cultures and like having brown skin and dark eyes and having like a big forehead and like, you know not looking particularly European, Eurocentric. It's not really valued in my culture."

This participant complicates the conversation even further by bringing in the factor of race. Fat bodies that are not white are considered even more unattractive than fat bodies that are white. This is something that she was taught by her culture, by her family, and she believes that. This

participant also did not consider herself healthy because of her weight and actively tries to restrict the food that she eats in order to lose weight. Both of these participants still subscribe to the definition of health 1 that was outlined in a previous section and because of that, they correlate attractiveness with weight as well. There were many other participants who had these thoughts and said that they believed so because of "what the movies say" and that they wanted to "thin themselves down" to look like what they are attracted to. This shows us that not only is attractiveness internalized based on weight but it is also internalized based on what individuals themselves are attracted to. The thought process is: if I am not attracted to bigger bodies, then how could I expect other people to be attracted to my bigger body?

Viewing att is a marker of being in the first stage of transition from health 1 to health 2 and this became evident as I talked to other participants who believed differently. One such participant acknowledged the beauty standard that he felt he was living in the shadow of but also that he would consider himself attractive independent of that:

> "I think I am attractive to a very particular type of person and I don't believe I'm like a beauty standard of whatever in the world, right? I'm not a thin body, so I don't think I would fit into that, but I do think that I appeal to the audience I am trying to appeal to."

He knows that he does not fit within the thin beauty standard, but because there are still people that are attracted to him, he is capable of acknowledging his own attractiveness. While this is a step in the right direction towards undoing weight bias, it is still dependent upon the value judgment of other people upon your individual body. The standard may be different, but it is still a standard set by someone else. Other participants were similarly on the scale moving towards health 2 and the understanding of attractiveness that comes with it, but their opinions of their

bodies manifested in other ways. One such participant found herself struggling with the idea of working with an American beauty standard as well as an international beauty standard:

> "So yeah, like I, I think I've always had a problem with the fact that like, I know that I'm considered thin here, but I wouldn't be considered then if I were to live abroad. And because the standard that I'm working with is like or the standard that I'm working with mentally is so different from the standard that I think people here would recognize like that, that messes with me a lot."

She knows that she's thin here, but that this thinness is socially constructed according to American standards and is dependent upon location. This impacts her own self esteem, but the acknowledgement of it is an important step in separating weight and attractiveness. She herself might not have internalized it, but the fact that she recognizes that the standard of beauty that is based in thinness is dependent upon the audience means that it is not inherently good to be skinny. This understanding is where we can locate a key factor in broadening the mitigation of weight bias. Another participant highlighted the next step when she responded to the question of attractiveness by saying:

> "Yeah, so a lot of my self esteem issues are tied to my body and I guess my weight and like how pretty I am in terms of like, being thin and being tall and you know all that and so like I really don't like my body and I'm trying to like appreciate it for like what it does like."

The most important part of this quote is her choice to focus on what her body does. She doesn't like how her body looks, doesn't think that she is thin enough or tall enough, but chooses to focus more on the capabilities of her body. This is another step towards health 2 because focusing on the physical abilities of your body means that you eat to achieve those things rather

than to be a certain weight or look a certain way. She still has self esteem issues, but she believes that the more that she focuses on her body as a vessel to do things rather than an object of desire, she can overcome those self esteem issues.

There were other participants who were closer on the scale to a health 2 understanding of their bodies and the manner in which they thought about attractiveness reflected that. One such participant talked about his body image saying:

> I think I think as far as body image goes, I think I could be in a little bit better shape, but I don't really focus on that as much now as I used to. My age I think, especially in the last few years, in an indirect way, but I think my focus has shifted in the last several years. I'm more like feeling after exercising and like eating, right like you feel good versus like I need to be the weight I was when I was 22 or I need to be like having this jean size"

He believes that he could be in better shape, but that is not his priority. Being a certain size is not his priority, but rather eating and exercising to feel good. When talking about their body image, all of the participants come back to weight in some way, and he is no exception. Notably, he is a plus sized male and has felt pressure to lose weight. At one point in his interview, he talked about how as he played sports in high school, he "naturally began eating less" and lost 90 pounds in a year. So, weight has been a factor in his relationship with food and exercise in the past, but now that he has moved towards a relationship with food that focuses on eating for the sake of energy and exercising for the sake of moving. This shift is a clear example of how changing from a health 1 to a health 2 mentality can decrease an individual's internal and external weight bias. Once a person believes that it is okay for them to be fat, it is easier to believe that it is okay for other people to be fat and that weight is not indicative of a person's health. This internal

intervention is the first step in mitigating weight bias, and the journey of these participants in between their understanding of these healths is an important tool for understanding mass applications of this mitigation.

Other participants experienced similar shifts in their mentalities in different ways, one talks about her experience coming to terms with her body size as she encountered more people of differing body types:

> "I was not the skinniest kid. And being Brazilian, I feel like I had bigger hips and then you know I was like maybe a little insecure about that. But as I've grown up, I've seen and known people with different body types and that has helped me realize that it doesn't matter for me personally."

This is another important aspect of weight bias intervention: exposure, not only to the idea that health is not correlated with size but to different body types generally. This participant was able to accept her body through the acceptance of other people's bodies. She is a good example of how related internal and external ideas of bodies are. All of the participants who expressed disdain and concern over their own bodies because of their size, in some small part, feel that way about other people because they feel that way about weight generally. This is why individual intervention is so necessary for decreasing weight bias, when people can feel better about their own bodies, they in turn can feel better about other people's bodies.

Discussion and Conclusions

This study sought to understand how a person's access to food can impact their relationship with food and their body. Through the series of interviews conducted in the hopes of achieving this goal I was able to formulate a more nuanced definition of access as well as health

and attractiveness. For college students in particular, the concept of access is a rapidly changing idea that is defined by the shift that they make from their parents providing their food to them providing food for themselves. In describing this shift in understanding, these participants revealed how their ideas of health and attractiveness were passed onto them from their parents and how they are either working to undo those ideas or integrating those ideas into their own definitions of these concepts. Ultimately, these results prove useful in that they offer up a more concrete idea of how weight bias can be perpetuated through generations, internalized by individuals, and ultimately externalized through their interactions with others. Understanding this process of how weight bias is continually constructed is the first step in targeting and eliminating that weight bias in social relationships as well as within the medical care system and ultimately society as a whole.

Defining Access

For this set of participants, food access was an increasingly nuanced part of their lives. Those that reported still living on campus expressed an experience of food that was incredibly different from those off campus, their ideas of access were not as limited and they commented on the abundance of university based food options around them. They also didn't view food as constrained by time in the same way as the participants that lived off campus did. In terms of off campus participants, nearly all of them expressed that walking to the grocery store limited the amount of food that they were able to buy and the frequency at which they grocery shopped. They described eating out and buying fast food and quick snack foods more than those on campus and also expressed guilt at spending money on those food items instead of groceries. The most important aspect of my findings is that despite the fact that there are more than 5 grocery

stores within a two mile radius of all of my participants, all of them reported feeling distanced from food and as if Chicago was more suburban than the places that they came from. This difference in understanding of their access comes from the fact that most of them did not have access to a car and those that did have a car did not feel this lack of access in the same way. The role of having a car in the conception of access is much more vital than the standard definition of a food desert accounts for and this gap was not mitigated for most of these participants by access to public transportation. Many of them reported feeling awkward carrying large amounts of groceries on the bus and discussed a detailed and planned out approach to grocery shopping in order to ensure that they could carry their food back. Ultimately, even with access to public transportation, participants that did not have a car limited their grocery shopping to what they could reasonably carry for fifteen minutes straight in both hands and because of this viewed their access to food as much more limited than it is defined as by the accepted parameters of a food desert. This difference is important to note because it ended up exacerbating the issues that existed for participants who were attempting to overcome the negative influence of their parents on food and their bodies because they still felt limited in how they could interact with their food.

Health and Attractiveness

The manner in which participants perceived their food access ultimately impacted their ideas about their own health and attractiveness. The main conclusion of this study is that people are shifting between their parents' concepts of health and attractiveness into their own and that understanding this shift is how researchers can begin to cater their weight bias intervention towards this shift, so what exactly is this shift? First and foremost, participants struggled against their parents' criticisms of their weight as they developed their own approach to healthy eating.

Many participants discussed fielding comments from their parents about recent weight gain or experiencing their parents going through a "health kick" that impacted the way their parents talked to them about their own exercise and food habits now.

From this struggle the participants whether consciously or subconsciously, created a divide between definitions of health, which this paper termed health 1 and health 2. The main distinction between these definitions of health is that health 1 is categorized by eating societally approved healthy foods and exercising in order to maintain a certain weight. Health 2 is defined by eating food in a healthy way, eating when you're hungry and eating until you are full and exercising for the sake of moving your body. In this shift from health 1 to health 2, or from their parent's mentalities about their bodies to their own processings about food and their bodies, participants shifted from a negative towards a more neutral opinion on their own attractiveness.

Final Thoughts

This study sought to understand how people's access to food can impact their relationship with food and their bodies and in doing so found a new way to define access through perception of distance and the person who is making your food as well as two distinct definitions of health among participants. While this study offers up a new lens of looking at access, health, and attractiveness, it is limited by the fact that it focuses solely on college students and not those who experience other definitions of access. Its usefulness for further research lies in the way that it develops a new way of understanding access and the impact it can have on people's personal perceptions of health in an effort to determine where to intervene to lessen weight bias in society.

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