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## Experiencing Food Allergy and Food Intolerance: An Analysis of Lay Accounts

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### ABSTRACT

This article offers an analysis of 28 lay accounts of the experience of living with either food allergy or food intolerance in England. We structure the presentation of our data in terms of Mike Bury's three types of narrative form – *contingent*, *moral* and *core*. We suggest that people with food allergies at risk of acute, severe and potentially fatal symptoms on exposure to allergens find their condition to be less *socially problematic* than do those who suffer intolerances to certain foods, which can result in chronic, but not life-threatening, symptoms. Drawing on the extant literatures on the sociology of food and eating we propose a conceptualization in relation to notions of identity, anomie and communality that attempts to make sense of this finding.

### KEY WORDS

food allergy / food intolerance / lay accounts

## Introduction

The apparent ubiquity of food allergies and food intolerance is a relatively recent phenomenon, and one that receives much popular, commercial and media attention. The historian Mark Jackson (2006), in his excellent study of allergies, argues that just as tuberculosis was the archetypal disease of the early 20th century, allergy is the metaphorical malady of the 21st. Indeed, some experts claim that 45 per cent of the population in the UK may have some form of food intolerance and 2 per cent are living with a food allergy (Allergy UK, 2008). Correspondingly, there are significant immunological, epidemiological (cf. Asero et al., 2007; Bjorksten, 2001) and clinical literatures on the subject (Teufel et al., 2007), but these are in stark contrast to the dearth of sociological interest in the matter. This is perhaps surprising given the everyday attention to, and interest in, what we eat and how it affects our minds, our moods and our bodies. How do people make sense of food-related symptoms? How do people feel if they experience allergic reactions to food? How do people come to recognize that the food they eat may be the source of bodily discomfort? To what extent does the avoidance of certain foodstuffs impact on social relations and notions of self and identity?

These questions deserve sociological consideration and speak to the sub-fields of the discipline: health and illness, the body, and food. Our aim in this article is to offer an understanding of what it means for individuals to live with food allergies and food intolerance and, in turn, to suggest that people's accounts enable us to gain some analytic appreciation of contemporary societal responses to food allergy and food intolerance. Our conclusion, based on our findings, suggests that those people with food allergies who are at risk of acute, severe and potentially fatal symptoms on exposure to allergens find their condition to be less *socially problematic* than do those who suffer intolerances to certain foods that can result in chronic and sometimes quite debilitating symptoms. Drawing on the extant literatures on the sociology of food and eating we propose a conceptualization in relation to notions of identity, anomie and communality that attempts to make sense of this finding.

To contextualize our empirical work we begin by providing a brief discussion of biomedical definitions of food allergy and food intolerance because, as we see later, the difference between the two is salient scientifically, culturally and symbolically, and is a distinction that was also meaningful to those interviewed for the study.

## Food Allergy and Food Intolerance

As we have discussed elsewhere (Nettleton et al., 2009), definitions of food allergy and food intolerance are socially constructed and contested categories which are subject to ongoing negotiation. However, within contemporary conventional medical discourse there is a significant consensus as to what constitutes

a food allergy. A reading of this orthodox medical literature on *food allergy* reveals that this term refers to an adverse *immune* response to a protein that the immune system does not 'recognize' as 'safe' (an antigen). From this perspective, when the body is first exposed to an antigen, it becomes 'sensitized' to it, so that any subsequent exposure triggers the immune system to react in a way that will rid the body of it. This immune response produces a specific antibody from the Immunoglobulin E (IgE) class, which in turn causes the symptoms of classical allergic reactions (Asero et al., 2007). Symptoms generally occur immediately and can include gastrointestinal disorders, skin disorders, respiratory problems or, most severely, anaphylaxis. Anaphylaxis, which is a systematic reaction, is potentially, though by no means invariably, fatal – the whole body is affected sometimes within minutes of contact with an allergen. Cases of people dying of 'anaphylactic shock' have received much media attention, although the total number of deaths in the UK from food-induced anaphylactic shock is estimated to be just 64 between 1992 and 2006 (Pumphrey and Gowland, 2007).

Although historically *food intolerance* was a term used to capture a variety of causes and effects, including allergic reactions, enzyme defects, pharmacological reactions and toxic effects, over recent decades it has been used to demarcate between immunological and non-immunological responses (Asero et al., 2007). Food intolerance is now taken to refer to reactions that, significantly, are non-immune mediated, having instead enzymatic, pharmacological, or unknown causes.

Within conventional science the distinction between food allergy and food intolerance has become solidified, with a view to limiting the former to IgE-mediated reactions which occur in tandem with symptoms, and defining the latter as those reactions which are not immune related. Evidence of raised IgE levels in conjunction with clinical symptoms are referred to as 'true food allergy' (Smith and Frew, 2003: 127).

However, during recent decades commercial enterprises have endeavoured to extend the definition of food intolerance by maintaining that there may be an immunological basis to such symptoms. They argue that raised levels of another antibody, IgG, are associated with clinical symptoms. This claim, that there is an immune-related food intolerance, is roundly dismissed within conventional medico-scientific circles where it is maintained that raised levels of IgG are a 'normal' immune response and are not indicators of any pathology. Nevertheless, companies across Europe and the United States market self-administered tests that claim to be able to 'diagnose' food intolerance by measuring the presence of food-specific IgG antibodies in a pinprick of blood (Nettleton et al., 2009).

In sum, medical and related scientific discourses maintain that food allergy and food intolerance comprise distinct categories and, whilst both may involve adverse reactions to food, in general the former are considered to be pathologically and clinically legitimate whereas the latter are not. These scientific narratives, and the relative degree of biomedical legitimacy associated within them has consequences for the experience of living with adverse food reactions and we explore these in more detail following a brief word about our study methods.

## Study and Method

The data reported on here form part of a much larger study designed to examine different aspects of the sociology of food allergy and food intolerance. Data for the study were gathered via a flexible mixed-method approach drawing on and combining ethnographic observation, semi-structured in-depth interviews, focus groups and documentary analysis. In summary, we examined five different ethnographic sites; carried out 34 ethnographic interviews; carried out 52 semi-structured in-depth interviews; undertook six focus groups; and examined articles, letters and commentaries in newspapers (local and national) and professional and trade publications, witness statements from the House of Lords Committee on Allergy, and scientific/clinical journal articles on food allergy and food intolerance. The 52 semi-structured interviews were with general practitioners (3); allergy consultants (3); immunologists (1); dieticians (1); nutritionists (1); private company staff (6); food suppliers (1); food retailers (1); food regulators (2); allergy charities (5); and individuals with food allergy and/or food intolerance (28). These final 28 interviews are our focus here.

Recruitment of people with food allergy and/or food intolerance was done in three ways: seven interviews were obtained via the services of NHS allergy clinics, who distributed leaflets and invitation letters to patients attending with suspected or diagnosed food allergy; eight were obtained via the services of the private food intolerance company who posted our leaflets along with their questionnaire, which they routinely send out to people who had taken their food intolerance test three months after they have received their results; and 13 were obtained via placing an advert in a local magazine, asking if people with food allergy and/or food intolerance would volunteer to participate in our research. Our sample of 28 is clearly non-random and consists of six men and 22 women who live with either food allergies (10) or food intolerance (18) in England. The youngest participant was 21 and the oldest was 94, all were white British. Interviews were carried out face-to-face in the participant's home, workplace or other location selected by them, or via telephone. All the interviews were recorded using a digital recorder and transcribed by an external transcription service and entered into Atlas.ti for analysis.

The analysis of participant accounts is informed by, and is informing, the findings of the wider study. Here we focus on these lay accounts in order to gain some sense of what life is like for people with food allergy and food intolerance in terms of the practical consequences of managing eating practices and symptoms. We adopt what Riessman (2008) calls a 'thematic' approach to the analysis in order to understand how actors narrate their experiences and to gain insight into the discursive repertoires they marshal when telling their stories. Mike Bury's (2001) widely cited typology of narrative types is particularly conducive to the thematic approach adopted here. We structure the presentation of our data in terms of Bury's three narrative forms – contingent, moral and core – and show that whilst there are differences between personal experiences, when

it comes to collective representations of food allergies and intolerance there is a remarkable degree of consistency. When telling a story people invariably draw on the language, ideas, beliefs, ideologies, metaphors and representations that are available to them. Thus, the stories told reveal as much about the culturally available discourses as they do about the minutiae of the teller's tale.

## Contingent Narratives

The contingent aspect of the narratives refers to the pragmatic consequences of living with symptoms; issues of diagnosing and managing illness; and ideas of proximate cause (Bury, 2001). How do people come to recognize that particular foods give rise to symptoms? As noted earlier, physical reactions to food allergies tend to be relatively immediate and comprise a limited set of symptoms such as vomiting, rashes, and breathing difficulties. Certainly, those interviewed who reported having food allergies experienced these types of symptoms, but the status of being 'allergic' to a given food was not necessarily obvious. The explicit acknowledgement and articulation of a *food allergy* was something that could emerge over time and with hindsight, even though physical reactions were etched in narrators' memories. Those living with food allergies could invariably recall instances of symptoms and relay the circumstances in vivid detail. For example, one woman in her 50s who is allergic to nuts described her first allergic reaction, which occurred when she was about four years old. The degree of detail suggests that the event itself was significant, and in order to gain a sense of this it is worth reporting at some length.

I had been shopping with my Mum and the greengrocer gave me a little treat – a peanut in a shell. And we were Roman Catholics, a few weeks later it would be; there was one Sunday, when I was bored. It had been sitting in my wool coat pocket. I can even remember the colour of the coat, blue, blue wool coat, and I just, I had my hands in my pockets and I thought ooh I'll try this. I opened it and started to eat this, this, the inside of it, the nut and ... the next thing I knew I was having to be rushed outside and I started vomiting ... Didn't connect it, obviously, my mum didn't connect it 'cos ... you didn't in those days, it wasn't one of these things that you, you were aware of, I just knew that all I could think of was the taste of this thing and I thought I, I just won't eat them again. Nothing else was made of it at the time. It went, that was it, I'd been sick, I never ate them again because I just didn't like the fact that, I just connected the fact I'd been sick with the peanuts, which actually now I know was correct (laughs). (Interview 8)

'Didn't connect it, obviously' is an interesting comment and, as this woman implies, this may be because talk of food allergies was, at the time, rare in everyday discourse. Furthermore, 'nothing else was made of it'; no action was taken, there was no sense that strategies were deployed to ensure a strict avoidance of the peanuts, and no designation of an allergic status was made. Later, in this same interview, we learn how she came to understand that her symptoms were due to an 'allergy', following the first of a number of hospital episodes precipitated

by anaphylactic reactions. Hence, the clinical significance of her symptoms was understood with the benefit of hindsight.

Although this incident occurred in the 1950s, more recent cases of allergic ‘diagnoses’ were not necessarily straightforward. For example, a 22-year-old woman recalled how:

I took a mouthful of this pasta ... and within a few minutes of me having it I got really short of breath and I felt really sick, and my tongue and my lips started to sort of tingle and they started to swell a little bit. And then I made myself sick to bring it all back up and I, I took my inhaler, 'cos I'm also asthmatic, and that sort of, it, it calmed it down a little bit, but we didn't, we didn't think anything of it ... I'm twenty-two now, so, must be six, seven years ago, so I was about sixteen, something like that. (Interview 27)

Some time later, her mother had taken her to see her GP on the advice of a family friend, and it was the GP who suggested that she might be allergic to nuts and referred her to an NHS allergy clinic. The family had assumed that it was something that she would ‘grow out of’, a comment echoed in other interviews, as was the view that nuts, eggs or whatever else triggered symptoms should simply be avoided.

The daily management of food allergy involves avoidance of the allergen and then, more rarely, dealing with symptoms if the food is inadvertently ingested (or in some cases touched or smelt). Almost all participants in the study ‘played down’ the problem – for them it was just ‘one of those things’ that people ‘got used to’. For example, some participants noted how fortunate they were by comparison to those people who lived with life-threatening diseases. Some noted that their family, friends or partners could be more anxious about the ‘problem’ than they were themselves. Avoidance of certain foods simply became part of daily life, which at times could be a nuisance, most especially when travelling or on holiday. The participants explained how they accumulate knowledge about what they can and cannot eat. Labelling of packaged food is helpful although the ubiquitous ‘may contain traces of ...’ labels on products were responded to pragmatically with people making judgments about the likelihood of risk.

The presence of allergens could be detected because those with allergies clearly developed an embodied awareness of offending food. Sometimes when foods were inadvertently tasted they could be dealt with promptly – as this woman in her early 30s explains:

At work the other day we were making toast, just for break and as soon as I put the toast in my mouth I said to someone ‘This has been in contact with nuts’ and they were like ‘Don't be silly’. So I went on a mad fact finding mission, and actually one of the cleaners had made herself some peanut butter sandwiches and used the same breadboard, and she didn't obviously realise. So I told her then, she was ‘Oh I didn't know’ and I said ‘Well no, you wouldn't know 'cos obviously I don't broadcast it, but please be careful next time’ but my, my lips went tingly and, and, you know, my tongue didn't swell but I definitely felt unwell. (Interview 23)



Such embodied awareness, however, is not so straightforward for those living with food intolerance. For these people recognition of symptoms and adverse reactions is more complex, not least because symptoms are rarely immediate. Indeed, the stories of those living with food intolerance were often accounts of living with medically unexplained symptoms (Nettleton, 2006). Symptoms such as skin conditions, bloating, pain, diarrhoea, fatigue and indigestion (sometimes in combination) had often been endured for years, with many undergoing a range of medical investigations including blood tests, endoscopies, colonoscopies, liver function tests, barium enemas and so on. Again reflecting research findings on studies of unexplained symptoms the search for explanations for symptoms could lead to feelings of anxiety and uncertainty. Alongside conventional medicine, some sought help from a number of alternative practitioners. Accounts were replete with stories of trying many therapies, medications and treatments before thinking about food. For example, one woman in her 50s with intolerance to wheat, fibre and milk explained:

I went to every medical profession under the sun at the time, from gastroenterologists to dermatologists. I went for specialist tests, because of the digestive symptoms I ended up having every part of my alimentary canal from opening to opening tested and checked ... Basically the symptoms always seemed to be digestive related, and I had just continuous, chronic diarrhoea yet could not control things at all, it was very difficult with work. Thankfully, I had an office next to a loo, but it was quite debilitating. I insisted on continuing to work because I could see it wasn't going to be something that was going to be resolved by taking a week off sick, but it was hard work living with the constant pain ... I tried self hypnosis ... I was doing yoga at the time, and I went to a gym. That's still therapy. So all this was also ongoing. And I was also having massage at the time, and reflexology ... It was over such a long period of time though you see. I mean when you're living with it for so long you lose the stamina to stick with anything. If things don't work most probably not after a long enough trial period, you move on, 'cause you're still so desperately hoping for that instant result, which you know isn't going to happen, but you still chase the holy grail. So I did try everything hoping for something I would be comfortable with, something my body would settle with, something that would trigger a change. (Interview 13)

The realization that symptoms could be food related was described as a 'revelation' and 'relief' after relentless searching, often with little support from health professionals. One woman in her 60s with intolerance to milk, cheese, tuna and egg explained:

I mean it's been a long haul because I've actually sort of worked it through my own way, through all these years, changing things gradually, because nobody wanted to listen, nobody really wanted to know, and nobody, nobody seemed to know what I was talking about anyway. Because it's only in the last couple of years that people have sort of realised that there are things like food intolerances. (Interview 3)

Once food had been entertained as a possibility some sought to explore this further through the use of the commercial food-testing laboratories (such as those discussed earlier), and indeed, for some, this did feel like they had discovered

the 'Holy Grail'. The 'discovery' that foods were the source of symptoms enabled the sufferer to adopt strategies to 'manage' their condition and, saliently, a number articulated this in terms of regaining control over their body and life. One woman in her 40s, who endured many years of digestive-related problems and irritable bowel syndrome both before and after a gall bladder operation, described how the findings of the commercial food intolerance test affected her confidence both physically and mentally:

Very positive, very positive because I feel I'm much more in control now, whereas before it was like, you know, my body had control of me but now I'm in control of it. (Interview 5)

Stories of long-term suffering of chronic debilitating symptoms, dispiriting searches for advice, treatments and support, anxieties that the symptoms were imagined or self induced and then a breakthrough – empirical confirmation that the illness could be explained and managed – are reminiscent of what Frank (1995) calls 'quest' narratives. The long search unearthed solutions and this could be shared with others. The quest narrative, writes Frank (1995: 115), is 'defined by the ill person's belief that something is to be gained through the experience'; the illness has become a metaphorical journey from which the ill person may gain self-awareness and/or the ability to help others through lay referral networks.

## Moral Narratives

Gaining, or regaining control over one's body, having the means to manage symptoms and experiencing relief that one's condition was not merely imagined or self-induced were characteristic of food intolerance stories. Yet ambiguity was present in these accounts, most especially in relation to eating in social situations or explaining to others that one had symptoms caused by food. Belief in the source of the problem was tempered through social interactions, where accepting or selecting food would have to be negotiated. There is a strong moral force in Anglo-Saxon countries which is premised on people being able to eat a wide variety of foods (Fischler, 2008). This is evident in relation to childrearing, where parents are encouraged to ensure that their children eat a variety of foods to ensure that they do not become 'fussy' eaters.

Eating a restricted diet is conceptualized as being 'fussy', 'faddy' or 'finicky'. However, it is perhaps not altogether surprising, given what we know about the significance of food in the construction of the self and social identity (Caplan, 1997). The negotiation of food avoidance for those with intolerances could be precarious and, in order to avoid disturbing social relations, many explained how they would make compromises.

I think some friends probably still think I'm a wee bit of a nutter (laughter). If people ask us out for a meal then I don't say: 'Oh God, I can't eat this or I can't eat that' you know. I'm afraid I just eat it and then I think to myself, OK, for the next few days I'm going to have to hide away quietly. Yesterday we actually went out for

a meal and I was served up cheesecake and normally I would say: 'Actually I've had quite enough' but I ate it, but this morning my, my eyes are all bloated, you know, puffy and I do feel quite woozy. (Interview 3)

Avoidance of foods because of food intolerance is associated with alternative and unconventional lifestyles, fashion, and trends, which in turn implicate the person who suffers from chronic, late onset food-related symptoms, as this woman in her early 60s now retired from a high-profile professional career explains:

Oh a bloody pain, God [laughter] and you find, you find that you think that you've turned into somebody that you always thought, years ago, 'Oh for God's sake, get a life'. You know: 'Can I have that sauce but without?' 'Can I have this without cream in it?' you know, and you'd just think my God, has this woman got nothing better to do? You know the sort of person you find at your table, thinking, slice it like this and all that crap, and you find that you're saying that, you know. Sometimes I just say, if it's one of these function dinners, I just say I'm a vegan. [...] I don't think [people] care less, I think they're probably used to neurotic women [laughter]. (Interview 1)

In the case of food allergy there is an identifiable allergen that must be avoided and that will, if the allergic person comes into contact with it, result in symptoms with relatively immediate effect; confirmation that the symptoms are 'genuine'. Those who live with food allergies, for the most part, found that their need to avoid certain foods was accepted by others – and their reaction was normally that of interest, sympathy or both. On only one occasion did a participant (a woman in her 30s with a nut allergy) report compromising because of social pressure, with unpleasant consequences:

I was travelling with my brother and we were with his friends. And we were on overnight bus from somewhere back to Istanbul, you know, backpacking and I ate some chocolate with nuts 'cos somebody was accusing me of being a too fussy eater and I should just eat the chocolate. And so I did and immediately actually spat it out, 'cos I knew, I saw the nuts in it. But then again, I got on the bus and it progressed into an anaphylactic shock that went on for some time. And, you know, it was all my brother could do is think 'just drink lots of water' and kept pouring lots of water down me. And, you know, he was very concerned 'cos we're in the middle of nowhere in Turkey (laughs) you know. I was twenty or something like that and, you know, a bus full of Turkish people, not round a tourist area. ... But it did actually go eventually. It took a lot of hours, and whether this was because I didn't actually swallow it, just sort of turned it over, and then I spat it onto the floor but some must have got in, enough to give me the anaphylactic shock. (Interview 18)

This case was an exception, but it does serve to demonstrate the extent to which being considered 'a fussy eater' is viewed as socially problematic. 'Intolerance' implies an altogether less clear-cut status than does 'allergy'. Not only that, but the very term itself also conjures up notions of 'small-mindedness', 'prejudice' or even 'bigotry' as a semiotic overlay to this ontological fuzziness. For example, one man in his 40s, who worked in catering and who himself had an intolerance to dairy, wheat and egg, articulated the suspicion that not all claims to food intolerance were 'genuine'.

Certainly when we're doing group catering there are the sort of people who come – a certain type – they're wanting attention, and it's a means of getting attention. I have a sort of mental list of about half a dozen people who come in regularly who I know what they will and won't eat, and you're never sure if it's just 'cos they don't like it or whether they actually can't. You know, I've got one lady, she can't have salmon, she'll have smoked salmon ... Now I think that says it all really. (Interview 10)

The manifestation of symptoms, a clinical diagnosis, and a condition which is considered to have an explanation within biomedical science all serve to support an authentic sickness identity. Echoing the clinical and scientific literatures on food allergies and intolerance, people who can confirm that they have a 'true food allergy' have, in Parsonian terms, both a legitimate biologically altered *and* socially altered state (Parsons, 1951). It behoves society to be sympathetic and support them – be it accommodating their needs in social situations and, increasingly, by providing information through labelling and the like so that they are not placed 'at risk'. Hence, the food allergic identity is relatively stable and is rooted in dominant medical discourse. However, those who experience chronic or late onset symptoms associated with food intolerance and who do not have recourse to conventional biomedical categorizations remain marginal and their status is questioned.

While the sick role stipulates that those who experience symptoms seek technically competent help and work to overcome or manage their symptoms, doing so in ways that do not conform to dominant biomedical approaches remains suspect. Food practices and styles of eating are core to individual and social identities, encapsulate prevailing norms and values and are emblematic of ways of living. In this sense accounts of food intolerance and allergies reveal more than merely the pragmatics and problems associated with living with them but also tell us something about collective notions – core narratives – about food, eating and contemporary social life.

## Core Narratives

Thus far, we have explored the pragmatic aspects of allergy and intolerance experiences articulated within contingent narratives and the differential personal evaluations of allergic and intolerant identities evident in moral narratives. Bury (2001) suggests, however, that stories of illness experience can also be analysed in terms of 'core narratives'. We deploy this notion here to refer to the socio-cultural contexts which inform the accounts: that is, we examine the discursive repertoires that our informants were able to draw upon. Thus, we shift from an exploration of individuals' accounts of their own experiences to the study of the social representations (Herzlich, 1973) of food allergy and intolerance. Bury (2001: 278) points out that:

[W]hen lay people construct and present narratives of their experience they do so within cultural settings which provide specific forms of language, clichés, motifs, references and other elements of linguistic and symbolic repertoires which allow and

constrain what is said and how it is expressed. The creative and active elements in personal narratives do not, though, mean that the speaker can always know or control what is being revealed or conveyed to others.

In our analysis of contingent and moral narratives, we have seen that there are differences between the pragmatic consequences, accounts of proximate cause, social negotiations and identities between those who live with allergies and those who cannot tolerate certain foods. However, when we consider the symbolic and cultural repertoires there is a degree of consistency throughout our data. For example, the notion that not being able to eat certain foods can invoke accusations of being a fussy or a faddy eater would be a case in point. This is clearly taken as an affront and, as we saw, in an exceptional case even led one participant who was allergic to nuts to risk eating food containing them in a remote location to counter such an accusation.

The commonality of cultural repertoires and shared discursive resources is most striking when participants reflected on ideas about the aetiology of food-related problems and the apparent increase in food allergies and food intolerances. Here we see a mix of theories that relate to the changing epidemiology of allergies that are found in the scientific literatures and explanations which tap into contemporary debates on food production, environmental risks, and 'unhealthy' eating. These, in turn, resonate with debates within more sociological literatures pertaining to reflexive modernization and the 'risk society'. Participants talked about the transportation of foods across the globe, food additives, pesticides and chemicals, 'TV dinners' and much more beside. One man, in his mid 60s, with an intolerance to yeast, provided an indicative rendition:

People are having so many pre-packaged foods. I mean the thing is we don't have them but, you know, people are buying off the shelf pre-packaged meals and the burgers and the junk foods and God knows what. Whereas we've nearly always stuck to sit down, normally cooked, home-cooked meals and salads. (Interview 24)

Similarly, the woman in her mid 30s who was allergic to nuts and who we heard from earlier said:

There's more contamination; the chemicals in food and that sort of thing. You know, sort of the age-old thing that people aren't what they used to be and everybody's wrapped up in cotton wool and not exposed to anything – dirt and that – when they're children. I don't know whether that's something to do with it. But people's immune systems aren't as good as they used to be because we eat lot of processed foods and stuff like that. (Interview 23)

Here we see echoes of the 'reflexive modernisation thesis' (Beck, 1992), the notion that health threats and risks are a result of humans tampering with nature; the 'hygiene hypothesis' (Strachen, 1989), the thesis which associates allergies with reduced exposure to dirt; claims that conceptualizations of health are 'saturated' with notions of immunity (Martin, 1990); and suggestions that increases in allergies are the result of contemporary methods of food production (Cone and Martin, 2003). Thus, prevailing explanations circulate and transcend academic and lay discourses, which is perhaps hardly surprising given their

shared metaphorical language and cultural resources. Uncertainty and complexity are the dominant themes (Nettleton et al., 2009). Virtually everyone interviewed commented at some point that they were unsure about what might give rise to their own food-related problems or allergies in general. The comment made by a man in his early 30s who was allergic to nuts is, again, indicative:

That's my impression, that there's been a real increase in allergies generally and asthma for instance, you know, diagnosed. You know when I was a kid I was the only one who had asthma, nowadays I think half my little girl's class have got asthma, and I don't think it's doctors diagnosing more cases, I think it's literally there is, there's an increase in it. It must be some change in the environment; *I don't know what it is.* (Interview 9)

Various explanations were offered, not least accounts that alluded to the fact that it was likely to be due to a multiplicity of reasons.

The whole life of the planet and the occupants of the planet are going helter-skelter, God only knows what doom we're going towards, the whole thing is out of balance and I think that holistic imbalance has got a lot to account for. (Interview 13)

Thus, we see that the interpretation of the experiences and the multiplicity of explanations proffered are both permeated by and, we would suggest, may serve to reinforce those within academic literatures. For this woman, and others, food allergies and food intolerance are the outcome of what Giddens (2000) calls the 'runaway world' – a world that has been 'messed up' by an amalgam of changes. These discursive resources are permeated by complexity thinking. The language and concepts of complexity comprise the metaphorical means by which lay people and experts come to make sense of, and describe, the social and physical world (Urry, 2003).

In sum, reflecting on the core narratives, wherein the speaker cannot always 'know' what is being conveyed (Bury, 2001: 278), we see that, at the collective and symbolic level, accounts of food allergies and intolerance have become emblematic of how we have 'messed up' our world creating a problem 'too big' to be solved. The morality discourse is also evident – not least in relation to the references to people who rely on processed foods, eat TV dinners, or who have become duped into thinking that they have allergies or intolerances through reading magazines or following fashionable diets.

## Concluding Discussion

In their report on allergies, the House of Lords Science and Technology Committee in 2007 concluded that: 'Allergic disorders can seriously impair quality of life for sufferers, and in some cases, can even lead to death' (p. 6). Undoubtedly, there is truth in this statement. However, it does contrast with the comment by one of the participants in this study that, 'it doesn't really bother me' (Interview 27). Living with a food allergy certainly creates many practical difficulties that have to be managed and attended to on a daily basis. However, in contrast to many

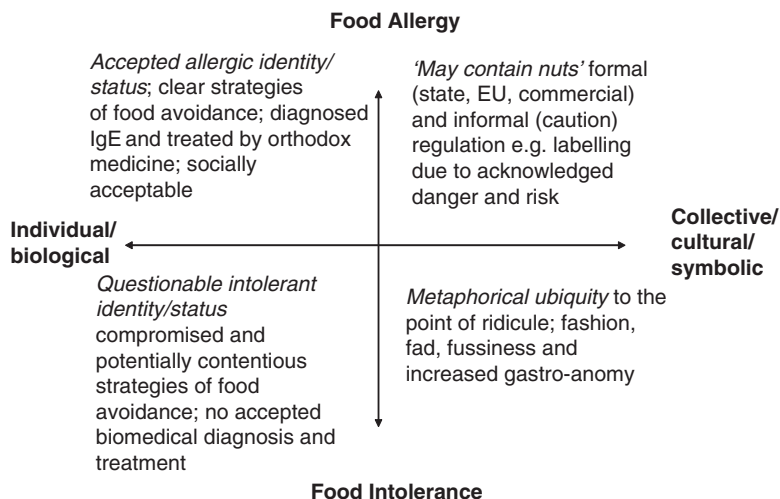
contemporary health-related concerns, it is not characterized by incalculable risk and uncertainty nor does it appear to carry a significant moral load.

Our data show that there is a degree of consistency between accounts when trying to explain what precipitates food allergies and intolerance; both are presumed to be the result of a complex array of socio-environmental factors, which constitute threats to the maintenance and reproduction of healthy bodies. However, those who live with a food allergy have recourse to an authoritative scientific discourse that confirms that they have a recognized biomedical condition. Furthermore, food allergies give rise to relatively clear-cut rules of food avoidance, whereas responses to food intolerances can be, easily, compromised. Thus those with food allergies were generally less concerned that they might offend social norms and disturb social values than were those with food intolerance, who have less legitimacy within orthodox science. Indeed, those with allergies seemed sanguine about their condition and were keen that it should not disrupt their lives. Although we reported one case where a woman ate chocolate containing nuts due to perceived moral pressure, this was very much an exception rather than the rule. We must, however, be cautious here. We are not suggesting that the suffering and symptoms experienced by those with food intolerance are in any way not real or valid; rather we are suggesting that, based on the accounts analysed in this study, they are experienced differently in terms of their social consequences. Although food allergy poses a very real health risk to individuals, it does not carry the same moral threat that can be experienced by those with food intolerance, and its management was relatively straightforward. As is the case with many other chronic conditions, living with allergy becomes normalized for those who live with it. The finding – that food intolerance appears to represent a greater ‘social’ problem for those who live with it than does food allergy – echoes the findings of studies about the experience of living with medically unexplained symptoms (Nettleton, 2006; Werner and Malterud, 2003). It is also a finding that begs further sociological scrutiny.

In order to gain an analytic appreciation of our findings we locate the narratives analysed within a broader context, by proposing a conceptualization that combines two sets of contrasts between, on the one hand, food allergy and food intolerance, and on the other the biological/individual and symbolic/collective responses to these conditions (see Figure 1).

Although the diagnosis of food allergy is problematic – not least because the presence of high levels of IgE does not inevitably correspond with clinical symptoms (Asero et al., 2007) – there is considerable consensus within the scientific literature about the mechanisms associated with these immunological reactions. However, as we discussed earlier, clinicians regard the detection of raised levels of IgE and a convincing medical history as a sound basis for diagnosing ‘true food allergy’. Thus, an *allergic status* can be conferred and strategies of food avoidance are relatively clear cut. However, within the context of complex modes of food production, processing and increased diversification of foods, the individual’s means of identifying allergens is sometimes difficult. Governments and the commercial sector have responded to this by labelling foods with the express intention





**Figure 1** Conceptualizing food allergy and food intolerance narratives

of informing people so that they are able avoid foods that could place them at risk. A prime example of this is the EU Directive (2003/89/EC) that all packaged foods must indicate whether they contain one of the 12 foods most associated with food allergies. As noted, such labelling requirements have given rise to the ubiquity of labels which state 'May contain traces of nuts' (and various concomitants), which in turn has become a motif of a society which appears to have become, at times, overly risk averse. To be sure, for individuals with food allergies these labels are helpful (although those that state that 'traces' of nuts, egg, wheat and so on may be present can be problematic). However, at a collective level, rather than providing reassurance, these regulations may serve to amplify anxieties; not least, because they remind us that we do not actually know exactly what we are eating.

As we have seen, food intolerance implies an altogether less clear-cut and therefore questionable identity than does the allergic 'binary'. Food avoidance strategies are compounded by categorical, taxonomic and moral uncertainties; they lack authenticity and endure greater 'gastro-anomy' (Fischler, 1980); and are compounded by the *metaphorical ubiquity* of 'allergy' (Jackson, 2006) and the ridicule prompted by phrases such as 'may contain nuts'. This phrase is now used in popular parlance to capture the irrationality of contemporary risk-conscious lifestyles (O'Farrell, 2005).

In his classic article, 'Food, self and identity', Fischler (1988: 275) posits that food is 'central to our sense of identity'. Transformations in food production and consumption and concurrent relaxations of social norms which regulate eating patterns, all contribute to 'the disturbance of modern identity' (Fischler, 1988: 288). Pursuing this thesis, Falk (1994) suggests that western societies have undergone transformations of what he calls 'eating communities', which comprises a shift from *gemeinschaft* to *gesellschaft*. In the former, food preferences are shaped by a shared social appetite – in Falk's terms the body is 'open', but individual



identity was undifferentiated. By contrast, in the context of *gesellschaft* the 'body is closed' but self and identity are 'open'; consequently, decisions about eating are left to individuals – thus foods are chosen and selected rather than being proscribed by shared values. In Falk's terms, in a traditional-eating community eating was a shared collective activity, a way of 'eating in' to a community. By contrast, in contemporary society, relentless food choices can serve to 'eat away' at notions of self and identity. In essence, in the past the social experience of sharing food was more important than the actual ingestion of any particular foods.

Falk's work therefore builds on Fischler's Durkheimian-inspired notion of 'gastro-anomy'.

Modern individuals are left without clear-cut socio-cultural cues as to what their choice should be, as to when, how and how much they should eat. Food selection and intake are now increasingly a matter of individual, not social decisions. And they are no longer under ecological or seasonal constraints. But individuals lack reliable criteria to make these decisions and therefore they experience a growing sense of anxiety. (Fischler, 1980: 948)

In a rather functional sense he suggests that the rise of 'food fads, fad diets, food sectarianisms, even new trends in culinary aesthetics' may be indicative of an aspiration to re-establish dietary regulations and norms in the face of a growing normlessness, which in turn are precipitated by our paradoxical relations with food (Fischler, 1980: 949–50).

According to Fischler, eating is an activity that is replete with paradoxes. Most famously, he talks about the 'omnivores paradox'. Humans, on the one hand, are curious and so experiment with foods, but on the other, are conservative and cautious. Maintaining this balance becomes tricky in post-industrial liberal eating communities, where we are inundated with choice. Extending this theme of paradoxical relations with food, Beardsworth and Keil (1997) suggest that food can be simultaneously a source of gratification and displeasure, and a source of health and illness. What is especially salient for our argument here is that there are features of contemporary life which serve to exacerbate all these paradoxes; 'many of the structural and ideological features of modern food systems have the effect of raising the visibility of the paradoxical nature of food and eating' (Beardsworth and Keil, 1997: 160).

Within a *gesellschaft* eating society, social relations become more ambivalent, paradoxical, and anomic. Rules governing what we can and cannot eat and what we 'ought' to put in our supermarket trolleys become critical signifiers of our identity. We are bombarded with advice, guidelines, scares, therapies, and nutritional information about the merits and demerits of food. How we respond and navigate this advice can be a precarious business and lays us open to evaluation by others. For those people who live with food intolerance and who, very often, have come to identify which foods cause them problems, only after years of trial and error, the status of their food-related identity could be an uneasy one. By contrast, those who live with food allergies, or 'true food allergies' as they are labelled in the medical literature, have a recourse to a dominant socially and scientifically legitimate authority.

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