

FACING THE CHALLENGES OF FEMALE OBESITY DURING MIDLIFE:
SOCIAL INEQUALITY, WEIGHT CONTROL AND STIGMA IN CLINICALLY
OVERWEIGHT AND OBESE WOMEN.

MASTER'S RESEARCH THESIS

Submitted to the Faculty of Graduate and Postdoctoral Studies (FGPS)

In partial fulfillment of the requirements for the MA in Human Kinetics degree

RACHELLE BINETTE

B. HK, University of Ottawa, 2013

School of Human Kinetics

University of Ottawa

© Rachelle Binette, Ottawa, Canada, 2016

Abstract

The increasing burden of chronic disease in ageing populations has shifted focus towards illness prevention and the self-management of health. Middle-aged and menopausal women's transitioning bodies, specifically with respect to weight gain and changes in body fat composition, have received much attention by public health officials during the alleged obesity epidemic. In addition to these transformations, socioeconomic status has been shown to interact with obesity by decreasing the psychosocial health of vulnerable women. Although public health actions have targeted the health practices of clinically obese women throughout the menopausal transition, their effectiveness is limited because of existing socioeconomic inequalities, narrow focus on body weight interventions, and the psychosocial impact of an obesity stigma.

Drawing on Bourdieu's sociocultural theory of practice, and namely his concepts of body *habitus* and *symbolic violence*, this study aims: (a) to identify the norms and values of clinically overweight and obese postmenopausal women from contrasting socioeconomic backgrounds with regard to the ways they treat and care for their body, and (b) to outline the sociocultural processes which incline them (or not) to pursue weight-loss strategies.

Forty semi-structured interviews were conducted with clinically overweight and obese postmenopausal women from underprivileged (n=20) and middle class (n=20) milieus in the city of Sherbrooke, Québec. An intersectional (gender, age, socioeconomic status) thematic analysis was employed in order to analyze the data and identify emergent themes within and between both socioeconomic groups.

This thesis is composed of two distinct studies. The first identifies the diverse contexts of occurrence of obesity stigma and weight shaming, as well as the contrasting responses between the two socioeconomic groups. Although all participants experienced obesity stigma, participants from lower social positions were more vulnerable to the psychosocial impact of dominant obesity discourses. In contrast, a higher access to social, economic, and educational resources provided middle-class women with more protection from weight shaming and discrimination. In the second article, from a public health perspective, the analysis of hierarchies of priorities, perception of control, as well as barriers and facilitators show that weight management needs to be understood as the outcome of a social process in which living conditions, material and psychosocial, offer a number of conditions of possibilities. Globally speaking, middle-class conditions privileged the adherence to public health recommendations, while socially deprived conditions inclined women to adopt unsustainable and risk-oriented weight-loss practices.

Acknowledgements

I would like to take this space to thank a few important people and groups. First, and most obvious, thank you to my thesis supervisor Alex Dumas. Your determination to produce high-quality work always inspired me to do my absolute best. Thank you for being so calm during periods of extreme stress and, above all, for encouraging me to take care of myself during this rigorous process. I really cannot thank you enough for all that you have done to prepare me for the next steps in my professional life.

Thank you to my committee members, Christine Dallaire and Marjorie Silverman, for providing constructive feedback during the initial stages of this project. Your expertise in sociology and social work were complementary in bringing this thesis project to the next level. To the School of Human Kinetics, thank you for providing me with all the tools I could ever need to succeed, from undergraduate studies until now. I would also like to thank the SOMET research group for their academic support, as well as the Canadian Institutes of Health Research (CIHR) for their funding of this group.

Going through the interview transcripts reminded me of how lucky I am to have such a supportive social network. To my best friend Paige, who contributed countless hours of editing for this project, thank you. Your thorough feedback really helped make this project the best it could be. To all my friends, colleagues, and co-workers, thank you for encouraging me every step of the way and for sharing this journey with me. It could never have been as fun without you all. Last, but certainly not least, thank you to my mom and dad, for everything. There are no words that could describe how grateful I am for your unshakeable love and support over the past 24 years.

Table 1. Summary of the research process: research problem and objectives, literature review, theoretical framework and methodology

Research Problem
Public health interventions have targeted the health practices of clinically overweight and obese postmenopausal women in order to reduce the burden of chronic disease. Their effectiveness, however, is limited because of (1) socioeconomic inequalities, (2) narrow focus of body weight, and (3) existence of an obesity stigma.
Research Purpose
- To identify the norms and values of clinically overweight and obese postmenopausal women from contrasting socioeconomic backgrounds with regard to the ways they treat and care for their body - To outline the sociocultural processes which incline them (or not) to pursue weight-loss strategies.
Research Objectives
To understand: - The relative importance of weight-loss strategies within their wider hierarchy of priorities - Their experiences of being clinically overweight and obese during mid-life - Their embodiment of obesity stigma - To what extent they experience <i>symbolic violence</i> linked to their body weight
Literature Review
- Midlife, obesity & chronic disease - Social inequalities of women's health and well-being - The dominant discourse of obesity - Female beauty ideals, body dissatisfaction and weight control practices during midlife
Theoretical Framework
Pierre Bourdieu's sociocultural theory of practice: body <i>habitus</i>, capital, and <i>symbolic violence</i>
Methodology
- Recruitment: Clinically overweight or obese (BMI >25 kg/m²) postmenopausal (no menstruation >12 months) women living in the urban sector of Sherbrooke, QC from underprivileged and middle class groups - Analysis based on the secondary use of data (90-minute in-depth semi-structured interviews) - Analysis: Horizontal and vertical thematic analysis, as well as an intersectional analysis

Table of Contents

List of Tables and Figures	viii
Legend	ix
Abstract.....	ii
Acknowledgements.....	iv
Table 1. Summary of the research process: research problem and objectives, literature review, theoretical framework and methodology	v
Table of Contents	vi
Chapter I Introduction	1
Chapter II Literature Review	9
Midlife, Obesity and Chronic Disease	9
The Obesity Stigma	13
Female Beauty Ideals, Body Dissatisfaction and Weight Control Practices during Midlife	16
Conclusion.....	21
Chapter III Theoretical Framework	24
Bourdieu's sociocultural theory.....	24
Habitus and lifestyle.....	24
Relation to the body.	26
Capital.....	29
Symbolic Violence.	33
Conclusion.....	35
Table 2. Research Design	36
Chapter IV Methodology.....	37
Research Method.....	37
Research Sample.....	38
Description of participants.....	39
Table 3.....	40
Characteristics of participants divided by socioeconomic groups.....	40
Recruitment of participants.....	40
Data Collection	41
Data Analysis.....	43
Thematic analysis.....	44
Quality of the Analysis.....	45

CHAPTER V Class responses to obesity stigma. Inequality, womanhood, and midlife	48
Chapter VI Inequality and weight control in clinically overweight and obese postmenopausal women	83
Chapter VII Conclusion	117
References.....	124
Appendix A Interview Guide	150
Appendix B Ethics Approval.....	155

List of Tables and Figures

Thesis

Table 1. Summary of Research	v
Table 2. Research Design	36
Table 3. Characteristics of participants divided by socioeconomic groups	40

Article 1: Class responses to obesity stigma. Inequality, womanhood, and midlife

Table 1. Participant Characteristics – Sociodemographic	78
Table 2. Participant Characteristics – Health and Lifestyle	80
Table 3. Contexts of Occurrence and Responses to Obesity Stigma. Summary of Data Reported by Clinically Overweight and Obese Women from Two Contrasting Socioeconomic Milieus	81

Article 2: Inequality and weight control in clinically overweight and obese postmenopausal women

Table 1. Participant Characteristics – Sociodemographic	110
Table 2. Participant Characteristics – Health and Lifestyle	112
Table 3. Social Variation of Weight Management Practices Between Clinically Overweight and Obese Postmenopausal Women from Two Contrasting Socioeconomic Milieus	113

Legend

BMI – Body Mass Index

HALE – Health-Adjusted Life Expectancy

HPA – Hypothalamic-Pituitary-Adrenal

LDL – Low-Density Lipoprotein

SES – Socioeconomic Status

WHOQOL – World Health Organization Quality of Life Questionnaire

Chapter I

Introduction

The growing gap between life expectancy and disability-adjusted life expectancy is a testament to the current epidemiological transition taking place in most societies – that is, a context where chronic and degenerative disease are displacing “pandemics of infection as the primary causes of morbidity and mortality” (Omran, 1971, p.150). Both gender and socioeconomic status have proven to be relevant axes of social stratification in order to determine priorities and solutions to improving population health.

Internationally, the persistence of women’s chronic disease is a major public health concern in ageing societies (WHO, 2013). In Canada, although women’s life expectancy is almost five years greater than men’s, they are more likely to suffer from chronic illness and mental health conditions (Statistics Canada, 2013). They experience, on average, the last 12 years of their lives in ill health (Statistics Canada, 2012), with over two thirds of women over 65 suffering from two or more chronic illnesses and adult women suffering from depression at double the rate of men (Rochon et al., 2011). In this respect, although midlife has been identified as a crucial period in women’s lifespan (Hardy & Kuh, 2002), few studies in sociology have explicitly studied its relation with socioeconomic factors, biological changes and health. In order to improve the quality of life of women in later life, it is crucial to improve our understanding of the social and material factors involved in illness and disease prevention during midlife (Turcotte, 2011).

Midlife, or the life period between ages 40 and 60, has been identified as a period involving critical social, psychological and biological changes that are key factors in women’s health and well-being (Winterich, 2007; McLaren & Kuh, 2004; Lovejoy,

Champagne, de Jonge & Smith, 2008). From a biological perspective, public health experts and systematic reviews on women's health state that hormonal and social changes that occur during menopause make women more susceptible to weight gain and chronic illness (Lovejoy, 2009). The increase in visceral body fat during menopause increases their risk of suffering from obesity and multiple chronic diseases (i.e. diabetes, cardiovascular disease and some types of cancers, Abdunour et al., 2012; Lovejoy et al., 2008). Women's health risks of chronic diseases during midlife are influencing health care policy because they contribute to the growing burden on government health expenses (Bierman et al., 2009).

In conjunction with these increasing health risks, neoliberal policies are shaping health and health care reforms. Health agencies have directed their focus on the prevention and management of chronic disease, shifting the focus from state responsibility for health to self-management of health (Sanders & Rogers, 2011). This has resulted in an increased focus on the management of risk factors through lifestyles and public policy (Cancer Care Ontario & Ontario Agency for Health Protection and Promotion, 2012). Behavioural models encouraging self-care have been proposed as a plausible solution and have grown in popularity in this political context; however, they have limited long-term success (Sanders & Rogers, 2011; Hardeman et al., 2002; Adams & White, 2003).

The specific issues of weight and weight gain have received much attention amidst the alleged obesity epidemic in the context of women's health. Clinical studies show that women are most susceptible to weight gain during reproductive transitions such as menopause (Ho, Wu, Chan & Sham, 2010; Sammel et al., 2003; Sternfeld, Bhat, Wang,

Sharp & Quensenberry, 2005). Although biomedical and clinical research have stressed the negative impact of obesity on health (Flegal, Kit, Orphana & Graubard, 2013; Joshy et al., 2013; Wang, Mi, Shan, Wang & Ge, 2007), an increasing number of studies are calling into question such conclusions by reevaluating the impact of weight on health and by contextualizing female experiences of the body within this social context (Tunaley, Walsh & Nicholson, 1999; Ogle & Damhorst, 2005). In fact, recent studies suggest that the assumption that being overweight leads to premature death is not entirely accurate, and that rather, epidemiological data shows that a significant increase in mortality is present when BMI is over 35 (i.e. classes II and III obese; Flegal et al., 2013). In sociology, critical obesity research has problematized the construction of obesity as a major health risk by arguing two critical positions: first, it calls into question the unambiguous use of weight as a significant risk factor of health, and second, it holds health professionals partly responsible for constructing an obesity stigma that has negative consequences on obese people's overall well-being (Gard & Wright, 2005, Poulain, 2009). Although many public health interventions have targeted adult women's obesity as a risk factor of chronic disease, few have systematically studied women's experiences of obesity during midlife.

Due to the complexity of the determinants of health, singling out clinical obesity as a sole risk factor of disease proves to be problematic (Poulain, 2009). In this respect, Poulain (2009) argues that although scientific research on obesity has helped clarify our physiological, biological and genetic understandings of obesity, sociological research can help uncover the social mechanisms that shape clinically obese people's experiences and ultimately their quality of life. For instance, it is argued that the obesity stigma has

physical, psychological and economic impacts for obese people (Ickes, 2011). Because of the social and moral dimension of obesity, health professionals targeting body weight need to consider the unexpected consequences of their interventions (Pearl, White & Grilo, 2014; Puhl, Moss-Racusin & Schwartz, 2007). Yet, even as weight gain is common with female ageing and restrictive body norms promoting thinness remain dominant, few studies have looked at middle-aged women's experiences of obesity and obesity stigma. Without denying that clinical obesity is an important factor of metabolic health and chronic illness, more studies are needed to better understand the various personal and social experiences of body weight and weight gain during midlife and to better understand women's lifestyles within the frame of public health.

While lifestyle interventions targeting obese women have had some success in reduced caloric intake and increased physical activity (Foster-Schubert et al., 2012; Jull et al., 2014; Simkin-Silverman et al., 2003), their long-term effectiveness is unclear (Curoni & Lourenço, 2005; Franz et al., 2007; Sumithran et al., 2011). Many theories have emerged to help explain the difficulty in maintaining a healthy body weight. For instance, endocrinologists have found that some of the hormones that regulate appetite, such as leptin, decrease significantly after weight loss in otherwise healthy obese patients (Sumithran et al., 2011). Psychological research has also attempted to shed light on the factors that lead to regaining weight in obese patients and have found that emotional eating (or eating to regulate mood) is a key psychological determinant (Byrne, Cooper & Fairburn, 2003). Although these theories explain the individual factors that lead to regaining weight after weight loss in obese people, they fail to identify specific groups that may be most at risk to regain weight and suffer from health problems. Sociological

research on women's health has shown that social position generates distinctive lifestyle practices (Power & Powell, 2002; Abel, 2008). Maintaining low calorie diets and adopting regular physical activity may be more difficult for some socioeconomic groups of women than others.

Although health and autonomy are prioritized as women enter midlife, the pressure to meet ideal beauty norms continues to be present. For instance, studies have shown that conforming to these norms improves social desirability, greater employment opportunities (Hurd Clarke & Griffin, 2008) and increased male attention (Carpenter, Nathanson & Kim, 2005; Dillaway, 2005). Weight gain during midlife signifies a distancing from the feminine ideal, and for the middle-class women who have benefited from this ideal, midlife can create a sense of loss of social worth (Hurd Clarke, 2000; Winterich, 2007). In this context, it is unsurprising that while most women feel social pressure to conform to such beauty norms, middle-aged women from higher socioeconomic status groups are more likely to be dissatisfied with their bodies (McLaren & Gauvin, 2002) and are more likely to take on restrictive weight control practices (Wardle & Griffith, 2001) than lower socioeconomic status groups. Although men are also subjected to body ideals as they age, middle-aged women face greater social consequences for their nonconformity to feminine beauty ideals (such as lack of employment and relationship opportunities) and thus embody the contemporary expression of the double standard between men and women in ageing (Carpenter, Nathanson & Young, 2006).

The complexity of middle-aged women's transitioning bodies and the interplay between biological, organizational, psychological, and social factors have been the

subject of much debate in public health (Forman, Mangini, Thelus-Jean & Hayward, 2013). Social factors such as socioeconomic status are related to women's health status at midlife; however, many of the pathways by which these factors have an effect on health are unclear. Socioeconomic status greatly impacts people's health and mortality (Canadian Institute of Health Information, 2008; Marmot & Wilkinson, 2001). It is a determining factor of the social gradient in health; the lower a person's socioeconomic status, the worse their health (WHO, 2003). While many economically developed countries offer universal health care, social inequalities in health appear to be widening, mainly as a result of higher increase in health of individuals of high socioeconomic strata and the growing gap between the rich and the poor (Mackenbach, 2012; Gustafsson & Hammarström, 2012; Krieger, Chen & Selby, 2001).

Two fundamental points must be identified for this study on obesity. First, a recent study (Burkert, Rásky, Großschadl, Muckenhuber and Freidl, 2013) has shown that socioeconomic inequalities in health are greater amongst clinically overweight and obese groups. The greater impact of socioeconomic variables for this group is explained by the increased risk factors and co-morbidities linked to low socioeconomic individuals. Second, although obesity is present in all positions within the social hierarchy, its prevalence amongst females follows a social gradient (Clarke, O'Malley, Schulenburg & Johnson, 2010); women of lower socioeconomic classes are more likely to be clinically obese and more likely to suffer from the consequences of excess weight (McLaren & Godley, 2009). Without denying individual agency in the context of weight control, it is important to shed light on the interaction between social structure and class tastes and lifestyles. Understanding the converging and diverging experiences of clinically

overweight and obese middle-aged women from contrasting social classes can help public health agencies frame interventions to improve health and quality of life for these groups of women.

Study Purpose

The purpose of this study was to identify the norms and values of clinically overweight and obese postmenopausal women from contrasting socioeconomic backgrounds with regard to the ways they treat and care for their body and to outline the sociocultural processes that incline them (or not) to pursue weight-loss strategies. More specifically, this study aimed to understand (1) the relative importance of weight-loss strategies within their wider hierarchy of priorities, (2) their experiences of being clinically overweight and obese during mid-life, (3) their embodiment of obesity stigma, and (4) to what extent they experience *symbolic violence* linked to their body weight.

Contributions

This study contributes to existing knowledge of women's experiences of being clinically overweight and obese during midlife. By drawing on women's personal biographies, the conclusions provide detailed contextual information of lifestyles for health professionals working with women in the period of midlife in order to better shape policies and interventions to improve the health and well-being of these women.

Overview

In Chapter II, I review literature on (a) midlife, obesity & chronic disease, (b) social inequalities of women's health and well-being, (c) the obesity stigma, and (d) female beauty ideals, body dissatisfaction and weight control practices during midlife. I then identify current gaps in the literature and how this study may help clarify existing misunderstandings. In Chapter III (Theoretical Framework), I outline Bourdieu's sociocultural theory of practice, specifically the concepts of *habitus*, capital and *symbolic violence*. The following chapter (Chapter IV: Methodology) reviews the data collection and analysis methods used within this study. Chapters V (Article 1) and VI (Article 2) present major trends within and between the two socioeconomic groups of participants with regard to their responses to obesity stigma and weight control practices. Lastly, Chapter VI (Conclusion) concludes and reflects on the application of such findings.

Chapter II

Literature Review

This review of literature outlines existing research on the social factors that influence the health and well-being of clinically overweight and obese postmenopausal women. The sections that follow are: (a) midlife, obesity and chronic disease, (b) social inequalities of women's health and well-being, (c) the obesity stigma, and (d) female body ideals, body dissatisfaction and weight control practices during midlife.

Midlife, Obesity and Chronic Disease

In its 2010 report on Health Care in Canada, the Canadian Institute for Health Information indicated that population ageing and increased chronic disease prevalence are currently two of the most significant drivers for health care costs. On average, Canada spends roughly \$1,700 in health care costs per person between ages 1 and 64, versus \$9,500 per Canadian over the age of 65 (Canadian Institute for Health Information, 2008). This amount can be increased tenfold for those with several co-morbidities, such as diabetes or heart disease (Canadian Institute for Health Information, 2008). With the Canadian population over 65 expected to climb to 24.5% by 2036, there is need for concern for the sustainability of its current universal health care system (Canadian Institute for Health Information, 2008).

Midlife is a period of complex change in women's lives that contribute to changes in quality of life and mental health (Hess et al., 2012; Jafarya, Farahbakhshb, Shafiabadib & Delavar, 2011; Mishra & Kuh, 2006). Psychosocial changes such as retirement, bereavement and children leaving the home lead to greater social isolation and changes in

eating and activity patterns (Elavsky, 2009; Nicolaisen & Thorsen, 2014). The hormonal and psychosocial changes during midlife are a key risk factor in women's mental illness (Freeman, 2010; Stroebe, Schut & Stroebe, 2007) and chronic disease (heart disease, cancer and pulmonary disorders, Committee on Women's Health Research, 2010; Guthrie, Dennerstein, Taffe, Lehert & Burger, 2004; Matthews et al., 2009). After menopause, women lose the protective effect of estrogen, which leads to a redistribution of fat mass to the abdominal region and entrains a poor metabolic profile and increased metabolic waste (Cignarella, Kratz & Bolego, 2010; Peppia et al., 2013).

Along with the changes that accompany menopause, women tend to gain weight during this transition. Women are more likely to become obese during midlife than earlier in their adult life, with 50% of women of menopausal age considered clinically overweight or obese in Canada (Statistics Canada, 2012; Jull et al., 2014). A number of studies have examined women's weight gain during the menopausal transition and its effect on cardiometabolic risk (Lovejoy et al., 2008; Abdunour et al., 2012).

Studies have shown that women of all weight categories tend to gain a significant amount of visceral fat mass during menopause; however, it is unclear to what extent this increase is due to hormonal or behavioural change, or a combination of both (Abdunour et al., 2012; Lovejoy, 2009). As obesity during midlife is a risk factor for cardiovascular disease, hypertension, type II diabetes, osteoarthritis and overall mortality, more research is needed to clarify the underlying sources of weight gain during menopause (Dennis, 2007; Whitlock et al., 2009)

Public health interventions have attempted to reduce the burden of chronic disease by encouraging obese individuals to self-manage their health by adopting healthy

practices (healthy eating and regular exercise) (Sanders & Rogers, 2011). Systematic reviews on women's weight control during the menopausal transition have found that regular aerobic and resistance training combined with a weight-reducing diet improved menopausal women's body fat percentage and bone density (Asikainen, Kukkonen-Harjula & Miilunpalo, 2004; Schmitz et al., 2007; Simkin-Silverman, Wing, Boraz & Kuller, 2003). Aside from physical health benefits, participating in physical activity has been shown to help older women feel greater physical control over their body and to reduce complications related to chronic disease (Sims-Gould, Hurd Clarke, Ashe, Naslund & Lui-Ambrose, 2010). However, recent research has shown that midlife presents a variety of barriers to the adoption and adherence to a regular exercise regimen (McArthur, Dumas, Woodend, Beach & Stacey, 2014). By adopting and maintaining healthy lifestyles during midlife, women can reduce their risk of many chronic conditions and improve their quality of life in later years.

Social Inequalities of Women's Health and Well-being

Social epidemiology has indicated that health and well-being are unevenly distributed among the population. In general, the lower a person's socioeconomic status, or the greater their social and material deprivation, the less physically and mentally healthy they are (Bierman et al., 2009; Krieger et al., 2001; Pampalon, Hamel, Gamache & Raymond, 2009; World Health Organization, 2003). It has become increasingly clear that increased health care spending has done little to reduce the social inequalities in health (Mackenbach, 2012). There are many theories that explain the process by which poverty produces significant differences in health. However, current trends suggest these differences are the result of a complex combination of individual health practices,

possession of resources, and the long-term stress of relative material and social deprivation (Charlesworth, Gilfillian & Wilkinson, 2004; Mackenbach, 2012; Phelan, Link, Diez-Roux, Kawachi & Levin, 2010). In their recent study, Burkert et al. (2013, p.5) allude to the fact that health disparities are larger amongst obese groups:

[T]he impact of the social background on health is higher for obese subjects than for normal weight and overweight subjects. In obese persons the social background has the greatest influence on the amount of physical exercise, impairment due to disorders, and the number of chronic conditions. [...] Additionally we were able to show that the SES has a greater impact on the overall quality of life of obese persons.... subjects with a low SES demonstrate worse health behaviours. They smoke more cigarettes per day and are less physically active.

These conclusions support the hypothesis that body weight issues are not solely responsible for ill health in later life, but rather through their interaction with socioeconomic factors such as lifestyle and psychosocial distress (Van Zutven, Mond, Latner and Rodgers, 2014).

Although women live longer than men, their health-adjusted life expectancy (HALE), or years of life free from illness, is on average 12 years less than their overall life expectancy (Statistics Canada, 2012). In Canada, this discrepancy is most pronounced in women from low socioeconomic status groups, with a ten-year difference between the health-adjusted life expectancy of women in the lowest and the highest income deciles (Statistics Canada, 2009). In fact, over one quarter of adult women from the lowest income quintile require assistance with activities of daily living versus just over 1 in 10

women from the highest income quintile (Bierman et al., 2009). This discrepancy in disability has been attributed to the higher rates of obesity and chronic disease in low socioeconomic groups (Ball & Crawford, 2005; Christensen & Carpiano, 2014; Everson, Maty, Lynch & Kaplan, 2002).

Public health initiatives focus on a self-care model which emphasizes physical activity and a healthy diet, but often overlook the sociocultural factors influencing healthy lifestyles and health outcomes (Cardona, 2008). Although public health agencies have focused on improving health beliefs, these types of interventions do not sufficiently take into account social and material circumstances that may constrain health practices (Cockerham, 2013). For Williams (1995), in spite of the fact that changes in health behaviour are promoted as a way to improve overall health, it has been suggested that these changes are more likely to improve the health of the socially advantaged than that of underprivileged social groups.

The Obesity Stigma

Rising obesity rates in both adults and children have raised concern over the health of the population. The term ‘obesity epidemic’ has reinforced a dominant obesity discourse, a condition resulting from sedentary lifestyles and high-calorie food consumption (Poulain, 2009). The obesity stigma, or the negative depiction of overweight and obese individuals, has been amplified amidst the alleged ‘obesity epidemic,’ and includes the belief that obese persons are personally responsible for their condition and that weight discrimination may encourage obese people to lose weight (Vartanian & Smyth, 2013). This type of stigma is evident in the weight loss interventions targeted at obese people that use messages that place blame on the individual (or in the case of

children, their parents) for failing to adopt a healthy lifestyle. Because the obesity stigma is “one of the last socially acceptable forms of discrimination” (Vartanian & Smyth, 2013, p.49), its impact is far-reaching in the lives of obese people.

Obesity stigma has negative consequences on health and life experiences (Brewis, 2014; Gard & Wright, 2005; Ickes, 2011; Poulain, 2009). Related psychological stress has created significant problems in terms of physical health and general well-being for obese persons’ (Muenning, 2008). In fact, a recent Austrian study has found that weight/shape concerns are as strong a mediator as health status in the association between obesity and psychosocial impairment for both men and women (van Zutven, Mond, Latner & Rodgers, 2015). Psychosocial distress, or the lack of subjective well-being and perceived social support can lead to body dissatisfaction and disordered eating. These findings support the implementation of a body acceptance framework, as weight/shape concerns reinforced by obesity stigma can have detrimental effects on overweight and obese people’s health and well-being.

Although biological, psychological, epidemiological and sociological research have underlined that many factors that contribute to obesity are environmental, these assumptions about obese people as personally responsible for their condition remain the norm (Puhl & Heuer, 2010). The passive acceptance of obesity stigma legitimizes the discriminatory treatment against obese people, which has been observed in educational, occupational and personal settings (Perks, 2012; Poulain, 2009; Puhl & Brownell, 2001). Health professionals that treat and care for obese individuals are at the heart of this cycle as they have the ability to support or refute the dominant discourse of obesity that portrays the obese individual as deviant and in need of care (Poulain, 2009).

Although alternative obesity discourses do exist, such as the ‘health at every size’ approach presented by fat activists (Farrell, 2011; Puhl & Heuer, 2010; Tylka et al., 2014), the dominant understanding of obesity continues to be one framed by the medical community (Kwan, 2009). The dominant discourse of obesity presents obesity as preventable and curable through diet and exercise, and is reproduced through both the health system and media focus on weight and weight loss (Puhl & Heuer, 2010). Interventions and policies that focus on behaviour change, such as those targeted to people with excess weight, tend to draw attention away from the conditions of existence that lead to poor health and shift it towards the individual’s responsibility for their own health (Puhl & Heuer, 2010). For instance, behaviour change interventions create the assumption that obese individuals choose to participate in unhealthy lifestyles, which leads to their excess weight. These types of interventions can be counterproductive because they place the blame on obese persons and reinforce the stigma against them (Vartanian & Smythe, 2013). This perception of weight and lifestyle, which is ever present in services for obese people, has led fat activists to create new ways of perceiving fat bodies by creating new services for obese people (Ellison, 2013).

Studies on the consequences of obesity stigma are suggesting that victim blaming, and specifically weight shaming, have both direct and indirect effects on obesity status (Harding et al., 2014; Major, Hunger, Bunyan & Miller, 2014; Pearl et al., 2014). A study of adults with a BMI between clinical classes “overweight” and “type I obesity” (BMI between 25 and 30 kg/m²) shows that those who felt discriminated because of their weight were 2.5 times more likely to become obese within four years than participants who did not report weight discrimination (Sutin, Stephan, Luchetti & Terracciano, 2014;

Sutin & Terracciano, 2013). By analyzing biological, psychological and sociological research on the effects of obesity stigma, Brewis (2014) has identified four mechanisms in which obesity stigma leads to weight gain:

- (1) Direct behavioural change: emotional eating and decreased motivation to be physically active is triggered by stress.
- (2) Indirect effects of psychosocial stress: psychosocial stress chronically activates the hypothalamic-pituitary-adrenal and leads to visceral fat accumulation.
- (3) Indirect effects via changes in social relationships: the type of social relationships obese individuals have reinforces poor dietary and activity practices that entrain weight gain (obese people tend to have more obese people in their network than non-obese)
- (4) Indirect structural effects of discrimination: a worsened socioeconomic condition (fewer employment opportunities and lower income) as a result of discrimination creates additional constraints to physical activity participation and healthy dietary choices.

These findings indicate that the effects of obesity stigma extend beyond mental health and can lead to weight gain, while also increasing the risk of poor health and quality of life (Brewis, 2014; Sutin & Terracciano, 2013). As women are more likely than men to feel discriminated against based on their body weight, they are most at risk for the repercussions of obesity stigma (Brewis, 2014).

Female Beauty Ideals, Body Dissatisfaction and Weight Control Practices during Midlife

In societies of the West, and increasingly in countries around the world, women are faced with unrealistic ideals of beauty. The female beauty ideal, although fluid in time

and space, currently portrays the ideal woman as thin, white and heterosexual (Bordo, 1990; Vinette, 2001). Also, women who adhere to such norms are depicted as attractive, fit and healthy (Walcott, Pratt & Patel, 2003). The construction and maintenance of the female ideal is partly related to the social influence of cultural producers of body knowledge, or ‘body experts’ – often people in positions of power in the medical, religious, media and educational fields (Shilling, 2003). These groups continue to define the legitimate female body type in order to reflect their body norms. Although the current ideal of female beauty is unattainable for most women, various cultural producers participate in socially constructing the body as malleable and transformable, implying that individuals who adopt legitimate lifestyle practices will shape an ideal body (Walcott et al., 2003). As Shilling (2003) argues, this “affects the recognition we have of our own body practices, and the body practices of others, as right and proper or in need of control and correction” (p.126). Women who do not measure up to the narrow standard of beauty, or do not reflect the product of legitimate practices, are depicted as unwilling (or unable) to invest in their appearance and require intervention (Clarke & Griffin, 2007).

Overweight and obese women face a double burden with regards to their excess weight; a woman’s excess weight is not only considered visually unappealing (according to Western feminine beauty ideals), it also assumes a state of poor health and a lack of self-care (Hurd Clarke & Korotchenko, 2009). While many women use weight loss as a way to live a healthier life and exercise agency, Robinson and Carrier (2004) problematize this notion, arguing that “the social emphasis on women regarding thinness, the emphasis on control over the body, and even the subtle messages that higher moral standing is obtained through starving and denial of pleasurable eating” are an extension

of patriarchal control over women's bodies (p.228). Indeed women's attempts to reach the feminine ideal are reinforced through appearance-focused industry practices, such as photo altering in the media and the health industry's focus on weight loss (Twigg, 2004). This information points to the fact that women are judged in comparison to an unrealistic standard of beauty constructed and maintained by our social institutions. As such, because women gain much social value based on their appearance, many women (such as obese and older women) are perceived as inherently flawed (Hurd Clarke & Korotchenko, 2009; Robinson & Carrier, 2004; Twigg, 2004). Some scholars have suggested a 'health at every size' approach (meaning that women can be physically and mentally healthy at any size) to public health as it minimizes the focus on body weight and takes into account the social factors that influence our health such as socioeconomic status, race and gender (Olmsted & McFarlane, 2004).

The medicalization of women's bodies has led to the belief that women's fertility is evidence of youth and functionality, and in this sense, menopause can create a fear of the loss of independence in middle-aged women (Cardona, 2008; Rubinstein & Foster, 2013; Vinette, 2001; Winterich, 2007). Although women inevitably face physical transformation as they age, research has shown that older women subscribe to a similar female beauty ideal of youth and slimness through bodywork practices (Hurd Clarke & Griffin, 2007; Tunaley, Walsh & Nicholson, 1998). Some research that suggests that although ageing women (aged 40-87) are aware of the current beauty ideal, they are less likely to perceive themselves negatively in relation to it than younger women (Grippio & Hill, 2007; Tiggerman & McCourt, 2013). In a study conducted by Hurd Clarke and Griffin (2007; 2008) on older women's beauty work practices, most women indicated that

they used appearance-altering practices as a form of liberation from ageist beauty norms. Although these women actively engaged in appearance interventions to improve their social value, these appearance-altering practices serve to reinforce ageist social values against themselves and those who do not attempt to change their appearance (Hurd Clarke & Griffin, 2007). In regards to age, while some researchers have argued that middle-aged women are less dissatisfied with their bodies (Allaz, Bernstein, Rouget, Archinard & Morabia, 1998), others have shown that women at their midlife are more likely to take on weight control practices to control their bodies for both appearance and health reasons (Ogle & Damhorst, 2005; Hurd Clarke, 2000; Hurd Clarke, 2002).

A result of the restrictive feminine beauty norms is body dissatisfaction. Body dissatisfaction is defined as the negative evaluation of the discrepancy between a person's perceived appearance and an ideal (McLaren & Gauvin, 2002). As the body is central in society, the practices a person takes part in and the way it shapes their body is a reflection of their position in social space (Shilling, 2003). Consequences of body dissatisfaction include depression, reduced quality of life, and avoidance of social situations which together lead to greater social isolation (McLaren & Kuh, 2004). Most research on body dissatisfaction contends that the gender divergence begins during adolescence when girls are expected to take on traditional gender roles (McCarthy, 1990) and that women are more dissatisfied with their bodies than men (Bearman, Martinez, Stice & Presnell, 2006; Olmsted & McFarlane, 2004). Other than gender, the relationship between body dissatisfaction and other social factors, such as BMI and age, is unclear. However, some studies, such as McLaren & Gauvin's (2002) study, found that body dissatisfaction is

correlated with BMI for women from affluent neighborhoods, while Hurd Clarke (2001) found that body dissatisfaction is present even for women advanced in age.

Body dissatisfaction as the result of an unachievable ideal of beauty is at the root of many weight-control practices and eating disorders. There appears, however, to be significant differences between the weight control practices of women of high and low socioeconomic status. Women of higher socioeconomic status are more likely to notice weight gain and also more likely to try to control their weight through restrictive (i.e. low calorie) and culinary (i.e. consumption of only “good” food) practices (Lhuissier, 2012; Wardle & Griffith, 2001; Jeffery & French, 1996). Lhuissier (2012) argues that high-socioeconomic-status women’s disposition for controlling their weight is a result of the social value attributed to slimness in prosperous social groups. Consequentially, women took on weight control practices to both distinguish themselves from women of the other classes and to advance their professional careers (Lhuissier, 2012). Women of the working classes are less likely to take on weight control practices and are more likely to adopt dangerous methods of weight control (e.g. laxatives, fasting and smoking) (Williams, Germov & Young, 2011; Jeffery & French, 1996). Thus, the difference in weight control practices between women of high and low socioeconomic status suggests a difference in their class *habitus* (reflective vs. instrumental relations to the body) (Bourdieu, 1984). As a heterogeneous group, women from different social positions have different predispositions to ascribe to the feminine ideal, and distinct ways of achieving that ideal.

Conclusion

Studies have explored the relationship between socioeconomic status and obesity (Ball & Crawford, 2005; Krieger, Chen & Selby, 2001), as well as between socioeconomic status and weight control (Wardle & Griffith, 2001; Williams, Gormov & Young, 2011). However, few have explicitly aimed to understand the social variation of women's weight control practices between contrasting socioeconomic classes, and the sociocultural process that predispose them to adopt weight control practices.

Midlife is a complex period in a woman's life, as hormonal and psychosocial changes are documented risk factors for mental illness (Freeman, 2010; Stroebe, Schut & Stroebe, 2007), chronic disease (Committee on Women's Health Research, 2010; Guthrie, Dennerstein, Taffe, Lehert & Burger, 2004; Matthews et al., 2009) and obesity (Abdulnour et al., 2012; Jull et al., 2014; Lovejoy, 2009; Statistics Canada, 2012). As socioeconomic status impacts health through many pathways (lifestyles, stress; Bierman et al., 2009; Krieger et al., 2001; Pampalon, Hamel, Gamache & Raymond, 2009; World Health Organization, 2003), it is clear that women from the lower socioeconomic classes are more likely to suffer from these conditions, especially for those who are overweight or obese (Burkert et al., 2013). Although the health concerns related to obesity are various, the obesity stigma may be equally as problematic (Gard & Wright, 2005; Poulain, 2009; Ickes, 2011). Obesity stigma has been linked to experiences of discrimination in education, occupational, personal, and health settings (Perks, 2012; Poulain, 2009; Puhl & Brownell, 2001; Puhl & Heuer, 2010). Further, experiences of weight shaming have been tied to increased weight gain in overweight adults, leading to

potential complications in health and well-being (Sutin, Stephan, Luchetti & Terracciano, 2014; Sutin & Terracciano, 2013).

Women are confronted by ideals characterized by slimness and youth, and so it is not surprising that women who reach menopause feel a loss of social value (Cardona, 2008; Rubinstein & Foster, 2013; Vinette, 2001; Winterich, 2007). Some research, however, contends that although older women are aware of current beauty ideals, they do not perceive their discrepancy from it negatively (Grippo & Hill, 2007; Tiggerman & McCourt, 2013). Still, body dissatisfaction is more common in women than men (Bearman, Martinez, Stice & Presnell, 2006; Olmsted & McFarlane, 2004) and some data suggest that there is a correlation between BMI and body dissatisfaction in middle-aged women (McLaren & Gauvin, 2002). Socioeconomic status also appears to be a significant social factor in women's disposition to control their weight, and the manner in which they attempt to control their weight (Lhuissier, 2012; Jeffery & French, 1996; Wardle & Griffith, 2001; Williams, Germov & Young, 2011). These findings call for greater sensitivity in health interventions in order to accommodate the contrasting socioeconomic practices and life experiences related to weight and improve the health and well-being of all overweight and obese women (Christensen & Carpiano, 2014).

Considering all the information on poor health and well-being of disadvantaged women, it is crucial that further studies consider the social variation in weight control practices and obesity stigma to understand their effect on health and health inequalities. In this context, the study of social variation of lifestyles is important because it helps us to understand how people from different positions within the social hierarchy treat their bodies and provides insight on the social factors that influence their predisposition to take

on preventative measures. With regard to weight control, the study of social variation allows us to assess the importance middle-aged obese women from different social classes attribute to achieving and maintaining an “ideal weight” within a wider hierarchy of priorities, and how the variation in weight control practices may contribute to the social gradient of health. While many obese women are confronted with an obesity stigma, women of low socioeconomic status are more likely to face stigma in other areas of their life (e.g. mental illness) and may thus be more susceptible to the negative effects of obesity stigma – such as isolation and a fatalistic attitude towards the possibility of successfully up taking preventative health practices. In this respect, the study of obesity stigma could partially explain the social variation in weight control and resulting health inequalities (such as cardiovascular disease) among overweight and obese middle-aged women.

This study focuses on the norms and values of clinically overweight and obese postmenopausal women from contrasting socioeconomic backgrounds with regard to the ways they treat and care for their body and to outline the sociocultural processes that incline them (or not) to pursue weight-loss strategies. More precisely, this study aimed to understand (1) the relative importance of weight-loss strategies within their wider hierarchy of priorities, (2) the experiences of being 'overweight' during mid-life, (3) their embodiment of obesity stigma, and (4) to what extent they experience *symbolic violence* linked to their body weight.

Chapter III

Theoretical Framework

Bourdieu's sociocultural theory

Sociological studies on women's weight control typically investigate weight control and body dissatisfaction through the lens of power relations built in social structure (Boltanski, 1971; Bolam, Murphy & Gleeson, 2004; Frie & Janssen, 2009). In this respect, Pierre Bourdieu's sociocultural theory of practice focuses on class-based differences in lifestyle practices and sheds light on the embodiment of class schemas and its effect on health (Bourdieu, 1984). Few scholars have performed a social class analysis of middle-aged women's body weight and its relation to weight control practices (Lhuissier, 2012; Williams, Germov & Young, 2011) and responses to stigma. I believe that Pierre Bourdieu's sociocultural theory of practice, and his concepts of *habitus*, capital and *symbolic violence* are useful tools to understand the impact of social position on clinically overweight and obese postmenopausal women's practices related to body weight.

Habitus and lifestyle

Pierre Bourdieu's sociocultural theory focuses on the embodiment of a person's social and material conditions of existence (Dumas, Laberge & Stratka, 2005, p.887). The body is central in Bourdieu's work, as it shapes and is shaped by conditions of existence and is thus the "most indisputable materialization of class taste" (Bourdieu, 1984, p.190). To understand class culture and class distinction with respect to lifestyles, Bourdieu (1984) developed the concept of the *habitus*.

The internalization of the division, or the embodiment of dispositions, refers to the way social structure becomes “deposited” in a person and shapes their perceptions and tastes, and in doing so predisposes them to take on some practices over others (Wacquant, 2005). This explains how people who have similar social and material conditions of existence tend to adopt similar lifestyles, and in turn legitimize their position within the social space (Cockerham, 2010). In *Distinction* (1984), Bourdieu argued that the *habitus* is:

“[...] not only a structuring structure, which organizes practices and the perception of practices, but also a structured structure: the principle of division into logical classes which organizes the perception of the social world is itself the product of internalization of the division into social classes” (p.170)

Habitus is considered preconscious, or pre-reflexive, because it is reflected through practices without conscious intent (Power, 2008; Williams, 1995). The pre-reflexive nature of the *habitus* makes it clear that internalized social conditions from early socialization are difficult to disembody. This may explain how, from a life course perspective, a person’s social conditions during childhood often determine their relative position within the social hierarchy during adulthood. As a person’s *habitus* is seemingly natural, and is shaped primarily by the social and material conditions of early life, it becomes ‘natural’ for people to take on different practices (Williams, 1995; Dumas and Laberge, 2005).

The *habitus* is constituted of schemes of appreciation, dispositions and perceptions. Taken together they shape tastes and lifestyles of distinctive social classes (Bourdieu, 1984). In *Distinction* (1984), Bourdieu explores the differences in tastes

between the elite and working-class groups in French society. What emerged is a social map of tastes, or the ‘space of lifestyles,’ whereby Bourdieu illustrates how taste classifies individuals by the distinctions they make between the valuable and the worthless (Laberge & Kay, 2002; Schubert, 2012). These tastes define a class’s propensity to participate in certain practices (and lifestyles), which can physically shape the body and situate the actor in social space. Bourdieu illustrates this difference by comparing the food consumption patterns of contrasting social classes in France during the 1960s. The results showed that people from the working classes preferred heavy, inexpensive foods, while the middle classes chose exotic, light foods. For working-class people, preferences were constrained by the ability to practice based on amounts and types of capital available to them, and thus make a virtue out of what they are already condemned to (Cockerham, 2013; Williams, 1995). While the analysis of 1960s class lifestyles in France does not necessarily apply to present-day lifestyles, it demonstrates that people from different classes will have different class *habitus* in a society structured by class.

Relation to the body.

By drawing on the concept of the body *habitus*, Bourdieu found that the working class and the professional class held two contrasting relationships with their body – namely instrumental and reflexive relations to the body. He explains that:

the social conditioning linked to a social condition tend to inscribe the relation to the social world in a lasting, generalized relation to one’s own body, a way of

bearing one's body, presenting it to others, moving it, making space for it, which gives the body its social physiognomy (Bourdieu, 1984, p.474)

Social position fashions a relation to the body. Boltanski's (1971) study on the social uses of the body (*Les usages sociaux du corps*, French culture in the 1960s) indicates that the way one treats and cares for their body is dependent on the values of the social class in which one is located, as well as the resources available to participate in legitimate practices. The working class has an instrumental relation to the body, while the upper class views the body as an end in itself (Bourdieu, 1978). Bourdieu explains that as the working class is overrepresented in labour-intensive forms of work they are more likely to value forms of practice that value strength and stamina (Williams, 1995). On the other hand, the professional class constructs the body as a project in which bodily appearance and self-care are most valued. These values translate to the preference and appreciation for different lifestyle practices that physically shape the body. These contrasting relations to the body are reflected in lifestyle choices (such as food consumption and physical activity) and reflect the values of particular social groups (Laberge & Kay, 2002). The relation to the body, which is shaped by social and material conditions of existence, fashions a distinct set of lifestyles, which in turn physically shape the appearance of the body and reflect a person's position within the social space.

An example of women's relation to their body can be found in *Distinction* (1984), where results from Bourdieu's study of 1960s French society showed that women from the professional classes are both more likely than working-class women to be dissatisfied with their bodies even though they spend more time on beauty practices. As the greatest human need is to feel recognized (p.166), Bourdieu (2000) argues that all beings seek

approval from others in their social position by developing a set of dispositions that reflect the values of their social group. As socioeconomically advantaged women come to understand their body as an end in itself, they are predisposed to embody the value of a slim, toned body through health-focused lifestyles. Although most women acknowledge the same ideal of beauty, socioeconomically advantaged women who do not conform to this body ideal feel shame, as they no longer distinguish their body from the bodies of the vulgar class (Williams, 1995; Boltanski, 1971).

Bourdieu's concept of 'relation to the body' (1984) is a useful tool for studying women's weight control practices. As socioeconomically advantaged women perceive their body as an end in itself, they value health-promoting lifestyles that fashion a slim, toned body. While most Bourdieusian studies on class *habitus* are based in Europe, Canadian studies suggest that class structures women's body *habitus* in Canada as well. Laberge and Sankoff's (1997) study of women's lifestyles and physical activities in Montreal found that women from contrasting social positions fashioned different relationships to their body (or body *habitus*), which mediated women's preventative health practices and degree of discipline towards healthy lifestyles. These findings reflect trends found in other, larger studies; women from the upper classes are on average thinner than women from the lower-middle classes (Krieger, Chen & Selby, 2001; Lhuissier, 2012), are more likely to be dissatisfied with their bodies (McLaren & Kuh, 2004) and take on weight control practices for any BMI (Jeffrey & French, 1998; Wardle & Griffith, 2001). In a recent Australian study, Williams, Germov and Young (2011) found that working-class women are more likely to gain weight during midlife than upper or middle-class women, and use potentially dangerous weight control practices (such as

smoking and fasting) to achieve weight loss. Lhuissier (2012) also found a variation in weight control practices among contrasting social groups. Among the French women interviewed, working-class participants saw their obesity as a problem that could only be cured using a remedy (in this case, surgery), while middle-class participants used restrictive dietary practices to control their bodies. These trends reflect Lee and MacDonald's (2009) conclusion that as women from contrasting social groups have different relations to their body, a "one size fits all" approach to health interventions is undesirable. Instead, public health agencies should tailor their interventions to correspond to women's relation to their body, that is to say whether they conceive the body as a means to an end or an end in itself.

Capital.

According to Bourdieu (1984), capital refers to "actually usable resources and powers [...], which distinguish the major classes of conditions of existence" (p.114). Capital is unevenly distributed among the population, and social agents are constantly in competition to maintain or improve their capital (Moore, 2012; Williams, 1995). The different forms of capital can be converted (to a limited degree) to other forms of capital (Bourdieu, 1986). For example, cultural capital in the form of legitimate knowledge on health-generating practices can be converted to physical capital in the form of a healthy (looking) body and social capital, through the possible connections with health professionals.

Bourdieu developed chiefly three distinct forms of capital: economic, social and cultural (Laberge & Kay, 2002). Economic capital very simply refers to any resource that

is “immediately and directly convertible into money and may be institutionalized in the forms of property rights” (Bourdieu, 1986, p.242). This includes money, investments and property. In modern capitalist societies, economic capital strongly influences and is influenced by other types of capital. Bourdieu stresses that economic capital is unstable, as it can be easily lost or gained throughout the life course (Moore, 2012).

Cultural capital refers to knowledge or practices that are of cultural value in a respective field (Carlisle et al., 2008). Bourdieu (1986) explains that:

“Cultural capital can exist in three forms: in the embodied state, i.e., in the form of long-lasting dispositions of the mind and body; in the objectified state, in the form of cultural goods (pictures, books, dictionaries, instruments, machines, etc.), which are the trace or realization of theories or critiques of these theories, problematics, etc.; and in the institutionalized state [i.e. educational qualifications], a form of objectification which must be set apart because [...] it confers entirely original properties on the cultural capital which it is presumed to guarantee” (p.244)

Cultural capital is the most unevenly distributed of capitals, and is the most difficult to acquire. As cultural capital is embodied, what many would call ‘being cultured’ requires complete immersion into that culture (of sport, politics, school, etc.). The complete immersion requires a considerable investment of time and access to fields of cultural production (which in themselves are restricted to members possessing enough cultural capital to participate), and is thus rarely achieved by those who have little capital to begin with (Bourdieu, 1986; Moore, 2012).

Social capital refers to the social networks one possesses. Bourdieu (1986) defines it as the:

“aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance and recognition – or in other words, to membership in a group which provides each of its members with the backing of the collectivity-owned capital, a ‘credential’ which entitles them to credit, in the various senses of the word” (p.246)

Rather than focus on the size of a social network, Bourdieu (1986) stresses the importance of the quality of relationships and how they may contribute to gaining other forms of capital. Therefore, having few reliable networks with greater amounts of capital contributes to a greater level of social capital than a large group of deprived acquaintances.

From Bourdieu’s work on capital, Shilling (1990) expanded the concept of physical capital, briefly alluded to by Pierre Bourdieu. Although often categorized as a subdivision of cultural capital, physical capital refers to “the development of bodies in ways which are recognized as possessing value in social fields” (Shilling, 2003, p.111). In their study on skate parks as a health resource, Dumas and Laforest (2009) argue that physical capital can be considered as separate from cultural capital and should be divided into two distinct dimensions, namely the health (in this article, the focus was on injury prevention) and aesthetic dimensions. The development of physical capital and participation in activities that shape the legitimate (i.e. healthy and aesthetically pleasing) body require spare time and economic capital, thus making it difficult for the working

classes as they have little free time away from necessity (Shilling, 1991). What is even more difficult for the working class is that the middle class has the “ability [...] to define their bodies and lifestyle as superior, worthy of reward, and as, metaphorically and literally, the embodiment of class” (Shilling, 2003, p.122). From this perspective, physical capital is a bodily reflection of one’s location in the social space and highlights social inequalities.

What is useful with this understanding of capital is that each form of capital interacts with the others to shape a person’s dispositions. In their study on Danish women’s health lifestyles, Christensen and Carpiano (2014) utilize Bourdieu’s concepts of social, cultural and economic capital to explain the social gradient of BMI. They found that although women from capitalist, heteronormative societies with high amounts of all capitals were most likely to participate in healthy practices, high amounts of single or combined capitals did not translate into healthy lifestyles, and thus there were multiple pathways that lead to good and poor health practices and body size (Christensen & Carpiano, 2014). For example, high cultural capital (but little economic capital) was linked to greater importance and participation in physical activity. However, it was also linked to unhealthy lifestyles such as smoking and the consumption of rich foods, leading to (on average) smaller bodies than those with little amounts of all capitals and (on average) larger bodies than those with high amounts of all forms of capitals.

Together, the different forms of capital interact to position people in relation to one another. The greater the value of one’s overall capital (i.e. the more resources and power they possess), the greater control one has over their life circumstances and the greater chance one has to acquire other forms of capital. As the upper classes have greater

amounts of capital and are able to exchange what they do have for other forms of capital, they are able to ensure that the capital they possess remains in their possession, while the “less-socially-valued” capital the working class possesses is more difficultly transferred or exchanged (Crossley, 2001). *Habitus* shapes and is shaped by the amounts of economic, social, symbolic, cultural and physical capital available throughout the life course (Power, 2008).

Symbolic Violence.

Symbolic violence is the naturalized oppression experienced by the dominated groups, as a result of the symbolic power exerted on them by the dominant social groups. As individuals are socialized, their schemes of perception and appreciation are constructed through the lens of dominant ideas of legitimacy. Thus, people understand themselves in comparison to dominant groups (Bourdieu, 2000). *Symbolic violence* stems from symbolic systems of power. Symbolic power is the ability to “impose meanings and to impose them as legitimate by concealing the power relations which are the basis of its force” (Bourdieu & Passeron, 1974, p.4). It is through a process of continuous distinction and interaction that dominant groups legitimize their position within the social space (Bourdieu, 2000).

To illustrate the presence of *symbolic violence* in the lives of dominated groups, Bourdieu applied this concept to the educational system in France during the mid-twentieth century (Schubert, 2012). As school is a social institution embedded with the values of dominant groups, the ways in which students are taught reflect these values. *Symbolic violence* is present in schools because students are imposed with dominant

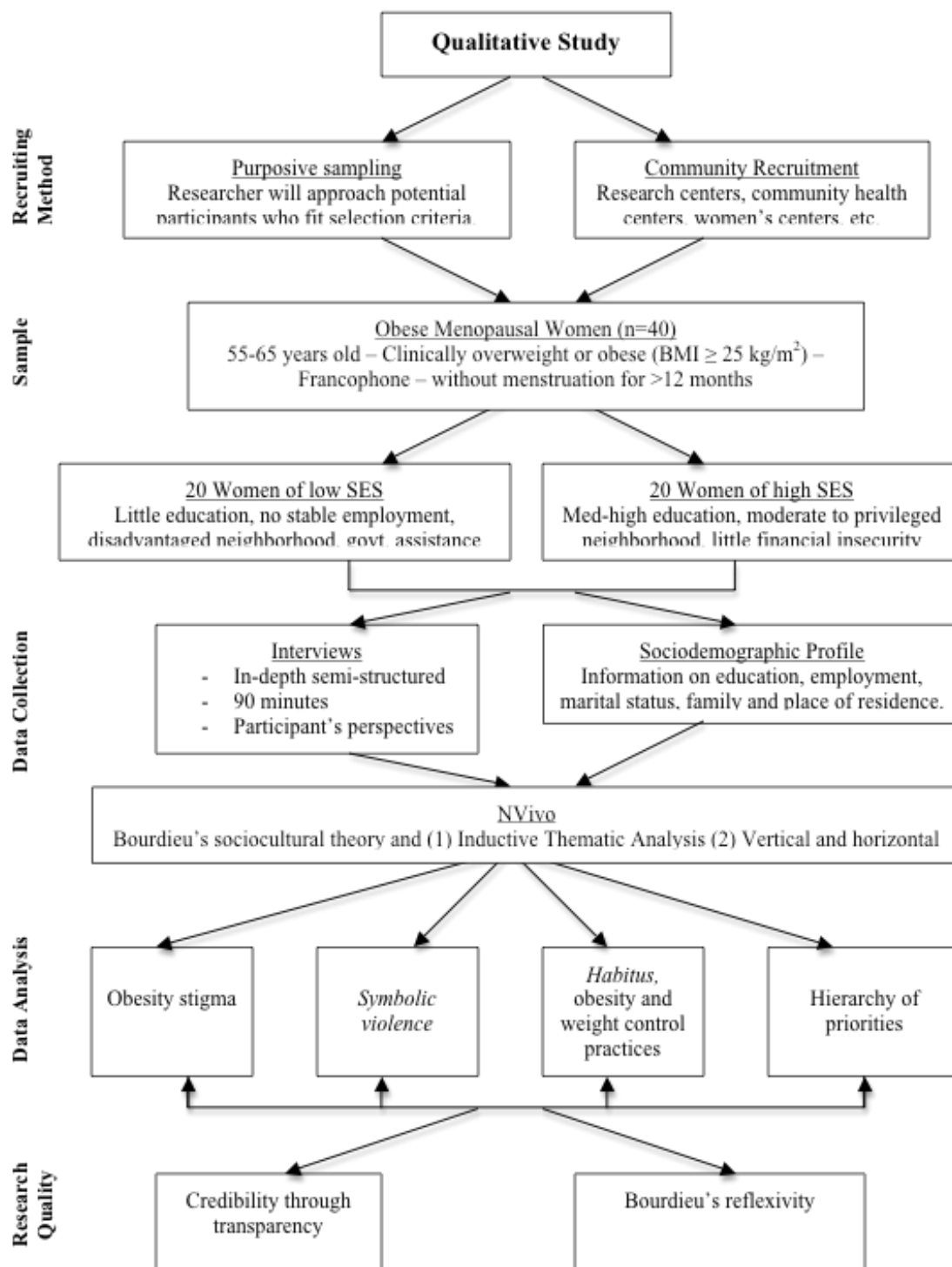
values, which are presented in a way that delegitimize other forms of knowledge and being. Thus, students who have not been socialized with these values (meaning they have different, 'less legitimate' tastes and perceptions) are excluded by the institution's dominant groups. Bourdieu argues that the poor educational achievement of working-class students is the result of *symbolic violence*, which, when successful, works to reinforce power relations (Shubert, 2012).

It is through immediate and continuous interaction with others that dominated groups experience positive and negative evaluations that shape their perception of being dominated (Bourdieu, 2000). The acceptance of the dominated position brings a form of social suffering and is partly reflected in what Bourdieu (2000) calls *bodily emotion* (p.169), which refers to feelings of guilt, shame, timidity and anxiety and are reflected through blushing, clumsiness and other ways of submitting to dominance. Charlesworth, Gilfillan and Wilkinson's (2004) work on working-class English men reflects *symbolic violence* in daily life and its effect on health. They argue that the biological processes that produce illness are caused by how we feel about our conditions of existence, what they define as the psychosocial effects of relative deprivation (Charlesworth, Gilfillan & Wilkinson, 2004). As we are relational beings, the feeling of being valuable to others is a justification for existing. The authors refer to shame as the social emotion because "it is through our fear of being seen as inferior or inadequate that we are rendered susceptible to the opinions and judgments of others, particularly to our social 'superiors'" (Charlesworth, Gilfillan & Wilkinson, 2004, p.52). Thus early experiences of feeling socially inferior through interactions with dominant groups cause feelings of shame, or the feeling of "being nothing" (Charlesworth, Gilfillan & Wilkinson, 2004, p.56). It is

through the embodiment of these feelings of shame, such as substance abuse and poor health practices, that *symbolic violence* is perpetuated.

Conclusion

In sum, Bourdieu's sociocultural theory and his concepts of *habitus*, capital and *symbolic violence* were integral in the structure and analysis of this study. This theory offers a unique lens to examine the study of social variation in lifestyle and health inequalities. I used the concept of *habitus* to understand how women's experiences and conditions of existence have shaped their perceptions of their clinically overweight and obese bodies and how this manifests itself in the weight-control practices they take on. I also explored how women's experience with *symbolic violence* shaped their perceptions in regards to health practices involving weight control.

Table 2.*Research Design*

Chapter IV

Methodology

The methodological section of this research thesis covers (a) qualitative research (b) the research sample and recruitment, (c) data collection, and (d) data analysis.

This study is part of the SOMET research project funded through the Canadian Institutes of Health Research (CIHR). The aim of this interdisciplinary team is to uncover the biological, psychological and sociological factors that influence weight regulation in women during critical periods of their lives and to use the findings to help create public health initiatives to help minimize body weight changes and its associated health issues. This particular branch of the study is interested in the ways women from different social classes treat and care for their clinically overweight and obese bodies during menopause.

While the participants had already been recruited, and the data collected and transcribed, my role within the project was to perform an in-depth analysis of the women's weight control practices and their experiences of obesity stigma.

Research Method

Qualitative research attempts “to make sense of, or interpret, phenomena in terms of the meanings people bring to them” (Denzin & Lincoln, 1994, p.2). Qualitative research functions in the belief that the interpretation of data is the result of the collaboration between the researcher and participant (Grbich, 2013). An interpretivist qualitative approach was used for this study, as it has been useful in previous studies interested in understanding the experiences of different social classes (Bourdieu, 1993). The interpretivist branch of qualitative research requires the researcher to interpret

people's perceptions and actions, based on the participant's conditions of existence, and to piece together this information to understand how they make sense of their world (Grbich, 2013).

This approach to research is closely in line with Bourdieu's sociocultural theory of practice, which emphasizes the importance of an *oubli de soi* (or the abandonment of presuppositions), in which an interviewer must place himself in the interviewee's shoes to understand his conditions of existence so that he may better understand his experiences (Bourdieu, 1993). Since the interpretive approach to data analysis may be limited by the researcher's subjectivity (Rubin & Rubin, 2012; Grbich, 2013), integrating Bourdieu's *oubli de soi* with the interpretivist approach can clarify the meanings individuals attribute to their experiences. This type of qualitative research was used in this study, and guided our interviewing.

Research Sample

This study conceives menopause as the critical point in women's lives where weight regulation has been identified as an issue. It draws on a non-probabilistic sample of clinically overweight and obese postmenopausal women (i.e. Body Mass Index (BMI) greater than 25). While women were recruited based on the state of their body weight, I recognize that weight can be a process from one body state to another and so I critically use clinical definitions of overweight and obesity in the context of this study. This type of sampling is most commonly used in qualitative research and is often referred to as "purposive sampling." It is commonly used in qualitative research as it allows the researcher to recruit potential participants that are suitable for the study.

Description of participants.

This specific study of the SOMET project recruited 40 clinically overweight and obese women between the ages of 55 and 65 who self-reported as being without menstruation for over twelve months. Body Mass Index (BMI) was used to determine overweight (25-29.9 kg/m²) and obesity (>30 kg/m²) status. All women were French-Canadian and all but one were heterosexual. We attempted to create equilibrium in the number of participants from low and middle-upper socioeconomic status to allow for greater comparison between the social classes. The sample was divided into two socioeconomic groups based on their educational qualifications, employment type (as well as partner employment), reliance on government support and level of social and material deprivation based on the Government of Québec's (2006) *Cartographie des variations canadiennes de l'indice de défavorisation matérielle et sociale* as these have been useful tools in determining socioeconomic status in previous studies (Bartley et al., 2005; McLaren & Kuh, 2004; Savage, Dumas & Stuart, 2013). The low socioeconomic status group was defined as women who are without stable employment, have poor educational qualifications, live in an economically disadvantaged neighborhood and require governmental or community support to pay for lodging and nourishment. The middle-to-high socioeconomic group included women who have a medium to high educational qualifications, live in a moderate to privileged neighborhood and have little to no financial insecurity.

Table 3.

Characteristics of participants divided by socioeconomic groups

Participant Characteristics	Low SES (n = 20) %	Upper and middle SES (n = 20) %
Age	58.9 ± 3.1 yrs	60.8 ± 2.6 yrs
BMI	² 34.6 ± 9.4 kg/m	² 30.5 ± 4.3 kg/m
Education ≤ 11 years	68.8	20
Receives financial aid	81.3	0
Single	75	40
Regular family contact	37.5	90
History of childhood abuse	68.8	5
Regular physical activity	30	95
Current smoker	20	5

Recruitment of participants.

Participant recruitment took place in the urban area of Sherbrooke, Québec. We used convenience sampling to ensure women corresponded to eligibility criteria. Women from the underprivileged group were recruited through social agencies and not-for-profit organizations that serve the underprivileged women's community, including the Comptoir Familial, Estrie Aide and Sherbrooke's municipal housing office, as well as

food banks and soup kitchens l'Armée du Salut, La Grande Table, Moisson Estrie and Chaudronnée de l'Estrie. Women from the upper and middle classes were recruited through educational research groups such as the Centre de recherche sur le vieillissement (CDRV), l'Université du Troisième Âge and Sercovie. We partnered with these organizations by posting information about the study on their bulletin boards, giving presentations about the study during program time and approaching potential participants directly. All women who participated were offered \$30 CAD as compensation for their participation.

Data Collection

A research assistant (Mélisa Audet, PhD student) and Professor Alex Dumas collected the data using two methods: (1) a sociodemographic survey and (2) a semi-structured interview. The sociodemographic survey was conducted orally before the bulk of the interview. This short survey helped assess educational achievement, employment, family, age of menopause onset, as well as height and weight of each participant to better contextualize their responses. Semi-structured interviews of around 90 minutes were conducted with each of the participants (see Appendix A), and were recorded on a digital recorder. The interviews took place in the location of the participant's choice, preferably with minimal distraction to foster a calm and open environment.

Active listening and natural conversation were used in order to ensure that the participants felt comfortable throughout the interview. Bourdieu (1993) emphasizes the importance of using natural conversation in an interview to get an unbiased construction of the interviewee's social world. The research assistant used a journal throughout the

interviews to note comments about the interview, including body language, significant changes in rhythm and other verbal and non-verbal characteristics of the interviewee's responses. These notes were used during the analysis to ensure proper understanding of linguistic peculiarities and body language as well as to address the subjectivity of the interviewer during data analysis.

Interview guide. The interview guide was developed based on Pierre Bourdieu's sociocultural theory. It covered questions regarding (a) socioeconomic status, (b) perception of available material and human resources and its relation to health practices (c) the women's relationship to their obese bodies, (d) experiences related to obesity and health practices and (e) the influence of health interventions during menopause on health practices. A total of 40 interviews were conducted and lasted roughly 90 minutes each. The main data sources were the women's relationship to their obese bodies and their experiences related to obesity and health practices. The interview was semi-structured in nature, meaning questions and probes were prepared in advance. However natural conversation and developing themes directed the interview. Although the interview guide was ideally completed in full, conversation flow and data saturation determined the actual length of the interview.

Ethical considerations. The University of Ottawa and the University of Sherbrooke granted ethical approval for this research project (See Appendix B). To keep consistent with ethical standards in interviewing, only women considered independent according to the Ministry of Health and Social Services were eligible to participate in the

interview. Every effort was made to ensure that each participant had the opportunity to read the consent form and had the opportunity to ask questions before the interview. Women with literacy issues had the consent form verbally explained to them in simple language. The consent form clearly stated that participants had the right to withdraw from the study at any time without consequence. Further, the women's real names were replaced by pseudonyms, and any information that could reveal the participant's identity would be excluded from the final report. All interview transcripts were stored on a password-protected computer.

All efforts were made to ensure that this study balanced the risks and benefits associated with its participation. Women were offered \$30 CAD in compensation for time spent away from other duties, parking, transportation, etc. While emotional discomfort could occur during the interview, all measures were taken to minimize it, and the women were reassured that any question that created discomfort did not need to be answered. To ensure each participant's comfort, they were given the choice of the location for the interview. Finally, before leaving each interview, the interviewer checked in with the emotional state of each participant.

Data Analysis

All interviews were transcribed verbatim from the digital recordings by a professional transcription agency¹. The transcriptions were then uploaded to NVivo data management software. Data management software has become very useful for qualitative data analysis as it allows the researcher to generate codes and tags which can easily be

¹ All interviews were conducted and transcribed in French. Interview excerpts used in the final report were translated by me and reviewed by the thesis supervisor.

retrieved from a multitude of interviews (Rubin & Rubin, 2012). It is important to note, however, that data management software cannot replace the researcher's thorough analysis of the data.

Within this specific branch of the study, I performed an analysis based on the secondary use of data, meaning that the data had already been collected and transcribed (but not analyzed), however, all coding and theme generation occurred based on my interpretation of the transcripts alone (i.e. no preliminary coding was provided).

Thematic analysis.

Thematic analysis is a “method for identifying, analyzing and reporting patterns (themes) within the data” (Braun & Clarke, 2006, p.79). Although there is no consensus on how to conduct a thematic analysis, Braun & Clarke's (2006) six-step method is versatile and adaptable to different theoretical frameworks.

This thematic analysis utilized Braun & Clarke's (2006) six-step method. The first step involved a first reading of all interviews to become familiar with the data. The second phase generated initial themes and concepts, which were coded using NVivo. For the purpose of this research, I used a form of hybrid coding, which is a combination of both inductive coding (dependent on data) and theoretical coding (shaped through theoretical framework). The greatest benefit of hybrid coding is that it allows the researcher to identify themes within the data itself, while also allowing for a detailed analysis of a particular theoretical aspect of the data (Rubin & Rubin, 2012; Braun & Clarke, 2006). Following initial coding, the third step involved the collating of codes to create themes. Step four required the researcher to review the themes to ensure that they

worked with their coded extracts, while step five involved naming and defining each theme. The sixth and last step of the analysis was to produce the report with vivid excerpts from the interview transcripts for each theme (Brawn & Clarke, 2006).

The thematic analysis comprised two individual levels of analyses of the 40 interviews: vertical and horizontal. I first performed a vertical analysis to explore each individual participant's life circumstances and her experience of obesity and weight control practices. I then performed a horizontal analysis to compare the experiences of women from underprivileged and middle classes and the experiences of women within the same class. All analytical procedures included intersections of gender, age and socioeconomic status and were conducted to understand how these social factors interact to create inequality in weight control practices and obesity stigma. This approach proved useful for studying inequalities within and between groups as it allowed for the understanding of how intersecting factors "impact the experiences" of these groups (Annendale, 2013, p.168). While I realize that culture and ethnicity are factors of social inequality, all participants in this study were white French Canadian women. Thus, in this study, the intersection is between women and class while the point of intersection is obesity during middle age.

Quality of the Analysis

Two key principles were used to ensure the trustworthiness of results: (a) credibility through transparency and (b) reflexivity.

Credibility refers to the "confidence in an accurate interpretation of the meaning of the data" (Whittemore et al., 2001, p.530). Credibility can be achieved through

transparency by keeping notes during the interview process and referring to them during the analysis (Rubin & Rubin, 2012). Keeping an audit trail also provides credibility through transparency because it creates a written trajectory of decisions related to the direction of their study (Cutcliffe & McKenna, 1999). Notes were taken by the research assistant throughout the interview process, and by me during the analysis in order to clarify and justify the direction of the analysis.

Reflexivity is an essential part of the research process because it involves an “active acknowledgement” that the researcher’s “actions and decisions will inevitably impact upon the meaning and context” of the results (Horsburgh, 2003, p.308). Bourdieu (1993) sees reflexivity as essential to the study of sociology, since by being reflexive, we are able to lend greater credibility to our work without being removed from it. Qualitative researchers know that it is by working directly with people that it is possible to obtain rich data. It was important, however, that the participants’ stories or experiences were not clouded by the researcher’s unconscious bias based on previous research and life experience (Wood & Altglas, 2010; Swartz, 1997). To be reflexive, Bourdieu argues, researchers should be less concerned with the lack of validity, and instead focus on submitting the researcher to the same rigorous analysis as the study itself (Swartz, 1997).

Since I did not assist in interviewing the participants for this study, I realize that I missed an important component of the participants’ stories. To improve the credibility of the analysis, I employed Bourdieu’s reflexivity by listening to the interview recordings while reading the transcripts. This allowed for the identification of variations in participants’ intonation, emphasis and volume. The use of a qualitative biographical approach to interviewing facilitated my ability to put myself in the participants’ shoes and

thus allowed me to perform a deeper level of analysis. Regular contact with the PhD student who conducted the interviews also allowed for a greater understanding of participant transcripts.

Conclusion

In sum, this study employed a qualitative approach to investigate the social variation of clinically overweight and obese postmenopausal women's weight control practices and experiences and responses to obesity stigma. The use of biographical semi-structured approach to interviewing allowed for a greater understanding of the cumulative effect of life experiences on participants' tastes and lifestyles in the context of excess weight. A six-step thematic analysis was performed vertically (to examine each participant's experiences) and horizontally (to compare the experiences of participants within same and from the contrasting socioeconomic group), while including intersections of age, gender, and socioeconomic status. Bourdieu's reflexivity was employed throughout the analysis in order to improve the credibility of this study.

CHAPTER V

Class responses to obesity stigma. Inequality, womanhood, and midlife

Obesity stigma has far-reaching social, psychological and physiological consequences for clinically overweight and obese individuals (Brewis, 2014; Galley, 2014; Poulain, 2009; Sutin & Terraciano, 2014). Obesity stigma refers to the “negative stereotypes that persons with obesity are lazy, gluttonous, lacking willpower and discipline, and personally to blame for their weight” (Puhl & Kyle, 2014, p.1). These stereotypes are manifested in different ways, and lead to bias and discrimination in a variety of social settings. Weight-based discrimination (exclusion or limited opportunities due to body weight) and weight shaming (devaluing an individual due to their body weight) are associated to fewer employment opportunities, lower likelihood of being in a romantic relationship (Fikkan & Rothblum, 2012), fewer preventive behaviours (Potter, Wallston, Trief, Ulbrecht, Joth & Smyth, 2015), and increased risk of weight gain (Sutin & Terraciano, 2014). Negative weight-related experiences are more common among women and increase with body mass index (BMI). A study on the occurrence of weight-based discrimination has shown that 21% of obese women (BMI 30-35 kg/m²) sense some form of obesity stigma in their daily lives compared to 2% of women within a normal range BMI (18-24.9 kg/m²) (Puhl, Andreyeva & Brownell, 2008). While obesity stigma is detrimental to health and well-being, its psychosocial impact on specific populations is under-researched, especially for people identified as possessing few social, economic and cultural resources. By drawing on Pierre Bourdieu’s theory of *symbolic*

violence, this qualitative study assesses the social variation of responses to obesity stigma between two contrasting socioeconomic groups of clinically overweight and obese women during midlife. By focusing on participants' resources, results identify the diverse contexts of occurrence of obesity stigma and weight shaming, as well as the contrasting responses between the two groups of participants. Given the potential of obesity stigma to decrease health and well-being, this study supports the need for a culture change in public health and the promotion of a "body size acceptance" approach in women's health.

Body appearance and normative thinness are dominant features of women's status in western cultures. As regularly argued, in this social context, aging and midlife threaten women's self-worth and social value (Tiggerman & McCourt, 2013; Tunaley, Walsh & Nicolson, 1998). For example, body dissatisfaction in middle-aged women can lead to depression and lower quality of life (Marshall, Lengyel & Utioh, 2012; McLaren & Gauvin, 2002; McLaren & Kuh, 2004). In the "*Hyper (in)visible fat woman*," Gailey (2014) argues that social control over women's bodies coupled with the medicalization of fat has created a social environment fertile for negative weight-related experiences. If detrimental effects of obesity on global well-being are now well documented, to our knowledge no research has focused on its interaction with socioeconomic status (SES) in the context of women's health during midlife.

Obesity Stigma and Public Health

Midlife is identified as a period involving critical social, psychological and biological changes influencing women's health and well-being (McLaren & Kuh, 2004; Lovejoy, 2009). Public health experts and systematic reviews on women's health state that hormonal and social changes that occur during menopause increase their risk of

weight gain, obesity and multiple chronic diseases (Abdulnour, Doucet, Brochu, Lavoie, Strychar, Rabasa-Lhoret & Prud'homme, 2012; Lovejoy, 2009). From a biological perspective, hormonal changes, shifts in adiposity, and a greater presence of triglycerides and LDL cholesterol significantly increase risk for cardiovascular disease after menopause (Dennis, 2007; Lovejoy, 2009). Increasing evidence shows that types II and III obese postmenopausal women are at a greater risk for high blood pressure, type II diabetes, osteoarthritis, as well as psychosocial distress (e.g. negative body image, social isolation; Borrell & Samuel, 2014; Dennis, 2007). In response to these risks, public health agencies have targeted this group of women, although it is unclear how weight-control rhetoric in health messaging is interpreted and involved in lifestyle changes.

The dominant obesity discourse reinforces the idea that excess weight leads to poor health outcomes, can always be prevented, and is a matter of personal responsibility. The indisputable nature of these assumptions, however, has often been challenged (Esmail & Basham, 2014; Flegal, Kit, Orphana & Gaubrand, 2013; Puhl & Heuer, 2010; Rich & Evans, 2005). Although promoting weight loss may seem desirable from a public health perspective, there are undeniable and counterproductive societal and institutional implications for clinically overweight and obese populations. For instance, obesity stigma has a significant negative impact on the health, self-worth (Poulain, 2009; Rich & Evans, 2005), life satisfaction, psychosocial distress (van Zutven, Mond, Latner & Rogers, 2015), social isolation and participation in healthy lifestyles (Lewis et al., 2011). Obesity stigma in the medical field has also been well documented. Scholars have identified the presence of weight biases within medical education and shortcomings in the ability of medical professionals to discuss body weight with clinically overweight and obese

patients. This institutional context, in addition to previous experiences of obesity stigma, has delayed obese patients' use of health-care services, especially among women (Dietz et al., 2015).

A recent study has determined that overweight individuals who experience weight discrimination are 2,5 more likely to gain weight and reach clinical obesity (Sutin & Terraciano, 2014). While not all women who experience this type of stigma respond to it in the same way, reviews suggest that, for many, obesity stigma creates a vicious cycle of behaviours and coping mechanisms that entrain further weight gain (Brewis, 2014; Tomiyama, 2014). In a review of the biological, psychological and sociological research on obesity stigma, Brewis (2014) identified four mechanisms through which stigma leads to weight gain: (1) direct behavioural change, (2) indirect effects of psychosocial stress, (3) indirect effects via changes in social relationships, and (4) negative socioeconomic effects of discrimination. Together, these four mechanisms mediate the relationship between weight discrimination and weight gain through increased emotional eating, chronic activation of the hypothalamic-pituitary axis (visceral fat accumulation), increased isolation within obese groups, and reduction of employment opportunities and insufficient income to participate in healthy lifestyles.

Although there has been considerable research on health inequalities, little is known on the experiences of obesity stigma and its consequences on the health and well-being of underprivileged groups. A recent epidemiological study indicates greater socioeconomic health inequalities among obese populations compared to non-obese populations (Burkert, Rásky, Großschädl, Muckenhuber & Freidl, 2013). As an explanation, the authors identify poorer health practices, less frequent preventative

medical checkups, and poorer quality of life (measured using the WHOQOL questionnaire on physical and psychological health, social relationships, and environment) within a lower SES obese population. These results suggest that poor social circumstances interact with obesity on lifestyles, health care utilization, and health.

Symbolic Violence, Social Recognition and the Body

As a bearer of symbolic value, the body has been a central component in social theory. The shape, size and general appearance of the body are conceived as forms of capital or resources for individuals. Because the body is transformed, adorned and shaped by various practices (e.g. sporting activities, diets or dress), it has been conceived as a medium by which individuals react to dominant social norms (Bourdieu, 1984). The body is also an object of study enabling researchers to understand wider issues of social structure and power relations. In Pierre Bourdieu's framework, the notion of physical capital (1984; Schilling, 1991) is used to operationalize the various forms of resources derived from the appearance and capabilities of the body. For example, Muriel Darmon's (2003) study on young anorexic French women shows how personal investments to lose weight provide social value and enable the acquisition of other forms of economic capital (valued forms of employment) and symbolic capital (social recognition).

Symbolic capital is at the heart of this theory. Dominant groups have a stronger potential to embody valued social norms and achieve social recognition by investing in socially valued forms of bodily practices. In contrast, those who possess fewer resources to conform to socially desired body traits are, in the words of Pierre Bourdieu (2000), more subject to *symbolic violence*. As opposed to coercive forms of violence, *symbolic violence* is a subtle violence, a seemingly natural form of oppression exercised by

dominant groups through symbolic power (Bourdieu, 2000). It is a versatile concept akin to the notion of ideology. Three ideas stemming from Bourdieu's (2001) concept of *symbolic violence* are relevant to studying the social variation of women's experiences of obesity: (1) the socially valued body forms, the power struggles within society, and the social significations given to the bodies of specific groups; (2) the oppression of stigmatized groups and the need for social recognition within a highly competitive social hierarchy; and (3) negative self-judgment as embodied domination.

In *Masculine Domination*, Bourdieu (2001), argues that women's struggle for recognition by conforming to prevalent beauty ideals maintains them: "in a permanent state of bodily insecurity, or more precisely of symbolic dependence [...] Continuously under the gaze of others, women are constantly condemned to experience the discrepancy between the real body to which they are bound and the ideal body towards which they endlessly strive" (p.65-67). While *symbolic violence* is inextricably linked to class, it goes beyond it by interacting with gender, ethnicity, and other social identities. Overweight women, for instance, can be subject to *symbolic violence* due to their body size, though belonging to a dominant class. Bourdieu (2001) calls into question the well-known concept of "body image" because it ignores that the subjective evaluation of the body is embedded in power relations, which are themselves inscribed in social structure. As he argues, "dominated groups" of women are overly "sensitive to certain public representations of power," and embody "a relation of domination" through *bodily emotion* (e.g. shame, timidity, anxiety, guilt) (Bourdieu 2000, 171). In her feminist reading of Pierre Bourdieu's theory of practice, Skeggs' (2004) builds on the concept of *symbolic violence* by arguing that it "exposes the temporal differences between types of

femininity, the practice of femininity and the different values attached to different forms” (p.24) and thus creates a class-gendered experience. For example, women of the working class hold few socially valued resources other than their femininity, but are judged and shamed due to their unsuccessful attempts to conform to dominant (middle-class) standards of femininity.

Pierre Bourdieu’s sociocultural theory is increasingly being applied to topics related to health and social inequalities in contemporary societies (Cockerham, 2013; Williams 1995). In a study on the unequal distribution of symbolic capital among, Charlesworth, Gilfillian and Wilkinson’s (2004) identified increasing social inequalities as a result of Britain’s eroding industrial sector and the low social value embodied through body language, speech and unhealthy practices of unemployed men. Few studies have drawn on this framework to analyze practices in the context of excess weight. Lhuissier (2012), for example, examined the class conceptions of the body and social variation of weight control practices between different occupational classes of French women. The lower socioeconomic strata of her sample were more inclined to adopt rapid and drastic weight-loss methods (weight-loss surgery, diet pills) exposing them to health risks. The idea of the body as capital has also been used in the context of weight control in order to understand the low priority given to body weight and personal health within the wider hierarchies of priorities of underprivileged young women in Canada (Dumas, Robitaille & Jette, 2014).

Methods

This study is part of a larger Canadian multicentered research project on health practices, chronic disease risk factors and weight management following the menopausal

transition funded by the Canadian Institutes of Health Research. This sociological component of the larger study focuses on the ways women from contrasting socioeconomic classes treat and care for their body. This specific sub-project recruited 40 clinically overweight or obese women between the ages of 55 and 65 who self-reported as being postmenopausal (absence of menses ≥ 12 months). BMI was used to determine overweight or obesity status (overweight = BMI 25-29.9 kg/m², obesity = BMI > 30 kg/m²). All participants were French-Canadian and were required to be independent². Data collection occurred in several neighbourhoods within the city of Sherbrooke, Québec.

Underprivileged and middle-class women were targeted for this study. Participants were divided in two groups by using a combination of criteria: level of education, present and previous type of occupation, necessity to receive external financial aid and level of social and material deprivation of the residential area (Gouvernement du Québec, 2006). Underprivileged participants were recruited through social agencies and not-for-profit organizations as well as food banks and soup kitchens. Participants from the middle class were mainly recruited through educational research groups.

In-depth semi-structured interviews were used to better understand the social variation of women's experiences of obesity and use of preventative health practices during midlife. Interviews began with a short survey to help assess the sociodemographic (educational achievement, employment, family) and personal (age of menopause onset, height and weight) characteristics of each participant. Interviews averaged 90 minutes in length and were transcribed in their entirety. The interview guide covered five main

² Participants were independent as defined by the Ministry of Health and Social Services of Québec (meaning they require less than one hour of care per day and do not receive assistance with any ADLs).

themes: socioeconomic status, participants' perception of available material and human resources, their relationship to body and health practices, their experiences related to excess weight and health practices, as well as their lifestyles and health practices. Experiences of obesity stigma were defined as any experience where women were made to feel shamed, inferior, or unjustly treated because of their weight.

All interview recordings were transcribed by a third party and imported into the data management software *N-Vivo 8* for a thematic analysis. A vertical analysis was first performed to explore each individual participant's life circumstances and her experience of obesity stigma. A horizontal analysis was then conducted to compare the experiences of participants from underprivileged and middle classes as well as those of women within the same class. As women's life experiences vary according to their social position, an intersectional analysis of gender and class was also performed. As McDowell (2006) argues, an "ungendered class analysis is no longer appropriate but then nor is unclassed gendered analysis" (p.842).

Participant Characteristics

[INSERT TABLE 1 HERE]

As identified in Table 1, participants (a) lived in a residential area characterized by fair to high levels of social and material deprivation, (b) were aged between 55 and 65 years ($59,9 \pm 3,0$ years) and (c) had a BMI- that categorized them as clinically overweight or obese ($32,2 \pm 6,9$ kg/m²). The underprivileged participants (n=20) experienced high social and material deprivation, had low training in formal education, were without stable employment and occasionally or regularly needed the services of soup kitchens, food banks, and financial assistance. The middle-class participants (n=20), resided in a

moderate to privileged neighbourhood, had little to no financial insecurity and held medium to high educational qualifications. Groups also differed in personal attributes. A contrast between women from underprivileged and middle classes is illustrated in their history of diagnosed mental illness (14 vs 6) and *overt weight shaming* incidents (10 vs 3). Key differences are also seen in their mean BMI (34 kg/m^2 vs 30.5 kg/m^2) and their living conditions: living alone (13 vs. 6), regular contact with children (women with children: 8/14 vs 18/18), victim of physical abuse (12 vs 1), victim of sexual abuse (6 vs 1), and history of alcoholism or drug addiction (8 vs. 1). While not all underprivileged participants were diagnosed with mental illness, many indicated frequent instances of psychosocial distress throughout their lives (undiagnosed feelings of anxiety, sadness). Women from the middle classes more often experienced acute depression and anxiety linked to traumatic events.

[INSERT TABLE 2 HERE]

As identified in Table 2, differences between underprivileged and middle-class groups are also highlighted in specific health and weight-control practices: regular attendance to medical exams (11 vs 19), current use of weight control practices after menopause (7 vs 20), use of a combined weight-loss strategy involving both physical activity and diet (2 vs 15). Their weight control history also differed. While underprivileged participants were more likely to have participated in weight control practices before reaching menopause (15 vs 12), they declined sharply after menopause (n=7).

Obesity stigma and social inequality

Results indicate that social position is a key mediator of experiences and

responses to obesity stigma. Table 3 identifies two salient themes that emerged from the analysis: (a) contexts of occurrence of obesity stigma, and (b) responses to stigmatizing weight-related experiences.

[INSERT TABLE 3 HERE]

Obesity stigma: contexts of occurrence

The horizontal analysis indicates that body weight is a significant factor influencing various social contexts for all women, i.e., romantic and social relationships, work and public spaces. However, the interview transcripts made clear that the type and degree of exposure to stigmatizing experiences varied strongly between socioeconomic groups. The intensity of occurrences of obesity stigma was identified as greater in underprivileged settings. Nearly half of underprivileged participants experienced overt obesity stigma on a *regular basis* (negative and degrading remarks by family, partners, neighbours, and strangers), while middle-class participants mentioned fewer experiences. Three principal contexts of occurrence are identified in the analysis: medical, family and public.

First, the medical context is often identified as an environment inducing obesity stigma. Underprivileged women, mentioned their apprehensions in discussing excess weight with their health care providers and perceived that their weight concerns were often met with condescendence: “*When I got there, the doctor spoke to me about my weight, and I found that she was, let’s say, cruel. I didn’t find her very nice. She was almost dismissing me, as if she felt I hadn’t tried hard enough*” (Tifrance, 59, part-time secretary). Recurrent discussions on weight loss and failed weight loss attempts during midlife increased negative experiences with health care providers and discouraged open

dialogue. For many, these approaches to weight management coupled with repeated failed weight-loss attempts contributed to pessimism towards lifestyle prescriptions. Many expressed what they perceived as uncompassionate attitude of their health-care providers: *“the doctor wanted me to lose weight [...] I tried [...] I had the impression that the doctor [...] wanted me to lose weight, by any means necessary”* (Touti, 57, social assistance beneficiary). These interactions were different within middle-class settings. Whereas a form of medical paternalism was present, the middle-class context was much less marked by condescending paternalism. As argued elsewhere, their cultural proximity with physicians and nurses engendered distinctive interactions and power relations (Dumas & Bournival, 2011). The patient’s social position clearly modified context in discussing sensitive issues such as body weight and increased critical dialogue, testifying to a more equalitarian relationship:

“Yeah, then I told him “I’m going to set one thing straight with you”, I told this to my doctor: [...] “my objective [...] is not to gain any more weight” [...] when you’ve never had a weight problem, you can’t understand what it’s like. Doctors, it’s in their nature, in their culture - a desire to heal, and at the same time, to feel like they hold absolute truth or knowledge” (Julia, 62, college professor)

Second, the intimate and family context was identified as another context of occurrence. The social networks of underprivileged participants were often limited and characterized by fragile, tense or unreliable social ties with family members and partners. Many had lived, or were living, in social isolation. They generally had poor emotional support and often mentioned a disproportionate emphasis on self-reliance when faced with adversity: *“let’s just say that I depend on myself. It’s one day at a time..I really try to*

encourage myself” (Karine, 63, social assistance beneficiary). They mentioned, especially when single, how obesity stigma enhanced their difficulties in engaging romantic relationships. Unstable relationships appear to make them more vulnerable to hurtful actions and demeaning remarks: *“because men, from the moment that you’re a little fat, you have more trouble [finding a partner] [...] Men have already told me that I was big, stuff like that [...] stuff like, if you were smaller, maybe, but now, no [...] well, it hurts, eh, it hurts”* (Catherine, 61, disability³). After confronting a former partner about a lack of affection in their relationship, TiFrance, remembers how *“he told me that he was disgusted by me, that he didn’t want to make love to me [...] because I’m fat”* (59, part-time secretary). Another participant echoes this experience: *“Blah, nobody even looks at me, nobody gives me any comments”* (Suzanne, 65, social assistance beneficiary). Underprivileged participants also noted devaluing comments from members of their family, such as being called *“the fat one”* (Maïka, 55, disability). After losing weight through bariatric surgery, Maïka explains how being temporarily thin brought her closer to her family (until she regained): *“It attracted people towards me [...] my family, they were really proud of me, they were all really happy for me, so I was happy that they were happy [...] they accepted me, calling me little Maïka. It was encouraging.”* Being overweight also brought negative attention to these women, particularly during family gatherings: *“in my family, everyone would talk about me - well she’s fat [...] she’ll never do anything with her life”* (Roseline, 59, social assistance beneficiary). The interviews with middle-class participants attested to much more support from their social

³ While all participants were independent as defined by the Ministry of Health and Social Services of Québec (meaning they require less than one hour of care per day and do not receive assistance with any ADLs), some participants were collected governmental disability benefits for functional disabilities.

environment: *“I really find that I’m fat. My current partner was telling me about one of his friends, who is overweight. I said ‘I’m fat too!’ He said ‘oh no, you’re alright’ - but no, I’m fat, look at me!”* (Déesse, 61, accountant). While they discussed unpleasant remarks made about their body weight, they were typically followed by reassuring comments: *“the remarks [my husband] makes, I don’t feel any less loved [...] he’s so kind that it balances itself out a bit. The goal is to tell me that I’ve put on some weight”* (Carole, 56, secretary). On many occasions, husbands provided reassurance by deemphasizing the importance of weight in determining social value: *“Well, he said: ‘I love you the way you are.’ You know love, they say it makes you blind - laughs”* (Gabrielle, 62, retired secretary); *“You always like having someone to tell you that you’re pretty, well anyways, my husband tells me often”* (Florence 1, day care provider).

Third, while both groups reported varying degrees of negative weight-related experiences within public context, the degree of hostility between both social environments differed substantially. The underprivileged participants more often reported mentioned belittling comments (e.g. cow, fat one) and actions (e.g. sneering, cruel jokes) from people (neighbours, soups kitchen attendees, strangers) in public spaces than their middle-class counterparts. During a conversation on weight shaming, Zora, an unemployed 58 year-old woman, described how she feels trapped living in low-income housing: *“I have an apartment, It’s like I live in the Bronx [...] people treat me poorly [...] I want to leave but I have no money to move.”* Offensive and depreciative remarks in public places (shopping malls, gyms, social gatherings) made them feel like targets for denigration and gave rise to feelings of isolation and self-consciousness: *“I feel like it’s directed towards me [...] I tell myself, ‘ok I should probably do something about this’”*

(Marie-Andrée, 59, social assistance beneficiary); *“when I used to go to the community gym, I was fat enough. I weighed 240 pounds at that point. I felt watched, like as if they were to say: “what is she doing here, she doesn’t belong here””* (Maïka, 55, disability). These experiences triggered existing mental health issues for many underprivileged participants: *“When I was in the group home, a guy asked me “how did you manage to get so fat?” [...] It bothers me a lot. So much so that I thought about suicide”* (Caroline, 55, social assistance beneficiary). The more affluent participants rarely described the incivility of their social environment. Although they occasionally came across evaluative judgments over their weight, they had stronger capacities to choose non-threatening spaces that minimally affected their social participation. They did not report any negative impacts on their professional trajectories: *“No, no, not at work. Everyone knows me for my competencies. At work, well I had a certain level of competence”* (Julia, 62, college professor). The professional occupations of middle-class women (teaching, social work, nursing) often deemphasized the importance of body appearance and weight: *“I had accepted that I was a little bigger than others [...] but I had the impression that my co-workers accepted me as I was”* (Florence 2, 62 retired nurse).

Responses to obesity stigma

The participants identified a number of individual responses to obesity stigma in order to increase or preserve their quality of life. Responses were subjectively experienced (referring to a state of mind or perception) or objectively enacted (referring to specific defensive practices). Body insecurity, disappointments and frustrations about body weight and attempts to manage body weight were shared between groups at one moment in their lives. All participants were challenged by the tensions between the

capacity to *disengage* from unrealistic body ideals, as substantial weight loss was unlikely, and the capacity to *engage* in weight management practices in order to increase quality of life.

In response to various forms of obesity stigma, many expressed the paradox of experiencing, on the one hand, shame and self-depreciation, and on the other hand, a distancing from weight-related expectations: *“If other people don’t find me beautiful, well then, that’s their problem”* (Marie-Andrée, 59, social assistance beneficiary); *“At first [my weight gain] really bothered me, now I weigh 163, but I was getting close to 170, that really bothered me [...] but now I love and accept myself as I am today”* (Nicole, 63, secretary). As argued by Bourdieu (2000), *symbolic violence* can bring a *tacit acceptance* of the limits imposed on the dominated. In this sense, rejection of weight norms observed here can be seen as a means for self-preservation that is far from being liberating: *“I’ve gained too much weight, I feel unwell, I go to get dressed, well that doesn’t fit, that doesn’t fit either, that’s too small [...] you look like a sack of potatoes [...] we call them rag bags [...] that’s where I get my clothes, but because I have excess weight, it makes it harder to find clothing my size because they have less of it there [...] I’ve accepted my weight. Personally, I don’t pay attention to that [...] it’s not important that I be thin or fat or that others be thin or fat, I will look at what’s inside rather than outside”* (Touti, 57, social assistance beneficiary).

Although participants from both groups shared negative experiences with body weight, their unequal resources fashioned distinctive means to respond to stigma, which may harm or benefit their health and well-being. As indicated in previous studies, underprivileged living conditions lower one’s sense of control and fashion a fatalistic

attitude towards sustaining a healthy lifestyle (Darmon, 2006; Dumas et al., 2014). While some underprivileged participants made sporadic attempts to conform to weight standards by concealing or temporarily losing weight, shame about body size increased withdrawal from social activities and healthy lifestyles: *“I had a friend, her father died, and I told myself that I was way too fat to go there [...] I was way too fat to go to the funeral home and show myself in public. I’m ashamed of my body”* (Caroline, 55, social assistance beneficiary); *“[I received negative comments from some acquaintances] because I was kind of fat [...] I would tell them that I knew I had to stop eating chips and chocolate, but being lonely makes me eat. [...] I’ll eat anything when I’m lonely”* (Hélène 2, 55, social assistance beneficiary). Others also chose to frequent non-judgmental social environments, often reserved for other stigmatized groups, in order to sense a form of equality: *“I feel good around those types of people [with mental illnesses] because I don’t feel judged”* (Roseline, 59, social assistance beneficiary). In the face of stigmatizing experiences, some women indicated occasional outbursts related to constant criticisms (from doctors, family, strangers). Here, Marie-Andrée (59, social assistance beneficiary) describes her reaction to being publicly humiliated for her weight by a man at the soup kitchen: *“One time, [this man at the soup kitchen] treated me like a [second class citizen because of my size], and let’s just say that I said some words that weren’t very catholic.”* Greater involvement in spiritual and religious activities facilitated the letting go of weight-related expectations. Through frequent worship and volunteering, participants were removed from isolation and felt that their body appearance was no longer at the forefront of interactions.

High levels of economic, cultural, and social capital facilitate dissociation from

weight-related expectations while maintaining social value. In the face of the dominant obesity discourse, middle-class participants indicated finding relief in their health status by managing their weight from a health perspective, making sense of personal weight-related experiences and rationalizing their losses in ‘body appearance’. Maya, a 58 year-old social worker, expressed the need for women in general to understand the unrealistic nature of beauty ideals in order to come to terms with social pressures: *“I find that it’s an exaggerated vision of the body. Because in each period of our life, whether we like it or not, our body transforms, we don’t have a choice. You can watch your lifestyle habits, but your body will change”*. Many of them learned to value personal traits other than body weight and appearance and called into question the idea that excess weight is always an indicator of poor health. Gabrielle 2, a 57-year-old administrative assistant, detaches herself from stereotypical obese identities: *“[my excess weight] isn’t because I drink two litres of pepsi per day [...] [people always imagine that people with excess weight] are always planted in front of the television with four litres of Pepsi”*. They also maintained a sense of distinction from unhealthy overweight persons by citing specific health and lifestyle differences: *“I have a coworker, he is huge! He’s diabetic. Geez, get yourself together! Do something! Those people, I have no respect for them, for their lifestyle [...] it’s just a question of willpower, I [eat healthy and exercise]!”* (Martine, 64, financial advisor).

Middle-class participants held long-term health goals and, for instance, prioritized healthy eating and exercising (strength and mobility regimens) in order to maintain their quality of life and their social role (mother, grandmother, spouse, caregiver): *“I want to keep my strength, I want to keep my vitality, I want to keep my positivism as long as I live*

[...] I want to enjoy being with my grandkids, not stuck on the couch and depressed” (Marie, 63, retired teacher); *“Now we’re able to live until we’re 85, so it’s important to be in shape. If you spend the last 15 years of your life waiting your chair waiting to die, that’s really awful [...] I’ve just become a grandmother, so I want to be able to sit on the floor with my granddaughter. I want to be able to play, to get on all fours, I want to be able to do that. When she gets older, I still want to be able to do things with her”* (Florence 2, 62, retired nurse). The more privileged group had a greater understanding of weight stigma and expressed more confidence in directly responding to critiques. In the following quote, Maya directly challenges medical prescriptions regarding her weight: *“I’m not okay with that [weight loss intervention] for this reason. So the doctor said: ‘that’s alright, you’re the boss’ ”* (58, social worker). In line with the theory of *habitus* and taste, they presented a more keen awareness and ability to adopt a variety of culturally valued practices (healthy diets, regular physical activity) that contributed to dissociating themselves from harsh stereotypes, which could potentially reduce their susceptibility of internalizing stigma. For instance, the negative stereotype of excess weight as being the result of ‘letting oneself go’ was often cited as a motivation to invest in body appearance and health practices. For Julia, overweight women are often pressured to police their weight-related practices in public spaces in order to avoid being easy targets: *“If you dress yourself like you don’t care how you look, it’s obvious that you’re not taking care of yourself. When you have excess weight, I find you have to think about that stuff even more”* (Julia, 62, college professor). Middle-class participants chose to frequent supportive social environments (private active leisure programs, such as hiking, long-distance biking excursions, and exercise classes such as Zumba, Aquafit),

which incited them to participate in health practices: “*So I go to the gym during the day, my classes are during the day, and I have a friend that goes with me [...] we have fun, we encourage one another, and it’s almost all women [...] we’re 6-7 in the class, we’re always the same gang, I like it, it motivates me*” (Marie, 63, retired teacher).

Conclusion

Obesity stigma has negative impacts on obese women’s psychosocial health, social isolation, use of health-care services, sense of self-worth, and participation in healthy lifestyles. Recent systematic reviews recognize the role played by obesity stigma in a vicious cycle involving physiological and psychological coping mechanisms leading to weight gain (Brewis, 2014; Sutin & Terraciano, 2014; Tomiyama, 2014). While socioeconomic status, and poverty in particular, are well-known social determinants of health, their interaction with obesity and obesity stigma is under-researched. This qualitative study investigated clinically overweight and obese women’s experiences of and responses to obesity stigma from a socioeconomic perspective. Drawing chiefly on Pierre Bourdieu’s concept of *symbolic violence*, the findings in this study indicate that economic and social deprivation facilitate the accumulation of negative weight-related experiences and engender responses to obesity stigma potentially contributing to health inequalities. In this study, lower social position increased psychosocial vulnerability to a dominant obesity discourse that devalues body and character during midlife. While all participants were targets of obesity stigma, access to social, economic, and educational resources protected middle-class women. To some degree, they could control some stigma-generating contexts, continued to invest in healthy lifestyles, and had the capacity to rationalize and minimize the importance negative weight-related experiences by

gaining fulfillment in other spheres of their lives.

Despite the implementation of social welfare policies and universal health care, socioeconomic status remains one of the most important determinants of health (Marmot, 2015). Results from this study indicate that, while obesity stigma has been studied from a gendered perspective, it is now crucial to include the socioeconomic dimension. In an editorial comment on the question of obesity stigma, social position, and health inequalities, Goldberg (2011) argued that American society is “imposing a qualitatively distinct form of suffering – stigmatization – on those already subject to deleterious socioeconomic conditions and experiencing the toll of those conditions on their lives and bodies” (p.788). This double burden of symbolic suffering may be the key to understanding how obesity and poverty interact to structure a distinct view of the world and a corresponding set of lifestyles.

In discussing the female experience of the body, Bourdieu (2001) expresses the need to go beyond a study of ‘body image’ because it ignores the integration of social structure in one’s self-evaluation of the body. He argues that the ‘perceived body’ is “socially doubly determined” (2001, p.64); on the one hand, its shape and deportment are the products of social conditions of existence (ex: working conditions, eating habits) and which reflect certain moral characteristics. On the other hand, the evaluation of these body characteristics is dependent on one’s own schemes of perception and appreciation (which themselves are the product of socialization), as well as those of the people they interact with. In this sense, recognizing power relations is essential to understanding how women from contrasting social positions experience their obese body, as well as the degree of the impact of obesity stigma within various social contexts. Within the current

dominant obesity discourse, body weight is a significant component of physical capital. The body is another vector of *symbolic violence* and social suffering. By focusing on affect, this research exposes the connection between emotions linked to stigma and dispositions: “It is because the body is exposed and endangered in the world, faced with the risk of emotion, lesion, suffering [...] and therefore obliged to take the world seriously [...] that it is able to acquire dispositions” (Bourdieu, 2000, p.140). All things being equal, social agents who occupy higher social positions appear to be better shielded against *symbolic violence*. Although all participants expressed many forms of resistance, the strength of such resistance is likely to vary between socioeconomic groups: “agents always find some defences, individual or collective, momentary or durable, being durably inscribed in *habitus*” (Bourdieu, 2000, p. 233). In this study, underprivileged participants were most exposed and vulnerable to obesity stigma. These experiences also triggered coping strategies which, while in the moment provided some protection from stigma, proved to be a risk for health and well-being in the long-term.

Drawing on sociocultural theory, social practices in the context of obesity are conceived as the product of the interaction between life chances (resources to control and capacity to act) and life choices (agency). This approach may be useful to explain the participant’s ability to exit or disengage from stigmatizing contexts (life chances) and their responses to stigma (dispositions or choices). Because significant and sustainable weight loss was unlikely among both groups, participants attempted to control (through a variety of methods) the environments in which they lived. Each participant’s social position shaped their sense of control over day-to-day living and, consequently, the ways in which they interacted with stigma. The concept of control over one’s environment is a

crucial contribution of this study, as it expresses strategies of the middle classes to maintain distinction despite their excess weight and helps to explain the responses made out of necessity among underprivileged participants.

Although clear differences were present between the two socioeconomic classes, the line of inquiry of this study may have obscured intra-class differences. Heterogeneity in individual life circumstances (e.g. stable romantic relationships) presented some differences in exposure and responses to obesity stigma among each socioeconomic group. Although individual differences were not captured in this analysis, a detailed analysis of class fractions (such as the very poor versus the unemployed and the middle versus upper-middle class) could have shed light on other factors leading to differences in participants' responses.

While the dominant obesity discourse in public health emerged from the recent neoliberal push for taking responsibility for one's own health, it fails to consider the influence of sociocultural factors on lifestyles. The well-dispersed idea of self-management of body weight reinforces the idea that obesity is evidence of failure to care for oneself (Cardona, 2008), and serves as justification for discriminatory, condescending and paternalistic practices towards overweight individuals. Lupton (2015) argues that the use of disgust in public health messaging in order to elicit behaviour change is ineffective, as it leads to the dehumanization of already stigmatized groups. Weight-loss campaigns, which portray the obese body in a negative light, go well beyond spheres of health and generate feelings of powerlessness, shame, and self-hatred in obese groups. In this study, participants from both socioeconomic groups indicated a variety of instances where they felt negatively judged for their "excess" body weight. However,

underprivileged participants much more often mentioned feeling of inferior and powerlessness in the face of such events.

Many scholars are calling for the promotion of body size acceptance in the health field, specifically the Health at Every Size (HAES) approach, as the current promotion of thinness as a motivator for weight loss can lead to irrational eating and exercise patterns in order to achieve unrealistic weight loss aspirations (Bombak, 2014; Gailey, 2014; Parham, 1999; van Zutven et al., 2015). Existing fears surrounding the “body size acceptance” movement as denying the health risks of obesity lack credibility; not all overweight individuals have health problems, weight loss interventions rarely have sustained success, and understanding risks is not associated to significant changes in lifestyles (Finkelstein, Brown & Evans, 2008; Parham, 1999). Studies supporting the implementation of a HAES approach to health care suggest that medical professionals should focus on the health benefits (versus the appearance or social acceptance benefits) of behaviour change in obese individuals (Dietz et al., 2015) and exercise greater sensitivity when discussing weight (Gray et al., 2011). Because *symbolic violence* is subtle and inscribed in social interactions, people holding roles of power (such as medical care providers) may not be cognizant of the impact of their interactions with clinically overweight women, especially the most vulnerable ones. When discussing body weight, health discourses interact with lay discourses on obesity, and may contribute to further stigmatization.

References

- Abdulnour, J., Doucet, E., Brochu, M., Lavoie, J.-M., Strychar, I., Rabasa-Lhoret, R. & Prud'homme, D. (2012). The effect of the menopausal transition on body composition and cardiometabolic risk factors: a Montreal-Ottawa New Emerging Team group study. *Menopause: The Journal of the North American Menopause Society*, 19(7), 760-767.
- Bombak, A. E. (2014). The Contribution of Applied Social Sciences to Obesity Stigma-Related Public Health Approaches. *Journal of Obesity*, 2014, 1-9.
doi:10.1155/2014/267286
- Borrell, L. N. & Samuel, L. (2014). Body Mass Index Categories and Mortality Risk in US Adults: The Effect of Overweight and Obesity on Advancing Death. *American Journal of Public Health*, 104(3), 512-9.
- Bourdieu, P. (1984). *Distinction: A Social Critique of the Judgment of Taste*. Cambridge, MA: Harvard University Press.
- Bourdieu, P. (2000). *Pascalian Meditations*. Stanford, CA: Stanford University Press.
- Bourdieu, P. (2001). *Masculine Domination*. California, USA: Stanford University Press.
- Brewis, A. (2014). Stigma and the perpetuation of obesity. *Social Science & Medicine*, 118(1), 152-158.
- Burkert, N. T., Rásky, É., Großschädl, F., Muckenhuber, J. & Freidl, W. (2013). The Influence of Socioeconomic Factors on Health Parameters in Overweight and Obese Adults. *PLoS ONE*, 8(6), 1-8.

- Cardona, B. (2008). 'Healthy ageing' policies and anti-ageing ideologies and practices : on the exercise of responsibility. *Medicine, Health Care and Philosophy*, 11(4): 475-483.
- Charlesworth, S. J., Gilfillan, P. & Wilkinson, R. (2004). Living inferiority. *British Medical Bulletin*, 69(1), 49-60.
- Cockerham, W. C. (2013). *Social Causes of Health and Disease*. Cambridge, UK: Polity Press.
- Darmon, M. (2003). *Devenir anorexique: une approche sociologique*. Paris, France: Éditions la découverte.
- Darmon, M. (2006). Variations corporelles. L'anorexie au prisme des sociologies du corps. *Adolescence*, 24(2), 437-52.
- Dennis, K. E. (2007). Postmenopausal Women and the Health Consequences of Obesity. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 36(1), 511-519.
- Dietz, W. H., Baur, L. A., Hall, K., Puhl, R. M., Taveras, E. M., Uauy, R. & Kopelman, P. (2015). Management of obesity: improvement of health-care training and systems for prevention and care. *The Lancet*,(), 1-13.
- Dumas, A. & Bournival, E. (2011). Men, masculinities and health. Theory and application. In J. Laker (Ed.) *Canadian Perspectives on Men and Masculinities. An Interdisciplinary Reader* (pp. 33-51). Toronto, ON: Oxford University Press.
- Dumas, A., Robitaille, J. & Jette, S. L. (2014). Lifestyle as a choice of necessity: Young women, health and obesity. *Social Theory & Health*, 12(2), 138-158.
- Esmail, N. & Basham, P. (2014). Obesity in Canada: Overstated Problems, Misguided Policy Solutions. *Fraser Institute*.

- Fikkan, J. L. & Rothblum, E. D. (2012). Is Fat a Feminist Issue? Exploring the Gendered Nature of Weight Bias. *Sex Roles*, 66, 575-92. doi: 10.1007/s11199-011-0022-5
- Finkelstein, E. A., Brown, D. S. & Evans, W. D. (2008). Do Obese Persons Comprehend Their Personal Health Risks? *American Journal of Health Behavior*, 32(5), 508-516.
- Flegal, K. M., Kit, B. K., Orpana, H. & Graubard, B. I. (2013). Association of All-Cause Mortality With Overweight and Obesity Using Standard Body Mass Index Categories: A Systematic Review and Meta-analysis. *Journal of the American Medical Association*, 309(1), 71-82.
- Gailey, J. A. (2014). *The Hyper(in)visible Fat Woman: Weight and Gender Discourse in Contemporary Society*. New York, NY: Palgrave Macmillan.
- Goldberg, D. S. (2011). What kind of people? Obesity Stigma and Inequities. *The American Journal of Medicine*, 124(8), 788.
- Gray, C. M., Hunt, K., Lorimer, K., Anderson, A. S., Benzeval, M. & Wyke, S. (2011). Words matter: a qualitative investigation of which weight status terms are acceptable and motivate weight loss when used by health professionals. *Public Health*, 111(1), 513-522.
- Lewis, S., Thomas, S. L., Blood, R. W., Castle, D. J., Hyde, J. & Komesaroff, P. A. (2011). How do Obese Individuals Perceive and Respond to the Different Types of Obesity Stigma that they Encounter in their Daily Lives? A Qualitative study. *Social Science & Medicine*, 73, 1349-1356.
- Lhuissier, A. (2012). The Weight-loss Practices of Working Class Women in France. *Food, Culture & Society*, 15(4), 643-664.

- Lovejoy, J. C. (2009). Weight Gain in Women at Midlife: The Influence of Menopause. *Obesity Management*, 5(2), 52-56.
- Lupton, D. (2015). The pedagogy of disgust: the ethical, moral and political implications of using disgust in public health campaigns. *Critical Public Health*, 25(1), 4-14.
- Marmot, M. (2015). *The Health Gap: The Challenge of an Unequal World*. Bloomsbury: New York, NY.
- McDowell, L. (2006). Reconfigurations of Gender and Class Relations: Class Differences, Class Condensation and the Changing Pace of Class Relation. *Antipode*, 38(4), 825-850.
- McLaren, L. & Gauvin, L. (2002). Neighborhood level versus individual level correlates of women's body dissatisfaction: toward a multilevel understanding of the role of affluence. *Journal of Epidemiology and Community Health*, 56, 193-199.
- McLaren, L. & Kuh, D. (2004). Women's body dissatisfaction, social class and social mobility. *Social Science & Medicine*, 58(1), 1575-1584.
- Parham, E. S. (1999). Promoting body size acceptance in weight management counseling. *Point-Counterpoint*, 99(8), 920-925.
- Potter, L., Wallston, K., Trief, P., Ulbrecht, J., Juth, V. & Smyth, J. (2015). Attributing Discrimination to Weight: Association with Well-Being, Self-Care, and Disease Status in Patients with Type 2 Diabetes Mellitus. *Journal of Behavioral Medicine*. doi: 10.1007/s10865-015-9655-0
- Poulain, J. P. (2009). *Sociologie de l'obésité*. Paris, France: Presses Universitaires de France.

- Puhl, R. M., Andreyeva, T. & Brownell, K. D. (2008). Perceptions of weight discrimination: prevalence and comparison to race and gender discrimination in America. *International Journal of Obesity*, 32(6), 992-1000.
- Puhl, R. M. & Heuer, C. A. (2010). Obesity Stigma: Important Considerations. *American Journal of Public Health*, 100(6), 1019-1028.
- Puhl, R. M. & Kyle, T. K. (2014). Pervasive Bias: An Obstacle to Obesity Solutions. *Institute of Medicine of the National Academies* (September 8).
- Rich, E. & Evans, J. (2005). 'Fat Ethics' – The Obesity Discourse and Body Politics. *Social Theory & Health*, 3(4), 341-358.
- Skeggs, B. (2004). Context and Background: Pierre Bourdieu's analysis of class, gender and sexuality. *The Sociological Review*, 52(s2), 19-33.
- Sutin, A. R., Stephan, Y., Luchetti, M. & Terracciano, A. (2014). Perceived Weight Discrimination and C-Reactive Protein. *Obesity*, 22(9), 1959-1961.
- Tiggerman, M. & McCourt, A. (2013). Body appreciation in adult women: Relationship with age and body satisfaction. *Body Image*, 10(4), 624-627.
- Tomiyama, J. A. (2014). Weight stigma is stressful. a review of evidence for the Cyclic Obesity/Weight-Based Stigma Model. *Appetite*, 82(1), 8-15.
- Tunaley, J. R., Walsh, S. & Nicolson, P. (1998). 'I'm not bad for my age': the meaning of body size and eating in the lives of older women. *Ageing & Society*, 19, 741-759.
- Williams, S. J. (1995). *Theorizing class, health and lifestyles: can Bourdieu help us?* *Sociology of Health & Illness*, 17(5), 577-604.

van Zutven, K., Mond, J., Latner, J. & Rodgers, B. (2015). Obesity and psychosocial Impairment: mediating roles of health status, weight/shape concerns and binge eating in a community sample of women and men. *International Journal of Obesity*, 39(1), 346-352.

Table 1

Participants' Characteristics - Sociodemographic

Characteristics	Underprivileged class (n=20)	Middle classes (n=20)
Age groups (years)		
55–59	11	6
60–65	9	14
BMI (kg/m ²)		
25–29.9 (overweight)	9	11
30–34.9 (type I obesity)	4	5
35–39.9 (type II obesity)	4	4
≥ 40 (type III obesity)	3	0
Highest level of education		
High school (incomplete)	6	1
High school	9	4
College	2	3
University	3	12
Marital status		
Single ^a	6	4
Divorced	8	3
Married	6	13
Personal attributes		
Lives alone	13	6
Children	14	18
Regular contact	8	18
History of alcoholism or drug addiction	8	1

Victim of childhood physical abuse	12	1
Victim of sexual abuse ^b	6	1
History of mental illness (diagnosed)	14	6
Experience of overt weight shaming ^c	10	3

^a One woman from each group was widowed.

^b All women who were sexually abused were also physically abused as a child.

^c Experience of overt weight shaming was characterized as any incident where participants were clearly made to feel inferior due to their weight.

Table 2

Participant Characteristics – Health and Lifestyle

Characteristics	Underprivileged class (n=20)	Middle classes (n=20)
Weight gain during menopause	18	20
Regular medical exams	11	19
History of weight control practices (adulthood before menopause)	15	12
Current use of weight control practices (post-menopause)	7	20
Physical activity & diet	2	15
Diet only	4	4
Physical activity only	1	1
Use of weight control professionals	6	9

Table 3

Contexts of Occurrence and Responses to Obesity Stigma. Summary of Data Reported by Clinically Overweight and Obese Women from Two Contrasting Socioeconomic Milieus

	Underprivileged class (n = 20)	Middle classes (n = 20)
Contexts of occurrence	(a) Medical: experience subservience when interacting with health professionals; shame when confronted about their excess weight; little knowledge of medical jargon (b) Intimate and Family: history laden with tense relationships and frequent demeaning remarks linked to weight from romantic partners, parents and siblings; few protective social support networks; believe their body weight acts as a barrier to social ties, social integration, employment opportunities and increase insecurities; are generally distrusting of people in their social environment (tense relationships) and feel their weight is an object of hostility (c) Public: experience overt weight shaming in public spaces (e.g. shopping centres, soup kitchens, walkways); feel they are likely targets for denigration because of their weight; feel they lack recognition in occupational settings due to their weight	(a) Medical: discussions about weight control increase friction in doctor-patient relationship; experience medical paternalism and frustration from physicians' cynicism and skepticism towards their genuine attempts to control weight (b) Intimate and Family: Are typically supported by friends and family with regards to their weight "complaints"; family members are generally courteous and sensitive; weight is of little importance within family values; strong networks offering protection and support from weight stigma/shaming; (c) Public: global sense of civility in public spaces (occasional evaluative judgments tied to weight in specific settings, e.g. grocery shopping, dating); low risk of shaming and disrespectful remarks within their social environment; feel their employment is secured due to their personal competencies; professional environment is characterized by little focus on body weight; active community ties linked to weight control strategies (walking partner, cooking clubs)

Responses	(a) Objective (outward): • Minimal control over avoiding/escaping contexts of obesity stigma • Lack the personal skills to defend themselves from stigmatizing contexts and preserve their self-worth; occasionally outburst • Retreat from social activities to avoid inferiorization (social gatherings, shopping centres) and gravitate towards non-threatening social environments for other stigmatized groups (centres for mental illness, soup kitchens) • Generally disengage from healthy lifestyles but make unsustainable, sporadic attempts to conform to weight standards (conceal/lose excess weight) (b) Subjective (inward): • Internalize negative weight-related experiences and hold unrealistic standards of satisfaction in terms of unrealistic weight expectations • Feel their excess weight is something that needs to be repaired (linked to inability to complete ADLs, work) but are fatalistic to change, and so feel the need to accept their body as it is; • Strive to adopt a non-judgmental life philosophy to body weight (“live and let live”) • Compare themselves with other, more overweight women in an attempt to improve their social value	(a) Objective (outward): • High degree of control over contexts of obesity stigma: • Use their education to reject judgments on their body and respond to critiques by emphasizing health-related facts (in the context of patient-doctor interaction) • Actively defend themselves in the face stigmatizing contexts and invest in non-stigmatizing relationships (changing medical providers) • Invest in self-presentation in the context of weight and health (body presentation, clothing, skin care, exercise, food); Participate in a variety of trendy, culturally valued weight control practices (vegetarian diets, organic, outdoor leisure) to embody health ideals (b) Subjective (inward): • Possess high knowledge to resist weight shaming discourses and make sense of negative experiences regarding weight • Have a keen sense of healthy lifestyles and detailed knowledge of complex determinants of health • Call into question the idea that excess weight is unconditionally the result of poor self-care and ill-health • Focus on personal traits other than body weight and appearance • Establish long-term personal and health objectives that are minimally weight-related • Maintain a distinction from “unhealthy” overweight persons.
-----------	---	--

Chapter VI

Inequality and weight control in clinically overweight and obese postmenopausal women

Health, body weight and menopause

Women's psychosocial conditions and biological transformations during mid-life are key predictors of chronic diseases. Life course events such as retirement, bereavement, and children leaving the home are linked to greater isolation and lifestyle changes, which are potentially detrimental to health (Pimenta et al., 2014; Willis, Gao, Leonard, DeFina & Berry, 2012). Concurrently, increased body weight and changes in body fat distribution during the menopausal transition are also associated with higher health risks (Lovejoy, 2009). After menopause, women lose the protective effect of estrogen, experience changes in metabolic profile and metabolic waste (Cignarella, Kratz & Bolego, 2010; Peppia et al., 2013). A systematic review on lifestyle interventions targeting body weight changes during menopause has established a connection between weight gain, lifestyle changes and health risk during menopause (Jull et al., 2014). In order to reduce the burden of chronic disease, public health agencies attempt to optimize means for women to self-manage their body weight through reducing caloric intake and increasing energy expenditure (Abdulnour et al., 2013).

Although female weight control practices have been largely investigated, few studies have included a socioeconomic focus in order to better inform public health policy on the intersections between poverty and female obesity (Lhuissier, 2012). Income is identified as a significant risk factor of mortality and disease in clinically obese

populations (Beydoun & Wang, 2010; Brennan, Henry, Nicholson, Kotowicz & Pasco, 2009). Food insecurity, a common situation for those living in poverty, has been linked to excess weight in women, with 37% of women living in a situation of food insecurity being obese (BMI >30 kg/m²) (Maisonneuve, Lamontagne, Blanchet, & Hamel, 2015). Recent data also indicate that socioeconomic health disparities are more pronounced amongst obese adults, identifying low income and psychosocial distress as two mediating variables (Burkert, Rásky, Großschädl, Muckenhuber & Freidl, 2013). These trends point to the complexity of the social determinants of weight management, as well as the need for further study to improve women's health and well-being in later life.

Social inequality in weight management

Critical obesity scholars and epidemiologists have called into question the unequivocal association between excess body weight and disease by emphasizing that health risks are almost exclusively associated to upper weight categories of clinical obesity and that the impact of social structure is scarcely considered (Flegal et al., 2013; Poulain, 2009). Three points are relevant to consider in this respect. First, data shows a significant increase in mortality only when BMI is over 35 (i.e. class II and III obesity) (Zheng & Yang, 2012), and that a BMI between 25 and 30 can be protective for health in some instances (Flegal et al., 2013). Second, although clinical obesity is present in all socioeconomic strata, it follows a social gradient where obesity rates for low-income women are systematically higher than those of higher-income (Clarke, O'Malley, Schulenburg & Johnson, 2010). Third, low-income obese populations statistically have unhealthier lifestyles, lower health care use, lower measures of quality of life, and higher likelihood of co-morbidities (Burkert et al., 2013). The burden of low socioeconomic

status women is expressed in their higher likelihood of becoming clinically obese and of suffering physical, social, and psychological complications linked to their excess weight (McLaren & Godley, 2009).

Sociocultural theory of practice

This study draws on Pierre Bourdieu's sociocultural theory of practice, an approach increasingly being applied to identify and understand the distinctive lifestyles of socioeconomic groups in the context of health inequalities. Specifically, the concept of *body habitus* (or relation to the body) is operationalized in order to (a) compare and contrast two different socioeconomic groups of women and (b) investigate their appreciation and disinterest in weight control practices. (1984, p.190).

Bourdieu (1984) identified two distinctive relations to the body that are relevant for this analysis: an instrumental relation to the body (the body as a means) of the working classes, and a reflexive relation to the body (the body as an end in itself) of the middle and upper classes. These values translate to the preference and appreciation for different lifestyle practices that physically shape the body. These contrasting relations to the body are reflected in lifestyle choices (such as food consumption and physical activity) and reflect the values of particular social groups. As a general rule, the attention and investments onto the body are dependent on the "profits" one can reasonably expect from them. Boltanski's (1971) seminal paper on the social uses of the body in French society (*Les usages sociaux du corps*) argued that middle-class women value health-promoting lifestyles that fashioned a slim, toned body, while working-class women were less inclined to invest in illness-prevention practices in favour of physical labour. Studies that have adopted this approach show that weight-control practices among the middle classes

are most often characterized by regular and planned physical activities, while less privileged women are more inclined to adopt risky weight-loss methods such as smoking and fasting (Christensen & Carpiano, 2014; Williams, Germov and Young, 2011). Anne Lhuissier (2012) examined the social variation of weight control practices between different occupational classes of women in France; women from the lower socioeconomic strata were more inclined to adopt rapid and drastic weight-loss methods (weight-loss surgery, diet pills), while upper strata occupational classes privilege sustaining moderate dietary restraint, culinary adaptations and “healthy cooking”. Class is also a structuring factor for body *habitus* in Canada. Laberge and Sankoff’s (1997) study of women’s lifestyles and physical activity in Montreal found that middle-class women were more also inclined to participate in physical activity as it shaped their body in order to conform to dominant health and lifestyle norms. Working-class women were less likely to be physically active because they were pessimistic towards the possibility that physical activity would improve their living conditions. Murielle Darmon’s (2003) study on anorectic young women in France highlighted that their middle-class ethos of asceticism and self-control facilitated the embodiment of extreme weight control regimens.

Few studies have specifically investigated the social variation of women’s experiences of weight and weight control in the context of public health priorities. This qualitative study provides an in-depth analysis of life circumstances shaping weight-control experiences in two contrasting socioeconomic groups of clinically overweight and obese postmenopausal women in Canada.

Methodology

The following study is part of a wider interdisciplinary research project funded through the Canadian Institutes of Health Research (CIHR)ⁱ. This sociological component recruited 40 clinically overweight or obese women between the ages of 55 and 65 who self-reported as being without menstruation for over twelve months. Body Mass Index (BMI) was used to determine overweight or obesity status (overweight = BMI 25-29.9 kg/m², obesity = BMI > 30 kg/m²)ⁱⁱ. All participants were independent of French-Canadian descentⁱⁱⁱ. Data collection occurred in several neighbourhoods within the city of Sherbrooke, Québec, a primarily francophone city in southern Québec, with a median personal income of \$56 403 (Statistics Canada, 2007). According to Statistics Canada's 2011 census, it has an unemployment rate of 6.9%, which is in line with Canada's national average of 6.8% and well below Québec's provincial average of 7.4% (Statistics Canada, 2012).

Underprivileged and middle-class women were targeted for this study. Group classification was determined by educational qualifications, employment type (as well as partner employment), and financial government support. To strategically recruit women from each group, neighbourhood level of social and material deprivation was determined by the Government of Québec's (2011) Atlas of social and material deprivation was used as it has been a useful tool in determining socioeconomic status in previous studies (Pampalon et al., 2008; Savage, Dumas & Stuart, 2013). Underprivileged participants were recruited through social agencies and not-for-profit organizations as well as food banks and soup kitchens. Middle-class participants were recruited through educational research groups.

In-depth semi-structured interviews began with a short survey to help assess the

sociodemographic (educational achievement, employment, family) and personal characteristics (age of menopause onset, height and weight) of each participant. Interviews averaged 90 minutes in length and were transcribed in their entirety. The qualitative interview guide covered five main themes: socioeconomic status, perception of available material and human resources and its relation to health practices, the women's relationships to their clinically overweight and obese bodies, experiences related to excess weight and health practices, and the influence of health interventions during midlife on health practices.

All interview recordings were transcribed by a third party and imported into the data management software N-Vivo8 for thematic analysis. A vertical analysis was first performed to explore each woman's life circumstances and her experience of weight and weight-control practices. A horizontal analysis was then conducted to compare the experiences of women from underprivileged and middle-class groups, as well as the experiences of women within the same class.

[INSERT TABLE 1 HERE]

As presented in Table 1, participants lived in areas that ranged from high to low social and material deprivation (according to the 9 levels of the Atlas of social and material deprivation), were aged between 55 and 65 years ($59,9 \pm 3,0$ years) and had a BMI that categorized them as clinically overweight or obese ($32,2 \pm 6,9$ kg/m²). The underprivileged classes (n=20) were characterized by personal histories of unemployment, poor educational qualifications, living in economically disadvantaged neighbourhoods, and by financial dependence on government benefits. The middle-class women (n=20) had a medium to high educational qualifications, resided in a moderate to

privileged neighbourhood, and had little to no financial insecurity. Key differences are also seen in their BMI ($M = 34 \text{ kg/m}^2$, $SD = 8.61$ vs $M = 30.5 \text{ kg/m}^2$, $SD = 4.27$) and their living conditions: living alone (13 vs. 6), history of diagnosed mental illness (14 vs 6), history of alcoholism or drug addiction (8 vs. 1), experiences of overt weight shaming (10 vs 3), regular contact with children (for women with children: 8/14 vs 18/18), victims of physical abuse (12 vs 1) and victims of sexual abuse (6 vs 1).

[INSERT TABLE 2 HERE]

Both groups also contrasted in their lifestyles (see Table 2). The contrast between women from underprivileged and middle classes is presented in their attendance to regular medical exams (11 vs 19), current adoption of weight-control practices post-menopause (7 vs 20) – specifically those involving both physical activity and diet (2 vs 15). Weight control trajectory also differed. While women from underprivileged class were more likely to have participated in weight-control practices before reaching menopause (15 vs 12), they declined sharply after menopause ($n=7$) in comparison to all participants from the middle classes who consistently engaged in some form of practice to control their weight.

Results

Results indicate that clinically overweight and obese women face a complexity of challenges linked to weight and weight control. Both socioeconomic groups expressed a shared desire to lose weight in order to improve their health, but sharply contrasted in their management of weight and known risk factors of chronic disease. A summary is presented in Table 3. Three points are identified in order to explain group differences: (a) weight management within the hierarchies of priorities, (b) perceptions of control

over weight and (c) barriers and facilitators.

[INSERT TABLE 3 HERE]

Weight Management within the Hierarchies of Priorities

Two main differences have been identified: the place of weight control within women's hierarchy of priorities and the type, frequency, and intensity of weight-control methods adopted. Although all participants desire to lose weight, the socioeconomic circumstances of underprivileged participants contribute to the prioritization of basic needs (food, shelter and social/affective needs), personal well-being, financial equilibrium, and access to life's simple joys: "*[to lose weight], for sure I spoil myself, I don't restrict myself, but no, limiting my food intake is not my priority, for me it's not to become depressed again that concerns me most*" (Grace, 57, social assistance). "*Sometimes, I'll have a good cheese. Oh God it's good!, I'll buy it once a month, I tell myself 'just once in a while'*" (Atly, 56, personal support worker). Many underprivileged participants justified their non-compliance to weight management guidelines provided by their doctors and mentioned their preferences for processed and satiating foods and disliking of exercise: "*I hate vegetables. I like potatoes, carrots [...] I don't like lettuce, it tastes like grass! eating that and grass is the same thing [...] in the morning, when I finish my 15 minutes of peddling, I'm fed up. I'm all sweaty - laughs - I'll tell you, I'm fed up*" (TiFrance, 59, cook). Finding and maintaining healthy romantic partnerships and being sexually appealing for potential partners arose as strong concerns for single women: "*sometimes I find it difficult [being alone], sometimes I wish I had someone to talk to, you know?*" (Taïna, 62, social assistance beneficiary). Lulu, a 55 year-old community outreach volunteer echoed the views of single women of her group: "Yes,

[feeling sexually attractive] is still important. Because I'm still into seduction, you know? I'm not 80 yet! I'd still like to meet someone, but when it comes to sexual relations, I wouldn't be comfortable with my body". Participants of the underprivileged group identified excess weight as a barrier to comfort and accomplishment of daily activities (cleaning living space, personal hygiene practices). The focus on daily life "uses of the body" represents the instrumental relation to the body typically embodied by underprivileged classes (Bourdieu, 1984). For instance, experiences of pain and physical restriction alerted them to the imminent possible loss of physical independence: *"Yes, I'm preoccupied because I feel that if I don't lose weight, I'll become handicapped sooner [...] I'll be in a wheelchair, and I want to stay away from that as much as possible"* (Thérèse, 59, social assistance beneficiary); *"I won't be in a wheelchair. That's for sure ! Some days, I'm not joking, I wake up in the morning and ouch! My ankle [...] then when I go to walk and it won't follow, I say – hey, you there, keep up [whistle] then I motivate myself and get up"* (Marie-Andrée, 59, social assistance).

In this social setting, efforts to lose weight reflected a short-term approach to weight loss. Poor social circumstances generated periodic caloric restriction, use of diet pills, and fad diets. Two underprivileged participants reported that they had undergone weight-loss surgery (gastric bypass, vertical banded gastroplasty). Weight management had always followed a *diet-relapse* pattern, which, as argued by Marshall et al. (2012), increases the risk of many conditions, including further weight gain, depression, heart disease and mortality: *"I've done weight watchers [...] and blah blah blah, "if you follow this and that you'll lose weight", and it worked! [...] But I've always regained the weight! and more!"* (Lulu, 54, community outreach volunteer); *"There came a point, where I*

weighed myself and I found it terrible [...] Now! I look at myself and, it's not nice. No! It's not me! So then, I put myself on a diet, and I lost 30 pounds [...] I put myself on a diet again, a low calorie one, I ate almost nothing [...] I regained 6 pounds after 6-7 months [...] Now I'm in the process of going back on the diet because I want to lose those pounds! I don't want to wait until I regain all the weight again" (Gisèle, 62, retired office clerk).

In contrast, the middle classes distinctively emphasized the social and health benefits of normative diets and active living. As reported elsewhere (Dumas & Laberge, 2005), this socioeconomic group is more inclined to embody preventive attitude and adopt long-term investment in health and more likely to invest in abstract biological notions and asymptomatic conditions that may lead to illnesses: *"I want to see my kids grow up [...] for me, that's important [...] to be there for my kids, to not be a burden [...] to do family activities with my kids, that's what's important"* (Clémence, 63, teacher); *"if I lose my physical potential, then I'll be sad. I'll be sad because that's all I have left of my life, to enjoy living"* (Florence 2, 62, nurse). Interview transcripts show the significance of maintaining social value by exposing their self-control and responsibility towards their health and body weight. Like many others, Marie feels she needs to bear values of maintaining good health for her children and grand children:

"You pass on your values [to the next generation], this is very important to me [...] I'm not going to say that it's ok to smoke and weigh 300 pounds, no no! I don't want my kids to see me that way. I don't want to be that way, and I don't want to project that image either" (Marie, 63, specialized teacher).

This group expressed the importance of monitoring their excess weight while being

“careful” of not letting “oneself go” (reflexive relation to the body). Moderate dietary restraint, avoidance of processed foods and regular, planned and structured physical activities (group fitness, biking, hiking) were frequently mentioned as part of their lifestyle *"[Physical activity] is part of our lifestyle, it always has been"* (Rosalie, 61, teacher). Although committed to controlling their weight, they also expressed limits in being too zealous about sacrificing pleasures of food in the context of family gatherings: *"I don't hate having a glass of wine, and I really love food [...] it was my son's birthday, so I ate a piece of cake. My kids said, 'now you're going to eat a piece of cake!'"* (Florence 1, 61, day-care owner). To modify their lifestyles and sustain a weight control regimen, many indicated they had cultured their tastes and habits by investing time, energy and resources towards active leisure practices light, healthy foods (vegetarian, natural, organic):

" I had never had a garden. Now, I have a giant garden that is twice as big as my living room. I've really become interested in gardening, reading about gardening, ecology, all that's stuff [...] I'm not vegetarian! but I eat a lot more fruits and vegetables than I do meat" (Marie, 63, specialized teacher).

" I was into organic food before I gave birth in the 70s, I worked, I made kasha, I made all my own cereals, I've been into that for ever [...] I'm not a purist but I liked more cereal, I eat more vegetarian food [...] but I also like meat. I'm a good carnivore! So my tastes are pretty diversified, I'm not strict but I'm interested in just about everyone" (Hélène 3, 63, social worker).

Perception of control over weight

If the notion of body *habitus* holds a strong normative orientation, it also is fashioned by the possibilities associated to one's social position, that is, in the embodiment of the capacities to adopt and benefit from specific health practices . The participant's capacity to control body weight and to modify lifestyles are two themes that were reflected in all interviews. However, both socioeconomic groups differed in terms of the power to likely succeed in controlling their weight. As previously identified, a general sense of powerlessness characterized the lives of underprivileged participants. Their social and material conditions, along with shared histories of failed weight-loss attempts, have fashioned a fatalistic attitude towards weight loss and weight control. Excess body weight is often justified by a defeatist attitude towards sustaining normative weight-control practices: *"We'll listen, I'm fat, and I'm going to stay fat! Whatever happens, happens"* (Touti, 57, social assistance beneficiary); *"I'll have the same health [even if I try to lose weight], it'll be the same"* (Zora, 58, disability). Further related expectations and personal investments were seen as additional disappointments: *"I weigh 280 pounds. Have you thought about how many pounds I'd have to lose? [...] I've been too disappointed to set goals. Even if I want to lose 10 pounds this month, [I won't lose it] [...] Realistically, I'll lose the weight I lose"* (Tifrance, 59, part-time cook).

Although women from the middle classes were pessimistic about achieving desired weight loss, they felt they could, to some degree, attain health, fitness and physical mobility levels through weight control practices in line with public health recommendations: *"I want to manage it myself. I know that by controlling my weight, I'll be able to reach a glycemic index value of 6"* (Hélène 3, 63, social worker). Rather than face disappointment in weight loss pursuits, women from the middle classes invested in

weight-control practices in order to manage disease risk factors and enhance well-being: *“What I really want is health. If I make gestures, which I feel, are adequate to reach an optimal level of health, then I’ll be relatively satisfied with my weight”* (Carole, 56, secretary). These participants indicated stronger control over the factors influencing healthy lifestyles (e.g. meals and physical activity), and while these practices did not always result in weight loss, they incorporated health recommendations within their transitioning lives.

Barriers and Facilitators

Three main barriers and facilitators to weight control practices were identified in the interviews: economic, social networks, and health care professionals. First, although underprivileged participants had basic knowledge of healthy lifestyles, they were unlikely to possess the resources necessary to participate in a lifestyle proposed by public health. For example, some relied on soup kitchens and food banks in order to eat a full meal per day, while others did not have a refrigerator to store fresh and wholesome food. In a conversation on the advice given by a health professional working in a weight-loss clinic, Touti (57, social assistance) explains her limitations due to financial barriers:

“The trick to lose weight, everyone knows it, there’s no magic recipe, it’s just to eat well and move more. But eating well isn’t that simple [...] ground meat is \$1.99 but if you look at extra-lean ground beef, it’s \$7 and some, so there’s obviously a significant price difference [...] I ate some hot dogs or a bologna sandwich, with some other food, anyways I didn’t lose any weight [when they weighed me at the weight loss clinic] and they said that it was because I had eaten fatty meats. Obviously I know that already, but I had nothing else! What

was I supposed to eat?"

Second, with respect to the quality of social networks, the large majority of them indicated the hardship of social isolation; many of them lived alone, had minimal (if any) contact with their family, and had few meaningful social contacts. They felt that their excess weight reduced the strength of their social ties and limited their acceptance in social groups: *"well yes [my weight bothers me], it's obvious, I felt rejected by everyone [...] because of my weight [...] often, people would call me fatty and all that, even my brothers and sisters"* (Maïka, 55, long-term disability). Lack of social support made the adoption and maintenance of healthy eating and exercise practices more difficult: *"it's the feeling of not having any help [...] well, I've always been all alone, you know?"* (Karine, 63, social assistance beneficiary). Emotional eating was also mentioned as a common reaction to feelings of loneliness and isolation: *"if I eat, it's because I'm eating my emotions [...] because I'm lonely"* (Thérèse, 59, social assistance beneficiary); *"I was lonely, so I would eat all sorts of things [...] it's like, for me, eating something sweet or something like that was like [...] a désennui"* (Roseline, 59, social assistance beneficiary); *"I started eating to fill the void [...] I snack when I'm lonely"* (Caroline, 55, disability).

While middle-class participants also identified emotional eating as a barrier to weight control, feelings of loneliness were more associated with periodic boredom than a permanent condition of social isolation: *"There was a period when I was sewing a lot for my daughter [...] I never thought about snacking! I had something to do"* (Julia, 62, college professor). Their social networks acted as facilitators in the adoption and maintenance of weight-control practices. By maintaining close relationships with former co-workers, friends, family, and children, the social networks of middle-class women

provided them with stronger supportive environments for sustaining weight control lifestyles. Significant others would propose or encourage food alternatives, friends and co-workers would gather for group leisure-time physical activity, and children would avoid bringing excessive junk food to family dinners. The following quote highlights the positive role played by middle-class women's social networks: *"having a good network of friends changes everything in my opinion [...] I have a good network [...] it's stimulating, you know?"* (Hélène, 63, nurse).

Third, the nature of relationships with health care professionals also acted as a barrier or facilitator to weight management. Underprivileged women experience difficult communication and a cultural distance with their medical practitioners. They often believed that their doctors held a condescending attitude when discussing their excess weight. This perception, supplemented by a misunderstanding of medical terminology, discouraged open dialogue: *"[The doctor's repetitive weight loss prescriptions] make me feel like doing nothing! It makes me feel like I'm fed up - laughs - stop talking to me about this. I may just be trying to avoid reality"* (Roseline, 59, social assistance beneficiary). As they were more likely to delay medical consultation and be reluctant to take prescription medication, close relationships with health care providers further hindered the early detection and treatment of disease. Taïna, a 62 year old unemployed woman questioned the caring ethics of medical professionals, believing they were more interested in her weight measurements than her well-being: *"There are some times when I ask myself if we're just lab rats [...] I'll ask questions and they'll just pass over them [...] sometimes they just go too fast"*.

Interview discussions on doctor-patient relations showed a greater capacity of

middle-class participants, who possessed a language level that enabled a smoother communication with their doctors, and the skills to assess and challenge medical prescriptions. Although all participants observed that health care providers made assumptions about their health and lifestyles based on their weight, their *cultural proximity* with medical professionals enabled them to actively collaborate in finding a suitable health regimen: *“Our relationship is more friend-like [...] She brought me an article about wheat intolerance [...] we do it all by email, she'll send me little messages like that”* (Hélène 3, 63, social worker). Many expressed how they assert themselves in the clinical setting and how they actively participated in decisions about preventative practices and treatment options: *“Well I told the doctor: ‘I'm not okay [with weight loss prescription X] for this and that reason’. Then he said: ‘that's okay, you're the boss’”* (Maya, 58, social worker); *“I also have the power to decide, you know, the doctor is really just there to give advice”* (Clémence, 63, teacher). As reflected in the following quote, middle-class participants were confident that their health care providers had their best interest at heart, despite expressing some frustrations:

“Yeah, then I told him ‘I’m going to set one thing straight with you’, I told this to my doctor: [...] ‘My objective [...] is not to gain any more weight’ [...] when you’ve never had a weight problem, you can’t understand what it’s like. Doctors, it’s in their nature, in their culture – a desire to health, and at the same time, to feel like they hold absolute truth or knowledge” (Julia, 62 retired college professor).

Conclusion

Although health care services in Canada have greatly improved middle-aged

women's health and well-being, epidemiological data continue to expose health inequalities among women. These inequalities are clearly reflected in the 10-year gap between the health-adjusted life expectancy of women in the lowest and the highest income deciles (Statistics Canada, 2009). Our results indicate that socioeconomic position remains an under-researched element in the study of clinically overweight and obese populations. In this respect, the impact of social factors (i.e., social position, gender norms and obesity stigma) on lifestyles (weight management) must also be seriously acknowledged. This analysis of weight control practices was guided by the concept of body *habitus* – a specific relation to the body fashioned by one's social position and social and material living conditions. This allows for a deeper understanding of how types of resources (capital) determine a social position (and respective living conditions) that fashion a *habitus* and orient distinctive lifestyles. Although middle-class women integrated weight control practices in their daily lives, few discussed making tremendous personal sacrifices to control their body weight. When considering social circumstances, it is unlikely that austere forms of weight control regimens expressed by underprivileged participants could be sustained over a long period of time. Globally speaking, middle-class conditions privileged the adherence to public health recommendations, while socially deprived conditions inclined women to adopt higher health risks in their attempts to lose weight. Drawing on the cultural-omnivore thesis⁴ (Warde, Wright & Gayo-Cal, 2007), it is possible that middle classes have greater ability to combine normative health lifestyles and occasional anti-normative practices such as high caloric food intake. It may

⁴ The cultural omnivore thesis contends that cultural capital, and specifically education, increases one's "awareness of the contestability of judgments about taste" (Bryson, 1996), permitting these individuals to participate in practices outside of legitimate culture.

be easier to relinquish one's preferences (or to go against one's taste) when one has the time, is convinced by its benefits, and is already fulfilled by other aspects of life.

By identifying the impacts of class-distinctive lifestyles, this study supports epidemiological work on increased health inequalities within obese populations (Burkert et al., 2013). Sociologists have long advocated for the consideration of life circumstances when analyzing health care choices and health lifestyles (Collyer, 2012). Healthy weight control, like other social practices, holds a symbolic value and a distinctive social significance for each social class. The analysis of hierarchies of priorities, perceptions of control, and barriers/facilitators show that weight management needs to be understood as the outcome of a social process in which living conditions, material and psychosocial, offer a number of conditions of possibilities. If all participants qualified as being clinically overweight or obese, their lifestyles, weight-control practices, and psychosocial health differed significantly, supporting the claims of multiple health profiles for a given body composition (Poulain, 2009).

From a methodological point of view, studies are pointing to the importance of using a biographical approach, especially focusing on early life trajectories, in order to examine the cumulative effect of life circumstances on health and well-being in later life (Elo, 2009; Krieger, Chen & Selby, 2001). Life trajectories characterized by physical and sexual abuse, neglect, social isolation and low social status disengage people from pursuing lifestyles in order to improve health and well-being; failed attempts to increase well-being contribute to generating a sense of helplessness towards successful outcomes. The strength of a biographical approach to interviewing allows for a deeper understanding of the effects of social and material conditions of existence on women's

relation to their body. The use of intersectional analyses of class and gender was also useful in gaining a deeper understanding of social inequality because it helped illustrate how women's life experiences vary according to their position within social space (McCall, 2005; McDowell, 2006). Although clear differences were present between the two socioeconomic classes, the line of inquiry of this study may have obscured intra-class differences.

Our results suggest that current public health norms are difficultly accessible to underprivileged women and may further contribute to their marginalization. The horizontal analysis showed a stronger focus on body appearance (rather than health) among underprivileged participants. As Mildred Blaxter (1990) argued, by reinforcing the achievement of body ideals through a specific set of health practices, public health agencies reinforce a stigma against underprivileged populations that face significant barriers to adopt these practices. By producing such a stigma, health experts further inhibit underprivileged groups' ability to flourish in the context of health. A partial solution aiming to increase weight control practices is a "health at every size" or "weight inclusive" approach, which focuses on the management of health and well-being (rather than solely on body weight) while minimizing obesity stigma (Puhl & Heuer, 2010; Tylka et al., 2014). Recent research on the weight-health connection suggests that obesity is not a consistent indicator of poor health (Flegal et al., 2013; McAuley & Blair, 2011), and that weight loss (through the adoption of various weight-loss practices: diet, exercise) does not always lead to better health (Gaesser, 1999). By modifying dominant public health discourses in order to focus on health markers, other than weight per se, health experts may be able to improve the adoption of health practices and the psychosocial

well-being among this group of women. Sociology can be useful in the study and implementation of such public health messaging as it offers a unique lens with which to consider the interaction between social and political dimensions of health, as well as their effect on many social groups struggling with body weight.

ⁱ The aim of this interdisciplinary team is to understand the biological, psychological and sociological factors that influence weight regulation in women during critical periods of their lives in order to create public health initiatives that minimize body weight changes and their potential health issues.

ⁱⁱ Participants self-reported postmenopausal status (absence of menses ≥ 12 months; WHO, 1981) as well as height and weight to determine overweight or obesity status (BMI $\geq 25\text{kg/m}^2$; Bessesen, 2008)

ⁱⁱⁱ Participants were independent as defined by the Ministry of Health and Social Services of Québec (meaning they require less than one hour of care per day and do not receive assistance with any ADLs). The purpose of selecting francophone participants was to minimize the influence of other cultural variables that could be significant in the study of women's relation to the body.

References

- Abdulnour, J., Doucet, E., Brochu, M., Lavoie, J.-M., Strychar, I., Rabasa-Lhoret, R. & Prud'homme, D. (2012). The effect of the menopausal transition on body composition and cardiometabolic risk factors: a Montreal-Ottawa New Emerging Team group study. *Menopause: The Journal of the North American Menopause Society*, 19(7), 760-767.
- Annandale, E. (2013). *Gender theory and health*. Medical sociology on the move (pp. 155-171) Springer.
- Bessesen, D. H. (2008). Update on Obesity. *The Journal of Clinical Endocrinology and Metabolism*, 93(6), 2027-34.
- Beydoun, M. A. & Wang, Y. (2010). Pathways linking socioeconomic status to obesity through depression and lifestyle factors among young US adults. *Journal of Affective Disorders*, 123(1-3), 52-63.
- Blaxter, M. (1990). *Health & Lifestyles*. London, UK: Routledge.
- Boltanski, L. (1971). Les usages sociaux du corps, *Annales. Histoire, Sciences sociales*, 26(1), 205-233.
- Bourdieu, P. (1984). *Distinction: A Social Critique of the Judgment of Taste*. Cambridge, MA: Harvard University Press.
- Brennan, S. L., Henry, M. J., Nicholson, G. C., Kotowicz, M. A. & Pasco, J. A. (2009). Socioeconomic status and risk factors for obesity and metabolic disorders in a population-based sample of adult females. *Preventative Medicine*, 49 (1), 165-171.

- Bryson, B. (1996). "Anything but heavy metal" symbolic exclusion and musical dislikes. *American Journal of Sociology*, 102(3), 884-899.
- Burkert, N. T., Rásky, É., Großschädl, F., Muckenhuber, J. & Freidl, W. (2013). The Influence of Socioeconomic Factors on Health Parameters in Overweight and Obese Adults. *PLoS ONE*, 8(6), 1-8.
- Christensen, V. T. & Carpiano, R. M. (2014). Social class differences in BMI among Danish women: Applying Cockerham's health lifestyles approach and Bourdieu's theory of lifestyle. *Social Science & Medicine*, 112(1), 12-21.
- Cignarella, A., Kratz, M. & Bolego, C. (2010). Emerging role of estrogen in the control of cardiometabolic disease. *Trends in Pharmacological Sciences*, 31(4), 183-189.
- Clarke, P. J., O'Malley, P. M., Schulenburg, J. E. & Johnson, L. D. (2010). Midlife Health and Socioeconomic Consequences of Persistent Overweight Across Early Adulthood: Findings From a National Survey of American Adults (1986–2008). *American Journal of Epidemiology*, 172(5), 540-548.
- Cockerham, W. C. (2010). Health Lifestyles: Bringing Structure Back. In W. C. Cockerham (Ed.) *The New Blackwell Companion to Medical Sociology* (pp. 159-183). West Sussex, UK: Wiley-Blackwell.
- Collyer, F. M. (2012). *Mapping the Sociology of Health and Medicine: America, Britain and Australia Compared*. Basingstoke: Palgrave Macmillan.
- Darmon, M. (2003). *Devenir anorexique: une approche sociologique*. Paris, France: Éditions la découverte.
- Dumas, A. & Laberge, S. (2005). Social Class and Ageing Bodies: Understanding Physical Activity in Later Life. *Social Theory & Health*, (3), 183-205.

- Elo, I. T. (2009). Social Class Differentials in Health and Mortality: Patterns and Explanations in Comparative Perspective. *Annual Review of Sociology*, 35(1), 553-572.
- Fikkan, J. L. & Rothlum, E. D. (2012). Is Fat a Feminist Issue? Exploring the Gendered Nature of Weight Bias. *Sex Roles*, 66, 575-92. doi: 10.1007/s11199-011-0022-5
- Flegal, K. M., Kit, B. K., Orpana, H. & Graubard, B. I. (2013). Association of All-Cause Mortality With Overweight and Obesity Using Standard Body Mass Index Categories: A Systematic Review and Meta-analysis. *Journal of the American Medical Association*, 209(1), 71-82.
- Gaesser, G. A. (1999). Thinness and weight loss: beneficial or detrimental to longevity? *Medicine and science in sports and exercise*, 31(8), 1118-28.
- Government of Québec. (2011). Atlas de la Santé et des Services sociaux du Québec: Variations locales de l'indice de défavorisation, 2011. Retrieved from: http://www.msss.gouv.qc.ca/statistiques/atlas/atlas/index.php?id_carte=1353
- Harding, J. L., Backholder, K., Williams, E. D., Peeters, A., Cameron, A. J., Hare, M. J. L., Shaw, J. E. & Magliano, D. J. (2014). Psychosocial Stress Is Positively Associated with Body Mass Index Gain Over 5 Years: Evidence from the Longitudinal AusDiab Study. *Obesity*, 22(1), 277-286.
- Jull, J., Stacey, D. Beach, S. Dumas, A. Strychar, I. Ufholz, L-A., Prince, S., Abdunour, J., Prud'homme, D.G. (2014). Lifestyle Interventions Targeting Body Weight Changes During the Menopause Transition: A Systematic Review. *Journal of Obesity*, 2014(824310), 1-16. doi: <http://dx.doi.org/10.1155/2014/824310>

- Krieger, N., Chen, J. T. & Selby, J. V. (2001). Class inequalities in women's health: combined impact of childhood and adult social class – a study of 630 US women. *Public Health*, 115(1), 175-185.
- Laberge, S. & Sankoff, D. (1988). Physical Activities, Body Habitus and Lifestyles. In J. Harvey (Ed.) *Not Just A Game: Essays in Canadian Sport Sociology*. Ottawa, Canada: University of Ottawa Press,
- Lhuissier, A. (2012). The Weight-loss Practices of Working Class Women in France. *Food, Culture & Society*, 15(4), 643-664.
- Lovejoy, J. C. (2009). Weight Gain in Women at Midlife: The Influence of Menopause. *Obesity Management*, 5(2), 52-56.
- Maisonneuve, C., Lamontagne, P., Blanchet, C. & Hamel, D. (2015). *Poids corporel et insécurité alimentaire chez les adultes Québécois en 2011-2012* (Institut national de santé publique du Québec: Surveillance des habitudes de vie N° 6). Québec, QC: Gouvernement du Québec.
- Marshall, C., Lengyel, C. & Utioh, A. (2012). Body Dissatisfaction Among Middle-aged and Older Women. *Canadian Journal of Dietetic Practice and Research*, 73(2), e241-7. doi: 10.3148/73.2.2012.e241
- McAuley, P. A. & Blair, S. N. (2011). Obesity Paradoxes. *Journal of Sport Sciences*, 29(8), 773-82.
- McCall, L. (2005). The Complexity of Intersectionality. *Signs: Journal of Women in Culture & Society*, 30(3), 1771-1800.

- McDowell, L. (2006). Reconfigurations of Gender and Class Relations: Class Differences, Class Condensation and the Changing Pace of Class Relation. *Antipode*, 38(4), 825-850.
- McLaren, L. & Godley, J. (2009). Social class and BMI among Canadian adults: A focus on occupational prestige. *Obesity*, 17(2), 290-299.
- Pampalon, R., Hamel, D. & Gamache. (2008). *Les inégalités sociales de santé augmentent-elles au Québec?* Institut national de santé publique du Québec.
- Peppas, M., Koliakia, C., Hadjidakis, D. I., Garoflos, E., Papaefstathiou, A., Katsilambros, N., Raptis, S. A. & Dimitriadis, G. D. (2013). Regional fat distribution and cardiometabolic risk in healthy postmenopausal women. *European Journal of Internal Medicine*, 24(8), 824-831.
- Pimenta, F., Maroco, J., Ramos, C. & Leal, I. (2014). Predictors of Weight Variation and Weight Gain in Peri- and Postmenopausal Women. *Journal of Health Psychology*, 19(8), 993-1002. doi: 10.1177/1359105313483153
- Poulain, J. P. (2009). *Sociologie de l'obésité*. Paris, France: Presses Universitaires de France.
- Puhl, R. M. & Heuer, C. A. (2010). Obesity Stigma: Important Considerations. *American Journal of Public Health*, 100(6), 1019-1028.
- Savage, M., Dumas, A. & Stuart, S. (2013) Fatalism and short-termism as cultural barriers to cardiac rehabilitation amongst underprivileged men. *Sociology of Health and Illness*, 35(8), 1211-26.
- Statistics Canada. (2007). *Sherbrooke, Québec (table) 2006 Community Profiles* Catalogue no. 92-591-XWE. Retrieved from:

- <http://www12.statcan.gc.ca/census-recensement/2006/dp-pd/prof/92-591/index.cfm?Lang=E> (accessed May 20th, 2015)
- Statistics Canada. (2012). *Sherbrooke, Quebec* (Code 433) and *Quebec* (Code 24) (table). Census Profile. 2011 Census. Statistics Canada Catalogue no. 98-316-XWE. Government of Canada. Retrieved from: <http://www12.statcan.gc.ca/census-recensement/2011/dp-pd/prof/index.cfm?Lang=E>
- Stroebe, M., Schut, H. & Stroebe, W. (2007). Health outcomes of bereavement. *The Lancet*, 370, 1960-1973.
- Tylka, T. L., Annunziato, R. A., Burgard, D., Daniélsdóttir, S., Shuman, E., Davis, C. & Calogero, R. M. (2014). The Weight-Inclusive versus Weight-Normative Approach to Health: Evaluating the Evidence for Prioritizing Well-Being over Weight Loss. *Journal of Obesity*. doi: <http://dx.doi.org/10.1155/2014/983495>
- van Zutven, K., Mond, J., Latner, J. & Rodgers, B. (2015). Obesity and psychosocial Impairment: mediating roles of health status, weight/shape concerns and binge eating in a community sample of women and men. *International Journal of Obesity*, 39(1), 346-352.
- Warde, A., Wright, D. & Gayo-Cal, M. (2007). Understanding Cultural Omnivorousness: Or, the Myth of the Cultural Omnivore. *Cultural Sociology*, 1(2), 143-164.
- Williams, L., Germov, J. & Young, A. (2011). The effect of social class on mid-age women's weight control practices and weight gain. *Appetite*, 56(1), 719-725.
- Willis, B. L., Gao, A., Leonard, D., DeFina, L. F. & Berry, J. D. (2012). Midlife Fitness and the Development of Chronic Conditions in Later Life. *Archives of Internal Medicine*, 172(17), 1333-1340. doi:10.1001/archinternmed.2012.3400

World Health Organization (1981). *Research on the menopause*. Geneva, Switzerland:

WHO scientific group the research on the menopause.

Zheng, H. & Yang, Y. (2012). Population Heterogeneity in the Impact of Body Weight on Mortality. *Social Science & Medicine*, 75, 990-996.

Table 1

Participant Characteristics - Sociodemographic

Characteristics	Underprivileged class (n=20)	Middle classes (n=20)
Age groups (years)		
55–59	11	6
60–65	9	14
BMI (kg/m ²)		
25–29.9 (overweight)	9	11
30–34.9 (type I obesity)	4	5
35–39.9 (type II obesity)	4	4
≥ 40 (type III obesity)	3	0
Highest level of education		
High school (incomplete)	6	1
High school	9	4
College	2	3
University	3	12
Marital status		
Single ^a	6	4
Divorced	8	3
Married	6	13
Personal attributes		
Lives alone	13	6
Children	14	18
Regular contact	8	18
History of mental illness (diagnosed) ^b	14 ^c	6

History of alcoholism or drug addiction	8	1
Victim of childhood physical abuse	12	1
Victim of sexual abuse ^c	6	1
Experience of overt weight shaming ^d	10	3

^a One woman from each group was widowed.

^b Women from the underprivileged class suffered from chronic depression, anxiety and bipolar disorder (which often interfered with daily function) while women from the middle classes experienced depression and anxiety linked to traumatic events.

^c Some underprivileged women were not diagnosed with mental illness, but suffered from some form of psychosocial distress.

^d All women who were sexually abused were also physically abused as a child.

^e Overt weight shaming was characterized as any incident where participants were clearly made to feel inferior due to their weight.

Table 2

Participant Characteristics – Health and Lifestyle

Characteristics	Underprivileged class (n=20)	Middle classes (n=20)
Use of prescription drugs	16	14
Weight gain during menopause	18	20
Regular medical exams	11	19
History of weight control practices (adulthood before menopause)	15	12
Current use of weight control practices (post-menopause)	7	20
Physical activity & diet	2	15
Diet only	4	4
Physical activity only	1	1
Use of weight control professionals	6	9

Table 3

Social Variation of Weight Management Practices Between Clinically Overweight and Obese Postmenopausal Women from Two Contrasting Socioeconomic Milieus

Underprivileged Class	Middle classes
Weight Management within the Hierarchy of Priorities	
• Prioritize short-term needs and desires: a) Fulfillment of primary needs: financial equilibrium, food (hearty food, feelings of satiety as criteria for daily diet), quality living space (i.e. to acquire and maintain safe and comfortable housing), social and affective needs (i.e. maintaining relationships with family, friends and significant others) b) Small pleasures of life (e.g. eating “junk food”, watching favourite television shows, social activities) c) Current physical autonomy and their body’s ability to perform daily tasks (i.e. activities of daily living or ADLs) despite “consequences” of excess weight (e.g. pain in knees and back, difficulty breathing)	• Prioritize long-term health and well-being: a) Managing risk factors of disease through the adoption of public health recommendations; emphasize the quality and health-giving potential of food and physical activities b) Controlling their current weight through weight control practices in order to preserve self-worth, as weight control allows them to be perceived as being: in control over self and health, a good role model for (grand), children and able to care for family c) Enjoying retirement activities (babysitting, walking, etc) free from illness/disability (i.e. “profiter de la vie”)

- Practices (type, frequency, intensity)
 - Adopt radical weight-control practices that: (a) require a high level of compromise, (b) are an inherent risk to health and (c) are a short-term approach to weight loss (e.g. high caloric restriction, diet pills, weight-loss surgery (gastric bypass, vertical banded gastroplasty)
 - Have low inclination, and express distaste for leisure or health-oriented planned and structured physical activity, adopt labour, transport and domestic types of physical activities
 - History of serial dieting-relapsing cycles; often abandon weight control strategies due to their unsustainable nature.
- Practices (type, frequency, intensity)
 - Adopt weight-control practices that: (a) combine physical activity and a healthy diet, (b) are moderate in intensity (e.g. taking an hour-long walk every week day) and modest dietary restraint (e.g. avoiding processed foods most of the time, portion control), and (c) are established as part of a routine to allow for long-term weight control
 - Distinguish themselves from dieters by taking a sustained lifestyle approach to weight control (focus on appearing natural, minimal restriction); focus on controlling their current weight (i.e. not gaining) without sacrificing pleasures linked to meals (e.g. family meals, wine with friends, etc.)

Control over Weight Management

Weight management	• Perceive they have low control over the factors that influence weight control practices (e.g. access and quality of physical activity) • Possess a fatalistic view towards weight control and attainment of public health norms on weight, perceive investment in weight-control practices as a path to further disappointment • Feel powerless toward significant weight control and weight loss (passive acceptance of excess weight)	• Perceive they have strong control over factors influencing meals and physical activity • Adopt and modify self-care practices in line with public health recommendations to their changing lives • Distinguish between weight loss and weight control; pessimistic towards weight loss, but persist with weight-control practices to maintain current weight and health (i.e. mobility and fitness)
-------------------	---	---

Barriers and Facilitators towards Weight Management

Financial	• Adopt low-cost weight control practices due to limited financial resources (e.g. walking, dietary restraint) • Consider prices of “healthy” foods inaccessible and overpriced: ○ Rely on food banks and soup kitchens to eat ○ Do not own functional refrigerator to preserve unprocessed food • Are mostly unable to afford gym memberships or community centre fees for physical activity programming	• Face few or no financial barriers to health and weight-control practices • Participate in private and public physical activities (e.g. AquaFit, aerobic classes) and self-directed sporting practices (e.g. biking, hiking, tennis)
Social Networks	• Rely on few meaningful social contacts (friends, siblings, children) for supporting weight control practices (e.g. group fitness program, adopt healthy eating practices) • Pursue individual-led physical activities and “healthy” eating practices (e.g. stretching exercises at home, aerobics videos) but rarely sustain them • Feel their weight reduces the strength of social ties and increases isolation	• Maintain a close relationship with former co-workers, friends, family, and children; feel supported to control weight by their network (e.g. partner will adopt new eating habits to support weight-control efforts, children will avoid bringing dessert to family meals) • Participate in group leisure physical activities (e.g. hiking groups consisting of former co-workers and friends, walking groups, AquaFit) • Feel they are valued by their entourage for personal traits other than body weight and appearance

Health Care Professionals

- Delay medical consultation and are reluctant to take prescription drugs (but submit to prescriptions by necessity)
 - Experience feelings of subservience when meeting with health care providers
 - Experience difficulty communicating with health care professionals (level of language, specific terms), gather health information from the internet
 - Feel health care providers are interested in weight measures more than patient well-being
 - Maintain close and collaborative relationships with health care providers
 - Make joint decisions (negotiate) on weight and weight control
 - Assert independence towards medical recommendations after personal research (e.g. academic literature) and second opinion
 - General trust that health care providers have their best interest at hand.
-

Chapter VII

Conclusion

Middle-aged and menopausal women's transitioning bodies is receiving much attention by public health institutions. Hormonal, personal and social changes occurring during this life period make women more susceptible to weight gain, accumulation of visceral fat and chronic illnesses (Lovejoy, 2009). In addition to body weight, when drawing on a socioeconomic perspective, clinically obese groups who are socially and materially deprived are more likely to suffer from chronic disease, to have a poorer quality of life and to be shamed because of their body weight, and less likely to adopt health practices than obese women from a higher socioeconomic strata. Although female obesity and its association with health and well-being has been studied extensively, more research needs to focus on the intersection between body weight, socioeconomic status and health (Burkert et al., 2013).

This study compares two contrasting socioeconomic groups of clinically overweight and obese postmenopausal women in order to develop a better understanding of the social variation of weight control practices and the different experiences of obesity stigma. It provides social scientists and health professionals with a better understanding of clinically overweight and obese women's experiences, relations to the body, and lifestyles in order to better adapt respectful and non-judgmental health and weight control interventions.

The dominant discourse of obesity reinforces values of self-care, health and body appearance by promoting specific sets of weight control practices. However, the social variation of health lifestyles reflects the general consensus expressed in previous studies;

the socioeconomic circumstances of women from the middle classes provide less barriers and a greater inclination to adopt healthy weight control practices (Jeffrey & French, 1998; Wardle & Griffith, 2001). Although no biometric measures were collected in this study, the interview transcripts support the theory of multiple health profiles for a given body weight (Poulain, 2009). Middle-class participants scarcely mentioned diseases directly related to their excess body weight, while underprivileged participants regularly complained of feeling trapped in a deteriorating overweight body.

In addition, the existence of an obesity stigma reinforces the idea that obesity is evidence of failure to care for oneself and contributes to weight discrimination and weight shaming in overweight groups (Cardona, 2008). In this study, although all participants attempted to lose weight, participants from the middle classes gained status in other life domains, which were neutral or more respectful of body size, and took comfort in their adoption of healthy lifestyles (i.e. portion control, regular moderate physical activity). In this context, it is highly plausible to argue that women of lower socioeconomic status, or those with low levels of social, economic and cultural capital, experience a greater degree of *symbolic violence*, shame and social inferiorization tied to their body weight.

This study primarily focused on the social and material living conditions of two contrasting groups of clinically overweight and obese postmenopausal women and the ways in which social position fashions a distinct relation to the body and corresponding sets of practices related to excess weight. Pierre Bourdieu's (1984) sociocultural theory of practice and concepts of *capital*, body *habitus* and *symbolic violence* contributed to operationalizing social and lifestyle inequalities. Similarly, the instrumental and reflexive

relation to the body exposed two contrasting orientations towards health, body weight and body appearance. On the one hand, the instrumental relation to the body of women from the underclass is characterized by short-term investments and by a perception of the body as a means to an end. Practically speaking, lower attention was provided to prevention of impairment and disease, especially when they were asymptomatic. On the other hand, a reflexive relation to the body typically embodied by the middle classes, fashioned a higher sensitivity to health, disease prevention, and long-term investments onto the body.

The concept of *symbolic violence* investigated participants' embodiment of body weight norms and their responses to obesity stigma. This notion refers to a subtle violence, a seemingly natural form of oppression exercised by dominant groups through the existence and use of symbolic power between both groups (Bourdieu, 2000). One key finding of this study furthers the understanding of underprivileged participants' psychosocial challenges and difficulties in adopting healthy lifestyles: a lower social position diminishes one's control over the exposure to obesity stigma and decreases one's capacity to defend oneself against it. As argued by Golberg (2011), the double burden of obesity and poverty constitutes a "qualitatively distinct form of suffering" in which low socioeconomic status individuals are more often subjected to obesity stigma and its variety of consequences.

The use of qualitative and biographical approaches to interviewing participants facilitated the examination of the cumulative effect of social circumstances on lifestyles during midlife (Elo, 2009; Krieger, Chen & Selby, 2001). These approaches show the importance of socially situating social practices in one's life trajectory and show the necessity to conceive lifestyle as the outcome of a socially acquired set of dispositions

that are nurtured over time. While the biographical approach to interviewing was not fully exploited in this analysis, it permitted the researcher to step into the participants' shoes and further understand the factors that contributed to the adoption of certain practices. The intersectional analysis employed in this study (gender, age and socioeconomic status) was conducted in order to understand the interaction of vectors of social inequalities in the specific context of obesity.

Body dissatisfaction in middle-aged and older women is detrimental to health and quality of life (Marshall, Lengyl & Utioh, 2012; van Zutven, Mond, Latner & Rodgers, 2015). Body dissatisfaction is intensified by weight discrimination and weight shaming, which have a negative impact on women's educational attainment, employment and romantic relationships (Fikkan & Rothblum, 2012). Experiencing obesity stigma increases likelihood of weight gain (Harding et al., 2014; Major, Hunger, Bunyan & Miller, 2014; Pearl et al., 2014; Schvey et al., 2014), leads to delaying medical treatment (Dietz, 2015), and lowers participation in health-enhancing activities (physical activity, diet; Lewis et al., 2011; Potter et al., 2015). Recent research on the effects of obesity stigma show that clinically overweight adults who experienced weight discrimination were 2.5 times more likely to become obese within four years of the study than participants who did not report weight discrimination, even after controlling for age, sex, ethnicity, and education (Sutin, Stephan, Luchetti & Terracciano, 2014). The processes by which these experiences interact with socioeconomic conditions and shape weight control practices have been investigated in this thesis. The results from this study suggest that underprivileged groups are more often exposed to obesity stigma in their social

environments (soup kitchens, low-income neighborhoods), and rarely possess forms of social value to protect themselves from it (loving relationships, successful careers, etc).

The interviews made clear that while body weight should not be ignored in the context of illness prevention, conversations around weight and lifestyles (particularity in public health and medical settings) require a significant shift away from the current weight-normative approach. A popular movement within obesity studies is the promotion of body size acceptance, specifically the Health at Every Size (HAES) approach. Scholars argue that because the current promotion of thinness as a motivator for weight loss can lead to irrational eating and exercise patterns in order to achieve unrealistic weight loss aspirations, it is counterproductive to addressing concrete risks to health and well-being (Bombak, 2014; Gailey, 2014; Parham, 1999; van Zutven et al., 2015). By modifying dominant public health discourses in order to focus on health markers, other than weight per se, patient-doctor interactions would focus less on body weight and more on health and well-being. The results of this study show that underprivileged women tend to view health and weight from a short-term perspective, and that when motivated by weight loss, often give up on healthy lifestyles. Current discourses on health and weight promoted by their health care providers are typically incongruent with their current lifestyles and further push underprivileged groups from adopting healthier weight-control practices. A greater emphasis on the priorities of underprivileged women at this age (such as maintaining mobility and strength), coupled with short-term practices to promote healthy lifestyles, may be the key to improving this sub-population's health, independent of their weight.

One important contribution of this study is the recruitment of two contrasting groups of clinically overweight and obese postmenopausal women. The analysis of their interview transcripts clearly indicates the impact of social position on weight-related experiences and health practices. Although clear differences were present between the two groups, the line of inquiry of this study may have obscured intra-class differences. Heterogeneity in individual life circumstances (e.g. stable romantic relationships) presented some differences in exposure and responses to obesity stigma within each socioeconomic group. Although individual differences were not captured in this analysis, a detailed analysis of class fractions could have shed light on other factors leading to intra-class differences in participants' responses.

Because participant recruitment and interviewing were performed by two other researchers (Mélisa Audet and Alex Dumas), the quality of the analysis may have been negatively affected by a lack of context. To minimize this, interviews were professionally transcribed and access to interview recordings was granted. Frequent communication with both researchers also enabled the triangulation of results and increased the validity of the interpretations.

The results in this study draw attention to the need for more research on the experiences of clinically overweight and obese women living in underprivileged circumstances. Most studies on women's weight control and obesity stigma exclusively recruit middle-class participants. Because underprivileged women have greater health risks in the context of excess weight, it is crucial to give them a voice in a field where they have often been excluded. In this setting, health professionals and policy makers

play a fundamental role in improving policy, research, and interventions directed towards this group.

References

- Abdulnour, J., Doucet, E., Brochu, M., Lavoie, J.-M., Strychar, I., Rabasa-Lhoret, R. & Prud'homme, D. (2012). The effect of the menopausal transition on body composition and cardiometabolic risk factors: a Montreal-Ottawa New Emerging Team group study. *Menopause: The Journal of the North American Menopause Society*, 19(7), 760-767.
- Abel, T. (2008). Cultural capital and social inequality in health. *Journal of Epidemiology and Community Health*, 62(7), 13-17.
- Adams, J. & White, M. (2003). Are activity promotion interventions based on the transtheoretical model effective? A critical review. *British Journal of Sport Medicine*, 37(2), 106-114.
- Annandale, E. (2013). Gender theory and health. *Medical sociology on the move* (pp. 155-171) Springer.
- Asikainen, T.-M., Kukkonen-Harjula, K. & Miilunpalo, S. (2004). Exercise for Health for Early Postmenopausal Women: A Systematic Review of Randomized Controlled Trials. *Sports Medicine*, 34(11), 753-778.
- Ball, K. & Crawford, D. (2005). Socioeconomic status and weight change in adults: a review. *Social Science & Medicine*, 60(1), 1987-2010.
- Bearman, S. K., Martinez, E., Stice, E. & Presnell, K. (2006). The Skinny on Body Dissatisfaction: A Longitudinal Study of Adolescent Girls and Boys. *Journal of Youth & Adolescence*, 35(2), 217-229.
- Bessesen, D. H. (2008). Update on Obesity. *The Journal of Clinical Endocrinology and Metabolism*, 93(6), 2027-34.

- Beydoun, M. A. & Wang, Y. (2010). Pathways linking socioeconomic status to obesity through depression and lifestyle factors among young US adults. *Journal of Affective Disorders*, 123(1-3), 52-63.
- Bierman, A. S., Ahmad, F., Angus, J., Glazier, R. H., Vahabi, M., Damba, C., Dusek, J., Shiller, S. K., Li, Y., Ross, S., Shapiro, G. & Manuel, D. (2009). Burden of Illness. In: A. S. Bierman (Ed.). *Project for an Ontario Women's Health Evidence-Based Report: Volume I*. Toronto: St. Michael's Hospital and the Institute for Clinical Evaluative Sciences.
- Blaxter, M. (1990). *Health & Lifestyles*. London, UK: Routledge.
- Bolam, B., Murphy, S. & Gleeson, K. (2004). Individualization and inequalities in health: a qualitative study of class identity and health. *Social Science & Medicine*, 59(7), 1355-1365.
- Boltanski, L. (1971). Les usages sociaux du corps, *Annales. Histoire, Sciences sociales*, 26(1), 205-233.
- Bombak, A. E. (2014). The Contribution of Applied Social Sciences to Obesity Stigma-Related Public Health Approaches. *Journal of Obesity*, 2014, 1-9.
doi:10.1155/2014/267286
- Bordo, S. (1990). Reading the slender body. In Jacobus, M., Keller, E. F. and Shuttleworth, S. (eds), *Body Politics: Women and the Discourses of Science*. Routledge: London.
- Borrell, L. N. & Samuel, L. (2014). Body Mass Index Categories and Mortality Risk in US Adults: The Effect of Overweight and Obesity on Advancing Death. *American*

- Journal of Public Health*, 104(3), 512-9. Bourdieu, P. (1978). Sport and Social Class. *Social Science Information*, 17(6), 819-840.
- Bourdieu, P. (1984). *Distinction: A Social Critique of the Judgement of Taste*. Cambridge, MA: Harvard University Press.
- Bourdieu, P. (1986). The forms of capital. In J. Richardson (Ed.) *Handbook of Theory and Research for the Sociology of Education*. Greenwood: New York. 241-258.
- Bourdieu, P. (1993). *La misère du monde*. Paris, France: Éditions du Seuil.
- Bourdieu, P. (2000). *Pascalian Meditations*. Stanford, CA: Stanford University Press.
- Bourdieu, P. (2001). *Masculine Domination*. California, USA: Stanford University Press.
- Bourdieu, P. and Passeron, J. C. (1977) *Reproduction in Education, Society and Culture*. Beverly Hills: Sage.
- Brennan, S. L., Henry, M. J., Nicholson, G. C., Kotowicz, M. A. & Pasco, J. A. (2009). Socioeconomic status and risk factors for obesity and metabolic disorders in a population-based sample of adult females. *Preventative Medicine*, 49 (1), 165-171.
- Brewis, A. (2014). Stigma and the perpetuation of obesity. *Social Science & Medicine*, 118(1), 152-158.
- Bryson, B. (1996). "Anything but heavy metal" symbolic exclusion and musical dislikes. *American Journal of Sociology*, 102(3), 884-899.
- Burkert, N. T., Rásky, É., Gro→schädl, F., Muckenhuber, J. & Freidl, W. (2013). The Influence of Socioeconomic Factors on Health Parameters in Overweight and Obese Adults. *PLoS ONE*, 8(6), 1-8. doi: doi:10.1371/journal.pone.0065407

- Byrne, S., Cooper, Z. & Fairburn, C. (2003). Weight maintenance and relapse in obesity: a qualitative study. *International Journal of Obesity*, 27(1), 955-962.
- Cancer Care Ontario, Ontario Agency for Health Protection and Promotion (Public Health Ontario) (2012). *Taking action to prevent chronic disease: recommendations for a healthier Ontario*. Toronto: Queen's Printer for Ontario.
- Canadian Institute for Health Information. (2008). *Health Care in Canada*. Ottawa, ON: CIHI
- Canadian Institute for Health Information. (2008a). *Reducing Gaps in Health: A Focus on Socio-Economic Status in Urban Canada*. Ottawa, Canada.
- Canadian Institute for Health Information. (2010). *Health Care in Canada*. Ottawa, ON: Abushomar, H., Anggawinata, S., Costa, M., Dudevich, A., Dwyer, C., Fagbemi, J., Gula, C., Gushue, S., Hader, J., Ji, H., Lam, D., Lee, C., Leeb, K., McPherson, M., Mueller, M., Parker, M., Veillard, J. & Yun, O.
- Cardona, B. (2008). 'Healthy ageing' policies and anti-ageing ideologies and practices : on the exercise of responsibility. *Medicine, Health Care and Philosophy*, 11(4): 475-483.
- Carpenter, L. M., Nathanson, C. A. & Young, J. K. (2006). Sex after 40?: Gender, ageism, and sexual partnering in midlife. *Journal of Aging Studies*, 20(1), 93-106.
- Cignarella, A., Kratz, M. & Bolego, C. (2010). Emerging role of estrogen in the control of cardiometabolic disease. *Trends in Pharmacological Sciences*, 31(4), 183-189.
- Charlesworth, S. J., Gilfillan, P. & Wilkinson, R. (2004). Living inferiority. *British Medical Bulletin*, 69(1), 49-60.

- Christensen, V. T. & Carpiano, R. M. (2014). Social class differences in BMI among Danish women: Applying Cockerham's health lifestyles approach and Bourdieu's theory of lifestyle. *Social Science & Medicine*, 112(1), 12-21.
- Cignarella, A., Kratz, M. & Bolego, C. (2010). Emerging role of estrogen in the control of cardiometabolic disease. *Trends in Pharmacological Sciences*, 31(4), 183-189.
- Clarke, P. J., O'Malley, P. M., Schulenburg, J. E. & Johnson, L. D. (2010). Midlife Health and Socioeconomic Consequences of Persistent Overweight Across Early Adulthood: Findings From a National Survey of American Adults (1986–2008). *American Journal of Epidemiology*, 172(5), 540-548.
- Cockerham, W. C. (2005). Health Lifestyle Theory and the Convergence of Agency and Structure. *Journal of Health and Social Behavior*, 46(2), 51-67.
- Cockerham, W. C. (2010). Health Lifestyles: Bringing Structure Back. In W. C. Cockerham (Ed.) *The New Blackwell Companion to Medical Sociology* (pp. 159-183). West Sussex, UK: Wiley-Blackwell.
- Cockerham, W. C. (2013). *Social Causes of Health and Disease*. Cambridge, UK: Polity Press.
- Collyer, F. M. (2012). *Mapping the Sociology of Health and Medicine: America, Britain and Australia Compared*. Basingstoke: Palgrave Macmillan
- Committee on Women's Health Research. (2010). *Women's Health Research: Progress, Pitfalls, and Promise*. Washington, DC: National Academies Press.
- Coveney, J. (2005). A qualitative study exploring socio-economic differences in parental lay knowledge of food and health: implication for public health nutrition. *Public Health Nutrition*, 8(3), 290-297.

- Crawford, R. (1980). Helthism and the Medicalization of Everyday Life. *International Journal of Health Services*, 10(3), 365-388.
- Curioni, C. C. & Lourenço, P. M. (2005). Long-term weight loss after diet and exercise: a systematic review. *International Journal of Obesity*, 29(1), 1168-1174.
- Cutcliffe, J. R. & McKenna, H. P. (1999). Establishing the credibility of qualitative research findings: the plot thickens. *Journal of Advanced Nursing*, 30(2), 374-380.
- Darmon, M. (2003). *Devenir anorexique: une approche sociologique*. Paris, France: Éditions la découverte.
- Darmon, M. (2006). Variations corporelles. L'anorexie au prisme des sociologies du corps. *Adolescence*, 24(2), 437-52.
- Dennis, K. E. (2007). Postmenopausal Women and the Health Consequences of Obesity. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 36(1), 511-519.
- Denzin, N. K. & Lincoln, Y. S. (1994). *Handbook of Qualitative Research*. London, UK: SAGE Publications.
- Dietz, W. H., Baur, L. A., Hall, K., Puhl, R. M., Taveras, E. M., Uauy, R. & Kopelman, P. (2015). Management of obesity: improvement of health-care training and systems for prevention and care. *The Lancet*, 386(9995), 1-13.
- Dumas, A. & Bournival, E. (2011). Men, masculinities and health. Theory and application. In J. Laker (Ed.) *Canadian Perspectives on Men and Masculinities. An Interdisciplinary Reader* (pp. 33-51). Toronto, ON: Oxford University Press.

- Dumas, A., Laberge, S. & Stratka, S. M. (2005). Older women's relations to bodily appearance: the embodiment of social and biological conditions of existence. *Ageing & Society*, 25(6), 883-902.
- Dumas, A., Robitaille, J. & Jette, S. L. (2014). Lifestyle as a choice of necessity: Young women, health and obesity. *Social Theory & Health*, 12(2), 138-158.
- Elavsky, S. (2009). Physical activity, menopause, and quality of life: the role of affect and self-worth across time. *Menopause*, 16(2), 265-271.
- Ellison, J. (2013). Weighing In: The "Evidence of Experience" and Canadian Fat Women's Activism. *Canadian Bulletin of Medical History*, 30(1), 55-75.
- Elo, I. T. (2009). Social Class Differentials in Health and Mortality: Patterns and Explanations in Comparative Perspective. *Annual Review of Sociology*, 35(1), 553-572.
- Esmail, N. & Basham, P. (2014). Obesity in Canada: Overstated Problems, Misguided Policy Solutions. *Fraser Institute*.
- Everson, S. A., Maty, S. C., Lynch, J. W. & Kaplan, G. A. (2002). Epidemiologic evidence for the relation between socioeconomic status and depression, obesity and diabetes. *Journal of Psychosomatic Research*, 53(1), 891-895.
- Farrell, A. E. (2011). *Fat Shame: Stigma and the fat Body in American Culture*. New York, NY: New York University Press.
- Fikkan, J. L. & Rothblum, E. D. (2012). Is Fat a Feminist Issue? Exploring the Gendered Nature of Weight Bias. *Sex Roles*, 66, 575-92. doi: 10.1007/s11199-011-0022-5
- Finkelstein, E. A., Brown, D. S. & Evans, W. D. (2008). Do Obese Persons Comprehend Their Personal Health Risks? *American Journal of Health Behavior*, 32(5), 508-

516.

- Flegal, K. M., Kit, B. K., Orphana, H. & Graubard, B. I. (2013). Association of All-Cause Mortality With Overweight and Obesity Using Standard Body Mass Index Categories: A Systematic Review and Meta-analysis. *Journal of the American Medical Association*, 309(1), 71-82.
- Forman, M. R., Mangini, L. D., Thelus-Jean, R. & Hayward, M. D. (2013). Life-course origin of the ages at menarche and menopause. *Adolescent Health, Medicine and Therapeutics*, 4(1), 1-21.
- Foster-Schubert, K. E., Alfano, C. M., Duggan, C. R., Xiao, L., Campbell, K. L., Kong, A., Bain, C. E., Wang, C.-Y., Blackburn, G. L. & McTiernan, A. (2012). Effect of Diet and Exercise, Alone or Combined, on Weight and Body Composition in Overweight-to-Obese Postmenopausal Women. *Obesity*, 20(8), 1628-1638.
- Franz, M. J., VanWormer, J. J., Crain, A. L., Boucher, J. L., Histon, T., Caplan, W., Bowman, J. D. & Pronk, N. P. (2007). Weight-Loss Outcomes: A Systematic Review and Meta-Analysis of Weight-Loss Clinical Trials with a Minimum 1-Year Follow-Up. *Journal of the American Dietetic Association*, 107(10), 1755-1767.
- Freeman, E. W. (2010). Associations of depression with the transition to menopause. *The Journal of the North American Menopause Society*, 17(4), 823-827.
- Frie, K & Janssen, C. (2009) Social inequality, lifestyles and health – a non-linear canonical correlation analysis based on the approach of Pierre Bourdieu. *International Journal of Public Health*, 54(4), 213-221.
- Gaesser, G. A. (1999). Thinness and weight loss: beneficial or detrimental to longevity?

Medicine and science in sports and exercise, 31(8), 1118-28.

Gailey, J. A. (2014). *The Hyper(in)visible Fat Woman: Weight and Gender Discourse in Contemporary Society*. New York, NY: Palgrave Macmillan.

Gard, M & Wright, J. (2005). *The obesity epidemic: Scence, morality and ideology*. New York, NY: Routledge/Taylor & Francis Group.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. New York, NY: Prentice-Hall, Inc.

Goldberg, D. S. (2011). What kind of people? Obesity Stigma and Inequities. *The American Journal of Medicine*, 124(8), 788.

Gouvernement du Québec. (2006). Cartographie: Variations canadiennes de l'indice de défavorisation matérielle et sociale en 2006. from:

http://www.msss.gouv.qc.ca/statistiques/atlas/atlas/index.php?id_carte=20061

Government of Québec. (2011). Atlas de la Santé et des Services sociaux du Québec: Variations locales de l'indice de défavorisation, 2011. Retrieved from: http://www.msss.gouv.qc.ca/statistiques/atlas/atlas/index.php?id_carte=1353

Gray, C. M., Hunt, K., Lorimer, K., Anderson, A. S., Benzeval, M. & Wyke, S. (2011). Words matter: a qualitative investigation of which weight status terms are acceptable and motivate weight loss when used by health professionals. *Public Health*, 11(1), 513-522.

Grbich, C. (2013). *Qualitative Data Analysis: An Introduction* (2nd ed.). London, UK: SAGE.

- Grippio, K. P. & Hill, M. S. (2008). Self-objectification, habitual body monitoring, and body dissatisfaction in older European American women: Exploring age and feminism moderators. *Body Image*, 5(2), 173-182.
- Gustafsson, P. E. & Hammarström, A. (2012). Socioeconomic disadvantage in adolescent women and metabolic syndrome in mid-adulthood: An examination of pathways of embodiment in the Northern Swedish Cohort. *Social Science & Medicine*, 74(1), 1630-1638.
- Guthrie, J. R., Dennerstein, L., Taffe, J. R., Lehert, P. & Burger, H. G. (2004). The menopausal transition: a 9-year prospective population-based study. The Melbourne Women's Midlife Health Project. *Climateric*, 7(1), 375-389.
- Hardeman, W., Johnston, M., Johnston, D. W., Bonetti, D., Wareham, N. J. & Kinmonth, A. L. (2002). Application of the theory of planned behaviour in behaviour change Interventions: A systematic review. *Psychology and Health*. 17(2). 123-158.
- Harding, J. L., Backholder, K., Williams, E. D., Peeters, A., Cameron, A. J., Hare, M. J. L., Shaw, J. E. & Magliano, D. J. (2014). Psychosocial Stress Is Positively Associated with Body Mass Index Gain Over 5 Years: Evidence from the Longitudinal AusDiab Study. *Obesity*, 22(1), 277-286.
- Hardy, R. & Kuh, D. (2002). Menopause and gynecological disorders: a lifecourse perspective. In D. Kuh & R. Hardy (Eds.). *A Lifecourse Approach to Women's Health* (pp.64-85). New York, NY: Oxford University Press.
- Hess, R., Thurston, R. C., Hays, R. D., Chang, C.-C. H., Dillon, S. N., Ness, R. B., Bryce, C. L., Kapoor, W. N. & Matthews, K. A. (2012). The impact of

- menopause on health-related quality of life: results from the STRIDE longitudinal study. *Quality of Life Research*, 21(3), 535-544.
- Ho, S. C., Wu, S., Chan, S. G. & Sham, A. (2010). Menopausal transition and changes of body composition: a prospective study in Chinese perimenopausal women. *International Journal of Obesity*, 34(1), 1265-1274.
- Horseburgh, D. (2003). Evaluation of qualitative research. *Journal of Clinical Nursing*, 12(1), 307-312.
- Hurd Clarke, L. (1999). "WE'RE NOT OLD!": Older Women's Negotiation of Aging and Oldness. *Journal of Aging Studies*, 13(4), 419-439.
- Hurd Clarke, L. (2000). Older women's body image and embodied experience: An exploration. *Journal of Women & Aging*, 12(3/4), 77-96.
- Hurd Clarke, L. (2002). Older women's perceptions of ideal body weights: the tensions between health and appearance for weight loss. *Ageing and Society*, 22(6), 751-773.
- Hurd Clarke, L. & Griffin, M. (2007). The body natural and the body unnatural: Beauty work and aging. *Journal of Aging Studies*, 21(1), 187-201.
- Hurd Clarke, L. & Griffin, M. (2008). Visible and invisible ageing: beauty work as a response to ageism. *Ageing & Society*, 28, 652-674.
- Hurd Clarke, L. & Griffin, M. (2008). Body image and aging: Older women and the embodiment of trauma. *Women's Studies International Forum*, 31(1), 200-208.
- Ickes, M. J. (2011). Stigmatization of Overweight and Obese Individuals: Implications for Mental Health Promotion. *International Journal of Health Promotion*, 13(3), 37-45.

- Jafarya, F., Farahbakhshb, K., Shafiabadib, A. & Delavar, A. (2011). Quality of life and menopause: Developing a theoretical model based on meaning in life, self-efficacy beliefs, and body image. *Aging and Mental Health*, 15(5), 630-637.
- Jeffery, R. W. & French, S. A. (1996). Socioeconomic status and weight control practices among 20- to 45-year old women. *American Journal of Public Health*, 86(7), 1005-1011.
- Josh, G., Korda, R. J., Attia, J., Liu, B., Bauman, A. E. & Banks, E. (2013). Body mass index and incident hospitalisation for cardiovascular disease in 158 546 participants from the 45 and Up Study. *International of Obesity* (advance online publication). DOI: 10.1038
- Jull, J., Stacey, D. Beach, S. Dumas, A. Strychar, I. Ufholz, L-A., Prince, S., Abdulnour, J., Prud'homme, D.G. (2014). Lifestyle Interventions Targeting Body Weight Changes During the Menopause Transition: A Systematic Review. *Journal of Obesity*, 2014(824310), 1-16. doi: <http://dx.doi.org/10.1155/2014/824310>
- Kosa, J., Antonovsky, A. & Zola, I. K. (1969). *Poverty and Health: A Sociological Analysis*. Cambridge, MA: Harvard University Press.
- Kramer, C. K., Zinman, B. & Retnakaran, R. (2013). Are Metabolically Healthy Overweight and Obesity Benign Conditions? A Systematic Review and Meta-Analysis. *Annals of Internal Medicine*, 159(11), 758-769.
- Krieger, N., Chen, J. T. & Selby, J. V. (2001). Class inequalities in women's health: combined impact of childhood and adult social class – a study of 630 US women. *Public Health*, 115(1), 175-185.

- Kwan, S. (2009). Framing the Fat Body: Contested Meaning Between Government, Activists, and Industry. *Sociological Inquiry*, 79(1), 25-50.
- Laberge, S. & Kay, J. (2002). Pierre Bourdieu's Sociocultural Theory and Sport Practice. In J. Maguire & K. Young (Eds.) *Theory, Sport & Society* (pp. 239-266). London, United Kingdom: Elsevier Science.
- Laberge, S. & Sankoff, D. (1988). Physical Activities, Body Habitus and Lifestyles. In J. Harvey (Ed.) *Not Just A Game: Essays in Canadian Sport Sociology*. Ottawa, Canada: University of Ottawa Press.
- Laughlin, G. A., Barrett-Connor, E., Kritz-Silverstein, D. & von Mühlen, D. (1999). Hysterectomy, Oophorectomy, and Endogenous Sex Hormone Levels in Older Women: The Rancho Bernardo Study. *The Journal of Endocrinology & Metabolism*, 85(2), 645-651.
- Lee, J. & MacDonald, D. (2009). Rural young people and physical activity: understanding participation through social theory. *Sociology of Health & Illness*, 31(3): 360-374.
- Lewis, S., Thomas, S. L., Blood, R. W., Castle, D. J., Hyde, J. & Komesaroff, P. A. (2011). How do Obese Individuals Perceive and Respond to the Different Types of Obesity Stigma that they Encounter in their Daily Lives? A Qualitative study. *Social Science & Medicine*, 73, 1349-1356.
- Lhuissier, A. (2012). The Weight-loss Practices of Working Class Women in France. *Food, Culture & Society*, 15(4), 643-664.
- Li, C., Borgfeldt, C., Samsioe, G., Lidfeldt, J. & Nerbrand, C. (2005). Background factors influencing somatic and psychological symptoms in middle-age women with

- different hormonal status A population-based study of Swedish women.
Maturitas, 52(3-4), 306-318.
- Lovejoy, J. C. (2009). Weight Gain in Women at Midlife: The Influence of Menopause.
Obesity Management, 5(2), 52-56.
- Lovejoy, J. C., Champagne, C. M., de Jonge, L. & Smith, S. R. (2008). Increased
visceral fat and decreased energy expenditure during the menopausal transition.
International Journal of Obesity, 32(1), 949-958.
- Lupton, D. (2015). The pedagogy of disgust: the ethical, moral and political implications
of using disgust in public health campaigns. *Critical Public Health*, 25(1), 4-14.
- Mackenbach, J. P. (2012). The persistence of health inequalities in modern welfare
states: The explanation of a paradox. *Social Science & Medicine*, 75(1), 761-769.
- Maisonneuve, C., Lamontagne, P., Blanchet, C. & Hamel, D. (2015). *Poids corporel et
insécurité alimentaire chez les adultes Québécois en 2011-2012* (Institut national
de santé publique du Québec: Surveillance des habitudes de vie N° 6). Québec,
QC: Gouvernement du Québec.
- Major, B., Hunger, J. M., Bunyan, D. P. & Miller, C. T. (2014). The ironic effects of
weight stigma. *Journal of Experimental Social Psychology*, 51(1), 74-80.
- Marks, N. F. & Shinberg, D. S. (1997). Socioeconomic differences in hysterectomy: the
Wisconsin longitudinal study. *American Journal of Public Health*, 87, 1507-1514
- Marmot, M. (2015). *The Health Gap: The Challenge of an Unequal World*. Bloomsbury:
New York, NY.

- Marshall, C., Lengyel, C. & Utioh, A. (2012). Body Dissatisfaction Among Middle-aged and Older Women. *Canadian Journal of Dietetic Practice and Research*, 73(2), e241-7. doi: 10.3148/73.2.2012.e241
- Matthews, K. A., Crawford, S. L., Chae, C. U., Everson-Rose, S. A., Sowers, M. F., Sternfeld, B. & Sutton-Tyrrell, K. (2009). Are Changes in Cardiovascular Disease Risk Factors in Midlife Women Due to Chronological Aging or to the Menopausal Transition? *Journal of the American College of Cardiology*, 54(25), 2366-2373.
- McArthur, D., Dumas, A., Woodend, K., Beach, S. & Stacey, D. (2014). Factors influencing adherence to regular exercise in middle-aged women: a qualitative study to inform clinical practice. *Bio Med Central Women's Health*, 14(49), 2-8.
- McAuley, P. A. & Blair, S. N. (2011). Obesity Paradoxes. *Journal of Sport Sciences*, 29(8), 773-82.
- McCall, L. (2005). The Complexity of Intersectionality. *Signs: Journal of Women in Culture & Society*, 30(3), 1771-1800.
- McCarthy, M. (1990). The thin ideal, depression and eating disorders in women. *Behavior Research Therapy*, 28(3), 205-215.
- McDowell, L. (2006). Reconfigurations of Gender and Class Relations: Class Differences, Class Condensation and the Changing Pace of Class Relation. *Antipode*, 38(4), 825-850.
- McLaren, L. & Gauvin, L. (2002). Neighborhood level versus individual level correlates of women's body dissatisfaction: toward a multilevel understanding of the role of affluence. *Journal of Epidemiology and Community Health*, 56, 193-199.

- McLaren, L. & Godley, J. (2009). Social class and BMI among Canadian adults: A focus on occupational prestige. *Obesity*, 17(2), 290-299.
- McLaren, L. & Kuh, D. (2004). Women's body dissatisfaction, social class and social mobility. *Social Science & Medicine*, 58(1), 1575-1584.
- Ministry of Health and Long-Term Care. (2007). *Preventing and Managing Chronic Disease: Ontario's Framework*. Ministry of Health and Long Term Care. Toronto, ON.
- Mishra, G & Kuh, D. (2006). Perceived change in quality of life during the menopause. *Social Science & Medicine*, 62(1), 93-102.
- Moore, R. (2012). Capital. In M. Grenfell (Ed.) *Pierre Bourdieu: Key Concepts* (2nd ed). Bristol, UK: Acumen Publishing.
- Moorman, P. G., Schildkraut, J. M., Iversen, E. S., Myers, R., Gradison, M., Warren-White, N. & Wang, F. (2009). A Prospective Study of Weight Gain after Premenopausal Hysterectomy. *Journal of Women's Health*, 18(5), 699-708.
- Muenning, P. (2008). The body politic: the relationship between stigma and obesity-associated disease. *BMC Public Health*, 128(8), 1-10.
- Nicolaisen, M. & Thorsen, K. (2014). Loneliness among men and women – a five-year follow-up study. *Aging & Mental Health*, 18(2), 194-206.
- Ogle, J. P. & Damhorst, M. L. (2005). Critical reflection on the body and related sociocultural discourses at the midlife transition: an interpretive study of women's experiences. *Journal of Adult Development*, 12(1), 1-18.
- Omran, A. R. (1971). The Epidemiologic Transition: A Theory of the Epidemiology of Population Change. *The Milbank Memorial Fund Quarterly*, 49(4), 509-538.

- Paeratakul, S., Lovejoy, J. C., Ryan, D. H. & Bray, G. A. (2002). The relation of gender, race and socioeconomic status to obesity comorbidities in a sample of US adults. *International Journal of Obesity*, 26(9), 1205-1210.
- Pampalon, R., Hamel, D. & Gamache. (2008). *Les inégalités sociales de santé augmentent-elles au Québec?* Institut national de santé publique du Québec.
- Pampalon, R., Hamel, D., Gamache, P. & Raymond, G. (2009). A deprivation index for health planning in Canada. *Chronic Diseases in Canada*, 29(4), 178-191.
- Parham, E. S. (1999). Promoting body size acceptance in weight management counseling. *Journal of the American Dietetic Association*, 99(8), 920-925
- Pearl, R. L., White, M. A. & Grilo, C. M. (2014). Weight Bias Internalization, Depression and Self-Reported Health among Overweight Binge Eating Disorder Patients. *Obesity*, 22(5), 142-148.
- Peppaa, M., Koliakia, C., Hadjidakisa, D. I., Garoflosa, E., Papaefstathioua, A., Katsilambrosb, N., Raptisc, S. A. & Dimitriadisc, G. D. (2013). Regional fat distribution and cardiometabolic risk in healthy postmenopausal women. *European Journal of Internal Medicine*, 24(8), 824-831.
- Perks, T. (2012). Physical Capital and the Embodied Nature of Income Inequality: Gender Differences in the Effect of Body Size on Workers' Income in Canada. *Canadian Review of Sociology*, 40(1), 1-25.
- PHAC & CIHI. (2011). Obesity in Canada: A joint report from the Public Health Agency of Canada and the Canadian Institute for Health Information.

- Phelan, J. C., Link, B. G., Diez-Roux, A., Kawachi, I. & Levin, B. (2010). “Fundamental Causes” of Social Inequalities in Mortality: A Test of the Theory. *Journal of Health and Social Behaviour*, 45(3), 265-285.
- Pimenta, F., Maroco, J., Ramos, C. & Leal, I. (2014). Predictors of Weight Variation and Weight Gain in Peri- and Postmenopausal Women. *Journal of Health Psychology*, 19(8), 993-1002. doi: 10.1177/1359105313483153
- Potter, L., Wallston, K., Trief, P., Ulbrecht, J., Juth, V. & Smyth, J. (2015). Attributing Discrimination to Weight: Association with Well-Being, Self-Care, and Disease Status in Patients with Type 2 Diabetes Mellitus. *Journal of Behavioral Medicine*. doi: 10.1007/s10865-015-9655-0
- Poulain, J. P. (2009). *Sociologie de l'obésité*. Paris, France: Presses Universitaires de France.
- Power, C. & Powell, T. (2002). Overweight and obesity from a life course perspective. In D. Kuh & R. Hardy (Eds.). *A Life Course Approach to Women's Health*. Oxford Scholarship Online.
- Puhl, R. M., Andreyeva, T. & Brownell, K. D. (2008). Perceptions of weight discrimination: prevalence and comparison to race and gender discrimination in America. *International Journal of Obesity*, 32(6), 992-1000.
- Puhl, R. & Brownell, K. D. (2001). Bias, Discrimination, and Obesity. *Obesity Research*, 9(12), 788-805.
- Puhl, R. M. & Kyle, T. K. (2014). Pervasive Bias: An Obstacle to Obesity Solutions. *Institute of Medicine of the National Academies* (September 8).

- Puhl, R. M. & Heuer, C. A. (2010). Obesity Stigma: Important Considerations for Public Health. *American Journal of Public Health, 100*(6), 1019-1028.
- Puhl, R. M., Moss-Racusin, C. A. & Schwartz, M. B. (2007). Internalization of Weight Bias: Implications for Binge Eating and Emotional Well-being. *Obesity, 15*(1), 19-23.
- Repta, R. & Hurd Clarke, L. (2013). “Am I Going to be Natural or am I Not?": Canadian Women's Perceptions and Experiences of Mentrual Suppression. *Sex Roles, 68*(1), 91-106.
- Rich, E. & Evans, J. (2005). ‘Fat Ethics’ – The Obesity Discourse and Body Politics. *Social Theory & Health, 3*(4), 341-358.
- Robinson, J. & Carrier, K. (2004). *The spirit and science of holistic health*. Bloomington: Authorhouse.
- Rochon, P. A., Bronskill, S. E., Gruneir, A., Liu, B., Johns, A., Lo, A. T. & Bierman, A. S. (2011). Older Women's Health. In A. S. Bierman (Ed.). *Project for an Ontario Women's Health Evidence-Based Report*. Ontario Ministry of Health and Long-Term Care: Toronto, Canada.
- Rubin, H. J. & Rubin, I. S. (2012). *Qualitative Interviewing: The art of hearing data* (2nd ed). Thousand Oaks, CA: SAGE Publications.
- Rubinstein, H. R & Foster, J. L. H. (2013). ‘I don’t know whether it is to do with age or t
o do with hormones and whether it is to do with a stage in your life’: Making sense of menopause and the body. *Journal of Health Psychology, 18*(2), 292-307.

- Sammel, M. D., Grisso, J. A., Freeman, E. W., Hollander, L., Liu, L., Nelson, D. B & Battistini, M. (2003). Weight gain among women in the late reproductive years. *Family Practice*, 20(4), 401-409.
- Sanders, C. & Rogers, A. (2011). Bodies, in Context: Potential Avenues of Inquiry for the Sociology of Chronic Illness and Disability Within a New Policy Era. In B. A. Pescosolido, J. K. Martin, J. D. McLeod & A. Rogers (Eds) *Handbook of the Sociology of Health, Illness and Healing: A Blueprint for the 21st Century* (pp.483-504). New York, NY: Springer.
- Savage, M., Devine, F., Cunningham, N., Taylor, M., Li, Y., Hjellbrekke, J., Le Roux, B., Friedman, S. & Miles, A. (2013). A New Model of Social Class? Findings from the BBC's Great British Class Survey Experiment. *Sociology*, 47(2), 219-250.
- Savage, M., Dumas, A. & Stuart, S. (2013) Fatalism and short-termism as cultural barriers to cardiac rehabilitation amongst underprivileged men. *Sociology of Health and Illness*, 35(8), 1211-26.
- Schmitz, K. H., Hannan, P. J., Stovitz, S. D., Bryan, C. J., Warren, M. & Jensen, M. D. (2007). Strength training and adiposity in premenopausal women: Strong, Healthy, and Empowered study. *American Journal of Clinical Nutrition*, 86(1), 566-572.
- Schubert, D. J. (2012). Suffering/Symbolic Violence. In M. Grenfell (Ed.) *Pierre Boudieu: Key Concepts* (2nd ed). Bristol, UK: Acumen Publishing.

- Schwartz, M. B., O'Neal Cambliss, H., Brownell, K. D., Blair, S. N. & Billington, C. (2003). Weight Bias among Health Professionals Specializing in Obesity. *Obesity Research*, 11(9), 1033-1039.
- Seale, C. (1999). Quality in Qualitative Research. *Qualitative Inquiry*, 5(4), 465-478.
- Shilling, C. (1991). Educating the Body: Physical Capital and the Production of Social Inequalities. *Sociology*, 25(4), 653-672.
- Shilling, C. (2003). The Body and Physical Capital. In C. Shilling (Ed.) *The Body and Social Theory* (2nd ed.) (pp.111-130). London, UK: SAGE.
- Simkin-Silverman, L. R., Wing, R. R., Boraz, M. A. & Kuller, L. H. (2003). Lifestyle Intervention Can Prevent Weight Gain During Menopause: Results From a 5-Year Randomized Clinical Trial. *Annals of Behavioral Medicine*, 26(3), 212-220.
- Sims-Gould, J., Hurd Clarke, L., Ashe, M. C., Naslund, J. & Lui-Ambrose, T. (2010). Renewal, strength and commitment to self and others: older women's reflections of the benefits of exercise using Photovoice. *Qualitative Research in Sport and Exercise*, 2(2), 250-266.
- Skeggs, B. (2004). Context and Background: Pierre Bourdieu's analysis of class, gender and sexuality. *The Sociological Review*, 52(s2), 19-33.
- Stacey, D., Jull, J., Beach, S., Dumas, A., Strychar, I., Adamo, K., Brochu, M. & Prud'homme, D. (2015). Middle-aged women's decisions about body weight management: A needs assessment and testing of a knowledge translation tool. *Menopause*, 22(4), 414-422.
- Statistics Canada. (2007). *Sherbrooke, Québec (table) 2006 Community Profiles* Catalogue no. 92-591-XWE. Retrieved from:

<http://www12.statcan.gc.ca/census-recensement/2006/dp-pd/prof/92-591/index.cfm?Lang=E> (accessed May 20th, 2015)

Statistics Canada. (2009). Income disparities in health-adjusted life expectancy for Canadian adults, 1991 to 2001. *Health Reports (82-003-X)*, 20(4). Government of Canada.

Statistics Canada. (2012a). *Canadian Community Health Survey*. Catalogue number 82-625-X2013001. Government of Canada

Statistics Canada. (2012b). *Table 102-0122 - Health-adjusted life expectancy, at birth and at age 65, by sex and income, Canada and provinces, occasional (years)*, CANSIM (database).

Statistics Canada. (2012c). *Sherbrooke, Quebec (Code 433) and Quebec (Code 24)* (table). Census Profile. 2011 Census. Statistics Canada Catalogue no. 98-316-XWE. Government of Canada. Retrieved from: <http://www12.statcan.gc.ca/census-recensement/2011/dp-pd/prof/index.cfm?Lang=E>

Sternfeld, B., Bhat, A. K., Wang, H., Sharp, T. & Quesenberry, C. P. Jr. (2005). Menopause, Physical Activity, and Body Composition/Fat Distribution in Midlife Women. *Medicine & Science in Sport & Exercise*, 37(7), 1195-1202.

Stroebe, M., Schut, H. & Stroebe, W. (2007). Health outcomes of bereavement. *The Lancet*, 370, 1960-1973.

Sumithran, P., Prendergast, L. A., Delbridge, E., Purcell, K., Shulkes, A., Kriketos, A. & Proietto, J. (2011). Long-Term Persistence of Hormonal Adaptations to Weight Loss. *The New England Journal of Medicine*, 365(17), 1597-1604.

- Sutin, A. R., Stephan, Y., Luchetti, M. & Terracciano, A. (2014). Perceived Weight Discrimination and C-Reactive Protein. *Obesity*, 22(9), 1959-1961.
- Sutin, A. R. & Terracciano, A. (2013). Perceived Weight Discrimination and Obesity. *PLoS ONE*, 8(7), e70048.
- Swartz, D. (1997). *Culture & Power: The Sociology of Pierre Bourdieu*. Chicago, USA: University of Chicago Press.
- Tchernof, A. & Poehlman, E. T. (1998). Effects of the menopause transition on body fatness and body fat distribution. *Obesity Research*, 6(3), 246-254.
- Tiggerman, M. & McCourt, A. (2013). Body appreciation in adult women: Relationship with age and body satisfaction. *Body Image*, 10(4), 624-627.
- Tomiyama, J. A. (2014). Weight stigma is stressful. a review of evidence for the Cyclic Obesity/Weight-Based Stigma Model. *Appetite*, 82(1), 8-15.
- Tunaley, J. R., Walsh, S. & Nicolson, P. (1998). 'I'm not bad for my age': the meaning of body size and eating in the lives of older women. *Ageing & Society*, 19, 741-759.
- Turcotte, M. (2011). Women and Health. In *Women in Canada: A Gender-based Statistical Report* (Statistics Canada Catalogue no. 89-503-X). Ottawa, ON: Government of Canada.
- Twigg, J. (2004). The body, gender and age: Feminist insights in social gerontology. *Journal of Aging Studies*, 18(1), 59-73.
- Tylka, T. L., Annunziato, R. A., Burgard, D., Daniélsdóttir, S., Shuman, E., Davis, C. & Calogero, R. M. (2014). The Weight-Inclusive versus Weight-Normative

- Approach to Health: Evaluating the Evidence for Prioritizing Well-Being over Weight Loss. *Journal of Obesity*. doi: <http://dx.doi.org/10.1155/2014/983495>
- van Zutven, K., Mond, J., Latner, J. & Rodgers, B. (2015). Obesity and psychosocial impairment: mediating roles of health status, weight/shape concerns and binge eating in a community sample of women and men. *International Journal of Obesity*, 39(1), 346-352.
- Vartanian, L. R. & Smyth, J. M. (2013). Primum Non Nocere: Obesity Stigma and Public Health. *Bioethical Inquiry*, 10(1), 49-57.
- Vinette, S. (2001). Image corporelle et minceur: à la poursuite d'un idéal élusif. *Reflets*, 7(1), 129-151.
- Wacquant, L. (2005). 'Habitus', in Jens Becket and Zafirovski Milan (Eds), *International Encyclopedia of Economic Sociology*, London, UK: Routledge.
- Walcott, D. D., Pratt, H. D. & Patel, D. P. (2003). Adolescents and Eating Disorders: Gender, Racial, Ethnic, Sociocultural, and Socioeconomic Issues. *Journal of Adolescent Research*, 18(3), 223-243.
- Wang, Y., Mi, J., Shan, X.-Y., Wang, Q. J. & Ge, K.-Y. (2007). Is China facing an obesity epidemic and the consequences? The trends in obesity and chronic disease in China. *International Journal of Obesity*, 31(1), 177-188.
- Warde, A., Wright, D. & Gayo-Cal, M. (2007). Understanding Cultural Omnivorousness: Or, the Myth of the Cultural Omnivore. *Cultural Sociology*, 1(2), 143-164.
- Wardle, J. & Griffith, J. (2001). Socioeconomic status and weight control practices in British adults. *Journal of Epidemiological Community Health*, 55, 185-190.

- Warin, M, Turner, K., Moore, V. & Davies, M. (2008). Bodies, mothers and identities: rethinking obesity and the BMI. *Sociology of Health & Illness*, 30(1), 97-111.
- Whitlock, G., Lewington, S., Sherliker, P., Clarke, R., Emberson, J. & Halsey, J. (2009). Body-mass index and cause-specific mortality in 900 000 adults: collaborative analyses of 57 prospective studies. *Lancet*, 373(9669), 1083-1096.
- Whittemore, R., Chase, S. & Mandle, C. L. (2001). Validity in Qualitative Research. *Qualitative Health Research*, 11(4), 522-537.
- Williams, L., Germov, J. & Young, A. (2011). The effect of social class on mid-age women's weight control practices and weight gain. *Appetite*, 56(1), 719-725.
- Williams, S. J. (1995). Theorizing class, health and lifestyles: can Bourdieu help us? *Sociology of Health & Illness*, 17(5), 577-604.
- Willis, B. L., Gao, A., Leonard, D., DeFina, L. F. & Berry, J. D. (2012). Midlife Fitness and the Development of Chronic Conditions in Later Life. *Archives of Internal Medicine*, 172(17), 1333-1340. doi:10.1001/archinternmed.2012.3400
- Winterich, J. A. (2007). Aging, Femininity, and the body: What appearance changes mean to women with age. *Gender Issues*, 24, 51-69.
- World Health Organization (1981). *Research on the menopause*. Geneva, Switzerland: WHO scientific group the research on the menopause.
- World Health Organization. (2003). *The Solid Facts: Second Edition*. R. Wilkinson & M. Marmot (Eds.). Copenhagen, Denmark: World Health Organization.
- World Health Organization. (2013). *World Health Statistics: Part III Global Health Indicators* (Report).

Zheng, H. & Yang, Y. (2012). Population Heterogeneity in the Impact of Body Weight on Mortality. *Social Science & Medicine*, 75, 990-996.

Appendix A

Interview Guide

Variation sociale du rapport au corps et des pratiques de santé à travers la transition ménopausique: Rôle des interventions de santé

Guide d'entretien

(1) Caractéristiques de l'environnement socioéconomique (conditions d'existence).

- Est-ce que vous pouvez me parler d'où vous venez? Votre milieu? Votre emploi? (Décrire le statut socioéconomique, couple ou célibataire;)
- Explorer les conditions d'existence et les trajectoires sociales en termes de santé, consommation médicale et style de vie

(2) Perception des ressources matérielles et humaines liées à diverses pratiques de santé (e.g., accès/obstacles à la consommation de nourriture de qualité, de services d'activité physique, professionnels de santé, programme de perte de poids, etc.).

Chacune des pratiques doit être discutée de façon à comprendre comment ces pratiques s'inscrivent dans une stratégie pour améliorer leur santé ou pour perdre du poids à travers la ménopause.

(Vérifier pourquoi. Santé ou apparence corporelle)

(3)

(3)

Pratiques visant la perte de poids

- Avez-vous déjà essayé de perdre du poids? Énumérez les diverses pratiques formelles et/ou informelles ayant été tentées dans le but de perdre du poids (circonstances, fréquence, est-ce que c'était la première fois?) Pourquoi? (Probe ici pour comprendre quelles étaient les désires reliés au corps intérieur (santé, performance, confiance en soi, etc.) extérieur (esthétique, appréciation des autres, relations d'amitié, acceptation sociale, etc.)
- Quelles sont les stratégies que vous avez essayées pour perdre du poids (Clinique de perte de poids, seule, avec une amie, etc.)? Avez-vous été satisfaite de la stratégie utilisée? L'environnement dans lequel ça se déroulait? Les

professionnels? L'intensité du suivi? Les installations?

- Pourriez-vous me faire part des barrières et des difficultés rencontrées dans ces démarches de perte de poids.

Activité physique

- J'aimerais que vous me parliez de votre activité physique (AP) actuelle (pratique depuis la ménopause) et changements survenus à divers moment critiques de votre vie (grossesse, ménopause, etc.).
- Vous-êtes vous déjà spécifiquement investie dans une pratique d'AP spécifiquement pour perdre ou contrôler votre poids corporel?
- Savez-vous s'il existe des endroits pour faire de l'AP près de chez vous? (Vérifier le niveau d'intérêt, accès-distance, prix, partenaires d'entraînement, horaire, etc.)
- Avez-vous déjà participé à un programme formel d'AP? Étiez-vous satisfaite du programme? De l'environnement? Des enseignements offerts? Des installations? De l'intensité? Des instructeurs?
- Pourriez-vous me faire part des barrières et des difficultés rencontrées dans votre participation à certaines AP (ex : blessures, contraintes au niveau de l'horaire, support social, etc.)

Habitudes alimentaires

- J'aimerais que vous me parliez de vos habitudes alimentaires actuelles (habitudes alimentaires depuis la ménopause) et changements survenus à divers moments critiques de votre vie (grossesse, ménopause, etc.).
- Est-ce que vos habitudes alimentaires ont changé en lien avec votre ménopause? Pourquoi? Est-ce que vous évitez certains types d'aliments que vous consommiez auparavant? Est-ce que vous limitez les quantités de certains aliments que vous consommez? Comment?
- Où est-ce que vous achetez votre nourriture de façon générale? (vérifier le niveau d'appréciation : prix-distance)
- Pourriez-vous me faire part des barrières et des difficultés rencontrées dans le fait de maintenir de bonnes habitudes alimentaire.

(3) Le rapport au corps et à l'obésité

- Est-ce que vous accordez beaucoup d'importance à votre corps? Pourquoi?
Qu'est-ce qui est important pour vous à cet égard (probe sur les goûts et dégoûts)?
- Quel est le facteur ou la personne ayant le plus d'influence sur votre apparence corporelle selon vous? Pourquoi?
- Est-ce que la perte de poids est une priorité dans votre vie? Pourquoi?
- Pourquoi croyez-vous que vous devez perdre du poids? (est-ce que cela a change avec les grossesses, la ménopause, etc.)
- Vous fixez-vous des objectifs en lien avec votre poids et votre image corporelle?

(4) Perceptions, attitudes/jugements et expériences relatives à l'obésité et aux pratiques de santé

Construction de l'obésité et ses sources

- Qu'est ce que l'obésité pour vous? Est-ce que l'obésité est différente entre les hommes et les femmes? Entre les femmes jeunes et vieillissantes? Comment? Pourquoi?
- Est-ce qu'un surplus de poids ou le fait d'être obèse vous inquiète? Pourquoi? (impact sur la santé)
- D'où est-ce que vous avez tiré vos connaissances actuelles sur l'obésité? (probe; types de médias)
- Êtes-vous intéressée par ce type d'information? Pourquoi? Que pensez-vous de ces informations? Est-ce que vous faites confiance à ce type d'information?
- Quelles sont les sources d'information sur l'obésité et la santé auxquelles vous faites le plus confiance?
- Il y a actuellement un intérêt médiatique important en lien avec l'obésité? Qu'en pensez-vous?
- Est-ce que vous trouvez que ces informations peuvent parfois devenir déroutantes?

Culture de la ménopause et construction de l'obésité

- Est-ce que votre perception de l'obésité et du surplus de poids a changé dernièrement? Pourquoi?

- Est-ce que votre partenaire perçoit l'obésité lors de la ménopause de la même manière que vous? Pourquoi?
- Comment vos perceptions avec ces personnes sont-elles différentes? Pourquoi croyez-vous qu'elles diffèrent?
- Qu'en est-il des autres femmes ménopausées que vous côtoyez? Perçoivent-elles l'obésité comme vous? Pourquoi?

L'expérience de l'obésité

- Est-ce que quelqu'un vous a déjà fait sentir comme si vous n'étiez pas d'un poids convenable? Pouvez-vous me parler de cette expérience (sentiments et actions menées suite à cette expérience).
- Trouvez-vous que davantage de pression est exercée sur vous pour que vous contrôliez votre poids depuis votre ménopause?
- Qu'est ce qui est le plus difficile à vivre pour vous dans le fait d'être ménopausée et en surplus de poids?
- Nous entendons régulièrement des commentaires négatifs sur les personnes obèses. Comment cela vous affecte-t-il? Est-ce que cela a changé depuis votre ménopause?
- Est-ce que certains aspects du discours des femmes sur le poids corporel vous dérangent?

(5) Rôle des interventions de santé sur les pratiques de santé pendant le ménopause chez la femme obèse

- Avez-vous consulté votre médecin et/ou tout autre professionnel de la santé pendant la période de changements liés à votre ménopause (environ 1 an)?
- Quels conseils en lien avec votre santé et votre bien-être avez-vous reçu lors de ces entretiens?
- Est-ce que cet intervenant perçoit l'obésité lors de la ménopause de la même manière que vous? Pourquoi?
- Comment vous êtes vous sentie lors de ces entretiens?
- Que pensez-vous des conseils reçus et des interventions proposées par cet intervenant de santé?

- Est-ce que ces interventions vous ont amenée à changer certaines de vos pratiques de santé (alimentation, activité physique, contrôle de poids, etc.)? Pourquoi?

(6) Questions de fermeture

- Quel type de conseil donneriez-vous à une femme ménopausée présentant un surplus de poids pour améliorer sa santé et son bien-être?
- Avant de terminer, j'aimerais savoir comment vous vous sentez personnellement face à l'entretien que nous venons d'avoir dans le cadre de ce projet de recherche.

Appendix B

Ethics Approval

Centre de santé et de services sociaux –
Institut universitaire de gériatrie de Sherbrooke
Health and Social Services Centre –
University Institute of Geriatrics of Sherbrooke

PAR COURRIEL

Sherbrooke, le 2 mai 2013

Professeure Isabelle J. Dionne, Ph.D.
Chercheure
Centre de recherche sur le vieillissement
CSSS-IUGS
1036, rue Belvédère Sud
Sherbrooke (Québec) J1H 4C4

Objet : Approbation finale du projet de recherche
Variation sociale du rapport au corps et des pratiques de santé à travers la transition ménopausique : rôle des interventions de santé
Dossier 2013-362

Pre Dionne,

Le Comité d'éthique de la recherche du CSSS-IUGS a évalué, en comité restreint, le projet de recherche cité en rubrique au vu des documents suivants, reçus le 19 mars 2013 :

- Formulaire de demande d'évaluation d'un projet de recherche, dûment complété
- Protocole de recherche intitulé « *Exploring the influence of health interventions on construction of obesity, weight regulation and health practices in postmenopausal women from contrasting socioeconomic milieu* », version 1 datée du 19 mars 2013
- Formulaire d'information et de consentement à la recherche, version 2 datée du 3 avril 2013
- Guide d'entretien, version 1 datée du 19 mars 2013
- Fiche d'identification, version 1 datée du 19 mars 2013
- Annonce de recrutement
- Lettre d'introduction du projet
- Budget du projet de recherche, version datée du 15 mars 2013
- Lettre d'autorisation des IRSC au Dr Denis Prud'homme, datée du 9 juin 2013, concernant la subvention d'équipe « *CIHR Team in Critical Periods of Body Weight Regulation : A Women's Health Perspective* »
- Rapport des réviseurs des IRSC
- Protocole de recherche relatif à la subvention d'équipe
- Curriculum vitae du Professeur Alexandre Dumas

Suite à l'évaluation de l'ensemble du dossier, j'ai le plaisir de vous informer que votre projet de recherche a été approuvé.

Quelques recommandations relatives au guide d'entretien sont cependant soumises à votre attention.

➤ Au point 5 – Rôle des interventions

Concernant l'avant-dernière question, le Comité soulève la pertinence de la garder dans sa formulation actuelle. De l'avis des membres, les questions doivent être formulées de manière à ne pas placer les participants d'un projet de recherche devant un dilemme auquel ils n'auraient pas été confrontés normalement. Aussi, les membres jugent que cette question pourrait placer certaines participantes dans une situation embarrassante, ce qui n'est pas le but recherché.

➤ Au point 6 – Question de fermeture

Le Comité suggère de s'enquérir de l'état de bien-être ou de malaise des participantes suite à l'entrevue qui pourra, pour certaines, être longue et confrontante.

Nous vous prions de bien vouloir nous transmettre, pour approbation, votre nouvelle version de ce guide.

La présente approbation éthique est valide pour un an à compter du 2 mai 2013, date de l'approbation finale. Un mois avant la date d'échéance, vous devrez faire une demande de renouvellement auprès du comité d'éthique de la recherche du CSSS-IUGS en utilisant le document du comité prévu à cet effet. Les formulaires pourront être complétés à partir du logiciel Nagano, que vous retrouverez sous l'onglet « Recherche » de la page web du CSSS-IUGS.

En acceptant le certificat d'éthique joint en annexe, vous vous engagez à :

- Soumettre, pour approbation préalable au comité, toute demande de modification au projet de recherche ou à tout document approuvé par le comité pour la réalisation de votre projet.
- Soumettre, dès que cela est porté à votre connaissance et s'il y a lieu :
 - les réactions indésirables graves, les réactions indésirables et inattendues et les accidents observés en cours de recherche, et ce, dans les six jours ouvrables qui suivent;
 - tout nouveau renseignement sur des éléments susceptibles d'affecter l'intégrité ou l'éthicité du projet de recherche ou d'accroître les risques et les inconvénients des sujets, de nuire au bon déroulement du projet ou d'avoir une incidence sur le désir d'un sujet de recherche de continuer sa participation au projet de recherche;
 - toute modification constatée au chapitre de l'équilibre clinique à la lumière des données-recueillies;
 - la cessation prématurée du projet de recherche, qu'elle soit temporaire ou permanente;
 - tout problème identifié par un tiers, lors d'une enquête, d'une surveillance ou d'une vérification interne ou externe;
 - toute suspension ou annulation de l'approbation octroyée par un organisme de subvention ou de réglementation;
 - toute procédure en cours de traitement d'une plainte ou d'une allégation de manquement à l'intégrité ou à l'éthique ainsi que des résultats de la procédure.

La présente décision peut être suspendue ou révoquée en cas de non-respect de ces exigences. En plus du suivi administratif d'usage, le CÉR pourra effectuer un suivi actif au besoin selon les modalités qu'il juge appropriées.

En terminant, nous vous rappelons que vous devez conserver pour une période d'au moins un an suivant la fin du projet, un répertoire distinct comprenant les noms, prénoms, coordonnées, date du début et de fin de la participation de chaque sujet de recherche.

Approbation finale
Dossier 2013-362

3

Le Comité d'éthique de la recherche du CSSS-IUGS est institué par le ministre de la Santé et des Services sociaux aux fins de l'application de l'article 21 du Code civil du Québec et respecte les règles émises par l'Énoncé de politique des trois conseils et les Bonnes pratiques cliniques de la CIH.

Je vous prie d'accepter, Professeure Dionne, mes meilleures salutations.

Monique Sullivan, Ph. D., LL. B.
Présidente

MS/sf

p. j. Certificat éthique
 FIC
 Lettre d'introduction
 Annonce de recrutement

PAR COURRIEL

CERTIFICAT D'ÉTHIQUE EN MATIÈRE DE RECHERCHE SUR DES HUMAINS

Le Comité d'éthique de la recherche du Centre de santé et de services sociaux - Institut universitaire de gériatrie de Sherbrooke (volet Institut) atteste :

1. Qu'il exerce ses activités de manière conforme aux *Bonnes pratiques cliniques*;
2. Qu'aucun des membres n'était en conflit d'intérêts lors de l'évaluation des documents soumis par le chercheur;
3. Qu'il a dûment évalué et approuvé les documents qui lui ont été soumis.

TITRE DU PROJET DE RECHERCHE

Variation sociale du rapport au corps et des pratiques de santé à travers la transition ménopausique : rôle des interventions de santé

LA PRESENTE APPROBATION A ETE DEMANDEE PAR :

Professeure Isabelle J. Dionne, Ph.D.
Chercheure
Centre de recherche sur le vieillissement, CSSS-IUGS

👉 L'approbation éthique pour ledit projet de recherche est valide jusqu'au 2 mai 2014

Le numéro de dossier attribué au projet cité en rubrique par le CÉR est le 2013-362

Monique Sullivan, Ph.D., LL. B.
Présidente

MS/sf

c. c. Madame Julie Berthelette, technicienne en administration, Centre de recherche sur le vieillissement, CSSS-IUGS

File Number: H04-15-17



Date (mm/dd/yyyy): 05/22/2015

Université d'Ottawa **University of Ottawa**
 Bureau d'éthique et d'intégrité de la recherche Office of Research Ethics and Integrity

Ethics Approval Notice

Health Sciences and Science REB

Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Role</u>
Alexandre	Dumas	Health Sciences / Human Kinetics	Supervisor
Rachelle	Binette	Health Sciences / Human Kinetics	Student Researcher

File Number: H04-15-17**Type of Project:** Master's Thesis**Title:** Facing the challenges of menopause: Social inequality and weight control in clinically overweight and obese women during midlife

Approval Date (mm/dd/yyyy)	Expiry Date (mm/dd/yyyy)	Approval Type
05/22/2015	05/21/2016	Ia

(Ia: Approval, Ib: Approval for initial stage only)**Special Conditions / Comments:**

N/A

File Number: H04-15-17



Date (mm/dd/yyyy): 05/22/2015

Université d'Ottawa **University of Ottawa**
 Bureau d'éthique et d'intégrité de la recherche Office of Research Ethics and Integrity

This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement (2010) and other applicable laws and regulations in Ontario, has examined and approved the ethics application for the above named research project. Ethics approval is valid for the period indicated above and subject to the conditions listed in the section entitled "Special Conditions / Comments".

During the course of the project, the protocol may not be modified without prior written approval from the REB except when necessary to remove participants from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the project (e.g., change of telephone number). Investigators must also promptly alert the REB of any changes which increase the risk to participant(s), any changes which considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project and safety of the participant(s). Modifications to the project, including consent and recruitment documentation, should be submitted to the Ethics Office for approval using the "Modification to research project" form available at: <http://research.uottawa.ca/ethics/submissions-and-reviews>.

Please submit an annual report to the Ethics Office four weeks before the above-referenced expiry date to request a renewal of this ethics approval. To close the file, a final report must be submitted. These documents can be found at: <http://research.uottawa.ca/ethics/submissions-and-reviews>.

If you have any questions, please do not hesitate to contact the Ethics Office at extension 5387 or by e-mail at: ethics@uOttawa.ca.

Signature:

Riana Marcotte
 Protocol Officer for Ethics in Research
 For Daniel Lagarec, Chair of the Health Sciences and Sciences REB