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Food unease: How Ozempic era master narratives burden fat people

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ABSTRACT

This article develops the twin concepts of *food ease/unease* by examining the effect of Ozempic era cultural narratives on fat peoples' relationship with food. Accordingly, I make three contributions to the literature on GLP-1RAs. First, I characterize four *master narratives* relating to food that stem from Ozempic era discourses. *Master narratives* were first theorized by Hilde Lindemann Nelson (2001): they are cultural stories through which people construct their *narrative selves*. I identify four relevant master narratives: the *miracle* narrative, the *ending* narrative, the *simplicity* narrative, and the *food noise* narrative. Second, I argue that these food narratives burden fat people with what I term *food unease*. Food unease makes the subjective experience of hunger and eating difficult, undesired, or interfere with life in an unpleasant or obtrusive way. Narratives that pathologize (fat) hunger and (fat) eating burden fat people insofar as fat people use them to make sense of their relationship with food. My third contribution is to show that the twin concepts of *food ease/unease* are more useful for thinking about GLP-1RAs' effect on peoples' relationship with food than the concept of *food noise*. By examining the impact of Ozempic era master narratives on fat people's relationship with food, I provide more reason to be circumspect about the popularity of these drugs. At the same time, I offer new concepts that can be used to construct counter narratives against oppressive cultural stories.

KEYWORDS

food noise; Ozempic; diet culture; bioethics; food ease; narrative hermeneutics

Introduction

I am a millennial able-bodied small fat white woman who has often experienced anti-fatness as an imperative to make myself smaller through restricting food intake. My relationship with food suffered until I learned about fat positivity, anti-diet culture, intuitive eating, and Health at Every Size.¹ I now have an appreciation for food that goes far beyond calories and food as “fuel”: food is saturated with social and political meaning, as well as affects like pleasure, disgust, and comfort. How frequently we eat, how much we eat, what kinds of food we eat, where we eat, and how we judge bodies given what they eat, are socially and politically mediated. Refraining from or consciously pursuing certain food can signify class, race, gender, moral identity, religious identity, cultural identity, and more (Lebesco and Naccarato 2008).

Given this personal trajectory, I have become protective over the important place food holds in fat people's lives, which motivates my concern with cultural narratives around Glucagon-Like Peptide-1 Receptor Agonists (GLP-1RAs), a class of drugs popularly known by brand names like Ozempic, Wegovy, Mounjaro, Zepbound, and Juniper (depending on national context).² GLP-1RAs have been around for over 20 years, originally developed to treat diabetes and regulate blood sugar under the brand name Ozempic (Suran 2023). They mimic the GLP-1 hormone, which increases insulin production when blood glucose levels are elevated. Early on, people observed that diabetics taking this drug were also losing weight. This observation generated an interest in testing the drug for “treating” fat embodiment, and the first trials for weight “loss”³ found that the drug was efficacious (Davies et al. 2015; Friedman 2024). It was discovered that the GLP-1 hormone suppresses appetite by targeting parts of the brain responsible for experiencing hunger and cravings while also slowing the rate at which the stomach empties – in turn prolonging the feeling of fullness after eating (Suran 2023).

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I first became aware of these drugs in 2020: public figures were being praised in popular culture for losing weight (Warin, Bombak, and George 2024, 53). The cultural obsession with weight “loss” is wrapped up in ideals of the good citizen, white femininity, and systems of neoliberalism, coloniality, and anti-Blackness (Choudhury 2021; Harjunen 2021; Lupton 1996). Indeed, weight “loss” drugs are produced within an Anti-Obesity Assemblage that has historical roots in anti-blackness and colonization (Fox 2018; Harrison 2021; Strings 2019). Still, something *felt* new about this weight loss: the amount of weight that celebrities were losing, and the way that this drug seemed like a public secret with speculation about who was or was not taking it (Warin, Bombak, and George 2024, 53). Over time it was revealed that celebrities had been losing weight using a “miracle” drug: Ozempic. In 2021, the US Food and Drug Administration (FDA) approved a new dose of GLP-1RAs for weight “loss,” under new brand names, as long as users met weight-related criteria (PR Newswire 2021; Weiss et al. 2022).⁴ In 2025, these drugs are becoming normalized for those who are not classified as “overweight.” People of all sizes are also turning to dangerous compounded versions which they can access without ever seeing a clinical expert (Suran 2023).

There is little evidence that weight “loss” can be sustained post-use, which means individuals may be consuming these for life or risk gaining weight back (Bombak 2023, 859; Rubino et al. 2021; Weiss et al. 2022). This can lead to weight-cycling, which has health risks and can lead to psychological suffering (Fahs and Swank 2025, 6; Greer 2025b). For many individuals, particularly those with larger bodies, these drugs typically result in a maximum weight “loss” of around ten percent. For someone who is 325 pounds, that would equate to 32.5 pounds, meaning that users could very well continue to be considered fat (Pawlowski 2024).⁵ In 2022 widescale prescription led to a shortage for diabetics who need GLP-1RAs as a matter of survival (Kolovos 2022).

These drugs come with a variety of negative side effects including nausea, vomiting, diarrhea, fatigue, and gastroparesis (paralysis of the stomach) (Ghusn et al. 2022).⁶ But GLP-1RAs also shift desires around food; both in terms of quantity and quality. Users can end up wanting to eat less than they are used to, losing pleasure from eating, developing new affects toward food like disinterest or disgust, and no longer liking certain foods (Reynolds 2023). But *this* potential negative alimentary impact of the drug is not part of the public narrative, and is not included in prescription instructions to doctors (Suran 2023). Even medical professionals that are conscious of fat oppression do not mention how the drug might negatively impact one’s relationship with food (Lexchin and Jutel 2025). Instead, the alimentary impact of the drug is portrayed in the public narrative as *positive*.

I have argued elsewhere that the phenomenological experience of taking GLP-1RAs can negatively impact one’s relationship with food (Greer 2025a). For instance, some users report no longer wanting to eat or cook, and have difficulty navigating the social and personal repercussions of this effect on their relationship with food. That argument focused on prospective users of this drug. But what about people who do not want to take this drug? How might the cultural explosion around these drugs and accompanying public narratives impact *all* fat people’s relationship with food? This paper seeks to understand how cultural messaging around these drugs is shaping fat people’s relationship with food regardless of whether they are users or not. Ultimately I interrogate cultural narratives suggesting that these drugs: (1) are miraculous; (2) the end of “bad” forms of eating that lead to fatness; (3) make weight “loss” simple through reducing the need to diet; and (4) suppress “food noise” that fat people supposedly suffer from.

One of the supposedly positive side effects of the drugs is its ability to quieten what has been colloquially termed “food noise.” This concept has become so prevalent that users often appeal to food noise when explaining why they like the drug (Jensen et al. 2025, 6). Despite the concept being widespread in the media, in patients’ narrations of their experiences, and even in some research articles on the efficacy of GLP-1RAs, it doesn’t have an agreed upon medical definition that would separate it from normal hunger. Journalist Dani Blum describes food noise as “shorthand for constant rumination about food” (Blum 2023). She associates the concept with “hedonic hunger,” a preoccupation with eating food for pleasure. This negative characterization of food noise is taken up by nutrition scientists Hayashi et al. (2023) who fit this concept into existing scientific literature by arguing that anecdotal accounts are referring to what the nutrition sciences term “food cue reactivity.” This body of literature presents “extreme” food cue reactivity as pathological, and as a cause of fat embodiment. The authors accordingly interpret the benefit of these drugs in terms of their ability to reduce “extreme” forms of food cue reactivity that make fat people struggle with what they term “food-related intrusive thoughts” and “maladaptive eating behaviors” (2).

However, *food noise* is not a pre-given category that exists outside of or prior to the medicalization of fatness and the pathologization of fat people's hunger. Madeline Ward argues that food noise as a term "medicalizes a perfectly normal enjoyment of food and pathologizes hunger" (Ward 2024). As I alluded to above and will discuss further in Section 2, food experiences are socially, politically, and personally important (Bell and Valentine 2013). Notably, Hayashi et al.'s analysis doesn't give nutrition scientists a mechanism for distinguishing between normal and abnormal hunger outside of the ideological values of ideal embodiment. Nor does their analysis dignify the social, political, and personal importance or meaning of eating and food.

This paper argues that hegemonic cultural narratives around food and GLP-1RAs pose an injustice to fat people in terms of how they set the conditions for their relationship with food. I argue that because of the dominant status of these cultural narratives, fat people can be forced into making sense of their internal bodily hunger cues and eating practices in a way that makes them experience what I term *food unease*. *Food unease* is an uncomfortable physiological or psychological response encountered in the construction of one's narrative self out of these oppressive narratives.

Section 1 historicizes healthism, the medicalization of fatness, and the hyper-surveillance and disciplining of fat people's appetite. Section 2 outlines my methodology. I use narrative hermeneutics to examine cultural narratives around GLP-1RAs, food, and fatness and how they influence fat people. Section 3 characterizes four *master narratives* that are embedded in Ozempic era discourses: the *miracle* narrative, the *ending* narrative, the *simplicity* narrative, and the *food noise* narrative. Section 4 argues that master narratives can create food unease for fat people who interpret their gustatory lives in light of these narratives, and who attempt to create a narrative self in response to these narratives. Disordered eating is one such manifestation of food unease. I conclude by reflecting on why the twin concepts of *food un/ease* are more useful than *food noise* to understand one's relationship with food.

Healthism, the medicalization of fatness, and the hyper-surveillance and disciplining of fat people's appetite

At the time of writing (November 2025) President Donald Trump's administration has announced a deal with drug manufacturers Eli Lilly and Novo Nordisk to make GLP-1RAs accessible to the wider population, proposing to sell them for \$150 per month (Manne 2025). This is in the wake of the administration cutting Supplemental Nutrition Assistance Program (SNAP) benefits which aid low-income families in purchasing food (Manne 2025). At a time when low-income families are struggling to feed themselves, the administration of the United States makes appetite suppressant drugs affordable. Meanwhile, Robert F. Kennedy Jr. describes "obesity" as a disease of poverty and television presenter Dr. Oz has claimed that Americans will lose 135 billion pounds by the mid-term elections (Manne 2025). The raced, classed, and fatphobic assumptions and implications bound up in this case go beyond the scope of this paper (Choudhury 2021). However, they usefully illustrate how the appetite and eating practices of fat people in the contemporary era are political and bound up in systems of race, class, and statehood.

The idea of "healthism" was coined by Robert Crawford (1980) to describe the felt-imperative to pursue individual health as one's most morally important life project: it is the idea that health derives from one's individual choices (368). From this logic we get neoliberal ideas about responsibility for the health of one's body, and about the productive and civilized citizen-laborer-subject (Choudhury 2021). If one is responsible for their healthy choices, then they become responsible for their unhealthy bodies. "Choosing" to be fat may be seen as "electing" to be disabled; a state of embodiment accompanied by stigma (Gibson 2022; Herndon 2002). At the same time, with the advent of the "obesity epidemic" in the latter half of the 20th century (a scientific categorization that inherited centuries' worth of racist science), slenderness has been equated with health, moral virtue, upper-class restraint, racial purity, and beauty (Bordo 2003; Strings 2019). Fatness has thus been pathologized as not just a disease, but as a public health crisis and personal failure (Colls & Evans 2009, 1053; Conrad 2007; Gaesser 1996; Gard 2010).

Through healthism and the medicalization of fatness, fat people have become positioned as responsible for changing their bodies through dieting in order to become healthy. Fat individuals are seen as having "failed" to "exert adequate self-discipline and self-surveillance and therefore require outside forces to intervene" (Trainer, Wutich, and Brewis 2017, 1). Fat people's appetite is

surveilled in eating contexts (Bombak 2015; Kianpour 2025), in weight loss clubs (Heyes 2006; O'Connor 2026), and in the school and workplace (Beatrice et al. 2025; Colls and Evans 2009; Morgan et al. 2011; Rawlins 2008). As fat people internalize panopticon-like surveillance around their eating habits they often turn to restrictive diets, which involve vigilant self-surveillance of the body—both through measuring it (using scales) and tracking calories/food (Coleman 2010; Dean 2014).

Cairns and Johnston (2015) discuss an emerging form of diet in the 2010s: the “do-diet,” where dieters “choose” health for themselves through their food choices. The do-diet frames itself in healthist terms of choice and personal satisfaction rather than restriction. However, this supposedly empowering message is undercut by the fact that the do-diet still postulates weight “loss” as “a universal goal, a discursive conflation of health and thinness evident in commonplace statements like ‘Your health—and your waistline—will thank you’” (2015, 160–161). Ultimately, the authors find that the do-diet reproduces fatphobia and healthism, since the discourse “equates health with thinness, and naturalizes weight loss as an automatic and positive benefit of healthy food choices” (171).

One pernicious medicalized understanding of fat embodiment is that fat people have “food addictions”: that all of us have a pathological relationship with hunger that explains our “abnormal” embodiment (Ryan and Savulescu 2025). This paradigm for understanding fat embodiment has resulted in several disciplinary techniques to curb the “abnormal” hunger of fat people. Historian Simmons (2025) explores how hunger has historically served as a tool, weapon, and scientific method in the U.S. to shape and control the behavior of marginalized groups. For instance, in the history of the United States, government agents frequently withheld food rations to coerce Native people to sell land, work for wages, and send their children to residential schools.

Fat people in the era of the “obesity epidemic” and diet culture know the political stakes of hunger well. Simmons explains that Ozempic “is the latest in a series of hunger-suppressant drugs, each derived from a new scientific understanding of hunger and how to stop it” (Simmons 2025, 140). Before Ozempic, she explains, the:

American marketplace was already saturated with weight-loss drugs. A parade of amphetamines and their derivatives—Benzedrine, phenmetrazine, phentermine, fenfluramine, ephedrine—filled pharmacies and medicine cabinets, one after the other. By the late 1960s, some 2 percent to 3 percent of the American population, or four million to five million people, were using amphetamines for weight loss (Rasmussen 2009, 238). As one weight-loss medication was banned because of toxicity, psychosis, or addiction, another took its place. (Simmons 2025, 140)

Another technique to suppress appetite, bariatric surgery, was invented in the 1950s. Here, parts of the physical stomach are cut out of the body with the result of the stomach feeling fuller quicker. Surveilling and disciplining ourselves through measuring our bodies, suppressing our appetite, eating only certain kinds of food, and exercising to “burn” calories, can be critiqued in terms of how it constrains one’s freedom to act, look, and weigh as one would otherwise. The body becomes shaped by overarching systems of oppression, and the subject’s motivations and desires to discipline their body become difficult to separate from these systems of oppression.

There is a growing literature critical of Ozempic era discourses, a term coined by Flora Blanchette-Oswald, which has considered the extent to which GLP-1RAs further anti-fatness and other systems of oppression (like ableism, classism, and racism) (Oswald 2024, 2). Blanchette-Oswald argues that Ozempic era discourses “perpetuate and deepen anti-fatness, and [...] mobilize internalized anti-fatness as a mechanism for promoting fat people’s engagement” with GLP-1 drugs (2). In-so-far as GLP-1RAs contribute to the elimination of fat embodiment, they constrain the freedom of fat people by normalizing thin embodiment and operating as a mode of individual self-discipline (Fox 2024, 29–59).

There are two main takeaways from this section. First, the medicalization of fatness, the gendered, racialized, and classed dimensions of anti-fatness, and the hyper-surveillance of fat people’s appetite, have a long history and contribute to unjust narratives around how certain classes of people are individually responsible for their health outcomes (Lozon 2021). Second, the very desire to lose weight through disciplining the body is socially, economically, and politically mediated. In this way, critiques of thin normativity go beyond critiques of dieting as ineffective.⁷ Whether weight “loss” interventions work or

don't work is in some sense peripheral to larger social-political issues about the role of oppressive structures and ideology in shoring up power for the elite.

Method: The power of narratives and the rhetorics of food

My methodological framing relies on an understanding of how Ozempic era discourses produce cultural *master narratives* that impact the construction of fat people's *narrative selves*. My analysis here is limited to Ozempic era narratives about fat people's eating practices and relationship with food.⁸ Section 2.1 will gloss Hilde Lindemann Nelson's (2001) theory of narrative identity. Section 2.2 will explain how food-based *master narratives* can impact one's narrative self. Section 2.3 will orient the reader to the rest of the paper.

Master narratives and the narrative self

Lindemann Nelson (2001) intervenes in narrative hermeneutics to argue that narratives and counter-narratives shape our understanding of ourselves, influencing human agency, experience, and power dynamics between social groups (MacIntyre 1984; Nussbaum 1990; Rorty 1989; Taylor 1989). She follows Charles Taylor in granting that "we grasp our lives in a *narrative* [. . .] in order to have a sense of who we are, we have to have a notion of how we have become, and of where we are going" (1989, 47). She develops his account further by examining how social power dynamics influence cultural stories in circulation, and thus how the construction of one's narrative self is impacted by the social world.

Master narratives are "stories circulating in our culture that embody socially shared understandings" (Lindemann Nelson 2001, 84). They are comprised of schemas: *scripts* and *stock characters*, which are "representative heuristic[s]" for events and people in the world (83). Because master narratives are comprised of representative schemas, they "serve as a kind of shortcut that saves us the trouble of having to create a story out of whole cloth" – they allow us to quickly craft complex representations of reality to ourselves and others (84).

Scripts are event-schemas which categorize a causal sequence of events, for example, the "restaurant script" contains such action as "entering" "ordering" "eating" "paying" and "exiting" scenes (83). Stock characters, or person-schemas, provide person-liches: for example, the "overanxious mother" stereotype might be used to understand a mother's annoying yet endearing behavior. Whether a person-schema represents the truth is beside the point: master narratives provide an interpretive schema through which a person makes sense of an experience. A schema is a category that forms an important basis for inference, judgment, and expectation: "the norms of the master narratives tell us how we are supposed to understand the people (including ourselves) to whom we apply them" (85).

A *narrative self* arises from a combination of different types of narratives. There are first-personal narratives of one's own life as one sees it, and there are second- and third-personal narratives where other people and the world narrates someone back to themselves. These do not always nicely dovetail. For instance, I may see myself as a hardworking student, and my father may see me as a lazy student. But while these narratives may conflict, the "stuff" of these narratives is commonly drawn from the same set of familiar master narratives: the very idea of what a student should look like, what laziness looks like and why it's bad, and what "the good life" entails, all derive from master narratives through which people make meaning.

Following Lindemann, I frame one's sense of self as pieced together through the stories that one tells about oneself. And these stories rely on innumerable master narratives circulating in the social world. One comes to an understanding of who they are through "selectively depicting and characterizing the acts and events of my life that are important to me, by characterizing *myself* in terms of the features of my body and personality that I care about, by plotting these various elements in ways that connect my stories to other stories and that give my stories their overall significance" (75). Personal identities and self-understandings are thus "narratively constructed, and [...] within limits, narrative constructions can be narratively reshaped" (69). Lindemann thinks that constructing the narrative self happens in a nonlinear fashion: one weaves a narrative self into a "tissue of tales" of many different stories and "overlapping fibres" (76). There is no definite number of narratives through which people understand their own lives and the lines between narratives can become blurred as they subsume or refer to each other.

For Lindemann, the use of narratives is not intrinsically problematic: human beings use narratives to make inferences, guide action, identify themselves and others, and so on. Narratives are a condition of human meaning-making in the first place. Still, they are normatively laden: they embody “norms in such a natural-seeming way that we aren’t aware of their prescriptive force at all, since their normative content is typically presented as description that makes no evaluative demands on us” (85). There is a problem, therefore, when those narratives which people draw upon to create their narrative self become oppressive and constrain the agency of the people whom they are about. One way this happens is when a dominant group constructs the identities of certain people through master narratives that mark them as morally subnormal, who then bear what Lindemann calls a “damaged identity” in the public sphere, and who thus cannot exercise their moral agency freely. Lindemann examines various groups of people about whom exist pernicious master narratives, like mothers, nurses, and transgender people. As she says, “our identities are shaped in part by what our actions say about us, but whether we will be seen as the sorts of people who can be held morally responsible for what we are doing in general, or as competent to perform certain sorts of tasks, has as much to do with the norms of those who assess our actions as with our ability to understand and act on those norms [. . .] If who I am is seen as morally sub- or abnormal, whether by me or by those others, I cannot act freely” (70).

The master narratives that govern meaning-making in human societies portray oppressed groups in such a way that is often taken for granted as common knowledge. This can lead to suffering because the “truth” that the master narrative underwrites further entrenches oppressive systems, power dynamics, meanings, and assumptions. For instance, pernicious stereotypes and scripts about individuals who belong to racial groups often participate in master narratives that underwrite whiteness and settler-colonialism. She notes that:

Pictures derived from master narratives are ‘notoriously resistant to the impact of disconfirming instances. [They] seem to circulate and become entrenched in the repertoires of many people and groups in the absence of many, or even, in the case of individuals’ beliefs, in the absence of any observed instances that might provide a basis for forming beliefs about the behavior or characteristics of a stereotyped group’ (Walker 1998, 193). That they’re taken to be accurate despite any amount of evidence to the contrary is the reason why these pictures hold us captive. Evidence has little impact on them, so the belief that the people they represent are actually ‘like that’ is hard to dislodge. Pictures created by master narratives are so strongly resistant to evidence because what they say about certain groups of people is only common sense, what everybody knows, what you don’t have to think about, what’s necessarily the case. (Lindemann Nelson 2001, 147–8)

Lindemann identifies that, when harmful master narratives dominate a culture’s social understanding, it leads to harmful social treatments toward those who are narrated as “wrong” or villainous. If you belong to a group that bears a stigmatized identity you may be hounded out of town, compelled to give up your job, or blamed for being too weak or too strong. You may think that you should always put others’ interests ahead of your own or live in the conviction that there is something seriously wrong with you (150).

However, people are not doomed to be determined by the stories circulating in culture: one way that oppressed agents can fight against master narratives is through constructing *counter-narratives*. Counter-narratives resist oppressive master narratives by offering alternative perspectives from which to re-assess and experiment with the scripts, stereotypes, norms, and practices of a community (67).

Food narratives

Deborah Lupton (1996) argues that food is much more than the experience of satisfying oneself, or the physical sensations of eating. Food is “inextricably intertwined with the symbolic – we cannot say where one begins and the other ends” (1996, 8). Our experiences of eating food and ideologies around food are a means through which we stake out our narrative identities: as critics, investigators, cooks, and citizens. For instance, Annemarie Mol (2021) discusses a program in Dutch schools where children are given vegetable scoring cards where they are asked to grade vegetables on their merits and flaws. After sixteen tries, each vegetable ends up with a grade between 1 (very bad) and 10 (perfect) (65). Over time the child might come to see herself as an investigator-critic who discovers after all that she likes the taste of brussels sprouts, but cannot stand broccoli. In eating and tasting, Mol argues we can adopt new stories about ourselves, “learning

to be affected, affecting. Taking pleasure, improving. Belonging, distinguishing. Caring, meddling. Satisfying, feeding. Chewing, appreciating. Listening, attending” (73).

This process of self-discovery is not always pleasurable: Mol discusses someone who finds pancakes disgusting as an adult because of a pancake-eating-contest-gone-wrong. Now, she avoids contexts where she would need to eat pancakes, because the smell alone makes her sick (67). Still, this food-related experience is a part of the sense of self that she narrates as significant. Food experiences enable a narrative self that judges experiences, allowing us to turn away from or towards social practices as we establish what we value. For example, food can be something that brings us together with our loved ones and can be the means through which we invigorate social ties. For instance, Mol brings us into the kitchen where she is making soup with her adult daughter, who compliments her and attends to the ingredients in the soup, signaling that she may want to take cooking lessons from her mother (63). Together they weave a narrative around their mother-daughter relation through their engagement with food.

Methodology

In what follows, I draw on evidence from popular culture, medical and public health texts, media, and individuals’ accounts to characterize four oppressive food-related master narratives that stem from Ozempic era discourses. Since these narratives are hermeneutic tools for fat people to understand themselves, and be understood by others, these narratives lead to fat people experiencing an undue proportion of food unease.

There are likely food-related master narratives within the Ozempic era discourse that I’m missing. It is not my aim to outline all of the possible narratives here, and I hope that others can contribute to the literature other narratives around food and GLP-1RAs. I chose the narratives in this paper because they are ones that I have observed in my lived experience as a fat person living in the Ozempic era who has chosen not to take GLP-1RAs. I’ve seen these narratives in advertisements, social media, magazines, and the news, I’ve heard these narratives in conversations with physicians, colleagues, and friends, and I’ve noticed these narratives in the academic literature on GLP-1RAs. These narratives contribute to my own experiences of food unease in the Ozempic era.

The fact that I arrived at these narratives based on my own experience does not disqualify my conclusions: it is methodologically central to much social scientific and humanistic inquiry that the positionality of the researcher influences the data she gathers, what she notices in the world, and so on (Small and Calarco 2022). It is common in narration studies and anthropology for several cultural stories, even competing or contradictory ones, to be posited at once.⁹ Emboldened by these methodologies, while it is true that someone else could look at these discourses and see other narratives, that does not mean that the stories I outline below are not there. The strength of my account should be evaluated based on the evidence I present. Since narratives connect with and invoke other narratives, the narratives I enumerate below do connect to each other. I discuss them separately because they are conceptually distinct, albeit with reference to each other.

Food narratives stemming from Ozempic era discourses

I now characterize four master narratives that permeate current popular culture, politics, medicine, and public health policy around food and novel weight “loss” drugs.¹⁰

These are:

- (1) The *miracle* narrative
- (2) The *ending* narrative
- (3) The *simplicity* narrative
- (4) The *food noise* narrative

The miracle narrative

In the Ozempic era, GLP-1RAs have been narratively constructed as miraculous—no other weight “loss” intervention seems as effective with such “minimal” intervention and “minor” side effects (Bombak 2023, 858–859). Miracles are surprising and welcome events that are portrayed as the result of divine agency, invoking progress-driven temporalities embedded in Western and Christian history and culture (Fox 2018). Miraculous narratives temporally order a series of causal events in such a way that makes the past and present undesirable and the future desirable. Part of the drug’s miracle is its promise to supplant the biomedical “necessity” of more aesthetically offensive and physically invasive interventions like bariatric surgery (some are estimating that the bariatric surgery industry will be obsolete in the next five years because of these “miracle” GLP-1 drugs) (Caplan 2024).

The narrative reinforces the medicalization of fat appetite: As Bombak says, the idea that these drugs produce “miraculous” results “reinforces the idea that certain bodies require now-available ‘cures’” (Bombak 2023, 858–859). It reinforces the pathologization of fat people’s eating practices, as if only a divine intervention could stop fat people from eating themselves to disease and death.

The *miracle narrative* also erases potential future negative effects of the drug on one’s relationship with food over time, and therefore elides the possibility of fat people having good reason to elect *not* to use this intervention. Within biomedical discourses, weight “loss” interventions are often only considered *synchronically*: as events that happen at one moment in time. However, one can understand medical interventions *diachronically*: as intervening in various relationships one has with their personal world over time. Taking a diachronic perspective, GLP-1RAs are supposed to be taken for a lifetime and will have mundane, interpersonal, everyday effects on users’ relationship with their body, food, and other people that are erased by this narrative.¹¹ The “miracle” narrative leverages the synchronic perspective: the decision to take this drug becomes a decision to let oneself be the subject of a miracle and be transformed. Drawing on the *miracle narrative* to construct one’s narrative self involves drawing upon fatphobic scripts and stereotypes about needing to be saved or transformed because of an intrinsically pathological relationship with food that needs intervention.

The ending narrative

Narratively speaking, these drugs have been positioned as “saving and rescuing people [from fat embodiment], or allowing [fat people] to flee the (assumed negativity of the) fat lifestyle” (Fahs and Swank 2025, 5). According to this narrative, GLP-1RAs are ending “bad” eating practices and food noise. Fatness and “over” eating are portrayed as something worth escaping through suppressing one’s appetite (Adler-Bolton et al. 2023; Basch et al. 2023). The Food and Beverage market is seeing the impact of this narrative, where the share price of diet brands (partly based on future-oriented speculation) has been impacted (Tatum 2025). Other diet brands are focusing their efforts on creating food that can supplement “healthy” weight “loss” alongside the consumption of semaglutides.

The Ozempic era exhilaration about the eradication of fat embodiment has a symbolic component, where much of the published scholarship on GLP-1RAs ignores the voices of fat people altogether. In their analysis of 749 news articles between January 2023 and January 2025, Breanne Fahs & Eric Swank found that most of the articles talked *about* fat people without ever talking *to* fat people. Many of the cases the articles mentioned were thin or small fat people; “leading to a nearly full erasure of those above 300 pounds” and collapsing the category “fat people” into a monolith (Fahs and Swank 2025, 4). In their discourse analysis, Fahs & Swank found no media coverage that emphasized that many people will likely still be fat even when taking these drugs (Fahs & Swank 2025, 6).

The narrative turns on the idea that, if it turns out that there is a “healthy,” simple, and effective weight “loss” option, critiques of diet culture and aspirational weight “loss” are rendered irrelevant. Some are discussing whether anti-diet culture and fat positivity are becoming obsolete, citing resurgences in pro-ana content and less diverse representation in the media (Pick 2023; Shanouda and Orsini 2023).

The ending narrative is the causal outcome of the miracle narrative: it is the miracle being pointed to. It risks further marginalizing fat people who cannot or do not lose weight using these drugs, or who choose not to take these drugs at all. It forces fat people to live in a world where they must make sense of themselves in a cultural light that gleefully anticipates the disappearance of their eating habits and their physical embodiment. This narrative thus reinforces the hyper-surveillance of fat people's embodiment and eating practices, and this surveillance is likely to disproportionately impact Black and brown and working-class folks given intersecting systems of oppression (Harrison 2021).

The simplicity narrative

A third narrative is that weight “loss” is *simple* using GLP-1RAs because food is no longer appealing to users.

For example, Fahs & Swank (2025) analyze a 2024 New York Times article on the transformation of people's taste buds while on weight “loss” drugs. They state: “Kenney has lost more than 100 pounds. And it has been easy, she said, because the treatments have transformed her experience of flavor and mouthfeel” (6). Another example comes from Start Willow (a weight “loss” medical company that offers compounded versions of GLP-1RAs that have not been approved by the FDA). The advertisement is an AI-generated picture of a cupcake with the words “less dieting and more living with GLP-1 tablets. No gym, just vibes (sic).” Much like AI imagery itself, this advertisement portrays GLP-1RAs using a deceptive illusion. In fact, users should still “watch” what they eat – for example, one should make sure to get the right amount of protein, fiber, and nutrients to mitigate potential complications. But the drugs are still constructed as easy weight “loss” “solutions” in the public imaginary. As Warin, Bombak, and George (2024) explain, “Semaglutide and its ilk are not alternatives to weight loss dieting; this is apparent from the requirement for lifelong use, food restriction and high rates of discontinuance. Rather, they are merely adjuncts to the lifelong pursuit of the feminine thin ideal, which are being pushed by Juniper as somehow emancipatory for women” (60).

The perceived simplicity of GLP-1RAs upholds the “calories-in-calories-out” model of weight “loss” which has long been critiqued by fat activists and eating disorder activists. It therefore also upholds the “good fatty” stereotype that fat people should take these drugs because they're easily available, will work for them, and have “minimal” side effects (Gibson 2022). Not taking these drugs, or failing to take advantage of the simplicity of the medical intervention, narratively positions fat people as difficult, “bad fatties”, social burdens, or even irrational.

The food noise narrative

In the background of the *miracle*, *ending*, and *simplicity* narratives is the *food noise* narrative. This is the idea that food noise is an objective phenomenon, that it must be destroyed (and that food quiet is desirable).

For instance, Fahs & Swank (2025) describe how “newspapers frame[] weight-loss drugs as a way to escape the annoyances of eating, or fatness altogether, using language of *rescue* and *escape* from both stigma and the fat body. This was particularly true for discussions of ‘food noise’ and how fat people became free of it” (5). Another study of the Ozempic era discourse found that it capitalizes on a specific understanding of pleasure that is associated with being “free” of various things. Warin, Bombak, and George (2024) explain: “Freedom is characterised on Juniper social media as a release from incessant ‘food noise/food chatter/head hunger . . . that doesn't shut up [and] overshadows other aspects of life.’ Patient testimonials highlight this freedom, as Stacey recounts: ‘Since Juniper I feel freedom. I've gone from always thinking about food to thinking about food as fuel’” (57). As Jensen et al. argue, “In clinical and lay terms alike, GLP-1RAs–induced food avoidance is framed as a ‘good’ outcome because it promotes weight loss. Thus, behaviors promoted for large-bodied individuals as ‘health-responsible’ would be considered disordered in thinner ones” (Jensen et al. 2025, 7).

Advocates of the benefits of GLP-1RAs argue that quietening the excessively loud food noise in fat people's heads enables them to act on their higher-order desires (to eat less food). Arguments in favor of GLP-1RAs draw on the concept of food noise in arguing that the drugs can promote fat peoples' autonomy.

For example, Savulescu and Ryan argue that the change in food desire can be “freeing.” When one has a substance-abuse problem, their desires can

[...] still dominate a person’s mental space, hijacking their attention. Semaglutide [...] frees a person from the problematic desire. They no longer want to eat at unhealthily high quantities. This frees up their mental space to pursue their goals and to have a better life. In a way, semaglutide enables a person to choose their own desires. This realises freedom and autonomy, on a higher order account of autonomy as desiring to desire. (Ryan and Savulescu 2025, 6)

Ryan & Savulescu engage in fatphobic narratives comparing fatness and food to alcoholics and alcohol: “There are many modes of facilitating behavior change. For example, Antabuse makes alcoholics nauseous if they drink alcohol. Bariatric surgery makes an [fat] person feel full and even sick if they eat too much. In many of these cases, the desire to engage in an unhealthy behavior remains” (Ryan and Savulescu 2025, 6). The food noise narrative is bound up with the “greedy fat person” stereotype. Because food noise positions fat people as always thinking about food and eating, and the drug as fixing them, it draws on this stereotype of the never-hungry, excessive fat person (Fahs and Swank 2025, 9).

If food noise must be destroyed, one can only wonder what will be left when it is gone. I think of the absence of *food noise* as *food quiet*, drawing inspiration from a 2024 New York Times article that Fahs & Swank analyze: “People taking drugs like Ozempic say their appetites evaporate. The constant ‘food noise’ in their heads—wondering what they’ll eat next, and when—goes quiet” (2025, 5). As Jensen et al. describe, many of their study participants saw the silencing of “food noise” as a much-desired feature of GLP-1RAs, rather than an adverse effect. However, they argue that “the most compelling social aspect of ‘food noise’ lies in its inseparability from the pathologization of hunger and eating, as well as from fatphobia. Hunger is a normal physiological response reframed [through food noise] as a problem to be solved by weight loss drug” (Jensen et al. 2025, 6).

Since GLP-1RAs are justified through eliminating food noise, they are also justified through promoting food quiet. But one must then ask why food quiet should be thought of as objectively good. As I mentioned at the outset, some have argued that Ozempic era discourses are increasing fatphobia by pathologizing normal food practices and experiences and pressuring people into disciplining themselves into being smaller and reducing the place of food in their life (Beckett 2024; Ward 2024).

Ozempic era narratives and food unease

To understand the impact of these master narratives on fat people’s experiences of eating in the Ozempic Era I use the idea of *food un/ease*. In my article, ‘Food Ease in the “Ozempic Era,” I define *food unease* as the absence of *food ease*, or when the pursuit of food ease is difficult or excessively laborious (Greer 2025a). *Food unease* makes the internal state of hunger and eating interfere with life in an unpleasant or obtrusive way. There are structural, historical, individual, economical, and psychological factors that will influence one’s ability to cultivate food ease. By cultivating food ease I do not mean only eating “healthy” or “good” food. Indeed, there are going to be some cases where an obsession with healthiness undermines food ease. Food ease, rather, is a subjective measure of one’s relationship with food; it is a feeling of comfort, and feels different for each person. Food insecurity, like what the recipients of SNAP are being threatened with in the autumn of 2025, can also interfere with food ease.

I see *food ease* and *food unease* as two extremes on a spectrum of relating to hunger, food, and eating. While perfect food ease may never be attainable, I think that people can value cultivating a specific relationship with this spectrum, often (but not always) pursuing food ease. There will be times when a person wishes to explore food unease. For instance, encouraging clients to eat past the point of satiety, to explore feeling uncomfortably full, is an important part of some eating disorder treatment. I see choosing to explore food unease as consistent with a larger project of valuing the cultivation of one’s relationship with food. And I think it is an injustice if one is, because of membership in a social group, forced into experiencing physiological or psychological discomfort through master narratives that stand outside of one’s direct control.

It is clear that physically taking this medication can create sensations amounting to food unease. For instance, a user reports: “At this point, I don’t think I can psychologically continue with Ozempic. It’s

making me afraid of solid food; I can't meet my work, relationship, and home responsibilities; and I feel too awful to exercise or enjoy life. Going to the ER sucks. I think I'm done for good" (Arillotta et al. 2023, 6). Jensen et al.'s (2025) study warns that these drugs create a gray area for health professionals and users alike, because what counts as "success" on GLP-IRAs would otherwise be deemed disordered eating. One of their participants based in the U.S. describes these drugs as "doctor-approved anorexia" (2025, 7).

Taking GLP-IRAs can raise the risk of eating disorders for anyone who has recovered from, currently lives with, is in active recovery for an eating disorder, or has a family history of eating disorders (Bartel et al. 2024). Ashley Moser explains: "While eating disorders are complex and often do not have a single identifiable cause, many people who develop eating disorders report dieting as a precursor [...] Knowing this, anyone prescribed weight loss drugs is at risk for the development of an eating disorder" (Mayer 2023). And physicians J. R. Richards and Khalsa (2024) present several case studies based on their clinical practice that illustrate the potential for taking GLP-IRAs to trigger or exacerbate restrictive eating behaviors (J. R. Richards and Khalsa 2024). Indeed, it seems that those who are most at risk for disordered eating are also most interested in trying GLP-IRAs and willing to tolerate their common side effects (Markey et al. 2025).

As described above, when a master narrative portrays a group in a negative light, or as a one-sided character, it can unjustly constrain their freedom and agency, because they are interpreted or interpret themselves in light of the story being told about them. When fat people understand themselves through the master narratives outlined in the previous section, they can start to experience food unease even if they are not physically taking the drug. The *miracle narrative* tells a causal story about fat people and their insatiable appetites, invoking a stereotype of a fat person who has a necessarily pathological relationship with food and eating. The *ending* narrative celebrates the end of fat embodiment and fat eating, and pathologizes fat people who betray the narrative as an unrealistic fantasy. The *simplicity* narrative positions those who refuse these drugs as difficult or irrational, encouraging the questioning of *all* fat people's eating practices. The *food noise* narrative pathologizes fat hunger itself, as noise to be silenced. Ozempic era master narratives pathologize fat appetite, and interpreting one's own internal bodily hunger cues and eating practices as pathological can contribute to food unease, as it can make one's natural hunger and desire to eat psychologically obtrusive, an object of concern, or anxiety.

Eating disorder recovery proponents are worried about Ozempic era discourses for this reason. For instance, the Eating Recover Center (ERC) based in the U.S. states on their website that they "do not agree with prescribing GLP-IRAs for weight loss because weight is not an indicator of health, and because these drugs buy into a problematic vision of the place food should hold in one's life" (Hardner 2024). These eating disorder experts are worried about the cultural impact of these drugs on everyone's vision of the place food ought to hold in their life. Meredith Nisbet-Croes, a national clinical response manager at the ERC puts the worry this way:

You can't engage in pop culture right now without being exposed to rhetoric around these medications. What's so concerning is that people's ability to have informed consent decreases once they are promised a 'magic solution' to their body size and shape [...] The theme of 'weight loss at any cost' is the true indicator that diet culture is at play here [...] Despite the significant side effects and dosage concerns, these medications are being heavily marketed in every arena: social media, magazines, reality TV and even Oprah's streaming special. We haven't seen a medication marketed this aggressively since Viagra. (Hardner 2024)

Because merely dieting is a risk factor for eating disorders, and a large amount of people have dieted at one point in their life, a large amount of people are at risk for being triggered into disordered eating by Ozempic era narratives, and a lot of them will likely be fat people, who are socially pressured to diet. Disordered eating in fat people is under-diagnosed because they do not fit the stereotype of what someone with an eating disorder "looks like" – the stereotype of someone with an eating disorder is a slender white young middle-class woman (Bordo 2003; Nwuba and Spinn 2024).

It should not be a surprise that the discourse around GLP-IRAs perpetuates food unease and creates the conditions for disordered eating. There is already an eating disorder literature that examines how "obesity" reducing interventions and anti-obesity biopedagogies often do this (Evans et al. 2008; Irving and Neumark-Sztainer 2002; LaMarre, Rice, and Jankowski 2017; Neumark-Sztainer et al. 2007). Indeed, in standard treatment for anorexia nervosa, aversion to food might be considered pathological, weight loss as aberrant,

and the desire to lose as much weight as possible classified an addiction (Larson 2021). Yet, the master narratives around GLP-1RAs promote these very same food-related features. Evaluating the impact of this drug on disordered eating is further complicated by the fact the “culture of compulsory thinness operates around discourses of denial and disguise”: a paradigmatic feature of disordered eating is deception of oneself and others about the extent to which food practices feel disordered (Cobb 2017, 190).

Conclusion

I have characterized four master narratives that stem from the fatphobic social imaginary of the Ozempic era. I have also explained why these master narratives risk leading to greater food unease for fat people. *Food un/ease* are useful concepts precisely because they clarify how the cultural stories that are told about fat people, combined with the hypersurveillance of fat bodies, negatively affect fat peoples’ relationship with food. I contend that these concepts are better for understanding fat peoples’ food practices when it comes to hunger technologies than *food noise*. This is because *food noise* is an intrinsically pathologizing concept; it locates an issue with the need or desire for food itself being *too noisy*, and it implies the desirability of the absence of such needs or desires, which can ultimately lead one into unpleasant, painful, or abnegatory experiences with food. *Food noise* is a binary concept: an experience that can be entirely avoided using a drug. This leads to an all-or-nothing mentality that is similar to disordered eating thinking (Cobb 2017).

In opposition, *food ease/unease* is a relative, scalar, and diachronic concept. “Noise” may make me at ease, and someone else uneasy. The same objective experience can produce heterogenous responses in people who perceive that experience. Accepting the heterogeneity of preferences and experiences allows the judgment of whether an intervention is working for someone to be subjectively justifiable. One may be more or less at ease in relation to food: ease is something one can pursue, and unease is something one can acknowledge without disavowing. One may value the life project of cultivating a relationship with food diachronically over time: pursuing ease or maybe even exploring some forms of unease. The relative, scalar, and diachronic nature of this concept allows more flexibility for people who are making sense of their eating practices in the Ozempic era. I do not want to further pathologize individual people who choose to take these drugs for reasons that allow them to pursue their desired relationship with food; I believe it is entirely possible that someone might take an appetite suppressant drug in order to pursue food ease. In this way, I hope that *food un/ease* can be used as a tool that can help construct counter narratives, against master narratives that burden and constrain the freedom of fat people.

Notes

1. While it was personally transformative for me, the Health at Every Size (HAES) movement, especially as conceived by Lindo Bacon, is flawed in several ways. It often employs healthist, racist, and ableist logics, and Da’Shaun L. Harrison has an important critique of HAES being a “reformist” project. See Bacon [2008] 2010; Carter-Kahn and Harrison (2021); Gibson (2022); Harrison (2021); Mercedes (2022).
2. While I am currently based in the United States, the sources I draw on examine Ozempic era narratives across the world, including Japan, Brazil, the United Kingdom, Australia, and Europe.
3. I put “loss” in quotation marks throughout this paper to mark the fact that losing weight through any medical intervention is not permanent. While weight may be suppressed, weight “loss” on these drugs is only temporary weight suppression, and weight restoration occurs with the discontinuance. Thank you to Reviewer 2 for suggesting this strategy.
4. Reviewer 1 asked how fat folks with Type 2 Diabetes are affected by this: Do they receive higher rates of medication because of their body size or does their diagnosis shield them from this? I could not find studies that addressed this question. The fact that this question has not been asked and studied further emphasizes the ableism inherent in Ozempic era discourses. There should be research on the frequency with which medical providers suggest that clients with diabetes move from Ozempic to Mounjaro/Wegovy/Zepbound/Juniper, and the narratives employed in suggesting such a switch.
5. Part of the explanation for this lies in the fact that one’s weight is not merely a result of a simple “calories-in-calories-out” calculation. So, even though people end up eating far less on these drugs, that does not mean they will lose a lot of weight. Another explanation has to do with the metabolic priority of the “set point weight” (Aamodt 2016). It is beyond the scope of this paper to explain in detail why people lose different amounts of weight on these drugs.

6. These drugs also come with a variety of negative side effects that are less directly related to food and eating, for instance: muscle loss and sarcopenia, pancreatitis, depression/thoughts of suicide, kidney failure, and increased risk of thyroid cancer (Ghusn et al. 2022; Novo Nordisk 2023; Reynolds 2023; Shu et al. 2022; Sodhi et al. 2023).
7. This point responds to a conversation between scholars who, on the one hand, argue these drugs might promote fat peoples' individual autonomy in the short-term insofar as they currently desire to pursue weight "loss"—even if ultimately the discourse further entrenches fatphobia (Ryan and Savulescu 2025). On the other hand, scholars point out that since permanent weight "loss" is near-impossible, this is only a temporary goal that risks the health of users long term because weight-cycling is dangerous. The in/efficacy of weight "loss" interventions is not important to all fat liberationists (some see it as only a minor point, and others see it as entirely irrelevant). The point of convergence for most fat liberationists is that the desire to diet in the first place is socially mediated. Thank you to Reviewer 1 for stressing this point.
8. My analysis is not exhaustive: characterizing and analyzing other narratives is the appropriate subject of future research. I remain agnostic about the extent to which Ozempic era narratives impact thin people's eating practices and relationship with food, despite this being an interesting topic.
9. A famous example of conflicting cultural scripts existing concurrently is given to us by James C. Scott (1990), who discusses two kinds of "transcripts" that exist at once in any interaction between privileged and oppressed agents. On the one hand, there is the *public transcript* which often makes up the historical record of an event. On the other hand, there is the *hidden transcript* which is an alternative record of what transpired, often from the perspective of a specific social group: this counter-narrative exists alongside the historical record, even though it offers a competing version of events.
10. I believe these narratives are distinct from narratives around previously popular weight "loss" drugs like FenPhen and Didrex. The first three narratives are at least distinct in degree – while potentially present in previous weight "loss" discourses, they were there to a lesser degree. The final narrative may be unique to GLP-1RAs. Thank you to Reviewer 1 for pushing me to think about this point.
11. Thank you to Reviewer 1 for inviting me to expand on these ideas.

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