Practising food anxiety: Making Australian mothers responsible for their families' dietary decisions

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Abstract

Concerns about the relationship between diet, weight and health find widespread expression in the media and are accompanied by significant individual anxiety and responsibilization. However, these pertain especially to mothers who undertake the bulk of domestic labour involved in managing their families' health and wellbeing. This article employs the concept of anxiety as social practice to explore

the process whereby mothers are made accountable for their families' dietary decisions. Drawing on data from an Australian study that explored the impact of discourses of childhood obesity prevention on mothers, the article argues that mothers' engagements with this value-laden discourse are complex and ambiguous, involving varying degrees of self-ascribed responsibility and blame for children's weight and diets. We conclude by drawing attention to the value of viewing food anxiety as social practice, in highlighting issues that are largely invisible in both official discourses and scholarly accounts of childhood obesity prevention.

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A series of recent news reports on food scandals, such as the infant formula scandal in China, in 2008, the contamination of lettuce with rat poison in Germany, in 2013, the BSE crisis in the UK in 1986 and the recent horsemeat scandal in Europe, and long standing debates about the nutritional value of certain diets[1, 2], highlight the social anxieties that frequently attach to the 'purity' and 'healthiness' of food. The recent rise of the discourse of childhood obesity prevention, with its prescriptions about healthy weights and diets and initiatives for tackling the 'epidemic' in childhood obesity, has taken these anxieties to a new level. Mothers, as the assumed custodians of their families' health and wellbeing, have been implicitly and sometimes explicitly the primary focus of preventive policies.

This article employs the concept of anxiety as social practice[3] to explore the process whereby mothers are made responsible ('responsibilized') for their families' dietary decisions. Drawing on data from our recent Australian research, which examined how mothers engage with the discourse of childhood obesity prevention[*], we explore the expectations that arise from discourses of maternal responsibility for weight and diet, and how mothers respond as they seek to undertake the work of feeding their families. We ask: how do mothers make sense of obesity related weight and diet information? Does this information inform practices of preparing and planning meals and, if so, how? And, to what extent, and how, is anxiety manifest in mothers' comments and reported food-related decisions?

In this article we argue that mothers' engagements with the discourse of childhood obesity prevention are complex and ambiguous. We emphasize the significance of mothers' 'communities of practice'[4] in shaping food-related anxieties, and the various ways in which mothers engage with the imperatives associated with obesity prevention as they seek to care for their families. We conclude by discussing the value of the concept of anxiety as social practice for revealing those factors that remain largely invisible within official discourses and scholarly accounts of childhood obesity prevention.

To ground our analysis, we begin by sketching the broader context in which anxieties about childhood obesity and prevention strategies have developed and are currently being taken up in Australia. We then introduce our theoretical approach, which draws on Jackson and Everts' (2010) framing of anxiety as a social practice, before introducing the empirical study from which our data are drawn.

ANXIETIES ABOUT CHILDHOOD OBESITY IN AUSTRALIA

In recent years, childhood obesity has become the focus of intense public concern. As with other perceived threats (e.g. in relation to medical, chemical, and environmental dangers), anxiety about bodily fat can be seen as a symptom of the heightened sense of uncertainty associated with the rise of late modern risk society[5]. In Australia, as in many other countries[6, 7, 8], concern surrounding 'obesity', particularly among children, is reflected in the many government reports and enquiries on these topics published over the last decade[9, 10, 11]. In 2008, obesity was declared a 'National Priority Area'[12]. Obesity is commonly described as a 'global epidemic' in this context, with calls for prompt action on the issue. As Julier[13] observes, labeling 'obesity' an epidemic implies the need for strategies to 'protect' the rest of society from those labeled 'obese', the assumed source of infection. Such labeling leads to punitive public policies and serves to create and support the diet, health and exercise industries that benefit from the production and marketing of diverse anti-obesity aids, dietary products, drugs, and household and personal items.

In certain respects, contemporary concern about obesity continues long-standing preoccupations with weight and health stretching back over two thousand years[14]. However, contemporary anxieties about childhood obesity need to be seen in their particular socio-political context—one characterized by shifting norms and expectations associated with neoliberal policies and changing gender relations. Neoliberalism shifts responsibility for health and healthcare from society on to the individual, and attributes blame for problems to particular groups. The term responsibilization has been used to describe 'the process whereby subjects are rendered individually responsible for a task which previously would have been the duty of another—usually a state agency—or would not have been

recognized as a responsibility at all'[15]. Researchers have explored the diverse ways in which individuals are responsibilized through neoliberal strategies of rule in contemporary Western societies. Thus illness, or 'non-normal' body size or shape, is seen as a product of individual 'free choice', involving faulty lifestyles and behaviours, such as eating too much or the wrong types of food. Like other areas of intense public concern, anxieties surrounding childhood obesity involve an object on to which fears and anxieties are projected[16]. Thus, poor nutrition and obesity are defined as problems to do with the bad choices of individuals—implicitly people of poor, working class background. This overlooks both how these problems are constructed and the role of social, economic and political factors in constraining people's life chances and consumption practices[17, 18]. Responsibilization in relation to obesity reflects wider judgments about a decline in social values, competence and skills, such as culinary expertise, especially among lower classes, and the need for strong moral direction from external parties—as exemplified by Jamie Oliver's UK television series Ministry of Food[19]. Childhood obesity discourse, in other words, reflects the 'moralization of risk' that is characteristic of neoliberal rule[20].

Women, as mothers, have long been primary targets of strategies of responsibilization in relation to children's weight, diet and health. This responsibilization assumes that women's ability to participate in the unpaid labour of caregiving is both natural and limitless, and that they have the time, energy and financial means to undertake the various tasks involved in feeding their families and monitoring their diets[21] (Firth, 2012: 43). The norm and expectation within neoliberalism is that women, as responsible maternal citizens, will undertake the bulk of emotional work within the family, and demonstrate this through their household food practices and monitoring and attending to their children's health. Women's involvement in paid labour outside the home, on the other hand, is often connected with increases in obesity in subtle ways. Convenience foods and fast foods are both assigned blame in the 'obesity epidemic', and both trends are linked to ideologies of 'good' and 'bad' mothering[22].

As Maher, Fraser and Wright[23] note, maternal responsibility begins well before birth, with gestation or even conception, and covers almost every conceivable child health and social outcome.

While food, body weight and fitness are areas of increasing maternal responsibilization (both directly through explicit discourses of maternal care, and indirectly through unspoken assumptions about mothers' and fathers' roles), they are by no means the only issues for which mothers are held responsible. Young people's drug use is another area, among many, in which mothers are regularly responsibilized. Their own drug use is the object of intense scrutiny, disproportionate with fathers', and children's outcomes, both drug-related and otherwise, are routinely linked to mothers' conduct[24] (see, for example, Boyd, 1999). It is interesting to note that accompanying heightened anxiety about diet and weight, and the rigid anti-fat ethic embedded in social and cultural accounts of health, is the framing of food as an illicit substance and over-eating as a form of addiction[25]. A media report concerning a recent Australian study, for example, claims that babies born to women who consume 'junk' food during pregnancy are born with an addiction to 'fatty foods'[26]. The medico-moral presentation of 'the future survival and health of offspring' - as determined by the body weight and eating habits of women prior to, during and after pregnancy - is pervasive. In this way, maternal diet and weight are linked to future addiction in children, illness, and shortened lifespans[27]. Our point in this article is not to single out food and eating as a unique area in which maternal responsibilization has arisen or in which maternal anxiety is especially pronounced; nor is it to collapse the different ways in which maternal responsibilization occurs. Instead, we aim to focus in this particular area as one entangled within broader processes of responsibilization.

Maternal responsibilization also bears the imprint of class and racist ideologies. Referencing the White House Task Force on Childhood Obesity's action plan, Firth argues that the health agenda in the US especially targets poor women of color (African American and Hispanic) residing in southern states, who are said to comprise the majority of people deemed obese. Health surveys find that the prevalence of obesity is much higher in these groups than among white populations. In short, 'the "obesity epidemic" is…racialised and gendered, an "epidemic" that affects certain people in certain places'[28]. Interventions do not address the conditions that shape the health of the poor; for example, the existence of 'food deserts' and lack of access to cheap nutritious food. Because women are ascribed primary responsibility for feeding their families, the burden of responsibility for the obesity epidemic

falls to women, who are highly regulated and morally policed[29]. On the other hand, Firth contends, the emphasis on the prevention of childhood obesity ascribes little agency to those currently deemed to be obese. Mothers are expected to play a role in monitoring their children's weight, but 'a mother's obesity is permanent and "unfixable"'. A mother's weight is seen to be of relevance only insofar as it poses a risk to her child's health status[30].

The situation described by Firth for the US is similar in a number of respects to that observed in Australia[31, 32]. That is, fears about childhood obesity can be seen to reflect wider anxieties associated with changing gender roles linked to women's growing participation in the paid workforce and the perceived threats to the traditional family unit, as well as judgments about the lifestyles of low socio-economic groups and ethnic minorities, particularly Aboriginal people.

Judgments about the economic, social and personal costs posed by the poor health of those from lower socio-economic groups are evident in recent Australian government reports on obesity. An example is the report, *Weighing It Up: Obesity in Australia*, which focused on the future implications of obesity for the healthcare system in light of what was seen as a growing incidence of obesity, especially among children[33]. As in other government reports published since 2000[34], in this report, Aboriginal people are seen as particularly 'at risk' (and implicitly as posing a risk to society) by virtue of their 'unhealthy' lifestyles, such as poor diets and lack of exercise. However, rather than addressing the economic and social conditions that underlie disadvantage and poor health status, policy efforts in Australia, and elsewhere, have focused on education and other measures to encourage 'healthy eating' and increased levels of physical activity.

While many reports acknowledge an environmental component to 'obesity' (referred to as the 'obesogenic environment')—with modern sedentary lifestyles and supermarkets being frequently acknowledged[35] (Colls and Evans, 2008) — 'the problem' is mainly framed in terms of the 'unhealthy choices' of individuals. There has been relatively little discussion about the role played by politico-economic and socio-cultural factors in shaping dietary patterns or about corporate control over the production, marketing and distribution of children's food. Government reports often attribute the causes of childhood obesity 'epidemic' to an imbalance between energy intake and energy expenditure:

an overconsumption of food, particularly that with high levels of saturated fats, combined with physical inactivity, linked in particular to 'screen culture' and an excessive reliance on motor cars and other energy-saving devices[36]. This energy imbalance model serves to individualize the problem, ascribing responsibility to the failure of children who are 'fat' or those who are assumed to have primary responsibility for feeding them, namely mothers.

How should this broad process of responsibilization be understood? The following discussion considers Jackson and Everts' theoretical framing of 'anxiety as social practice' as a way to conceptualize the processes by which these fears about childhood obesity are formulated in public discourse and social policy, and come to characterize women's own engagement with their families and roles.

ANXIETY AS SOCIAL PRACTICE

In Jackson and Everts'[37] social practice perspective, anxiety is understood in terms of its *social significance*. Treated as a shared experience, it is understood as generated and sustained through diverse means, such as media reporting and public health campaigns. This perspective directs attention to the social, historical and geographical dimensions of anxiety, and involves analysis of how anxieties are framed, mediated, and institutionalized. In analyzing the practices of anxiety, attention is paid to how anxiety is distributed and contained at either individual or societal levels, and varies across time and space[38]. In analyzing the discourses of childhood obesity prevention, the perspective turns attention to the assemblage of practices of anxiety that contribute to responsibilizing mothers (e.g. media representations, health information dissemination via childcare centres, schools and child health clinics), including the language used to describe obesity, its dimensions, and its causes (e.g. 'epidemic', 'BMI (body mass index), 'unhealthy eating/weight'). This social practice perspective differs from a lay or colloquial perspective on anxiety as a solely subjective or intra-psychic experience, as in an excessive worry, or a clinical/biomedical discourse on anxiety as a chronic condition, 'pathology', or 'disorder' (for example, 'generalized anxiety and worry disorder', as defined by lists of symptoms and behaviors described in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5))[39]. The

fears that are framed by the media and articulated in policies and regulation do not necessarily manifest as individual anxieties; for example as expressions of 'worry' about the healthiness of food, or 'fear of fat'. Both the expression and experience of anxiety will be mediated by factors such as gender, class, ethnicity, and place of residence. However, anxieties are often distributed widely among the population, as evident in the history of public health. For example, social anxieties about cholesterol and its contributions to heart disease, contributed to by diverse health authorities, vested industry interests, and the media since the 1950s, have fuelled individual anxieties about dietary fat[40].

Jackson and Everts' concept of 'anxiety as social practice' highlights the *communities of practice* within which anxiety is produced, experienced and responded to. The authors identify 'three different types of practices that accompany, frame and are affected by social anxieties'. The first are the practices of framing that 'arrange the event', which include the news media and scientific and expert practices that define the subjects and objects of anxiety. As Jackson and Everts note, 'whether an event arouses anxiety depends on its framing'[41]. The second are the 'practices of annihilation' that refer to those efforts oriented to destroying the subjects or objects of anxiety. This typically involves educating people about the dangers of obesity and employing strategies to eliminate 'unhealthy' diets or promote 'healthy' diets. And the third are the practices shaped by contemporary anxieties that are part of everyday life, 'and whose disruption further entrenches those anxieties', such as shopping where certain items are sought or avoided[42]. Examples of the latter include the consumption of 'healthy' organic produce or choosing one form of transport over another, or avoiding travel altogether. In order to properly understand the dynamics of anxiety—how it develops, strengthens or wanes—one needs to understand how it is articulated between different 'communities of practice'. As Jackson, et al.[43] (2013) argue, the strength and persistence of anxieties derive from the way they are routinized and institutionalized, and circulate between and are embedded within particular communities (2013: 31-32).

The distinction that Jackson and Everts make between anxiety as a *social condition* and anxiety as an individual experience or pathology is useful in analyzing the connections and disconnections between wider social conditions and imperatives and individual practices and experiences (see also Jackson, et al., 2013). For example, individual expressions of anxiety about certain types of food (e.g.

its wholesomeness) and 'healthy eating' may be explored in relation to wider sociocultural anxieties about diet. As Jackson and Everts observe with reference to food, anxieties may be largely contained at the individual level (e.g. parental worries about food allergies and food intolerances), or extend to wider concerns (e.g. 'food scares') where individuals may not personally feel anxious but nevertheless be implicated in the social condition *as consumers*[44] (2010: 2794). Further, certain anxieties, such as those relating to conditions such as bulimia and anorexia, may occupy an 'intermediate position', in that they include a personal biographical dimension as well as showing evidence of cultural variability in their manifestation.

While Jackson and Everts do not explore resistance to anxiety, or the potential for anxiety to be mobilized for social change, this is implicit within their perspective on anxiety as a social condition. Those subject to anxiety-laden discourses on health and weight, for example, may individually or collectively resist ideals of 'healthy living' or 'normal weight', such as is evident with the fat acceptance movement and the smokers' rights movement. Further, heightened anxieties, for example, about food risks, may provide the occasion for drawing public attention to the factors that contribute to those anxieties, such as the existence of certain risks and or the failure to annihilate those risks. For example, in recent years, various food anxieties, such as associated with BSE (Bovine spongiform encephalopathy) ('mad cow disease') in the UK, Canada, and elsewhere in the late 1980s and early 1990s, focused media attention on the health risks posed by modern industrial cattle-farming, especially the use of introduced ingredients, including protein supplements[45, 46].

In this article our aim is to consider how mothers creatively negotiate maternal responsibility in relation to the day-to-day management of their children's health, diet and weight. In so doing, we locate expressions of maternal anxiety within broader 'communities of practice' through which food anxieties are socially sustained and circulate.

METHOD

Our study involved a combination of semi-structured interviews undertaken with mothers and long daycare service providers, as well as a textual analysis of public health, training and the policy

literature on childhood obesity in Australia. Thirty in-depth semi-structured interviews (60-90 minutes in length) were undertaken with mothers and service providers at three day-long childcare centres in the inner and greater Melbourne area in 2011. Eight mothers and two childcare workers were interviewed at each site. Given our focus on mothers' responsibilization, this article is based on the findings of the interviews with the mothers only (n = 24). Ethical approval was gained through the Monash University Human Research Ethics Committee.

A number of methods were used to recruit participants to the study. With the permission of child care centres, recruitment notices were placed on communal noticeboards and in the pigeonholes used by the centres to distribute information to parents. At two of the centres, Directors also invited mothers to participate by circulating recruitment notices via the centres' e-mail lists. The recruitment notice included the project title, 'Improving Australia's response to childhood obesity: Prevention education and its impact on mothers and families', and described the project's aim; viz. 'to discover mothers' and childcare professionals' experiences of childhood obesity prevention and caring for young children's health and weight'. This notice also described what was involved in participation. All interviewees were offered a $30.00 gift voucher for their time. After recruitment notices had been distributed, the research assistant (CT) also attended each of the centres at peak drop-off and pick-up times to introduce herself and speak to mothers about the study, and to answer any questions they may have had.

The mothers all had pre-school age children, from 0-5 years of age, but children discussed in the interviews ranged up to 16 years of age. The socio-demographic indicators of the first childcare centre (hereafter Eastern Childcare) and the second childcare centre (Southeastern Childcare) were comparable in that they were both located in suburban areas, one closer to the inner city, with relatively high median house prices and income brackets. Mothers at Eastern Childcare and Southeastern Childcare were all partnered and drawn from a diverse range of ethnic backgrounds, including Anglo-Australian, Chinese, Indian, French and Irish from Eastern Childcare, and Anglo-Australian, Chinese, Sri Lankan, Greek and Irish from Southeastern Childcare. Eastern Childcare was notably distinct from the other sites in that it was located in a university, so most of the women interviewed were working at

the university in professional (2 of 8) or academic roles (3 of 8), or undertaking postgraduate degrees (2 of 8), and consequently juggling work, study and family responsibilities. The mothers at Southeastern Childcare had a more diverse range of educational backgrounds and most worked in more middle-level professional occupations, such as public and private sector administration (5 of 8), with one mother employed part-time in retail, one undertaking a childcare certificate and one working part-time as an accountant.

The third childcare centre, Western Childcare, is located in a suburb over 60 kilometers away from Melbourne inner city, and had a median house prices considerably lower than the other two sites (approximately one-third of the other two sites). Western Childcare included a large proportion (4 of 8) of full-time mothers who had high childcare responsibilities. The average age of women in Western Childcare was considerably younger than in the other two sites, half were under the age of 25 and half of the women were also single. Nearly all identified as Anglo-Australian (7 of 8), with one mother from Africa who was studying English while taking full responsibility for her child as a sole parent. Two of the mothers were employed part-time in care work and customer service respectively, and one mother was undertaking a childcare certificate. Whilst participant numbers were relatively small, our recruitment of women from the three centres reached mothers from a broad range of social and cultural backgrounds. In so doing we aimed to address, at least in part, the significance of socio-economic positioning and ethnicity, that are often absent in public discussions about childhood obesity.

The interviews explored a range of issues relating to diet and weight, including information on mothers' own roles within the household and responsibilities in relation to the planning and preparation of family meals. We asked mothers about the types of food their children preferred and how they accommodated these preferences; whether they had any concerns about their children's diet and/or weight and, if so, the nature of these concerns and how they responded; whether they received or had sought any information about children's diets and health; views on their childcare centre's approach to health issues, particularly diet and obesity, and their role in this area; and views on childhood obesity, its causes and implications. We also asked mothers about the composition of their household; their ethnic backgrounds and (if relevant) their period of residence in Australia, and their own occupation

and, if married or in a relationship, their partner's occupation. The interviews were recorded, transcribed verbatim by a professional transcriber, and coded using the qualitative data management program, QSR NVivo. The research team adopted a collaborative approach to coding the data. When all the transcripts had been read, a broad coding framework was developed around themes of food, mothering, emotions, children and weight using an inductive approach to the data. Codes were then discussed and refined in team meetings and via email communications. Dominant themes that were a focus of team discussions were refined, to include expressions of maternal responsibility, anxiety and resistance, and these led to the detailed analysis conducted here. In quoting our respondents, we indicate both the childcare centre attended by their child and the respondent's ethnicity, and use pseudonyms to protect individuals' privacy.

MOTHERS' ENGAGEMENTS WITH THE DISCOURSE OF CHILDHOOD OBESITY

As noted, anxieties about diet, weight and health arise and are sustained within and circulate between different 'communities of practice'. For mothers with young children, the feminized spaces that they daily inhabit, such as childcare centres, child health clinics, and children's play groups are likely to be of particular significance in this regard. Other potential influences are media in its diverse forms, including television, the Internet, and print media including newspapers and popular magazines that frequently carry information about obesity, diets and lifestyles. Some of these media (e.g. news) have been found to frequently stigmatize overweight and obese persons[47]. It is within these communities that childhood obesity is 'framed' as a problem of inadequate diets, an absence of physical activity and over-exposure to 'screen culture'—a framing reinforced in contexts of preventive healthcare, peer information exchange, and the provision of expert advice.

The interviews revealed that mothers' views and practices in relation to diet were, at least to some extent, shaped by wider anxieties about childhood obesity. In most accounts, mothers subscribed to a framing of childhood obesity prevention that held them as primarily responsible for monitoring, managing and being anxious about their children's weights and diets. The anxieties attached to the discourse of childhood obesity prevention indeed can be seen to have offered the women a resource for

enacting motherhood and confirming their identities as mothers. During the interviews, the mothers presented themselves as highly attuned to matters concerning children's weight and diet, referring to information derived from various sources as popular media (e.g. TV personality Jamie Oliver), childcare centres, and/or from attendance at child health clinics where their children were regularly weighed or where advice was given. In their comments, they often made reference to public health terminology, suggesting some exposure to scientific and expert sources. In discussing such sources, some mothers without any prompting used terms such as 'BMI (body mass index), 'healthy eating' or 'healthy food'. For example,

> What they do at the 2 year appointment is they weight [sic], they measure, they do this and she checked Chloe's BMI and apparently her BMI is higher than what it should be, body mass index and so she told me to put Chloe on lite milk and to watch what she eats.
>
> (Caroline, Southeast Childcare, Sri Lankan)

Interviewer: Do you know how they measure obesity in children?

> Leah: I assumed it was BMI…I assumed they did height and weight measurements. I've certainly heard height and weight being floated around in a lot of the sort of school based stuff that my colleagues may be doing and certainly you know that's, those are the measurements that they do in relation to just mapping her, my daughter's sort of development in the early childhood years.
>
> (Leah, Eastern Childcare, Northern Irish)

When discussing their children's diets, mothers often distinguished between 'healthy' and 'unhealthy', or 'good' and bad' food. They identified what they believed to be 'healthy' diets—comprising, typically, fresh fruit and vegetables, grilled rather than fried food, and 'home-made' rather than pre-prepared meals—while rejecting what some described as 'junk food' or 'crap'. Foods or ingredients such as sugar, butter, cream, pasta, rice and hamburgers were frequently demonized as 'bad' or 'fattening'. Mothers emphasized the importance of moderating children's consumption of the latter kinds of foods, with exceptions sometimes made for 'special occasions'.

In short, mothers sought to present themselves as responsible maternal citizens, shown by their attentiveness to information about weight and diet and by efforts to inform themselves about the 'healthy' foods that they should feed their families. Although our data do not allow us to confirm whether mothers' food practices were in line with their views, those they described as 'healthy' were, in the main, those presented as such in recent health promotion materials.

Further, when asked who in their family took responsibility for planning and preparing meals, all the mothers nominated themselves. Two married women stated that their husbands played a strong role or carried a relatively equal share (Hannah, Jenny, both Eastern Childcare—French, and Chinese, respectively). Mothers in Eastern Childcare were more likely than mothers from Southeastern Childcare and Western Childcare to report support from male partners in domestic activities, including sharing of childcare and food choice and preparation. However, the partners' contributions were, in the main, deemed to be marginal and mostly involved the occasional preparation of meals, such as cooking a favourite dish, rather than undertaking the day-to-day management of their family's diet. Some mothers mentioned that their partners (one of whom was of the same sex) participated in the preparation of meals, but that they tended to take over because they were 'better cooks' or had a wider repertoire of dishes or enjoyed cooking more. While we did not interview the partners in order to ascertain their views on their contributions to feeding their families, these findings confirm earlier research on the gender division of labour in domestic food work[48, 49, 50, 51]

While mothers in general sought to present themselves as responsible maternal citizens by being attentive to and showing concern about their children's diets, their engagements with expert knowledge and imperatives were by no means uniform. Our sample of mothers from each of the childcare centres was small, so comparative generalizations are not easy to make, but we noted that women from the poorer Western childcare, of predominantly Anglo-Australian background, seemed somewhat more inclined than women from the other two childcare centres to portray maternal responsibility as an unquestionable 'fact of life'. This may reflect different expectations about motherhood and responsibility related to their lower socio-economic status, or resignation to their role as primary carers or sole parents.

When asked why she took responsibility for her child's weight and diet, for example, one participant replied: 'I am their mother and if I just let them do whatever, what would become of them? One would waste away and be skinny, one would be...who knows, see that's why, who else is gonna teach them?' (Margaret, Western childcare, Australian-Italian) When asked if she felt a sense of responsibility for her children's diet and weight, one mother of two girls replied: 'yes, very much so… I am the one who cooks, I am the one who buys…you know if I bought pizza every night and stuff like that it would just…as a mother I would not be doing my job' (Nicole, Southeastern Childcare, Anglo-Australian). This mother's comments neatly capture a view shared among many of the mothers; that not properly attending to their children's diets would be a failure of maternal performance. Some emphasized the importance of guiding children while they were young, to prevent weight and health problems later in life, underlining women's self-defined role as primary socializing agents within their families.

Given this assumed maternal responsibility, it is not surprising that mothers often expressed the belief that they fell short of what was required of them. This was evident in the comments of virtually all the mothers to varying degrees. For example, Bani worried about the 'right age' at which to introduce her children to certain foods:

> I was a new mum in this country and it was stressful to hear what kind of foods to give and stuff like that. Yeah, because you have to give it to them at the right age, so when they're ready, you have to keep looking out for signs that they show that they're ready to eat food and if you introduce it too early it's not good, if you introduce it too late it's not good. (Bani, Eastern Childcare, Indian)

These comments suggest a high degree of vigilance among mothers in monitoring their children's weight and diet. At the same time, mothers articulated subtle variations in the degree of their attentiveness according to factors such as the age of their children, work commitments, and (as in Bani's case) familiarity with cultural expectations. Some mothers, such as Bani, above, were recent

immigrants and were unsure about Australian norms and expectations in relation to diet and weight, or grappled with dietary habits which were different from and sometimes seen as less healthy than those of their own culture. Caroline, another mother, of Sri Lankan background, who had an Anglo-Australian partner, expressed doubt during her interview about whether she was providing her child with 'healthy food', and claimed to rely on 'common sense' when making decisions about meals. She indicated that in her culture and in her family cooked meals with 'lots of vegetables' was the norm, and expressed concerns about her child being invited to parties for friends of English or Australian background, where 'all they eat was sugar all day'. She commented,

> Like we worry about the day that she gets invited to a birthday party where it's at McDonalds, because I am going to have to say no, it's not a part of our food group or what we eat, sorry but Chloe won't be coming because we don't give her McDonalds. Like all of that stuff, all the salt, the sugar, you know, all of that is what leads to obesity you know whereas we don't give her that.

Like Caroline, a number of other mothers mentioned being 'worried', 'concerned', or 'stressed' in relation to decisions about their children's diets, talk of guilt or undertones of guilt was also evident. For example, 'If he was, yeah, if he was underweight or overweight, I suppose I would feel responsible and you'd have that guilt.' (Celeste, Southeastern Childcare, Anglo-Australian); and, 'I know that if my lifestyle was different well I probably would be making different choices so I suppose I feel a bit guilty about that.' (Lisa, Eastern Childcare, Anglo-Australian) Such expressions of worry and guilt could reflect unresolved anxiety, in that mothers felt uncertain about their maternal performance but were reluctant to accept responsibility.

Similar expressions of worry and guilt were noted in two seminal studies on food and families. In her US study of family feeding practices, DeVault found that the women who were interviewed also expressed anxieties about their maternal performance, especially in relation to whether they were *doing enough* for their children. Women commonly expressed feelings of guilt and doubt about whether they were meeting social expectations of being 'good mothers'[52]. In their study of food practices in UK

households, Charles and Kerr[53] also found that women worried about the 'healthiness' of food, with fresh food seen as a 'natural goodness', and about the use of pesticides and herbicides. 'Convenience foods'—foods that are tinned or packaged—were negatively connoted, and when used, were the source of guilt.

DeVault's study and Charles' and Kerr's study, however, were completed *before* the onset of elevated anxieties about obesity, particularly childhood obesity, and the contributions of diet to body weight and health. The discourse of childhood obesity has brought into play new maternal imperatives in relation to children's weight, diet and health—namely in respect to self-education about 'the problem of obesity' and being hyper vigilant about children's eating habits. As Boero[54] notes, the obesity epidemic differs from earlier epidemics of contagion in that the risk of becoming obese has become more salient to the definition of 'the problem' than a condition or disease. Within this discourse, everyone is at risk; however, some are more at risk than others[55]. Further, while the public health focus on specific populations remains significant, there has been a growing emphasis on solutions at the individual level. The obesity epidemic, Boero observes, is characterized by 'the rapid spread of fear'—a fear of fatness and fat bodies—along with calls for vigilance[56]. Consequently, stigmatization and blame of both children who are deemed to be 'fat' or 'obese' *and* of the parents or carers who are assumed responsible is common. Weight-based stereotypes are rife in Australia[57], as in other countries[58]. A number of the mothers expressed worry that others would judge them about their children's weight, and some made judgments about other parents in this regard. The use of stereotypes about 'obese' or 'fat' people as lazy, or as having poor diets, or as not exercising were not uncommon. However, anxieties were often implicit, as in the sustained attention mothers gave to their children's diets (whether they were 'balanced', whether they were eating 'enough', how to negotiate their dislikes) and levels of physical activity, and defensiveness in regard to assumed failure about adequately monitoring their own children's weight and diet.

Women's views and experiences in relation to worries about stigmatization and blame, however, varied somewhat across the three study sites. Mothers from Eastern Childcare and Southeastern Childcare seemed to be more sensitive than mothers from Western Childcare to perceived

judgment, stigma and blame concerning mothering, children's 'unhealthy' diets and obesity. They made more references to what other mothers do and what their children eat, perhaps reflecting acute anxiety about their performance of motherhood. It may be that mothers from this more middle-class and ethnically diverse group are subject to a different cultural logic in relation to parenting anxiety. Or, it could be that being part-time carers, with many juggling their caring responsibilities with paid work, they experienced guilt about not adequately fulfilling their maternal roles. However, all mothers, to varying degrees, revealed anxieties about their maternal performance in feeding their families and about the consequences of failing to adequately fulfill their maternal responsibilities.

RESISTANCE TO RESPONSIBILIZATION

While, by their accounts, mothers sought to 'do the right thing' by showing due concern for and remaining vigilant about their children's weight and diet, responsibilization was not uncontested. That is, while in the interviews many of the mothers used contemporary public health terminology (e.g. 'obesogenic culture', 'obesity epidemic', and 'healthy eating'), and generally sought to present themselves as informed, responsible maternal citizens, they were sometimes overtly critical of expert discourses or expressed views or recounted actions that suggested that these discourses may have had limited influence on actual food practices. Further, mothers' anxieties were not completely internalized or contained to the individual level in the sense of them expressing worry only about their own maternal performance. They also included anxieties about the impact of wider issues, such as the definition of 'obesity' and modern lifestyles, on children's diets.

Mother's engagements with the discourse of childhood obesity involved a dynamic interaction between individual experience and action, on the one hand, and social practices and norms, on the other, presenting a complex picture of responsibilization. Thus, while mothers' anxieties about their children's weight and its relationship to diet and health tended to mirror wider anxieties about childhood obesity, and its causes and implications, their responses sometimes indicated a critical stance in relation to this discourse. Our findings were in line with other research that indicates that mothers may be distrustful of healthy eating messages[59] and may draw on a variety of sources when making

decisions about their dietary practices[60, 61]. In articulating their responses, mothers referred to, variously, scientific or expert evidence (e.g. BMI as a measure of obesity, genetic-based characteristics or diseases) and lay knowledge derived from media, personal experiences, and participation in their community (e.g. popular views on 'fate' or 'bad luck'). As previous research has revealed, lay knowledge, such as that pertaining to risk and risk management, may exert a more direct and powerful influence on views and actions than expert discourses[62].

Some mothers also questioned the very language of epidemic used in obesity discourse:

> I think we are as a nation becoming more bigger I suppose and not necessarily…there are more overweight people maybe, but I sort of worry that it is sort of…there is a bit too much hype around it and that can create negative affects…. I think there is sort of a fine line between saying it's an epidemic and that there is an issue. I think there is an issue, maybe not so much an epidemic.
>
> (Glenda, Western Childcare, Anglo-Australian)

The mothers were especially critical of and concerned about the stigmatizing implications of the use of BMI measurements with young children: 'I thought [it] bizarre: two years old and she is being measured for her BMI' (Caroline, Southeastern Childcare, Sri Lankan); '…at this stage I think they're too young to me to classify as fat or obese. I mean if [they're] four or five years old and …they start getting, become like a ball, then I would say they're fat but not at her age.' (Jenny, Eastern Childcare, Chinese) A number of mothers used the word 'chubby' to describe young children, in some cases evidently avoiding the use of terms like 'fat' or 'obese'. For example, Jenny went on to speak of her daughter: 'She's got a bit of a chubby face but I guess at her age to me I'm not so worried about her being chubby at her age because she's only two and a half. I'd rather her being chubby than too skinny, to be honest.'

One mother, Leah, expressed a worry, shared by some other mothers, about the impact of 'healthy eating' messages on her daughter:

> I just don't want her to be told it's bad if you eat such and such; it's good if you eat such and such. I totally disagree with that type of approach to health promotion and particularly around diet. I think the potential adverse consequences of that are profound and I am reluctant if they're sending very, very strong messages about bad and good foods….
>
> (Leah, Eastern Childcare, Northern Irish)

In short, a number of mothers objected to moral judgments that are based upon health promotion information and voiced concerns that expert information and related practices may generate anxieties among their own children or other children. They often offered well-reasoned arguments for rejecting expert discourse. Fears that young children may be adversely affected by expert advice on weight and diet were common, with some mothers referring to the potentially deleterious consequences of placing too much emphasis on appearance in general. Mothers from the higher socio-economic areas represented by Eastern Childcare and Southeastern Childcare tended to offer more detailed explanations in this regard. As a group of generally highly educated mothers, some of whom occupied senior positions in paid employment, who have had experience living in different countries, this may reflect their exposure to a wider range of views on the relationship between diet and weight, and therefore greater confidence in challenging 'the experts'. The mothers' critical stance in relation to expert information may at least partly explain the findings of recent survey research indicating a relatively low compliance with dietary guidelines among middle-aged Australian women[63]. Some mothers likely reject advice that they see as based upon fallacious assumptions and that unfairly attributes blame and express their resistance through not complying with such advice.

Indeed, some mothers' comments revealed their belief that parents were *not* always to blame. Mothers often absolved themselves or others from blame, with some acknowledging that either they or other parents sometimes had limited control over their children's weight. Children's weight was seen to be influenced variously by 'genes' or a family history of weight problems, the eating habits of other family members (husbands were sometimes mentioned), constraints of time leading to 'unhealthy' eating, and cultural eating practices (e.g. 'treats' at children's parties)—the latter referred to by some

mothers of European and Asian background. Prue offered a complex view on the factors shaping a child's body size:

> I had…long ago I watched a show about a childhood, healthy eating and I could see all the interviews they had done on all different families. You can see if the parents are big they probably end up big or the other way around. And it does not necessarily be a genetic, it might just be because of family habits. If kids see mum and dad eating huge portions of ice cream after dinner they think that's normal so it's full of emotion in a way. It's your brain processing the wrong information.
>
> (Prue, Southeastern Childcare, Chinese)

Prue's comments indicate belief in both a genetic (and perhaps a neurological) influence on a child's body size—which suggests this is outside the control of the individual and that the parent is blameless—*and* a family influence—which suggests the potential for control by parents who are thus blameworthy. In articulating such theories of causation, mothers often drew on a combination of scientific discourse (e.g. on the role of genetics in obesity) and lay knowledge and/or personal experience (e.g. derived from popular media) to offer complex 'vocabularies of motive' for attributing responsibility and blame[64].

Mothers also cited factors other than individual disposition or family influence that may shape their or other mothers' food practices or affect body weight. Children's particular eating practices—a number said their children were 'fussy eaters'—posed challenges for those seeking to offer children 'balanced' diets. Other mothers reported that attempts to plan a 'family meal'—an enduring ideal of familial cohesiveness[65]—was sometimes thwarted by the unpredictability of their children's eating patterns. References to media influence and the pressures of modern lifestyles—factors indeed cited in some recent government-sponsored health promotion programs as affecting weight and health (e.g. Filling the Gaps, 1998-2010; 'Kids – "Go For Your Life"' (2006-2011))—were also common. And,

pressures of time created by work and childcare commitments were said to sometimes make it difficult to prepare 'healthy meals'.

When asked, 'Why do you think adult people develop problems with their weight?' one mother responded:

> Because like if they're working and they're tired and they don't want to cook they just go to Macca's [MacDonalds] or Hungry Jacks, KFC [Kentucky Fried Chicken] and they just constantly eat that stuff or you know they cook something that's easy like pasta, it doesn't take long to cook. It's just bad food choices.
>
> (Megan, Eastern Childcare, Anglo-Australian)

A number of mothers mentioned that the 'fast pace of life' led parents to take what for them were 'easy options', with 'take-away' or 'unhealthy' options being frequently mentioned. As one mother (Petra, Eastern Childcare, Anglo-Australian) expressed it: now everything is fast, fast, fast, get it done, quicker pace and less healthier options.'

In summary, such comments underline mothers' complex engagements with the individualizing discourse of childhood obesity and recognition of and in some cases anxiety about the impact of various influences on body weight and 'healthy eating' that are largely or wholly outside individual control. Further, while their words and reported actions reveal anxiety about maternal performance and a fear of failing to fulfill related responsibilities, their inability to meet ascribed ideals of motherhood does not necessarily mean that they accepted blame. Responsibilization, in other words, is a process that is ambiguous and partial. In this respect, the diffuse practices of anxiety articulated by the mothers in our study were clearly prompted and shaped—and not in uniform ways—by the multiple social forces that exerted influence over their own and their children's food behaviours.

CONCLUSIONS

By employing the social practice perspective, our study offers a novel portrayal of the dynamic process by which mothers are made responsible for their families' dietary decisions. In particular, it challenges accounts of obesity discourse that suggest that responsibilization is uniform, absolute and uncontested. While mothers are responsibilized by childhood obesity discourse, as we demonstrated, this process is neither straightforward nor unambiguous. Our study contributes to food and culture research by providing a nuanced understanding of the interaction between social imperatives concerning diet, health and weight and individuals' experiences and actions. It shows that individuals may resist individualizing and stigmatizing discourses and may not fully internalize socially ascribed responsibility and blame.

Our analysis reinforces the need to place healthy eating messages in a wider context, with recognition given to the environments and cultures in which they are received[66, 67]. Such a contextual approach can assist in countering the assumption that individuals are deficient in their understanding about nutritious diets as well as stereotypes and attributions of blame that characterize obesity discourse. It is important to give voice to mothers' views since they provide important insights not only into contemporary cultural anxieties about food, body weight and health, and their impacts, but also into how local cultural milieu may influence individuals' lives, including dietary decisions. Viewing anxiety as social practice encourages consideration of the ways in which such experience is mediated, sustained, and connected to wider cultural anxieties. As Jackson argues, there is often a disjuncture between expert advice on 'healthy' eating and the realities of life for many - particularly low-income-families that reflects a divergence between expert and lay rationalities. What are defined by experts as 'unhealthy' options, for example, may be perfectly rational food choices from the perspective of mothers who judge that they can provide an equivalent number of calories more cheaply via 'convenience foods'[68].

Analyzing anxiety as practice also suggests areas of concern to which both mothers and fathers might turn their attention. As previously noted, a number of mothers questioned the use of the language of 'epidemic', and the application of the 'obesity' label to young children. However, aside from some references to the role of advertising in promoting 'unhealthy' food, few mothers expressed concerns

about the wider politico-economic and socio-cultural influences on how weight and diet issues are defined and on the food options that are available to them. The childhood obesity discourse largely ignores the wide variety of factors that influence 'healthy eating' practices such as corporate control over the global food market that affects the production, distribution, pricing and quality of foods[69]. This discourse offers no scope to reflect on the role of the 'obesity industry'—including the many groups who profit from treating 'the obese'—in creating anxiety about 'the obesity problem'[70]. While some official reports on childhood obesity identify marketing and advertising as major contributors to children's poor diets, preventive policies and programs do not offer strategies for tackling the marketing practices that target children, which would raise questions about corporate social responsibility[71]. Further, while official reports often acknowledge the impact of 'modern lifestyles', including 'screen culture' on low levels of exercise, few offer substantive policy recommendations on how to address this issue. Using the concept of anxiety as practice can allow exploration of the role of public health and other discourses in shaping individual experiences in subtle, sometimes unexamined ways, and the stakes individuals may hold in practices that both constrain and invite self-making.

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