

**BODY AND CAPITAL:
UNDERPRIVILEGED WOMEN'S RELATION WITH HEALTH AND OBESITY**

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Abstract

In this context of an alleged ‘obesity epidemic’, many social scientists have observed that biomedical sciences and consumer culture have created a *dominant obesity discourse* which is becoming central to various forms of health interventions. The current emphasis on weight control is generating a rhetoric that shapes society’s perceptions on the healthy body, and is stigmatizing those who are obese and overweight. Sociologists agree that women are especially prone to be negatively affected by this discourse because of gendered social pressures on the body. Considering the issue of social class, literature shows that underprivileged women have poorer health, higher obesity rates, and face more constraints to follow a healthy lifestyle.

Drawing from Pierre Bourdieu’s socio-cultural approach, this qualitative research project aimed to: (a) understand the responses to current body norms and expectations tied to health and physical appearances amongst underprivileged young women; and; (b) understand to what extent the dominant obesity discourse is inscribed in these women’s bodily habitus.

Fifteen semi-structured interviews were conducted with young women living in precarious living conditions in the Hull-Gatineau region. The interview guide was adapted to capture their perceptions on health and weight. A thematic approach was used to analyse and divide the data into codes, themes, and patterns.

Results highlight that participants were aware of the dominant obesity discourse through their perceptions, sentiments, and dispositions towards bodily norms and expectations. Despite their awareness, underprivileged living conditions generated other sets of priorities, such as motherhood, achieving economic stability, completing education, and

gaining physical independence which were far greater preoccupations. Underprivileged young women's 'choice of the necessary' is based on optimizing resources and prioritizing needs and responsibilities. Findings support the use of Pierre Bourdieu's concepts which consider the effects of various aspects of underprivileged living conditions on lifestyles.

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Chapter I

Introduction

Statement of the Problem

Healthism is an ideology advocated by medical institutions, media and other cultural instances that shapes our moral frameworks and influences our daily practices in the pursuit of health (Crawford, 1980; Lupton, 1996). This ideology is gaining interest amongst sociologists because it creates a social environment in which people are criticized, judged and evaluated according to their health practices and physical attributes of their body (Wright & Harwood, 2009).

Currently, one of Canada's most pressing health concern is the possible rise of an 'obesity epidemic'. Public Health Agency of Canada (2009; 2011) has repeatedly mentioned how obesity rates in Canada have nearly doubled between 1978 and 2011. This national institution estimates that 25.4% of Canadians are obese while an additional 36.7% are said to be overweight¹. By giving attention to the rise of obesity rates, Canadian public health interventions and health care professionals are increasingly preoccupied by the physiological implications of obesity (Public Health Agency of Canada, 2011; Gard & Wright, 2005; Oliver, 2006). Additionally, although the large scale fights against obesity has clearly begun, many social scientists are calling into question the strategies that are used and their value for the good of society and the wellbeing of individuals (Sharma, 2011).

In the midst of the growing attention towards an 'obesity epidemic', physiologists, physicians, dieticians, physical educators and other health professionals are persistently

¹ Canadian guidelines for body weight classification use Body Mass Index (BMI) and waist circumference (WC) to measure overweight and obesity rates (Health Canada, 2003; The Public Health Agency of Canada). BMI is an equation which utilizes body weight (Kg) and height (m²) to estimate health risks according to body weight.

offering a number of strategies to encourage weight loss and healthy living (Evans & Colls, 2009). However, many sociologists are suggesting that scientific literature and media have participated in amplifying the seriousness of the problem of obesity (Gard & Wright, 2005; Oliver, 2006). In health promotion, this emphasis generates a *dominant obesity discourse*, a rhetoric which shapes society's perceptions on the healthy body and stigmatizes those who are obese and overweight (Gard & Wright, 2005; Wright & Harwood, 2009). Several sociologists are criticizing the effects of the dominant obesity discourse by stating that the social repercussions of this discourse (e.g. discrimination, stigmatization) are more harmful than the physiological complications associated with obesity (Gard & Wright, 2005; Oliver, 2006). As described by Wright & Harwood (2009), I argue that the prevailing obesity discourse in public health has reached a status of ideology and that it is counterproductive as a health promotion strategy as it can be detrimental to the wellbeing of vulnerable populations.

Many sociological critics have highlighted the negative impact of the dominant obesity discourse (Gard & Wright, 2005; Rail, Holmes & Murray, 2010; Wright & Harwood, 2009). Generally speaking, it creates assumptions that people with excess weight are victims of some form of biological predisposition and suffer from a character defect (laziness, lack of self-control, and over indulgence in unhealthy practices) (Blaxter, 1997; Poulain, 2009). It has also been shown that obese and overweight individuals have fewer opportunities to participate in social activities, are more likely to encounter discriminations and prejudice in the fields of employment, education, and reported having fewer intimate or successful long-term relationships (Rothblum, 1992; McLaren & Kuh, 2004).

Some sociologists attest a direct link between women's body weight and their social status (Falkner, Neumark-Sztainer, Story, Jeffery, Beuhring & Resnick, 2001; Poulain, 2009). Because they are subjugated to strict bodily expectations, girls and women who do not correspond to the beauty ideal experience more adverse social, psychological and educational complications resulting from an obesity stigma (Falkner et al. 2001; Griffiths, Wolke, Page & Horwood, 2006). Feminist authors have been arguing for decades that women's status is strongly dependant on socially valued body norms (Bordo, 1993; Skeggs, 1997; Wolf, 1990). For women, maintaining their body weight within a certain margin does not only represent conformity to a moral health standard, it is also a means to achieve something beyond that is deeply connected to an increase in their social status and personal value (Moore, 2010) .

If gender is at stake in this issue, social class is also a significant factor. There is a body of evidence that shows that underprivileged populations have poorer health, have higher obesity rates, and face more constraints to follow a healthy lifestyle (Boltanski, 1971; Bourdieu, 1984; Poulain, 2009). Considering the connection between life circumstances and health practices, socioeconomically disadvantaged women have been shown to embody a particular relation to their body, one which often differs from the norms established by dominant discourses on health (Boltanski, 1972; Williams, 1995). While underprivileged women already face structural, economical, and personal barriers to acquire a healthy lifestyle (Cockerham, 2005; Reid, 2007), why should they give importance to their health and body weight?

While the dominant obesity discourse is especially concerned with the size and shape of the body, I argue that this discourse may blur and obstruct other significant factors that

influence health. I also support the idea that its articulation with bodily appearance can have negative consequences on women's health such as the loss of social value, social isolation or loss of self-esteem. In this sense, the dominant obesity discourse can act as a social barrier. It is therefore essential to critically assess the extent to which the dominant obesity discourse is embodied or not by specific groups of women and its influence on bodily dispositions.

Previous epidemiological studies have shown the clear prevalence of obesity amongst lower income groups (Marmot, 2006; Poulain, 2009). In addition, research on women's body appearance has shown the disadvantage of underprivileged women to meet up socially valued standards of beauty (Poulain, 2009; Skeggs, 1997). However, to our knowledge, no studies have focused on this group of women's experience with the dominant obesity discourse, notably the health and body weight standards promoted by North American culture.

Purpose of Study

Despite the growing attention given to the issue of weight and obesity by both biomedical and social scientists (Campos, Saguy, Ernsberger, Oliver & Gaesser, 2006; Gard, 2004), few studies investigated how the dominant obesity discourse impacts the experiences and practices of underprivileged women. As part of a larger study which explores young Canadian women's discursive constructions of health and obesity (Rail & Dumas, 2008), the global aim of this study were: (a) to capture the values of underprivileged women with regards to their health and body, and; (b) to examine their relations to the body by outlining the socio-cultural factors which do or do not incline them to pursue in health practices and weight loss management.

More specifically, drawing on Pierre Bourdieu's socio-cultural approach, this smaller study aimed: (a) to understand the responses to current body norms and expectations tied to health amongst underprivileged young women, and; (b) to understand to what extent the dominant obesity discourse is inscribed in these women's bodily habitus.

Contributions

This qualitative research contributed to develop practical knowledge that will assist health professionals to contextualize their interventions in order to improve health amongst young women living underprivileged social circumstances. More precisely, by focusing on their experiences and their social perception of health and the body, this research informs organizations that intend to promote healthy lifestyles for young women by providing them with alternative solutions that will better serve the goal of increasing the well being of young adult women. Finally, by understanding the needs and life circumstances of these women, this study informs health specialists and researchers of the effects of certain discourses. One important challenge of this study was to hold a critical distance from an over-biological understanding of obesity that has been shown to have a negative social and personal impact on people's health and wellbeing.

Overview

The literature review in the following chapter will be divided into four parts. The first section outlines how the dominant obesity discourse has become a powerful mediator which influences the ways by which we treat and care for the body. Following this, the second part will illustrate the effects of the dominant obesity discourse on marginalized populations. Next, I will illustrate how the dominant obesity discourse is pervading women's lives. The

fourth section will combine the previous three to elucidate young underprivileged women's social constraints to health.

The proposed theoretical framework saw Pierre Bourdieu's socio-cultural theory of practice. This framework allowed us to explore the underlying socio-cultural mechanisms which legitimize women's health and bodies. The fourth chapter will outline the methodological approach which framed and guided this qualitative research. More precisely, data collection and data analysis were inspired by Bourdieu's theoretical framework. The findings are presented in an article format in the following two chapters. Finally, a concluding chapter summarizes the findings of this research by proposing avenues of research for scholars who are interested in the issue of health and social inequality.

Chapter II

Literature Review

The following chapter provides a review of the sociological literature on the emergence of a dominant obesity discourse and its implications regarding gender expectations. It is divided into four sections: (a) the social construction of the dominant obesity discourse; (b) the consequences on marginalized populations; (c) the pervasiveness of the obesity discourse in women's lives, and; (d) women's social constraints to health.

The Social Construction of the Dominant Obesity Discourse

The growing attention given to the 'obesity crisis' has brought many authors to draw on the works on Michel Foucault in order to understand the emergence of a dominant obesity discourse (Gard & Wright, 2005; Wright & Harwood, 2009). The concept of discourse is often used to illustrate how forms of knowledge shape our views on the human body and eventually influence our lifestyle (e.g. Evans & Colls, 2009; Wright & Harwood, 2009).

For Foucault (1976), discourse is defined as a set of statements or unquestioned knowledge regarding any given issue. It has become a powerful mean "influencing the ways of thinking about health and about bodies" (Wright & Harwood 2009; p, 1). It is through discourse that people become docile and adopt health regimens advocated by legitimized forms of knowledge provided by authorities (e.g. physicians, health professionals, researchers) (Evans & Colls, 2009; Rich & Evans, 2005; Wright & Harwood, 2009).

Also drawing on Foucauldian ideas, Wright and colleagues (2006) argue that the dominant obesity discourse has generated new forms of disciplinary practices² which influence the ways people monitor, treat and care for their bodies. In their paper, they coined the term '*biopedagogies*' to represent pedagogies of *bios* (life) which form part of an apparatus of governmentality that centers upon regulating life: how to live, how to eat, how to move, how to look. Biopedagogies are focused on controlling bodies to reduce obesity and to protect everyone from the "risks" of obesity (Rail & Dumas, 2008). In this sense, biopedagogies refer to, on the one hand, the endeavors of health experts (i.e. physicians, health researchers, physical educators, other health professionals) who participate in the reproduction of the dominant obesity discourse, and on the other hand, on significant spheres of society (i.e. family, mass media, and schools) in which the dominant obesity discourse is being reproduced (Wright & Harwood, 2009).

The success of regulating the body depends on the legitimacy of those who produce the obesity discourse (i.e. medical institutions, researchers, health promoters) (Gard & Wright, 2005; Wright & Harwood, 2009). In this sense, the status of research institutions and the educational credentials of health professionals strongly contributed to legitimize the dominant obesity discourse (Maurer & Sobal, 1999; Paquette & Raine, 2004). Health professionals are most influential when recommending and suggesting a particular series of health practices (Evans & Colls, 2009; Wright & Harwood, 2009). For example, in their qualitative study on body image, Paquette & Raine (2004) noted that female patients who consult health professional rarely call into questioned professional advice.

² A Foucauldian notion referring as the mechanisms which correct behaviors by means of observation. Disciplinary practices are characterized as making 'docile bodies' through panoptism. According to Wright & Harwood (2009), disciplinary practices functions by controlling populations through regulation.

The conformity to a social ideal is often used as a strategy to regulate health practices and to reduce obesity. Maurer & Sobal (1999) suggest that the promotion of self-discipline by health professionals is reinforced by the promise of the acquisition of a socially desired body. Likewise, Parham (1999) argues that: “the desire to be slender is so strong and so widely held that dieticians have become accustomed to using it as a means of motivating behavior changes” (p. 920). Essentially, health professionals have access to a number of strategies to promote healthy living. However, in the same breath, their chosen method often encourages a strong conformity to ideal body norms (Parham, 1999). In this sense, in this way, health professionals also participate in the transmission of socio-cultural norms of thinness conceived by the dominant obesity discourse (Maurer & Sobal, 1999; Paquette & Raine, 2004; Parham, 1999).

Asides from direct health promotion efforts, sociological research has shown that social interactions also contribute to produce and disseminate the dominant obesity discourse. For example, social scientists posit that health practices are often passed on through family dynamics, from parents to children (Cockerham, 2005; Field, Camargo, Taylor, Berkey, Roberts & Colditz, 2001). Through socialization, children are likely to internalize their parents’ health practices such as their nutrition and physical activity practices (Field et al., 2001; Evans, Davies & Wright, 2004). Dominant health discourses are thus passed within the family setting (Wright & Harwood, 2009).

A number of studies have concluded that health enhancing practices are also promoted in popular culture through mass media (magazines, television or Internet) (Bordo, 1993; Lee & MacDonald, 2010; Wright, O’Flynn & MacDonald, 2006) and that children, adolescents and adults construct ideas and values pertaining to ‘normal’ weight according to

the images seen and read within these media sources (Paquette & Raine, 2004; Wright et al., 2006). In fact, information regarding body weight management is becoming increasingly accessible through modern technology (Banas, 2008; Pandley, Hart & Tiwary, 2003).

Furthermore, schools are also a common area where the dominant obesity discourse is being reproduced amongst children (Gard & Wright, 2001; Webb, McCaughy MacDonald, 2004; Wright et al. 2006). Wright et al. (2006) have illustrated that children along with adolescents critique their peers' physical appearance, often referring their peer's body weight as an indicator of their health and fitness. Consequently, overweight and obese children are more likely to become victims of bullying and report having more negative experiences in school settings (Griffiths et al., 2005; Webb et al., 2004). Accordingly, through such social interactions, children and teenagers learn what is considered an acceptable body weight.

The Consequences on Marginalized Populations

This discourse generates disparities between those who conform to these ideals and those who do not. Because there is a social variation of obesity rates in society (Poulain, 2009), it is essential to critically assess how the dominant obesity discourse may be more harmful for certain populations rather than others. Considering this issue, this section will discuss the ways by which the dominant obesity discourse promotes a 'blaming the victim' approach by instilling people's self-responsibility regarding their health practices (Crawford, 1998; Wright & Harwood, 2009).

In discussing the ideology of the politics of victim blaming, Robert Crawford (1998) argues that the ideology surrounding the dominant obesity discourse entails that "individuals, if they take appropriate actions, if they, in other words, adopt life-styles which avoid

unhealthy behavior, may prevent most diseases” (p. 84). As such, individualizing health, which consists of taking responsibility for one’s health, has been turned into a moral responsibility (Crawford, 1998; Blaxter, 1997). This scheme of thought implies that those who are obese and experience poor-health have adopted a careless lifestyle and lack will, thus blaming the individual for neglecting their body and their health (Blaxter, 1997; Rich & Evans, 2005).

Victim blaming often engenders a negative socio-cultural impact amongst those who do not conform to body weight recommendations (Gard & Wright, 2005; Oliver, 2006; Poulain, 2009). Drawing on Goffman’s notion of stigma (1986), many authors have shown that overweight and unhealthy individuals are likely to encounter more discriminations and prejudice at work and in school, and are more likely to face obstacles when searching for a life partner (e.g. Rothblum, 1992; McLaren & Kuh, 2004). These prejudices towards obesity also actively stress people to self-monitor their body weight (Rodin, 1993). As such, victim blaming becomes a social mean to control behaviors (Crawford, 1998).

Drawing on the previous statements, Rich & Evans’ (2005) critical assessment regarding the obesity discourse also highlights the moral responsibility regarding health and body weight:

“(…) the pressure to obtain the right body size/shape is not simply about being healthy, but carries moral characterizations of the obese or overweight as lazy, self-indulged and greedy. In other words, feeling fat carries personal evidence of stigma which can evoke feelings of guilt, shame, and stigma.” (Rich & Evans, 2005; p. 352)

Associating health practices with personal values distinguishes individuals within society (Maurer & Sobal, 1999; Poulain, 2009). However, the process of individualizing health practices, that is, leaving individuals with the responsibility to adopt a ‘proper’

regimen, neglects the social and individual factors which determine to some extent people's lifestyles, and this especially amongst those living underprivileged social circumstances (Cockerham, 2005; Poulain, 2009). In this sense, the dominant obesity discourse is not tailored towards those who statistically experience more obesity and poor health (Borders, Rohrer & Cardarelli, 2006; Morrow, Hankivsky, Varcoe, 2007).

While the many public health interventions are indeed noble, they have yet to acknowledge the extent of how social and economical factors are meshed within individual's lifestyles (Borders et al., 2006). In fact, a large repertoire of sociological articles has provided explanations regarding the different lifestyles amongst social classes, suggesting that health practices vary strongly according to life circumstances (Boltanski, 1972; Cockerham, 2005; Williams, 1995). In fact, Pierre Bourdieu's (1984) pioneering research has documented how social classes carry distinctive bodily dispositions. Bourdieu's work highlights the social and cultural variations of bodily dispositions and how life circumstances (i.e. barriers and opportunities) orient people's choices, practices, and preferences.

Several social scientists have followed Bourdieu's approach to lifestyle. Cockerham (2005), along with several other theorists (Boltanski, 1971; Williams, 1995) concur that differences in living conditions have been shown to fashion distinctive actions and practices amongst social groups, such as their preferences in food, physical activity, or hobbies. For instance, Cockerham (2005) posits that people develop particular dispositions towards the body. Social variations in body care, (i.e. the way people feed, exert, dress, and treat their body) have been described as a way for people to gauge their choices and actions in function of their constraints and opportunities (Cockerham, 2005; Boltanski, 1971; Williams, 1995). Drawing on this approach, because social groups possess different amounts of material

goods, economic capital, and knowledge, health lifestyle disparities between social groups become inevitable (Cockerham, 2005; Poulain, 2009; Williams, 1995). These authors contest the individual approach public health initiatives have developed across the last few decades by arguing that their efforts should target social inequality instead.

The Pervasiveness of the Obesity Discourse in Women's Lives

Many sociologists agree that women are especially prone to be negatively affected by the dominant obesity discourse because of gendered social pressures that increase their preoccupation with their body (Bordo, 1993; Reischer & Koo, 2004). Susan Bordo's (1993) pioneering work on the relation between women and body weight suggest that women's bodies are particularly subjected to strict body norms. To illustrate these trends, the Public Health Agency of Canada (2003) reported that approximately half of all North American women experience body dissatisfaction and that 59% of Canadian women are weight conscious. Women face much pressure to obtain a slim body, and women of all shapes and sizes engage in weight management, such as dieting and regular exercise (Wright et al. 2006). Additionally, some women adopt unhealthy weight loss practices like eating disorders and excessive exercise in order to obtain a socially valued body (e.g. Darmon, 2006; Paquette & Raine, 2004).

Bordo (1993) further adds that body weight hold strong symbolic value that creates disparities amongst women (Bordo, 1993). Building on Bordo's work, Reischer & Koo (2004) suggest that women's bodies have become a mechanism of social power;

“(...) the slender body ideal symbolizes not only an aesthetic ideal but also the internal disciplines that may be necessary to achieve it (...) Within this economy, beauty is not merely a desirable asset but a legitimate and necessary qualification for a women's rise in power (...)” (p.301).

Many feminists' authors have argued that women's body awareness would explain their high investments of time and money in order to conform to a socially valued body (Bordo, 1993; Dittmar, Beattie, Friese, 1995; Hayhoe, Leach, Turner, Bruin & Lawrence, 2000). In this context, it is no surprise that weight management has become multibillion-dollar industries (Public Health Agency of Canada, 2003; Rodin, 1993).

Feminists in particular have endowed much attention to the recommendations and messages addressed to women and their bodies (e.g. Moore, 2010; Reischer & Koo, 2004). Sarah Moore (2010), a contemporary sociologist of health, proposes a critical argument illustrating the 'morality' of health and slimness messages that particularly target women. Moore (2010) explains that women were historically expected to maintain and adopt a healthy regime for reproductive purposes. To constantly monitor nutritional intake, fitness regimes, and to adopt health-promoting beliefs are indeed affiliated with feminine behaviors (Moore, 2010). She points out that, "[d]oing health may become a means of doing gender" (p. 112). Women are not only subjugated to a discourse of slimness and health, but are also finding themselves caught in this discourse where, not only health, but social desirability is to strive for (Bordo, 1993; Moore, 2010).

By drawing on a gendered lens, women are uniquely positioned within the dominant obesity discourse. They are simultaneously exposed to a dominant discourse of obesity and femininity; both discourses promote normalizing health practices such as dieting, regular exercise and self-discipline in order to acquire a body deemed healthy and beautiful (Bordo, 1993; Reischer & Koo, 2004). While feminine norms promote the idea that women's social value is strongly tied to her body, the obesity discourse also mirrors the possibility for women to gain social value (Reischer & Koo, 2004). The body of women can behold power

by becoming a means to acquire other valued resources (McCall, 1992; Shilling, 2004). As noted by feminists and sociologists, this symbolic value is unequally dispersed amongst women and is essentially linked to various constraints and opportunities inherent to their social context (Featherstone, 1991).

Employment is one of many areas where women are able to draw power (economic and social capital) (i.e. networking, promotions) (Hidri & Louveau, 2005; Trautner, 2005). For example, Hidri & Louveau (2005) observed that women adopt weight management and health practices in order to be employed in particular work environments. They report that women can adopt a lifestyle which conforms to the stereotypes of their desired profession. Certain occupations promote certain types of bodies which conform to the ideologies associated with that specific employment (Hidri & Louveau, 2005; McCall, 1992).

Work environment is one of many areas where women are required to negotiate the health practices and dispositions in order maximize their social value (Bourdieu, 2001; Hidri & Louveau, 2005). Sociologists have highlighted the opportunity for women to convert their socially valued physical dispositions into other resources (i.e. economic, social value, social networking) (Bourdieu, 1984; Rodin, 1993; Trautner, 2005). In fact, Bourdieu (1984) notes in *Distinction* that upper-class and working class women manage bodily practice differently in order to maximize economical and symbolic profit. He proposes that:

“(…) working-class women, who are less likely to have a job and much less likely to enter one of the occupations which most strictly demand conformity to the dominant norms of beauty, are less aware than all others of the ‘market’ value of beauty and much less inclined to invest time and effort, sacrifices and money in cultivating their bodies” (p. 206).

However, Bourdieu suggests that some living conditions of working-class women make them aware of the power associated with body appearance as they must “obtain the

highest profits” (Bourdieu, 1984; p. 206). In this following example, Trautner’s (2005) study on nude dancers illustrates the ability to convert physical appearances into economic income. In this particular context, these dancers, prominently from a working-class family, had very little education to convert into economic capital. However, they were able to “profit” from their body in this particular context. “By using their appearances to simultaneously do gender, heterosexuality, these women increase their financial gains while at the same time conforming to, legitimating, and perpetuating dominant cultural ideals” (p.778). Thus, according to women’s social circumstances, they negotiate their intellectual, physical, or social attributes in order to maximize “profit” (Hidri & Louveau, 2005).

Although some women benefit from the obesity discourse, those whose weight does not conform to normative beauty standards face greater social obstacles (McLaren, 2007) and report facing more employment discrimination (i.e. not being hired, denied promotions or raises, fired or pressured to resign or urged to lose weight), participate in less activities and social events, and are less likely to marry (Rothblum, 1992). As previously mentioned, obese and overweight women are more likely to experience downward economic and social mobility due to the evaluation of their appearance and the assumptions about their poor health (McLaren, 2007; Rothblum, 1992). Through her meticulous work regarding obesity discrimination, Rothblum (1992) suggests:

“(…) one is poor, and, because of factors associated with low income, one becomes obese. In fact, there is evidence for the reverse association: obesity causes poverty. That is, first one is obese, and because of the low prestige associated with obesity, one drifts into a lower social class” (p. 66-67).

Referring to men, masculinity theorist R.W. Connell’s (1993) argues that: “Though men in general gain the patriarchal dividend, specific groups of men gain very little of it.” (p. 64). This can also be applied to women as not all of them reap the same benefits from a

dominant discourse of femininity which praises health, slimness and beauty amongst women. By managing their weight, women are also participating in a power game that might socially and economically benefit or disadvantage them on the basis of what they look like (McLaren, 2007; Poulain, 2009; Rothblum, 1992).

Women's Social Constraints to Health

Social inequality is a major determinant of health and lifestyle (Boltanski, 1971; Cockerham, 2005; Williams, 1995) and should be considered in any attempt to study women's relationship with weight and obesity. From a health promotion perspective, because socioeconomic disparities appear to be persisting in time, it becomes important to understand the connections between the obesity discourse and social groups that have been identified as 'at-risk' of health problems (WHO, 2006a). Because healthy living has become a personal and moral responsibility (Crawford, 1980; Wright & Harwood, 2009), it is possible that these issues will contribute to amplify social and economic disparities amongst social classes (Poulain, 2009). The following section presents articles which illustrate the relationship between social class, gender, and lifestyle, as well as the particular obstacles to health which restricts underprivileged women to adopt socially valued health practices (Poulain, 2009; Reid, 2007).

Although it has been shown that women's health practices are closely related to their living conditions (Boltanski, 1971; Cockerham, 2005), public health initiatives, however, continually neglect the social conditions which take part in the daily lives of underprivileged women (Borders et al., 2006; Morrow, Hankivsky, Varcoe, 2007). In Canada, underprivileged women are subject to low paying employment, often earning yearly salaries

which are below the national low income cut-off (LICO)³, which is below 22 000\$ per annum in Canada (Statistics Canada, 2009). This salary leads them to increase their “working time at the expense of time available to attend to nutrition and food preparation, less active lifestyles, and so on” (Hankivsky, 2007; p. 185). Underprivileged women spend approximately 60% on food, housing, and clothing only (Hankivsky, 2007). Furthermore, women’s roles as wives, mothers, homemakers and caregivers also increase their unpaid daily work demands (Hankivsky, 2007), adding yet another struggling factor young women commonly face.

As seen through several studies, women’s social and material environment, such as their housing location, neighborhoods, and surrounding facilities have been shown to impact their lifestyle (Bava, Jaeger, Park, 2008; Hopkins, 2008; Poulain, 2009). These geographical factors either allow or restrict women’s accessibility to proper food, recreational facilities, hospitals, community centers, transit services and so forth (Hopkins, 2008; Matheson, Moineddin & Glazier, 2008). Due to the disadvantaged housing location, which also decreases their accessibility and opportunity to buy healthy food, women were found to buy low-cost, energy-dense (i.e., junk) foods. Women’s immediate environment has a strong impact on women’s diet quality and physical activity patterns (Hopkins, 2008; Matheson et al., 2008).

Poverty has also been tied to poorer access to insurance benefits, workers compensation benefits, as well as health benefits (Reid, 2007). In other words, underprivileged women face challenging daily realities which tend to disregard health

³ Low Income Cut Off (LICO) is an indirect measure of poverty in Canada. LICO after taxes, for a single person is approximately 22 000\$ (Statistics Canada, 2009). For example, this amount in Canada only covers for basic needs such as food, shelter, and clothing. LICO varies according to family size and the size of community.

promoting messages advocated by public health interventions (Bava et al.; Reid, 2007). In this sense, public health interventions must be aware of the social and cultural factors that shape underprivileged young women's approach to body weight and health practices.

Health practices are one part of class culture and also the result of socialization. Luc Boltanski's (1971) seminal work on social variations of body care clearly illustrates the relationship between living conditions and embodied preferences, values, and tastes towards the body. When considering how gender and class influences social variations of body care, he states that women from different socioeconomic status have a contrasting relation to the body. For example, women of the higher social classes preferred a slender body and adopted more self-monitoring practices (e.g. nutrition, regular exercise, etc.). Working-class women, however, preferred fattier and heavier meals (i.e. pork, potatoes, lard, etc.) (Boltanski, 1971; Poulain, 2009). Women of affluent social classes treat their body as a project, as a means to acquire resources whereas women living underprivileged social circumstances preferred a sturdy body and engaged less in such beautification practices. As such, the working-class conditions of women predispose them less to cultivate the body. Boltanski's work, illustrates that women are shaped by their life circumstances.

Furthermore, Lee & Macdonald's (2010) qualitative study has recently illustrated the various ways in which young women of different social and geographical locations (i.e. women living in rural areas) negotiate the dominant obesity discourse within their own life contexts. Like women living underprivileged social circumstances (Reid, 2007), rural women are often perceived as neglecting legitimized forms of physical activity and health practices because they have restricted opportunities to participate in formal sport and activity (Lee & Macdonald, 2010). Therefore, there is a clear disadvantage for women who face obstacles to

health resources, lack time and money, and simply have embodied dispositions which do not prioritize health behaviors advocated by public health interventions (Cockerham, 2005; Reid, 2007). It therefore becomes crucial to consider the socioeconomic conditions of young underprivileged women which also have limited opportunities to adopt legitimate health practices advocated by public health interventions.

Conclusion

Underprivileged women face many challenges in order to conform to dominant discourses applied to the body. Many studies that are concerned with social class issues have shown that these women are not only suffering from the impact of social and material deprivation, but also of being socially diminished by normative discourses on the body (Lee & Macdonald, 2010). Health initiatives therefore need to be aware of the impact of their messages (Maurer & Sobal, 1999; Paquette & Raine, 2004). It is thus crucial to foster new interventions and messages that will lessen the negative social repercussions fashioned by individualizing health discourse (Borders et al. 2006).

Following this review of literature, there remains very little information regarding how healthism and the obesity discourse are taken up by young women living in underprivileged social circumstances and how it shapes the ways they treat, feed, perceive, exert, and dress their bodies. Previous research display working-class women as having very little opportunity to convert their physical capital into other valued resources (Lee & Macdonald, 2010). While there remains a clear social advantage for women who conform to standards of body weight and physical appearances advocated by health interventions and cultural practices, those who do not conform may suffer social consequences.

While the relationship between women's socioeconomic status and weight has been illustrated by many quantitative studies (McLaren, 2007; Poulain, 2009), few qualitative studies have sought to understand to what extent the dominant obesity discourse is embodied by the young women living underprivileged social circumstances. Therefore, my study aimed to: (a) understand the responses to current body norms and expectations tied to health and physical appearances amongst underprivileged young women, and; (b) understand to what extent the dominant obesity discourse is inscribed in these women's bodily habitus

Chapter III

Theoretical Framework

Pierre Bourdieu, Gender and the Relation to the Body

Previous qualitative research has focused on the implications of popular media on young women's perception of health and body weight (Wright et al. 2006), the cultural and institutional factors which fashion women's body image (Paquette & Raine, 2004), and the embodiment and resistance towards the obesity discourse (Harper & Rail, 2010; Lee & Macdonald, 2010). However, few qualitative studies have explored the issue of embodiment with regards to underprivileged women. I believe that Pierre Bourdieu's concepts of habitus, physical capital, and symbolic violence were best suited to display the relationship between the dominant obesity discourse, underprivileged women and their relation to the body (i.e. tastes, preference, and choices relative to the body).

In *Distinction* (1984), Pierre Bourdieu exposed the complex interaction between social class conditions, bodily dispositions and social hierarchy. His sociocultural theory has shown that the body is a source of power and social stratification. In *Masculine Domination* (2001) he frames his approach within a gender framework and argues that women are unevenly equipped to conform to the ideal body norms. For Bourdieusian Feminists, the bodies of women living in underprivileged social circumstances are a source of their social disapprobation and stigma (Skeggs, 1997; 2004).

Habitus, Gender and Obesity

The dominant obesity discourse is a contextual concept which helps to understand certain forms of knowledge pertaining to weight and health are perceived as more legitimate

than others. This discourse becomes a powerful way of manipulating and influencing society's perceptions towards the body (Rich & Evans, 2005; Wright & Harwood, 2009). As Bourdieu notes, the dominant obesity discourse within the field of health "is reproduced by institutions capable of imposing universal recognition of the dominant language" (Bourdieu, 1991; p. 40)⁴. Drawing on Foucault's work, Hall defines discourse as "a group of statements which provide a language for talking about (...) a particular topic at a particular historical moment. It influences how ideas are put into practice and used to regulate the conduct of others" (Hall, 1997; p. 44).

Several authors have attempted to make the link between discourse and Bourdieu's concept of habitus. Allen Luke (1992) achieves this task by stating that discourse is a powerful heuristic tool which speaks and creates norms regarding health practices. Therefore, Luke argues that discourse is inscribed in the body, on the way one treats, cares, feeds, and exerts the body (Luke, 1992). According to his theoretical argument (1992; 1996), the bodily habitus is fashioned by the discourse that have become legitimate through the efforts of cultural producers (Bourdieu, 1991; Luke, 1992).

Luke's work (1992) on discourse and its inscription on to the body attests that the habitus is shaped by discourse. This concept of habitus is referred as a set of embodied schemes of dispositions which generates actions, practices, and preferences (Bourdieu, 1984: 170). More precisely, the bodily habitus reflects a particular relation to the body and is defined by Bourdieu (1984) as:

⁴ Bourdieu's notion of fields is "arenas of production, circulation, and appropriation of goods, services and knowledge, or status centered on a particular issue (...)" (Laberge & Kay, 2002, p. 253). Fields are areas which struggle for capital in order to gain legitimacy. The field is useful here to consider how actions and power are situated within a specific setting (Lee & Macdonald, 2010; p. 207).

“(…) an incorporated principle of classification which governs all forms of incorporation, choosing and modifying everything that the body ingests and digests and assimilates, physiologically and psychologically. It follows that the body is the most indisputable materialization of class taste (…) which express[es] in countless ways a whole relation to the body, i.e., a way of treating it, caring for it, feeding it, maintaining it, which reveals the deepest dispositions of the habitus (Bourdieu, 1984; p. 190).

Apart from established norms, Pierre Bourdieu also acknowledges a number of social, cultural, and environmental factors which fashion the bodily habitus (Bourdieu, 1977; 1984). Although he does recognize discourse as a generator of practices and norms regarding health practices (Bourdieu, 1984; 1991), he argues that other factors also generate actions - factors which do not necessarily conform to established societal norms (Bourdieu, 1984). As such, Bourdieu states that objectively classifiable conditions of existence (e.g. income levels, education credentials, cultural dispositions, etc.) fashion one’s habitus. In this sense, the habitus corresponds to “[an] internalized form of class conditions and of the conditionings it entails (Bourdieu, 1984: p.101). Hence, the bodily habitus, i.e. relation to the body, can be understood as the different ways of managing the body. Through his ethnographic observations, he observed that according to past experiences and life circumstances, people who share similar living conditions develop a similar bodily habitus (Bourdieu, 1984).

For example, Bourdieu has coined the terms *instrumental* and *reflexive* relations to the body to highlight the habitus of working class and upper class groups. Those living affluent social conditions perceive their bodies as an end to itself (reflexive relation to the body). As such, this group’s bodily dispositions prioritize their health, bodies, and physical appearance. They engage in practices which enhances their state of health (e.g. regular physical activity, healthy dieting, regular visits with physicians, etc.) (Bourdieu, 1984). Their tastes and preferences in food, physical activity, and bodily appearances differ from those

experiencing underprivileged social circumstances, who in turn, perceive the body as a mean to an end (instrumental relation to the body). For the latter, the body is an instrument which allows the person to acquire the appropriate materials in order to acquire basic necessities (Shilling, 2004). In the same line of thought, Luc Boltanski's (1971) empirical research has shown the relationship between living conditions and bodily dispositions between social classes. The author argued pervasively that the attention given towards the body and health increases with socioeconomic status. Income, educational credentials, and occupational status were strong predicaments of the amount of attention given towards the body.

In the past, feminists have critiqued Bourdieu for neglecting gender as a factor which generates action, tastes, and preferences regarding the body (McCall, 1992; Skeggs, 1997). Shortly following these critiques, Bourdieu (2001), acknowledged that there is indeed a gendered or 'sexually characterized habitus' (p. 3). In *Masculine Domination* (2001), he argues that the gendered habitus is an important factor in generating gendered bodily dispositions. As such, women's bodily habitus is at the source of societal expectations of femininity (Bourdieu, 2001; Huppertz, 2004; McCall, 1992).

His analysis of women's relation to the body cautions sociologists against an over psychological approach that would be devoid of the power relations that are embedded in social structure (Bourdieu, 2001). In this respect, it is important to avoid the confusion between the notions of 'body image' and 'relation to the body'. In *Masculine Domination* (2001), Bourdieu argues that:

"The relation to one's own body cannot be reduced to a 'body image', in other words the subjective representation ('self-image' or 'looking-glass self'), associated with a certain degree of 'self-esteem' (...) and which is largely built up from the objective representation of the body, descriptive or normative 'feedback' supplied by other (parents, peers, etc.). Such a model forgets that the whole social structure is present at the heart of the interaction,

in the form of perception and appreciation inscribed in bodies of the interacting agents. (...) Thus, the perceived body is socially doubly determined. On the one hand, in even its seemingly most natural aspects (its volume, height, weight, musculature, etc.) it is a social product that depends on its social conditions of production through various mediations (...) On the other hand, these bodily properties are apprehended through schemes of perceptions whose use in acts of evaluation depends on the position occupied in social space. (...) Thus, the gaze is not a simple universal and abstract power to objectify: (...) it is a symbolic power whose efficacy depends on the relative position of the perceiver and the perceived and on the degree to which the schemes of perception and appreciation that are brought into play are known and recognized by the person to whom they are applied” (p. 63-65).

Therefore, Bourdieu acknowledges that the ‘relation to the body’, unlike ‘body image’ is doubly determined. On the one hand, it is determined by a field of cultural production that fashions social and cultural expectations linked to the body (i.e. normative aspects related to shape, size, and appearance of the body). On the other hand, it is fashioned by women’s taste and judgments on the body, which is strongly characterized by her social position in society in the structuring effects of her life circumstances (i.e. income, education, culture, upbringing, etc.) (Bourdieu, 1984). Hence, this concept must be understood within the structure-agent dichotomy.

The relation of the body is a key concept in order to analyze how gender, social class, and bodily discourses are embodied by underprivileged women. Similarly to Lee & Macdonald (2010) and Luke (1992), this concept enabled me to study the bodily habitus of young women drawing on an analysis of their dispositions, tastes, preferences and practices linked to obesity and health.

The Struggle over Capital: Physical Capital and Symbolic Violence

The study of young women's bodily habitus is a pertinent approach for this study since the dominant obesity discourse is particularly oriented towards the size and shape of the body. As mentioned by Jean-Pierre Poulain's (2009) sociological approach to study obesity, the presence of the dominant obesity discourse contributes to amplify the disparities between women who have and have not acquired a socially valued body. As seen above in the literature review, women's bodies can be viewed conceptually as a form of capital which can allot social value and opportunity (Reischer & Koo, 2004; Shilling, 2004).

Body and capital.

Bourdieu considers capital to be a form of resource or power which is part of wide system of exchange (Bourdieu, 1984). Capital, which exists in various forms (i.e. economic, cultural, symbolic, and physical) and are subject to power struggles over their inherent value within a society (Swartz, 1997). In North America, economic capital (i.e. income levels) and cultural capital (i.e. educational credentials, verbal facility, and bodily dispositions) are highly valued, thus granting legitimacy and social value to those who have acquired these types of resources (Swartz, 1997). For example, if one has high levels of economic capital, one can acquire higher levels of education, and later on, obtain a respectable and high paying employment. Capital is therefore a resource that empowers, allowing individuals to manage their life opportunities and to gain social prestige (Bourdieu, 1984; Gorley, Holroyd & Kirk, 2003). In contrast however, the lower the volume of capital, the more ill-equipped a person is to face life's contingencies.

Although economic and cultural capital grants opportunity, Chris Shilling (1991; 2003) considers the body as a form of capital. Chris Shilling views physical capital as a way of modeling the body according to socially valued standards. Through the management of the body, the formation of physical capital is acquired through athletic competency, health behaviors and physical appearances (Shilling, 1991; 2003). Physical capital thus brings other forms of valued resources (i.e. income, occupational prestige, social networking, social value, etc.).

When observing how physical capital and gender are interrelated, Wacquant's (2004) ethnographic observations with male boxers in Chicago illustrates the importance for these athletes to develop their physical capital, i.e. boxing capabilities, in order to acquire other forms of valued resources tied to masculinity. Through the management of their athletic capabilities, these young men are able to gain income, social prestige, and display their masculinity (Shilling, 2004; Wacquant, 2004).

For women, Huppatz (2009) argues that physical capital is negotiated through health behaviors and aesthetic practices which are often converted into economic and symbolic profit (Huppatz, 2009). For example, women who have acquired high levels of physical capital (i.e. beauty, slimness, appearance of health), are able to acquire higher paying jobs and are more socially valued than women who have little socially valued physical capital (McLaren & Kuh, 2004; Rothblum, 1992).

However, numerous theoretical papers insist that women from affluent social classes have greater opportunity to convert their physical capital into other resources (Shilling, 2004; Skeggs, 1997). Yet, Shilling (2004) states that underprivileged young women have less time, resources, and interest "to cultivate the body outside of its relation to necessity" (Shilling,

2004; p. 475), and simply have different priorities which disregard the importance given to physical capital by North American society.

Within the context of the dominant obesity discourse, legitimizing this form of physical capital, devalues the bodies and lifestyles of women who lack such physical capital (Skeggs, 1997). This means that certain types of bodies are valued more than others and thus likely providing unequal opportunities to women (McCall, 1992; Shilling, 2004).

Body and symbolic violence.

As mentioned previously, the dominant obesity discourse is intertwined with power relations. Lee and Macdonald (2010) theorize that power and capital are indeed associated with the dominant obesity discourse and that it is perpetuated through women's lives. In this sense, the dominant obesity discourse values a specific form of physical capital. Through this process, the standards of legitimate forms of physical capital are embodied and negotiated by women, thus producing *symbolic violence and social suffering* amongst women who lack particular bodily dispositions and traits. This fundamental concept in Bourdieu's theory can be understood as:

“(...) a gentle violence, imperceptible and invisible even to its victims (...) [and] offers a privileged opportunity to grasp the logic of the domination exerted in the name of a symbolic principle known and recognized both by the dominant and by the dominated - a language (...), a *lifestyle (or a way of thinking, speaking and acting)* - and, more generally, a distinctive property, whether emblem or stigma (...).” (Bourdieu, 2001; p. 2).

This quote illustrates the dynamic relation that characterizes symbolic violence. In the context of this study, symbolic violence is a two way relation between those who exert it (through legitimizing physical attributes and lifestyles), and those who are subjugated by it (by internalizing negative attributes of their body and lifestyles as unworthy). Conceptually

speaking, those who are targeted by symbolic violence are generally marginalized and underprivileged groups and are also those who experience social suffering. Symbolic violence and social suffering are thus two poles of a power relation. Hence, symbolic violence is a form of discrimination which allots opportunities to those who adhere to the rules and norms of society, and denying opportunities to those who lack conformity (Schubert, 2007).

In this model, dominant/dominated relations are taken-for-granted and negotiated by women. Bourdieu illustrates that the habitus embodies these relations of power, stating symbolic violence as manifested in the following fashion:

“So the only way to understand this particular form of domination is to move beyond the forced choice between constraint (by forces) and consent (to reasons) (...) The effect of symbolic domination (whether ethnic, gender, cultural, or linguistic, etc.) is exerted not in the pure logic of knowing consciousnesses but through the schemes or perception, appreciation and action that are constitutive of habitus and which, below the level of decisions of consciousness and the controls of the will, set up cognitive relationship that is profoundly obscure to itself.” (Bourdieu, 2001; p. 37)

As such, Bourdieu’s work in *Masculine Domination* (2001) states that women’s embodied scheme of thought and dispositions, i.e. their bodily habitus, is the product of embodiment of the power relations which exist within symbolic violence (Bourdieu, 2001). In fact, its inscription through women’s bodily habitus can be seen through their feelings of guilt, shame, and humiliation by accepting their lifestyles and bodies as lacking social value (Skeggs, 1997).

Beverly Skeggs (2004), a contemporary Bourdieusian feminist, focused on the symbolic violence experienced by underprivileged women. She argued that socially disadvantaged women are more prone to disregard their health and pay less attention to their body appearances in order to cater to their basic needs. Consequently, underprivileged

women can be labeled as lacking self-discipline by their upper-class counterparts. Underprivileged women are therefore constantly in a losing battle, unavoidably experiencing social depreciation because their life circumstances fashions their lifestyle and health regimen (Skeggs, 1997).

As such, Pierre Bourdieu's sociocultural theory provides a rigorous conceptual framework which delineates how both dominant obesity discourse and life circumstances are inscribed in women's habitus. More precisely, while the dominant obesity discourse promotes slimness and health as valued physical capital, the body is a source of social inequality which highlights symbolic violence, especially amongst socioeconomically disadvantaged women (Shilling, 2004; Skeggs, 2004).

Chapter IV

Methodology

This chapter highlights the methodological approach that guided my research. It will present the: (a) research method; (b) research sample and recruitment strategy; (c) data collection process, and; (d) data analysis method.

Research Method

This study is part of a larger research project which analyses young Canadian women's discursive construction of health and obesity amongst young women (Rail & Dumas, 2008). This smaller study aimed to have a better understanding of how the dominant obesity discourse fashions underprivileged young women's relationship with the body. A qualitative research is defined as an approach by which the researcher is active in the collection, analysis, and interpretation of data (Creswell, 1998). Denzin and Lincoln (1994) further provide a concise definition by stating that qualitative research attempts "to make sense of or interpret phenomena in terms of the meanings people bring to them." (p.2). For these authors, the researcher does not attempt to manipulate variables, but rather focuses on the participants' perspectives and meanings regarding a particular issue (Creswell, 1998; Denzin & Lincoln, 2000). As such, it was thus essential to choose a methodological approach which favored the participants' perceptions.

Several authors have highlighted the important contributions qualitative research has made in sociological research. This methodology allows researchers to study topics that have seldom been explored, and also empowers participants to provide comprehensive responses to an obscure phenomenon. A qualitative approach further entails researchers to develop a

more detailed understanding of the underlying principles in play when the broader image remains insufficient (Creswell, 1998).

Likewise, the interpretive dimension of qualitative research is also emphasized by several authors (Creswell, 1998; Guba & Lincoln, 1998; Rubin & Rubin, 2005). For this study, the approach chosen is best defined by Rubin & Rubin (2005) as follows: “Interpretivist researchers try to sort through the experiences of different people as interpreted through the interviewees’ own cultural lenses and then weigh different versions to put together a single explanation.” (p. 30). Hence, when analyzing the data, I interpreted the interviews provided in order to develop a better understanding of their social conception regarding the dominant obesity discourse.

Finally, as for the data analysis, it was essential to illustrate and to consider women’s unique experiences which are fashioned by their gender and social class conditions. Leslie McCall (2005) sensitizes scholars to consider the multiple dimensions of social life which fashions the dispositions of participants. Therefore, throughout the analysis, I did not intend to unite women by generalized categories of social inequality, but to rather acknowledge both individual circumstances and the shared experiences which fashions this group of women’s schemes of perceptions, dispositions, and appreciations regarding their body, weight, and health.

Research Sample

This study was part of a larger research project which analysed young Canadian women’s discursive construction of health and obesity (Rail & Dumas, 2008). The general aim of this larger project was examine and deepen our understanding of the connections between, on one hand, dominant obesity discourse and, on the other, young women’s

discursive constructions of the body and health. The larger study is recruiting approximately 80 young women between 18 and 25 years old. These participants came from varied cultural, ethical, and socio-cultural sub-groups within the Ottawa-Montreal region. The smaller study presented here consisted of analyzing the embodiment of the dominant obesity discourse by young francophone women who are experiencing underprivileged social circumstances.

Description of participants.

The targeted population for this smaller study was francophone women aged between 18 and 29 years old and residing in underprivileged neighbourhoods in Gatineau Québec. I purposely recruited women with little or no post-secondary education and who shared the same ethnical background in hopes to observe general tendencies amongst the interviews. Seventeen underprivileged women participated in the semi-structured interview, however, two interviews were disregarded because participants did not fit the selection criteria. In total, the interviews of 15 French Canadian women living underprivileged social circumstances were used to draw and analyze their experiences with regards to health and obesity discourses. Eleven of the 15 participants were mothers, none of the participants were working during the time of the interview, and all were receiving some form of governmental funding.

Recruitment of participants.

Participants were recruited within underprivileged neighbourhoods in the Ottawa-Gatineau region and were selected according to the following criteria: (a) female participants must be francophone and between 18 and 29 years of age; (b) participants must live in an underprivileged dissemination area as described by Statistics Canada (below 22 000\$)

(Statistics Canada, 2009), and; (c) participants have either a college degree or no post-secondary education.

Recruiting methods were followed using ethical guidelines from the University of Ottawa Ethics Board. Participants were recruited through purposive sampling and were recruited using two methods. First, I explored underprivileged neighbourhoods of the Ottawa-Gatineau region. More precisely, I directly recruited participants within their workplace, commercial areas and/or educational institution. I explored these areas and directly spoke with potential participants, explaining the necessary information regarding the study. An information letter was also given during this time, which provided additional information with regards to the study. Participants were able to accept or decline the invitation to participate either by phone, email, or directly (during initial contact) (See appendix B for Participants' Recruitment Letter).

The second recruiting method consisted of displaying recruiting posters in community organizations that intervene with young women living in underprivileged neighbourhoods. An information letter was given to these organizations explaining the necessary information regarding the study. Participants who have acknowledged the recruiting posters were able to contact the research assistant by telephone or e-mail. (See appendix B for Information Letter for Organizations).

The second method proved to be most successful. Most participants were recruited through community centres that intervene with vulnerable populations (e.g. single mothers, socioeconomically disadvantaged populations, ethnically diverse populations). Making an initial positive contact with community centre organizers was key to gain the interest from the underprivileged women who belonged to these organizations. While the recruiting

process was challenging, the need to intervene and understand marginalized populations remains a difficult task.

Data Collection

Data was collected using a participant-centered conversation guide. Participants took part in a 90 minute semi-structured conversation. These semi-formal conversations were tape-recorded and allowed the participants certain flexibility in their topics of conversation and also allowed them to discuss their past and present experiences with regards to their body and health. These recorded conversations allowed me to proceed to a thematic analysis by identifying common and emerging themes. The conversation guide has been adapted to capture the participants' perceptions with regards their weight, body and health. The semi-structured interviews took place at a time and location of the participant's choice, e.g., their apartment, an empty lounge or space associated to a public building, in order to allow participants to feel at ease throughout the interview.

Interview guide.

Generally speaking, in-depth interviews allow researchers to delve into participants' personal opinions on specific issues (Rubin & Rubin, 2005). According to Bourdieu (1999), interviews are useful in order to reconcile the social, historical, and demographic elements which contextualize how the participants' social position influences their perspectives regarding an issue.

The interview guide for this study has been developed according to Pierre Bourdieu's social cultural theory (See appendix A). As such, it highlights the: (a) characteristics of the

socio-economic environment, e.g., underprivileged social circumstances; (b) perception of the importance attributed to body weight and health; (c) perceptions, dispositions, and sources of constructions of body weight/health, and; (d) perception of human and financial resources available, e.g., access/barriers to quality food, physical activity services, health professionals and weight loss programs, etc. Some demographic information was collected before the interview through a short questionnaire in order to contextualize the participants' life contexts and to enrich the qualitative data found within the participants' narratives. This information included the participants' socio-demographic factors such as their age, education and income levels, occupation, and neighbourhoods. In the same spirit, as suggested by Pierre Bourdieu (1999), extra notes were taken after each interview; they included the location of the interview, the emotional state of the participant, the vocabulary, intonations and rhythm of the interviewee's speech, and also their gestures and body language. This allowed me to maintain some degree of authenticity of the interviews.

Ethical considerations.

General ethical considerations were respected in order to respond to the criteria set forth by the University of Ottawa's Ethics Board. This was assured by reinforcing confidentiality and anonymity, reassuring that all participation is voluntary, and making it explicitly known that digital tapes will be destroyed at the end of the project and that transcripts will be identified through the use of pseudonyms. Furthermore, any specific information or incidents that could be considered as revealing the identity of a participant was altered in such a way to protect the individual while at the same time maintaining the integrity of the original data.

Prior to the interviews, consent was obtained on the written consent form distributed only after the researcher has repeated the necessary information regarding the study. The researcher went through the form and highlighted all the details of the study and emphasized that participation is strictly on a voluntary basis. The women contacted were under no obligation to participate, and they were free to withdraw at anytime during the study if they wished.

It was crucial to maintain a sensitive and empathic attitude when interacting with research participants. Since participants experience underprivileged social circumstances, I assured to create a comforting atmosphere by speaking in layman's terms and language. In order to ensure that a relative comfort level was maintained, I also shared my personal experiences with health and weight. Creating a friendly environment was essential to minimize power relations and to allow participants to feel at ease when engaging in the conversation, thus encouraging an honest and authentic conversation between participant and myself (Bourdieu, 1999) I made every effort possible to ensure that an empathetic and respectful atmosphere (i.e. regarding the participants' needs, personal choices, and personal situation) was established and that participants were treated with care and dignity. Nonetheless, given that the researcher and participants only met once, I cannot neglect the fact that responses from participants may have been altered.

In the event that any of the participants experienced any discomfort with any of the questions they were asked, they were reassured that they did not have to answer. Moreover, participants were informed that they are free to withdraw from the study at any time without prejudice. Finally, I was extra sensitive to the identity of the participants. The participant's

integrity was respected by creating a comforting atmosphere when conducting the interviews.

Data Analysis

Data analysis consisted of the three following components: (a) interview transcription and data management; (b) thematic analysis, and; (c) research quality. The proposed research design summary can be found following this chapter.

Interview transcription and data management.

In order to properly analyze the collected data, each interview was transcribed using data management software N*Vivo. Transcriptions were unabridged in order to maintain the authenticity of the interviews. Nuances within the recorded interviews, such as pauses and hesitations, repetitions and interviewees' emotional state, such as laughter were identified by parenthesis within each transcription.

Once each interview has been transcribed, they were imported within N*Vivo before proceeding to a thematic analysis compatible with the conceptual framework of Pierre Bourdieu. Data management consisted of organizing and regrouping the data according to pre-determined as well as emerging themes. Quantitative data, such as the participants' socio-demographic characteristics was considered while reviewing the data.

According to Boutin (1997), qualitative data analysis, though it may employ various procedures in accordance with the objectives of this study, utilizes similar analysis methods. This research drew from a thematic analysis approach, which is generally defined as identifying previously classified themes and patterns within the data (i.e. interviews)

(Aronson, 1994). Once all the material has been categorized, the researcher proceeded to creating sub-themes, also known as splitting and splicing the data into specific bits of information. Using this method was useful for two reasons: first, it allowed me to develop a better understanding of my participants' interviews according to their social, cultural, and personal backgrounds, and; second, it allowed me to confirm if there are indeed any differences or similarities between participants' interviews. As such, the researcher does not anticipate any similarities or differences between the interviews, but rather utilizes the codes, themes, and patterns and relates it to theory to build a valid and scientifically founded argument (Aronson, 1994; Rubin & Rubin, 2005).

Foremost, following the transcription, I thoroughly read each interview in order to familiarize myself with the data. Afterwards, the information provided by the participants was be regrouped into themes and categories according to commonalities found in the interviews. Rubin & Rubin (2005) suggests analyzing the data vertically in order to illustrate and consider the participants' unique experiences, that is, to verify the relation between participants' life circumstances and their own life trajectory. Additionally, horizontal data analysis, also known as a comparative analysis, allowed me to find similarities and differences between the interviews. By considering both horizontal and vertical analysis, I was able to illustrate the unique and shared experiences of young women living underprivileged circumstances with regards to the dominant obesity discourse. Although I did recognize each participants' unique life circumstances as a determining factor of their acquired perspectives, finding similarities between their interviews allowed me to draw a certain degree of theoretical generalizability amongst participants (Denzin & Lincoln, 2000).

Thematic coding, a qualitative data management approach, was used to organize data into codes, themes, and patterns. Thematic coding is defined by Boyatzis (1998) as:

"a complex model with themes, indicators, and qualifications that are causally related (...) A theme is a pattern found in the information that at a minimum describes and organizes the possible observations and at maximum interprets aspects of the phenomenon (...) The themes may be initially generated inductively from the raw information or generated deductively from theory and prior research" (Boyatzis, 1998; p. 4).

Furthermore, Rubin & Rubin (2005) suggest that coding qualitative data should correspond to the same degree to the theoretical concepts and themes found in literature (i.e. deductive coding), and to themes which interviewees frequently mentioned and indirectly revealed (i.e. inductive coding). As mentioned in Chapter III, I purposely analyzed the data according to Bourdieu's concepts. Therefore, I focused on particular themes such as the bodily dispositions, symbolic violence and social suffering. In order to clarify and simplify the methodological approach to my research, a copy of the research design summary can be found in Table 1 following this chapter. It provides additional information regarding the themes which were anticipated in accordance with Bourdieu's conceptual framework. This chosen analysis method allowed me to verify if our literature corresponds with participants experiences, and to discover new themes which have not been anticipated (Rubin & Rubin, 2005).

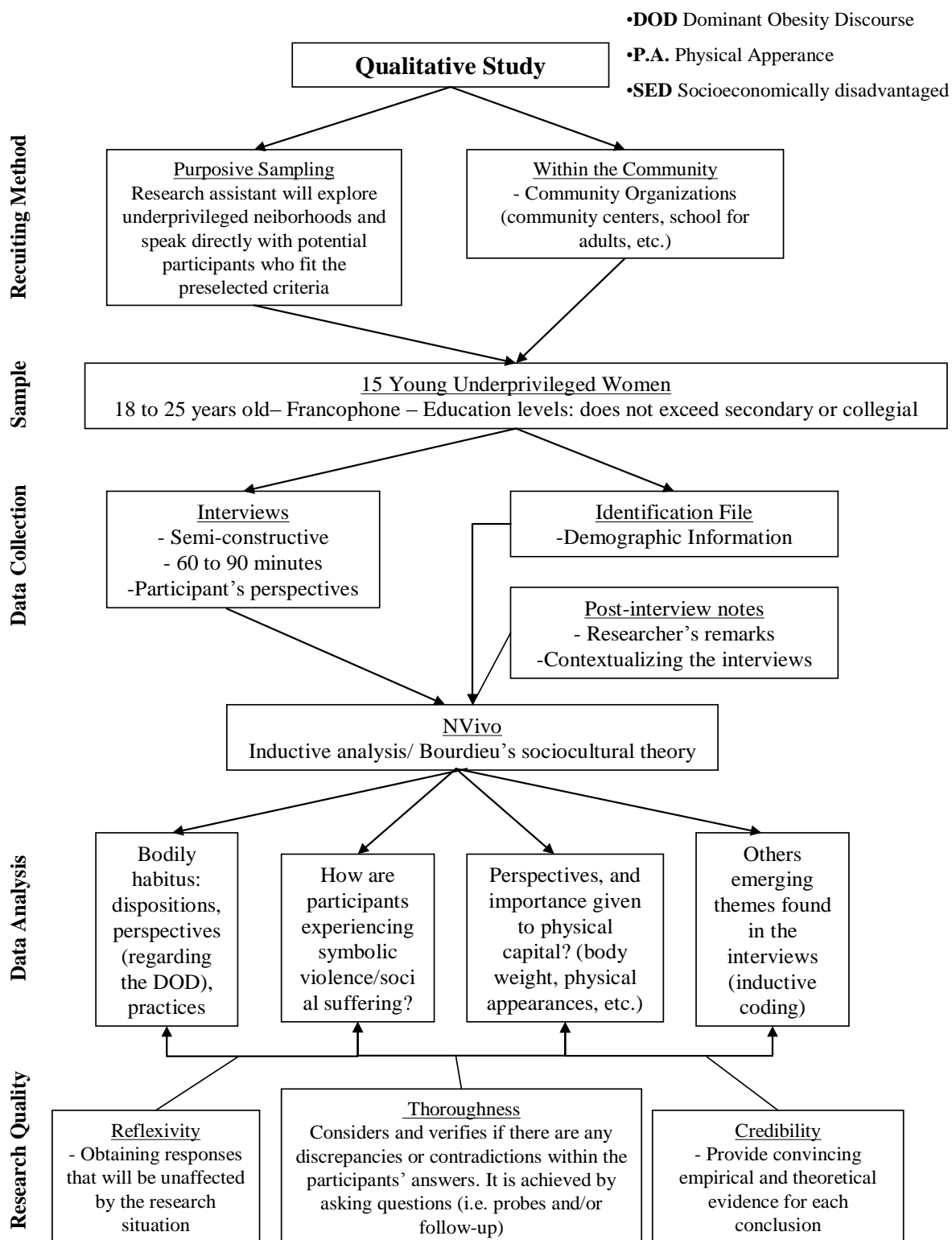
Research quality.

The research quality depended on the rigorous procedures adopted by the researcher. In order to validate the findings of this research, it is essential to highlight the following three qualities which guided this study: (a) reflexivity; (b) thoroughness, and; (c) credibility through transparency.

First, reflexivity must be considered when interacting with participants. This criterion takes into account how the researcher may affect the answers obtained by the interviewee. It is therefore essential to remain aware of the possible affect the research context will have on the responses (Bourdieu, 1999). I nonetheless attempted to remain as natural as possible, thus engaging in a conversation that would ordinarily happen during daily interactions with the hopes of obtaining authentic responses from the participants. Therefore, the acknowledgment of my own position in relation to the participants' allowed me establish some degree of trustworthiness with regards to the data collected (Denzin and Lincoln, 2000).

Second, thoroughness must be considered since it allows the researcher to verify any discrepancies or contradictions within the participants' answers. Thoroughness can be achieved by asking questions (i.e. probes and/or follow-up) when the participants' answers are either incomplete or unclear (Rubin & Rubin, 2005). Therefore, these questions allowed me to identify nuances within the participants' answers which prompt complete and coherent results.

Finally, several authors aim to achieve credibility through transparency in order to legitimize qualitative research (Creswell, 1981; Rubin & Rubin, 2005). Transparency can be understood as the ability to see the steps the researcher has taken to collect and analyze data. Rubin & Rubin (2005) further add that transparency involves a thorough research process, by which the researcher carefully records interviews, and takes notes after each interview (i.e. regarding the ambiance of the interview, state of the interviewee, and other various details which enrich the final reports). These steps allowed me to develop a credible report, meaning that I have presented convincing evidence for each conclusion (Rubin & Rubin, 2005).

Table 1: Research Design Summary

Chapter V

Article 1

Social Suffering, Weight Regulation, and Underprivileged Women's Struggles over Physical Capital

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Abstract

Dominant social representations of the body are constructed by various social institutions such as public health organizations, mass media, and the fashion industry. Recent debates on the embodiment of ideal body norms raise concerns over their negative repercussions experienced by underprivileged groups and the consequences on their quality of life. The purpose of this study is to understand the responses to current body norms and expectations tied to health and physical appearance of women living in underprivileged circumstances. Pierre Bourdieu's concept of symbolic violence was used in order to understand the tensions faced by women struggling for valued forms of physical capital. Fifteen underprivileged young women took part in a 90-minute semi-structured interview and shared their perceptions and experiences with regards to their health and body weight practices in the context of limited opportunities provided by their material living conditions. Following a qualitative thematic data analysis, the findings suggest that these young women experience many forms of social suffering, that are expressed through their feelings of shame, humiliation, frustration, and exasperation. This study highlights the personal, emotional, and social repercussions of rigid body norms experienced by those involved in a struggle for social acceptance and social value.

Key Words

Sociology, Bourdieu, physical capital, symbolic violence, health, femininity, social class.

Introduction

Dominant social representations of the body are constructed by various social institutions such as public health organizations, mass media, and the entertainment and

fashion industry. Recent debates on the embodiment of ideal body norms raise concerns over their negative repercussions experienced by underprivileged groups and the consequences on their quality of life. By focusing on social inequality and gender, this article aims to understand responses to current body norms and expectations tied to health of women living in underprivileged circumstances. This study contributes to inform health interventions and messages by exploring if underprivileged young women experience internal conflicts related to bodily appearances.

Social inequality is a persisting problem that has brought low social status feelings of low self worth amongst vulnerable populations within all economically advanced societies (Bourdieu, 1984; Skeggs, 1997). Because the body is a key component of one's social status (Bourdieu, 2001; Rodin, 1993), sociologists of health have argued that the normative health standards promoted by public health institutions (e.g. health professionals, medicine, policy makers) have participated strongly in hierarchizing people according to a valued form of 'health capital' (Blaxter, 1997). Although health institutions' aim is to improve health and prevent diseases, they also unwillingly contribute to promoting specific ideals of body appearances over others (Oliver, 2006; Parham, 1999).

For instance, weight regulation policies linked with the alleged 'obesity epidemic' illustrate the negative effects of public health interventions on the quality of life of individuals. Recent debates in sociology are highly critical of the management of obesity by public health institutions. By promoting a narrow concept of the ideal body, a strict lifestyle regimen, and by individualizing health problems, these institutions participate in discriminating, devaluing and stigmatizing those who are considered obese, overweight, or who appear to neglect their health (Gard & Wright, 2005; Poulain, 2009). Such discourses

induce feelings of guilt and decrease the well-being of those who do not conform to subsequent health norms (Poulain, 2009).

Women are especially prone to be negatively affected by these messages because of gendered social pressures on the body. For example, the Public Health Agency of Canada (2003) reported that approximately half of all North American women experience body dissatisfaction and that 59% of Canadian women are preoccupied and surveying their body weight. The promotion of normative standards of the healthy body are individualizing lifestyle that has stigmatized poorer groups, and are further socially diminishing socioeconomically disadvantaged women who are less equipped to adopt body weight management and health practices (Gard & Wright, 2005; Parham, 1999).

If the connection between health and gender has been previously discussed, there remains a need to develop more detailed knowledge on the experiences of the body and the quality of life of specific social groups. There is also a large body of evidence that shows that underprivileged populations have poorer health, have higher obesity rates, and face more constraints to follow a healthy lifestyle (Reid, 2007; Shilling, 2004). Their social and material life circumstances fashions class dispositions which do not tend to prioritize health behaviours advocated by public health interventions (Blaxter, 1997; Williams, 1995). Hence, improving population health, while avoiding its negative consequences, remains a challenge for researchers in health promotion.

Women's Struggle over Physical Capital

Many frameworks have been forwarded to explain the negative repercussions that rigid bodily norms can have on the quality of life of women. In *Masculine Domination* (2003), Pierre Bourdieu provides an intricate theory for understanding the power struggles

involved over valued forms of resources in society. Pierre Bourdieu's concept of capital represents various forms of resources (i.e. economic, cultural, symbolic, and physical) that are subject to power struggles over their inherent value within a society and that are part of a wide system of exchange (Bourdieu, 1984).

For Bourdieu, people who hold positions of power hold higher amounts of capital and have the power to marshal valued forms of capital in comparison to those in less privileged positions. In other words, the more one has power, the more he or she has the ability to possess valued forms of capital. Drawing on Bourdieu's framework, Chris Shilling (1991; 2003) develops the idea of the body as a form of capital. He thus acknowledges 'physical capital' as the "social formation of bodies by individuals through sporting, leisure and other activities in ways which express a class location and which are accorded symbolic value" (Shilling, 1991: p. 654). Through the management of the body, the formation of physical capital is acquired through athletic competency and physical appearances (Shilling, 1991; 2003). Physical capital can bring other forms of valued resources such as income, occupational prestige, social networking, and social value.

In a discussion on the interrelation between physical capital and gender, Loïc Wacquant's (2004) ethnographic observations with boxers in Chicago illustrates the importance for male athletes to develop their physical capital, (i.e. boxing capabilities), in order to acquire other forms of valued resources tied to masculinity. Through the management of their athletic capabilities, these young men are able to gain income, social prestige, and display their masculinity (Wacquant, 2004).

As for women, physical capital is particularly expressed through their physical appearance (Bourdieu, 1984; 2003). Kate Huppatz (2009) argues that physical capital is

acquired through health behaviors and aesthetic practices which are often converted into economic and symbolic profit. For instance, women who have acquired high levels of socially valued forms of physical capital are more socially valued than women who have little of it (McLaren & Kuh, 2004; Rothblum, 1992). This symbolic value is unequally dispersed amongst women and is essentially linked to various constraints and opportunities inherent to their social context (Featherstone, 1991; Huppatz, 2009).

When considering the issue of class, ethnographers observed that underprivileged women were found to have less time, resources, and interest to cultivate the body out of necessity and to have priorities other than acquiring physical capital (Bourdieu, 1984; Miller & Brown, 2005; Reid, 2007). Understanding the body in terms of capital accounts for the fact that certain body types are more valued than others and likely providing unequal opportunities, especially with respect to women (McCall, 1992; Shilling, 2004).

Bourdieu and Shilling's work on physical capital enlightens how public health initiatives contribute to the reproduction of messages concerning socially valued bodies. Legitimizing desirable physical appearance and slimness, without considering its social consequences, may participate in devaluing women who lack such physical capital and who lack the resources to acquire it (Skeggs, 1997; 2004).

Social Suffering: Underprivileged Young Women's Struggle for Physical Capital

By providing value to a specific form of physical appearance and health, health promotion initiatives are contributing to a rhetoric where people, especially women, are being judged on account of their physical appearance (Maurer & Sobal, 1999). Susan Bordo's (1993) pioneering work on the relation between women and body weight suggests that women's bodies have become a mechanism of social power. Through socialization,

women embody legitimate body norms, thus participating in *symbolic violence* and producing *social suffering* amongst those who do not or are unable to conform to body and health ideals.

Bourdieu's concept of symbolic violence can be understood as:

“(…) a gentle violence, imperceptible and invisible even to its victims (…) [and] offers a privileged opportunity to grasp the logic of the domination exerted in the name of a symbolic principle known and recognized both by the dominant and by the dominated - a language (...), a *lifestyle (or a way of thinking, speaking and acting)* - and, more generally, a distinctive property, whether emblem or stigma (...).” (Bourdieu, 2001; p. 2).

By highlighting the reinforcement of social norms and the experiences of stigma, this quote illustrates the relation that characterizes symbolic violence and social suffering. This latter concept is also a key to understand the struggles experienced by socioeconomically disadvantaged women who hold less economic capital and resources. Social suffering often finds itself as emotional (e.g. shame, guilt, envy) and bodily expressions (posture, body language) which are most manifested amongst those who are poor and powerless (Kleinman, Das & Lock, 1997).

Andrew Sayer's (2005) work in the 'Moral Significance of Class' expands Bourdieu's concept of social suffering by identifying key observable attributes characterized as emotional and bodily dispositions. He focuses on the effect of social positioning and past experiences on the responses in light of social inequality. Sayer underlines that messages are interpreted according to social positioning, and therefore generate different responses and consequences amongst those involved. For example, women's social suffering can be understood by their experience of shame, humiliation, frustration, and exasperation in response to the high expectations towards women's physical appearance set forth by public health policy, mass media, and the fashion industry.

In the same line of thoughts, Lee & MacDonald (2010) have shown that rural young women, who also lack resources, are not only suffering due to their lack of opportunity to engage in formal sporting settings, but also of being socially diminished by sociocultural bodily ideals of slimness. They have few opportunities to convert their physical capital into other valued resources. By conceiving the body as a form of capital, there remains a clear social advantage for women who have the means to conform to standards of body weight and physical appearances.

Pierre Bourdieu's theory provides a rigorous framework which can help understand underprivileged young women's struggles with the legitimate forms of the body (physical capital). According to Bourdieu (1984) and Sayer (2005), the relation to the body is tied to social position and past experiences, but is also fashioned by one's interpretation of a rhetoric. As such, it is crucial to further acknowledge the impact of health discourses that are inevitably tied to the body.

Methodology

This qualitative study is part of a larger research project which analyses young Canadian women's social construction of health and obesity (Rail & Dumas, 2009). In this smaller study, underprivileged young women were targeted because their precarious living conditions make it particularly difficult to adopt a lifestyle proscribed by health interventions and because they are susceptible to experience social suffering due to their experience with social inequality. Participants were recruited through community organizations that intervene with underprivileged groups (e.g. ethnic minorities, socioeconomically disadvantaged groups). Participants had to be French Canadian, aged between 18 and 29 years, with no post-secondary education, and reside in an underprivileged geographic area within the Hull-

Gatineau region (i.e. average annual income below 22 000\$) (Statistics Canada, 2009)⁵. Fifteen women took part in one 90-minute semi-structured interview.

The interview guide for this study was developed according to Pierre Bourdieu's social cultural theory. Participants were asked to share their thoughts, experiences, and sentiments with regards to female bodily expectations. Some demographic information was collected before the interview through a short questionnaire in order to contextualize the participants' life contexts and to complement the qualitative data found within the participants' interviews. This information included the participants' sociodemographic factors such as their age, education, income level, occupation, and neighborhood. Table 1 summarizes the participants' sociodemographic characteristics.

⁵ Poverty in Canada is defined by the Low Income Cut Off (LICO), an indirect measure of poverty in Canada. LICO after taxes, for a single person is approximately 22 000\$ (Statistics Canada, 2009). For example, this amount in Canada only covers for basic needs such as food, shelter, and clothing. LICO varies according to family size and the size of community.

Table 1: Sample Characteristics

Pseudonym	Age	Educational Level	Marital Status	Number of children
Cassandra	23	High School	Common law	0
Arielle	27	Grade 8	Single	1
Solange	20	Grade 8	Common law	1
Amélie	18	Grade 9	Common law	1
Adèle	21	Grade 9	Common law	1
Francine	25	Grade 4	Single	0
Jacqueline	25	Grade 9	Single	3
Victoria	26	Grade 8	Single	2
Karine	22	Grade 9	Common law	1
Julie-Anne	21	Grade 11	Common law	3
Dominique	29	Grade 9	Common law	3
Chantal	18	Grade 8	Single	1
Manon	25	High School	Single	0
Jocelyne	24	Grade 11	Common law	0
Sophie	21	Grade 10	Single	1

The interview guide was developed according to Pierre Bourdieu's sociocultural theory and highlights the following: (a) characteristics of the socio-economic environment, e.g., their background and past experiences; (b) perception of the importance attributed to body weight and health; (c) perceptions, attitudes/judgments et sources of constructions of body weight/health, and; (d) perception of human and financial resources available, e.g., access/barriers to quality food, physical activity services, health professionals and weight loss programs. Each interview was transcribed using the qualitative data management software N*Vivo. Transcriptions were unabridged in order to maintain the authenticity of the interviews⁶. Once each interview was transcribed and thoroughly read, a thematic analysis

⁶ All interviews were translated from French to English by the authors. We have attempted to preserve the language level used by the interviewees to illustrate the women's expressions. The names used in this article are

was performed drawing on Pierre Bourdieu's and Andrew Sayer's conceptual frameworks. Data analysis and coding consisted of organizing and regrouping the data according to anticipated and emerging themes.

Data was first analyzed and coded vertically, allowing the researcher to read each interview in its entity. Analysis then proceeded to horizontal coding which allows the researchers to find similarities and differences across all interviews. The codes corresponded to themes found in the literature, but also allowed us to code themes which have not been anticipated.

Study Context and Findings

None of the women were employed at the time of the interview, and all received a low income provided by social support, family allocations or government grants. These women were faced with pressing and immediate concerns, such as achieving economic stability, completing their high school education, and attending to family responsibilities. An overview of the interview transcripts shows that all participants experience some degree of social suffering over their struggle for physical capital (i.e. health and physical appearance). Although we cannot neglect the fact that most people experience some degree of social suffering throughout their life, underprivileged groups experience it with greater intensity given their social position and within the context of social inequality (Bourdieu, 1984; Charlesworth et al. 2004; Sayer, 2005).

As expected, all participants expressed awareness of the circulating messages regarding women's conformity to health and bodily ideals. Even though they expressed their

fictitious. None of the participants were employed at the time of the study and their income was provided by financial aid, government grants, or family allocations.

health and body weight to be less of a priority compared to fulfilling family responsibilities and completing their education, several agreed that health and bodily appearances were desirable features that renders social value. Most participants experienced social suffering through their feelings of shame, humiliation, frustration, exasperation, and their general experience of receiving patronizing comments from family members, partners, and colleagues. Their bodily dispositions, which developed in response to strict health and body standards ideals, led some participants to resist normative health practices by adopting self-defeating behaviors. Their feelings, emotions, and bodily dispositions in response to normative health practices will be discussed in detail below. Bourdieu (1984) and Sayer's (2005) work on symbolic violence and social suffering are used as conceptual tools to understand the relation between class and gender in light of strict body norms.

Responses to body norms

In this particular context, the concept of emotional dispositions is understood as a response that arise in light of strict body norms and expectations. For Sayer (2005) social position and past experiences shape these dispositions, and should be considered when studying lifestyle practices. Whilst asking questions on their responses to women's health and body expectations, many participants express internal conflict between what they should and should not do. These feelings were expressed in various ways and in different degrees depending on the context of the individual. Shame, humiliation, frustration, exasperation, and loss of respectability with regards to their health and bodily appearance are all common dispositions that were discussed by the participants. When discussing topics concerning health and the body, several participants suggested often experiencing these uncomfortable feelings.

Shame, for example, is a reaction “evoked by failure of an individual or group to live according to their values or commitments, especially ones concerning their relation to others and goods which others also value, so that they believe themselves to be defective” (Sayer, 2005: p. 152). It is an important response to consider because it is a process by which social order⁷ is reproduced and it further involves a cycle whereby people, especially those from lower socioeconomic stratum, embody the expectations and standards of normative frameworks of the body, and therefore discipline and punish themselves for contesting them (Sayer, 2005). Although these women’s emotional dispositions with regards to their own bodily appearances were mostly of a demeaning nature, they felt that these standards were unachievable given their disadvantaged socioeconomic circumstances. They were aware that the life circumstances, constraints, and past experiences acted as a barrier to adopt the dominant standards of health and bodily appearance.

Participants also often expressed feeling shameful about their economic situation, and how it led them to give little attention to health and physical appearance. For example, Dominique, a 29-year old mother of three children, often expressed her awareness that her living conditions do not allow her to adopt an active and healthy lifestyle. In the following citation, she expresses her shame and envy (i.e. two emotions often expressed amongst the participants) when facing culturally valued bodily ideals that seem unattainable.

Everywhere I go, I hear people talk about the ideal girl with the perfect body. She has to be tall and slim, and you know, it’s having to look good all the time! I watch TV and you see all these shows about Tyra Banks or the Bachelor and god! You can’t do anything else but to want to be like that! That’s all you see! You go buy clothing and its skinny jeans everywhere. If you want to buy bigger clothing, it’s like 20 bucks more! (...) Our budget

⁷ Social order is a Bourdieusian term which refers to the binary oppositions, such as man-woman, dominant-dominated, high-low, rich-poor, which functions as a social mechanism structuring specific fields of social life.

doesn't allow us to exercise or do any sort of activity either, you know? If I wanted to sign up at Curves [an exercise facility for women] or a gym, well it costs a lot of money!

Also exemplifying shame and envy is Francine who is paraplegic and suffering from a series of health complications (e.g. kidney problems and hypertension) associated with her spina bifida. She also faces socioeconomic barriers due to her disability, and further mentioned feeling envious of able women (i.e. physically and economically) who can look attractive in nice clothing.

When I go to the mall and see a really nice dress, that's when I feel most envious and disappointed that it wouldn't fit me. Women who have a good size and enough money would be able to get it and to buy all the clothes they want. I try not to think about it, but once in a while, if I see something through the window of a store, I feel disappointed.

These findings reflect those of Rail, Holmes, and Murray (2010) who suggest that disabled individuals may feel a great deal of shame and guilt because they are not likely to achieve socially ideals of the body.

As seen in a recent study (Harper & Rail, 2010), women who have had experience with pregnancy struggle with the pressures to conform to feminine bodily norms. After giving birth to her daughter, Karine, a participant from our study, believes she has a hormonal imbalance because she has gained extra weight. She expressed that she has lost self-confidence and further adds that she does not have the appropriate income to buy clothing and afford a membership at a health and fitness centre.

I used to go to the gym often with my boyfriend before I had my daughter. But now, I would never go; I don't want people to notice me! I'd like to go, but I just need that motivation, I need someone to join me. It was just easier and more motivating to go to the gym and buy clothes at the mall before I had my daughter. There were a lot of things that were easier to do when I was smaller. For example, buying and finding clothes I like. Now, I wouldn't even go to the mall because for one, it's deceiving to see a shirt that I like,

but probably doesn't have my size. Second, the extra money I do have is spent on clothing for my daughter.

Participants also express experiencing shame when they consider to have failed to achieve normative and legitimate health and bodily ideals. Manon, for example, is experiencing socioeconomic instability due to her experience with bipolar affective disorder. Ever since she has been taking medication to regulate her condition, Manon reported to have gained weight due to the cravings induced by the prescriptions. In other words, she feels trapped, despaired, and ashamed: she is aware that she has gained weight, however her priority remains completing her education in order to acquire employment and to gain independence.

Well, my weight becomes a problem when I walk from my car to the mall, and think to myself: "oof!" I feel over heated; I'm out of breath, and sweating like crazy. I can't always do what I would like to do. It's shameful! I tell myself "Geez! I should be able to do this!" I'm not even able to run for 30 seconds without being out of breath. I don't want people to see that I'm affected so easily! (...) I'm not happy with the weight gain, but I tell myself that finishing school and becoming independent is more important right now.

Generally speaking, feelings of shame were experienced when participants believed to have neglected or failed to achieve female bodily standards. Beverley Skeggs (2004), a Bourdieusian feminist, argues that socially disadvantaged women are more prone to disregard their health and physical appearances in order to cater to basic needs and responsibilities (e.g. food, shelter, motherhood). These women can feel socially diminished because they are aware that they may be labeled as lacking self-discipline by their upper-class counterparts (Skeggs, 2004).

Social suffering was also referenced through exasperating attitudes and humiliation derived from the offensive and condescending comments from family members, partners, colleagues, acquaintances, and health professionals. Humiliation, for example, arises when

there are public displays of inferiority. If one feels shame about a particular condescending comment, it may further ridicule the victim, leading to humiliation. They viewed patronizing comments regarding their bodies as relentless pressure to conform to dominant bodily norms, and reported that these were hurtful, belittling, and demanding. The women felt patronized by receiving unnecessary comments on a daily basis.

Amélie reported feeling humiliated about her current physical state. Not only is she receiving demeaning and patronizing comments from her mother and her boyfriend, she states that she felt foolish after hearing a comment from an acquaintance.

Recently, I was at the mall and I saw one of my old friends. When she saw me, she said “Hey! How’s it going? It looks like you’ve gained quite a bit of weight!” And she said that in front of other people! I know that it shows that I’ve gained weight, but to say that out loud in front of people I don’t even know! Sometimes it’s not what people tell me, but by the way they look at me. I can see it! It’s very annoying! They don’t realize that I gave birth recently and that it really changed my life.

Negative past experiences with bodily appearance also induced emotional responses. Arielle reports receiving condescending comments from physical educators and teachers at school during her youth which had lasting effects on her perception of health and the body.

When I was younger, my gym teacher often picked on the chubby girls. He would say to me in front of the whole gym class: “You have to do more exercise because you’re a little fatty! Let’s go, run!” Oh yeah, I’ve often had these sorts of comments from teachers! I hated it so much! But they had no idea how life was for me at home. My parents never preoccupied themselves too much about nutrition and physical activity.

Several other participants also mentioned feeling distressed when receiving demeaning comments from their family members. Although some were not receiving the same extent of public humiliation as other participants, they still reported feeling socially diminished when hearing hurtful comments, especially when criticism came from those close to them.

My dad and his side of the family have always teased me about my big ass. I never appreciated these comments... I'll show them though! (Victoria)

My brothers and my ex-boyfriend would tease me all the time about my weight. I'm not too good to discuss about my emotions, but I felt really ugly, I didn't feel good. For years, my stomach felt like it was in a knot. I felt so horrible inside and out. I felt judged by everyone. I avoided leaving the house. I'd do the groceries, but I was hoping no one would notice me. (Jacqueline)

In a discussion on respect and respectability, these ideas were also expressed by Sayer (2005) who argued that distressful emotions are triggered when people held in respect show signs of discontent and depreciation.

Similarly, the participants often expressed having much frustration when facing social inequality through discrimination. As such, some of the women reported feeling discredited when being denied employment in which they are skilled. To illustrate, Chantal believed to have been refused an employment opportunity due to her lack of conformity to a bodily ideal.

I once applied for a job as a cook. I knew the owners pretty well, and they knew I had experience. But they took the young girl who had no experience and was much younger but she was prettier and was more physically attractive than me. I was able to take on more responsibility, and they took the girl who's a minor and didn't know a thing about the job. It's not complicated. They took her because she is smaller and prettier than me (Chantal).

All of the quotes above show that these women are not only suffering from the impact of social and material deprivation, but also feel socially diminished by normative discourses on the body. As argued by Sayer (2005), “[t]he very presence of wide disparities of wealth, coupled with the tendency for advertisers to invite consumers to see their consumption as a measure of their worth, could be said to have the effect of humiliating the poor.” (p. 161). Responses to strict health and body norms must be considered in every effort

to understand embodied dispositions and choices regarding health and the body in health promotion and in the negative role it may play when it publicizes the ‘healthy body’ and devalues ‘unhealthy bodies’.

Distancing from body norms.

While several participants remained aware of body norms and standards, some distanced themselves from these norms and prioritized other aspects of their lives (e.g. education, employment, motherhood). Drawing from their negative experiences, several participants resisted dominant ideals of the body and adopted anti-normative practices. Experiences influence the reception of norms, and people who negatively experience social inequality can develop ethical positions that lead to anti-normative lifestyles (Sayer, 2005). Given that symbolic violence originates from unequal distribution of resources and opportunities, several participants strongly contested health and body norms, and resisted them by rejecting health practices proposed by health institutions. In this sense, reactions shape people’s practices and bodily dispositions, even if sometimes, these reactions went against a healthy lifestyles and their ‘self-interest’.

For example, Arielle explains how her experience in childhood and young adulthood led her to adopt anti-normative health behaviors.

On the social level, people used to look at me a lot. I used to be bigger, so people stared at me. And as a lifeguard, people expect you to be fit. Have you even seen a lifeguard who weighs over 200 pounds? I tried to give my co-workers the impression that I was making an effort to lose some weight. I would bring healthier meals at work, but really, as soon as I got home, I would just eat junk food. I wanted them to think that I was at least making an effort and that I just couldn’t lose any weight. I tried avoiding the looks and the judgments; I didn’t like them, though I didn’t really care about my health.

Similarly, Jacqueline hides her eating behaviors from her daughters. Although she promotes healthy eating in the presence of her children, she will eat sweets and fast food when her children are sleeping or attending school.

I do eat healthier now to promote healthy eating to my daughters, but not all the time. I will accept to eat fatter foods. At night, when they are sleeping, I'll eat chocolate and chips. I hide it because I want my kids to eat well.

Anti-normative dispositions were also regarded as detachment from socially valued body norms, whereby participants became unconcerned with their health and body appearance. After receiving regular criticism on her weight, Amélie called into question the nature of her personal relationship, became more or less unresponsive to such criticism and developed a nonchalant approach to her health and body.

My boyfriend mentions something about my weight every day. He'll mention it once, or several times a day. He'll say: "look, you have to lose weight, you're getting pretty fat! At least try to stay in shape, try to lose weight, eat better food!" I'm not really doing anything to help myself because, the thing is that I feel fine in my skin. Of course I'd like to lose some weight. But he says it so often that I'm fed up! I'm starting to wonder if he accepts me for who I am. I just feel... I feel like he doesn't appreciate me and that he doesn't love me for who I am sometimes.

Distancing from body norms was also expressed through feeling detached from health and beauty ideals. Exemplifying this is Julie-Anne, a 21-year old mother of three children who explained throughout the interview that she has gained extra weight since the birth of her children. Julie-Anne shows much less concern for her health and bodily appearance because of her more pressing parental responsibilities. Her experience with receiving constant negative feedback regarding her body from her mother and family physician led her to reject these critics by becoming unconcerned with her health and physical appearances.

When people tell me I gained weight, I was like ‘yeah, so?’ I don’t care what people think of me. But if I had a friend who came up to me and told me that I gained weight and I should watch my health, that I might experience some complications from it or whatever, well that’s better. But just saying ‘you’re fat!’ well, you know what? Eat shit! If people see something that I can’t see, for example, if my health was deteriorating, well that would be fine, I can accept that. But if you just tell me ‘well, you’re pretty fat now’, well I’ll just say ‘thank you very much, and what would you like for me to do?’

Participants’ experiences with negative and patronizing comments led them to resist and to adopt anti-normative behaviors. In this sense, these responses towards ideal body norms could be interpreted as reactions of underprivileged women to symbolic violence.

Conclusion

This article aimed to illustrate the struggle underprivileged women face to conform to ideal body norms. The results suggest that women were most often experiencing social suffering through feelings of shame, humiliation, frustration, and exasperation in response to strict health and body norms. These responses were evoked by failure to achieve strict health practices and desirable physical appearances set forth by dominant representations of the body.

The normative body which encompasses health is perceived as a valued form of physical capital and have become a source of social inequality which can engender social suffering, especially amongst socioeconomically disadvantaged women. Not only do women in general face much pressure to manage their physical appearances through health practices, the analysis of the interviews show that women living disadvantaged social circumstances feel obligated to adopt a lifestyle and physical appearance that are often unattainable for them. Underprivileged women face many challenges in order to conform to physical appearance standards of slimness and beauty advocated by health promoters.

Pierre Bourdieu's approach to symbolic violence and social suffering as well as Andrew Sayer's recent extensions to Bourdieu's concepts were useful in understanding the responses, dispositions and practices of underprivileged women in context of social inequality. People's social position and their responses to ideal body norms should be the object of further study in order to better gauge the impact of health promotion messages, especially towards underprivileged groups.

This article exposes the repercussions of promoting dominant social representations of the body. As producers of normative representations of the body, actors in health promotion can participate in discrediting the lifestyles of those who face social, personal, and material barriers to health. This study also unveils the drawbacks of having strict bodily norms on the personal level, and illustrates how they act as symbolic violence. Hence, in order to mitigate negative impacts of health norms and improve health, public health institutions should consider women's social position, their resources, and their past experiences.

This study included a small number of participants living in the same city and facing very similar social circumstances (i.e. single mothers, age, ethnicity). The need to intervene and understand marginalized populations remains a difficult task. While this study primarily recruited Caucasian French-speaking women, the acknowledgement of other points of view of underprivileged women (e.g. cultural minorities) would be beneficial. Public health interventions would benefit from studying a larger number of women living in underprivileged circumstances. Having a broader perspective on the repercussions caused by societal expectations of women's bodies would allow researchers to inform public health

policies on innovative and constructive frameworks that have less negative consequences for marginalized populations.

Chapter VI

Article 2

Young Women and Poverty: Are Health and Weight Their Priorities?

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Abstract

In light of the alleged 'obesity epidemic', health promotion initiatives and interventions offer a variety of mediums encouraging Canadians to take up a healthy lifestyle in order to prevent complications associated with obesity. Despite these efforts, scholars in critical health sociology have called into question the lifestyle approach in health promotion by sensitizing health promoters to the sociocultural barriers to health and the stigma experienced by those who do not conform to normative lifestyles. Drawing on Pierre Bourdieu's concepts of bodily habitus and 'choice of the necessary', the purpose of this qualitative study is to develop a better understanding of underprivileged young women's dispositions with regards to health practices and weight concerns. Fifteen in-depth interviews were conducted with French-speaking young women living in underprivileged circumstances. Thematic analysis was done in accordance with Bourdieu's framework. The findings suggest that the participants' incentives, or lack of, to engage in health and weight management were strongly influenced by their immediate needs and responsibilities. Catering to family responsibilities, completing education, finding employment, achieving financial stability, and attending to pressing health concerns were stressed as priorities to attain a state of well-being. This research highlights the need to inform health initiatives and decision makers to foster appropriate interventions and messages for underprivileged young women that will better respond to their needs and the barriers to their pursuit of health.

Key Words

Sociology, Bourdieu, health, obesity, lifestyle, young women, social class.

Introduction

The Public Health Agency of Canada (2011), in collaboration with the Canadian Institute for Health Information, has recently published a document stressing the various facets of the ‘obesity epidemic’ including its prevalence, determinants, contributing factors, as well as its health and economic implications. The publication and distribution of this report was quickly followed by a series of newspaper editorials and health bulletins across Canada (Obesity Panacea, 2011; Doctors of Weight Loss, 2011) restating the health risks associated with obesity and issuing warnings about the repercussions of neglecting normative health guidelines. These forums regularly present mortality and morbidity notes associated with obesity and assumptions related to its social consequences on Canadian society. As exemplified by the Toronto Star (2011) “[un]checked, [obese individuals] will face health complications such as heart disease and diabetes, further reducing [their] quality of life and straining Ontario’s healthcare system”.

Health sociologists have voiced three major concerns over contemporary health promotion initiatives. Firstly, they have underlined a number of unintended consequences created by various organizations that have labeled obesity as a disease and have uncritically promoting individual-centered approaches to lifestyle change. As an integral part of lifestyle, efforts to modify behavior should consider the impact of social structure, life circumstances, and life contingencies which shape the opportunities and dispositions for engaging in health practices. This increased attention given to health by medical institutions, media and other cultural instances has been referred as "healthism", an ideology which shapes our moral frameworks and influences our daily practices in the pursuit of health (Crawford, 1980; Lupton, 1996). Sociologists consider healthism as engendering a ‘blaming the victim’

approach which entails that “[if] individuals take appropriate actions, if they, in other words, adopt life-styles which avoid unhealthy behavior, may prevent most diseases” (Crawford, 1998: p. 84), thus imposing responsibility upon people to adopt a healthy lifestyle (Crawford, 1998; Wright & Harwood, 2009).

Secondly, despite the good intentions of various forms of public health promotion initiatives, the late Mildred Blaxter (1993), a key figure in health sociology, suggested almost two decades ago that current publicity regarding health practices are reinforcing adherence to health standards and bodily ideals by stigmatizing people who do not conform to health norms, thus creating unrealistic expectations that can be detrimental to the well-being of marginalized social groups (e.g. socioeconomically disadvantaged populations, immigrants, elderly populations). In the field of health promotion, the emphasis on weight regulation and health practices have generated a rhetoric which shapes society’s perceptions on the healthy body and stigmatizes those who are obese and overweight (Gard & Wright, 2005; Wright & Harwood, 2009). This creates a social environment in which people are criticized, judged and evaluated according to their health practices and their physical attributes (Wright & Harwood, 2009).

Thirdly, health promotion initiatives and related publicity, while strongly encouraging healthy practices, do not often account and consider the social inequalities within the population. Sociology has shown that the social variation of health, lifestyles, and bodily dispositions between socioeconomic strata is intimately correlated to socioeconomic circumstances and to social inequality. For instance, socioeconomically disadvantaged groups often experience a perpetual sense of urgency in respond to immediate needs such as food, shelter, and employment (Hankivsky, 2007; Miller & Brown, 2005). Given their living

conditions, they are characterized by a strong present-time orientation and weaker preventative attitudes (Boltanski, 1971; Dumas & Bournival, 2011). In relation to health, living close to conditions of necessity reduces the ability to prevent illnesses whereas more affluent socioeconomic groups have greater latitude to invest in future health (Dumas & Laberge, 2005).

If we wish to promote health practices amongst socioeconomically disadvantaged populations, it is crucial to identify up-stream factors of specific social groups that account for the engagement in healthy practices. By drawing on this wider perspective this research seeks to inform health promotion initiatives and decision makers to foster appropriate interventions and messages for underprivileged young women that will better respond to the needs and the barriers to their pursuit of health without being prejudicial to them.

Very little sociocultural research has focused on contextual factors influencing the uptake of health practices for underprivileged women. The aim of this study is to understand to what extent the life circumstances of underprivileged young women fashion their dispositions to engage in health practices. Pierre Bourdieu's approach to social classes, embodied dispositions, and health provides us with the necessary tools to explore the meanings underprivileged young women give to their health and body.

Bodily Habitus and the Choice of the Necessary

The rhetoric surrounding healthism suggests that certain forms of knowledge about health and weight are perceived as more legitimate than others and are a powerful means to influence social representations of the body (Rich & Evans, 2005; Wright & Harwood, 2009). Although most English language authors have used Foucauldian perspectives to understand discourses on the body, Pierre Bourdieu's theory of habitus has also been

proposed as a valid framework. As argued by Allen Luke (1992) discourse (i.e. sets of statements or unquestioned knowledge regarding any given issue) are inscribed in the habitus by instilling a particular way one treats, cares, feeds, and exerts the body. This approach enables a closer focus on the lived body and acknowledges the social variations of embodiment through one's social position and the cultural and environmental factors associated with it (Dumas & Turner, 2006).

As expressed by Bourdieu (1984), the bodily habitus reflects a particular 'relation to the body', and is defined as:

“(...) an incorporated principle of classification which governs all forms of incorporation, choosing and modifying everything that the body ingests and digests and assimilates, physiologically and psychologically. It follows that the body is the most indisputable materialization of class taste (...) which express[es] in countless ways a whole relation to the body, i.e., a way of treating it, caring for it, feeding it, maintaining it, which reveals the deepest dispositions of the habitus (Bourdieu, 1984: p. 190).

The bodily habitus is a set of socially constructed and embodied schemes of dispositions which generates actions, practices, and preferences. Hence, it can be understood as the different attitudes to word the management of the body. For instance, without being exclusionary, Pierre Bourdieu (1984) has coined the terms *instrumental* and *reflexive* relations to the body in order to highlight respectively the habitus of working class and upper class women. Working class conditions bring about a conception of the body as a tool or a means to an end in order to fulfill imminent necessities (e.g. acquiring food and shelter, taking care of their children) (Bourdieu, 1984; Shilling, 2004). As such, underprivileged groups' tastes and preferences in food, physical activity, and bodily appearances differ from

upper class women who in turn, hold a reflexive relation to the body and who perceive the body as a project and an end in itself⁸.

In this line of thought, Chris Shilling (2003) argues that women living affluent conditions, such as educated women who are earning medium to high yearly wages, are better positioned and have a greater interest in participating in physical activity whereas women experiencing poverty are in a problematic position to engage in physical activity or leisure because of their social position and lack of resources. In this sense, social and material living conditions of women have a strong impact on their degree of interest to adopt a healthy lifestyle.

Conceptually speaking, the bodily habitus allows researchers to analyze how social class circumstances shape preferences in health practices according to conditions of necessity. For groups living in underprivileged social circumstances, health may be undermined, as Bourdieu would argue, “when there are so many things that come first” (1984: p. 375). As defined by Bourdieu (1984) *the choice of the necessary* refers to:

“a taste for necessity which implies a form of adaptation to and consequently acceptance of the necessary. The fundamental proposition that the habitus is a virtue made of necessity is never more clearly illustrated than in the case of the working classes, since necessity includes for them all that is usually meant by the word, that is, an inescapable deprivation of necessary goods” (Bourdieu, 1984; p. 372).

As a concept, ‘the choice of the necessary’ will allow us to analyze to what extent the habitus orients underprivileged young women’s incentives, priorities, and practices with regards to health and weight management practices.

⁸ Members of the more affluent social groups are more inclined to perceive their bodies as an end to itself (reflexive relation to the body); consequently, these women’s bodily dispositions prioritize their body, health, and weight. They engage in practices which enhance their health (e.g. regular physical activity, healthy dieting, and regular visits with physicians).

Methodology

This study is part of a larger research project which analyses young Canadian women's social construction of health and obesity (Rail & Dumas, 2009). For this particular study, underprivileged young women were the targeted population because they face several structural and personal barriers to health practices. Participants were recruited within low-income neighborhoods in the Hull-Gatineau region, primarily through community organizations that intervene with vulnerable populations (e.g. low income groups and ethnically diverse neighborhoods). These organizations either allowed us to display recruiting posters in their facilities or to speak directly with their clientele. Participants were selected by the following criteria: female, francophone and aged between 18 and 29 years, no post-secondary education, and reside in an underprivileged geographic area as defined by Statistics Canada (i.e. below 22 000\$) (Statistics Canada, 2009). This study was approved by the University of Ottawa Ethics Board.

Fifteen women took part in a 90-minute semi-structured interview aimed at capturing their perceptions with regards to their health and weight. Interviews were digitally recorded and took place at a time and location chosen by the participants. The interview guide was developed according to Pierre Bourdieu's sociocultural theory and explored: (a) the characteristics of their socio-economic environment, e.g., their background and past experiences; (b) the importance given to health and the body; (c) their perceptions, attitudes, tastes, and dispositions regarding health practices, and; (d) their perception of human and financial resources available, e.g., access/barriers to quality food, physical activity services, health professionals and weight loss programs. Extra notes were taken after each interview; these included the location of the interview, the emotional state of the participant, the

vocabulary, intonations and rhythm of the interviewee's speech, and also their gestures and body language. Interviews were transcribed, and these were unabridged in order to maintain authenticity. Following the transcription, we thoroughly read each interview to familiarize ourselves with the data⁹. In order to properly analyze the collected data, each interview was analyzed using data management software N*Vivo. Table 1 illustrates our participants' socio-demographic characteristics.

Table 1: Participants' socio-demographic characteristics

Pseudonym	Age	Educational Level	Marital Status	Number of Children
Cassandra	23	High School	Common law	0
Arielle	27	Grade 8	Single	1
Solange	20	Grade 8	Common law	1
Amélie	18	Grade 9	Common law	1
Adèle	21	Grade 9	Common law	1
Francine	25	Grade 4	Single	0
Jacqueline	25	Grade 9	Single	3
Victoria	26	Grade 8	Single	2
Karine	22	Grade 9	Common law	1
Julie-Anne	21	Grade 11	Common law	3
Dominique	29	Grade 9	Common law	3
Chantal	18	Grade 8	Single	1
Manon	25	High School	Single	0
Jocelyne	24	Grade 11	Common law	0
Sophie	21	Grade 10	Single	1

Data were thus analyzed through a thematic analysis in order to identify themes and patterns within the interviews. The information provided by the participants were regrouped

⁹ All interviews were translated from French to English by the authors. We have attempted to preserve the language level used by the interviewees to illustrate the women's expressions. The names used in this article are fictitious. None of the participants were employed at the time of the study and their income was provided by financial aid, government grants, or family allocations.

into themes and categories according to semantic affinities found within the interviews. As suggested by Rubin & Rubin (2005), data were analyzed vertically in order to consider the participants' unique experiences, that is, to verify the relation between participants' life circumstances and their own life trajectory. Additionally, a horizontal analysis was also performed in order to find similarities and differences between the interviews. Thematic analysis therefore allowed us to relate our conceptual approach to our themes and patterns. Although participants each had a unique biography, their life circumstances were similar and were a determining factor of their social position and lifestyle.

Prioritizing Responsibilities and Needs

The findings highlight how underprivileged young women's lifestyle and relation to the body were strongly fashioned by their living conditions. Their dispositions to adopt health practices are for reasons different from those promoted by health initiatives. From the outset, an overview of the results strongly supports the idea that women embodied an instrumental relation to the body. Although past literature has documented their relation to the body as attitudes and dispositions contra health guidelines (Bourdieu, 1984; Wacquant, 2004), results show that this association could be further developed as this trait of the habitus was beneficial for some of the participants' health, and harmful for others. For instance, some women reported becoming more sensitive to health issues and tended to improve health to a certain extent. These women brought minor changes to their health when confronted with responsibility such as those involving motherhood, achieving economic stability, completing education, and attending to pressing health concerns.

On the same breath, other women were less sensitive to the issue of health given their immediate responsibilities and need to attend to pressing concerns. In this sense, these

women's dispositions to engage in health enhancing practices were contingent upon their condition of necessity. The following sections will illustrate how these women's instrumental relation to the body and sensitivity towards health were beneficial for a number of participants, and harmful for others.

Giving my child what I never had.

The participants of this study face many concerns which act as a barrier to their pursuit of health. However, for some of the mothers, childbearing served as a precursor to reflect upon their health and responsibilities. Eleven out of the fifteen women interviewed were mothers of one to three children. Although teenage and young adulthood pregnancies have declined in the last quarter century due to the increased awareness and accessibility of contraceptives, underprivileged women are more likely to become pregnant at younger ages than their more affluent counterparts (Statistics Canada, 2008).

Childbearing had shaped these women's degree of interest to pursue health and weight managing practices: they either became more sensitive to their health and therefore adopted a health regimen in order to instill healthy practices amongst their children, or disregarded their own health for the sake of their children's well-being. As a rupturing event in their life course, motherhood brought a sense of reflexivity which either triggered an interest in health practices, or became conflicted with it by becoming preoccupied solely by their children's well-being.

A common trend amongst the mothers was the tendency to reflect upon their own lifestyle after giving birth. During the interview, many reported consuming tobacco, drugs, and alcohol on a regular basis before their pregnancy. For example, Arielle, a 27-year old single mother, expresses the educational function of modifying her lifestyle for her child.

I am more preoccupied with health now. I've become more aware of this with my daughter's birth. Since I've had her, I've become aware of things: if I don't take my health to heart, well, I will become sick quicker. The faster I become sick, the less time I will spend with her [my daughter]. So I better preoccupy myself by my daughter's health and well-being. Plus, to have known my parents who did nothing because they were sick, it's not what I want for daughter! I have to take care of myself in order to be able to see my daughter grow, you know? I want to see my progeny well off.

The benefits reaped from a healthy lifestyle for Arielle were not only for her own well-being, but particularly for her daughter to benefit from good health throughout her life. Julie Bettie (2003) discusses the development of accountability when underprivileged women become mothers. For single young mothers, having a child provides "routes to adulthood and the responsibility that comes with it can be employed to gain respect" (Bettie, 2003: p.67). For example, Victoria, a 26-year old mother with two children, reported that it remains essential to foster a good relationship by inculcating healthy practices to her children.

It's important that I teach my kids to be active. We often walk and go biking. My son has a lot of energy so we do a lot of activities: we go to the pool and we bike. I just bought some skates to go ice skating. I'm really happy with the fact that, like I tell myself that I may not be working at the moment, but I'm always there for my kids! I'm happy that I can be there for them you know? I couldn't ask for better. But if I were obese, well... I don't want that for my kids. I want to give them a good example.

Inculcating healthy practices by providing 'good examples' arose amongst many of the mothers' interviews and tended to engender a concern for a healthier lifestyle. While childbearing remains an opportunity for these women to develop accountability for their actions, becoming a primary caregiver led other mothers to preoccupy themselves mostly by their children, disregarding their own health practices.

Some underprivileged women who are preoccupied by their roles as primary caregivers felt like the responsibilities associated with motherhood led them to disregard their personal health for the sake of their children's. For instance, Julie-Anne, a young mother aged 21

years explained how her children have changed her priorities regarding her personal health. She clearly stated that her own health has been set aside for the sake of her children's well-being; what counts for her is to provide for her children and fulfill her parental responsibilities.

My children are my priority. For them, I'll make them a good supper but I'll just sit and eat anything because I don't want to take the time to eat with them because I have to feed my baby. So while they eat, I don't eat at the same time because I can't do two things at once. If I take a bite of my food, my baby will cry. I'll just wait and eat alone. And since I've had my kids, I gained weight, but I don't care about that, I'm still a good mother. I would say that if I weighed 300 to 400 pounds and I had three kids and I did nothing with my life and sat on the couch all day and I tell them "make your own food". But no, I get up, I clean, I feed my children, I do everything!

Chantal also displays similar views. This 18-year old mother who suffers from hypothyroidism (i.e. a deficiency of the thyroid gland leading to weight gains) and asthma receives financial aid to support herself and her son. Her low income forces her to budget according to priorities, which denies her the possibility of purchasing her prescriptive medication for the sake of her son's needs and expenses.

I guess I do sacrifice a few things for my son's health. For a while now, I have only been able to afford his medication for his teeth. I had to stop taking my prescriptions that treat my hypothyroidism because I just couldn't afford both. I also have to stop renewing my asthma pumps so I can afford his medication. He is by no doubt the priority. I can manage without my medication.

Miller & Brown (2005) suggest that mothers are confronted by the moral responsibility of fulfilling their family responsibility, which becomes a constraint to their own health and well-being. Childbearing and care giving therefore either provoked or constrained these mothers to preoccupy themselves by their health and weight management. Their experience with motherhood had led them to develop a relation to health and weight which is strongly determined by the well-being of their children.

Prioritizing immediate needs: income, education, and time.

The participants' dispositions to adopt health practices were also strongly dependent upon income, education, and time. According to Hankivsky (2007), the income received by single Canadian women who are unemployed lead them to spend at least 60% on food, housing and clothing (Hankivsky, 2007). Furthermore, young women who are mothers and caregivers also increase their unpaid daily work demands (Hankivsky, 2007). By attempting to fulfill their imminent necessities (e.g. food, shelter, care giving), these women's life context, such as the lack of income, education, and time, act as personal and structural barriers limiting opportunities for upward mobility.

The participants were more likely to integrate themselves in the labour market (e.g. waitresses, bar maids, nurse's aids, and personal and home care aids), in order to increase their income or to pursue their education in view of a future career. Cassandra, a 23-year old young woman, had returned to an adult high school to acquire her nurse's certificate. Her dispositions to remain healthy and to maintain her weight are conditioned by her appointment as a nurse's aid and the need to earn income. Her health practices and body weight allow her to respond to immediate necessities such as the need for income.

My weight is important because, well the work that I do requires me to have a lot of energy. And if you are not healthy physically, you cannot do this type of work. You move from one room to another to change the sheet of the beds, to clean the patients and everything. If I don't have the energy required, I will have to find another job!

In *Distinction* (1984), Bourdieu explained the differences between the interests the different social classes have in the use of the body. He argued pervasively that the attention given to the body and health increases with socioeconomic status. Income and educational credentials are considered to be strong determinants of the amount of attention and care

given towards the body. As such, the relation to health and weight of underprivileged women is strongly influenced by their lack of resources and their needs. Amongst all the participants, Dominique faced the most critical economic and educational disadvantages. She is part of a family of five, comprised of her partner of 13 years and their three children. Two years prior to the interview, her partner became unemployed, and since then, the entire family has been living off social security. During our interview, she expresses her economic difficulties which limited her opportunities to engage in health practices, such as formal physical activities and healthy eating.

Our budget doesn't allow us to exercise or do any sort of activity, you know? If I wanted to sign up at Curves [an exercise facility for women] or a gym, well it costs a lot of money! And I have three kids, so their activities come first. As for food, healthy foods are the most expensive. We are a family of five, so I have to take my budget into consideration; we must have enough food for the month. I have to keep track of these things.

Kempson, Bryson & Rowlingson (1994) coined the notion of 'strategic adjustment', referring to mothers' management of imminent necessities, priorities, and budget. Similarly to gendered and class adjustment, Pierre Bourdieu (1984) states that the habitus responds to diverse situations and demands by a practical sense which allows different socioeconomic groups to coordinate preferences and actions towards the realization of desired outcomes.

In this line of thought, the lifestyle of these women can be understood as an adjustment to the requirements of being a mothers and to the conditions of necessity. In another interview, Solange, a 20-year old single mother, explains her past struggles with drug addiction and her two years of treatment and rehabilitation. Although she showed a keen interest in exercising, eating well, and caring for her health, her priority is to finish school in order to be able to provide for herself and her daughter. For Solange, well-being is achieved through educational and self-fulfillment rather than health practices.

My health and weight are more or less my priority. I can't say that it is because if it really were my priority, I would start exercising and quit smoking right now. My time is spent on my studies because I want a good life. I'm also often with my daughter. But at least with her we go for a stroll in the park. If money wasn't so tight though, I'd like to treat myself and get a gym pass, I'd like to get into aerobics. But that will come with time. (Solange)

In addition to poor income, many young women mentioned lack of time as constraining their health. Several participants had returned to school in order to obtain their high school diploma, therefore having very little time and money to participate in formal physical activity. They lived by their children's well-being and daily routines: their breakfast, lunch, supper, bathing and bed time. On top of keeping up with their children's routine, they also had to juggle their household chores and daily errands. They constantly negotiated constraints such as time and budget which impeded on time devoted to personal care and leisure. Chantal and Jacqueline, for example, are young single mothers who often mentioned the issue of time as their main constraint. These mothers are also attending community centres once to twice weekly to complete their high school education, adding another responsibility to their agenda.

When I arrive at home [from the community centre], it's 4pm. I have to make supper, and after that I have to clean, do the dishes, then it's bath time and then I put him to bed at 7pm. I still have his routine to follow because if I put him to sleep after 7pm, well then I'm done! He won't fall back asleep. (Chantal)

At the moment, I'm taking care of my three kids by myself and I'm always running around for them. But we still walk sometimes; we play outside and in the snow. I don't play any sports or any sort of formal physical activity right now, but it's because I don't really have the time either. I have to manage my time and finish my education. If I did have the time, I'd like to train or to hit a punching bag. But as I said, I don't have the time, so I take care of my kids, and I do a lot of cleaning. (Jacqueline)

For these mothers, the time spent for their personal and recreational activities is very limited. While several claimed to have an interest to pursue physical activities, their interest

in maintaining a healthy lifestyle and monitoring their body weight were most often suppressed by their need to foster more pressing and immediate concerns. The above quotes illustrate the connection between life circumstances, imminent needs, and lifestyle, as well as express the constraints that many participants face because they lack disposable income and time, obligating them to attend to more pressing responsibilities such as family care.

Gaining physical independence.

Two of the women interviewed were more sensitive to the issue of health because they suffered various forms of physical or psychological complications that limited their opportunity to integrate within the work sphere, to participate in social activities, or to acquire their desired health status. While they reported wanting to live a 'normal life', they showed greater sensitivity to monitor and prioritize their health in order to maintain a functional body and to gain independence. Avoiding hospitalization and actively participating in society were some of the benefits expected from their health regimen (e.g. eating habits, physical activity, medical appointments, and medication). In the following quote, Francine, a 25-year old women who is paraplegic and suffering from a series of complications (e.g. kidney problems and hypertension) associated with her spina bifida expresses her incentive to adopt health practices.

I have a lot of health complications and last year, I almost died because I had a bladder infection. So now I have to watch how much salt I eat if I want to prevent infections. That experience scared me so I have to watch what I eat if I want to live. I also have to watch my weight because it affects my mobility when I have to move out of my chair. Sometimes I have trouble moving my legs because they are so heavy. I just have to watch for that.

Similarly, Manon, a 25-year old who has been diagnosed with bipolar affective disorder three years prior to the interview shared a similar view. Daily physical activity is

necessary and vital because without the proper combination of psychological and physical well-being, she would be unable to fulfill daily obligations, such as doing her groceries, going to school or any other socially oriented activity. Ever since she has been taking medication to regulate her condition, Manon reported to have gained a lot of weight due to the cravings induced by the prescriptions. While she reported being slightly preoccupied by her weight gain, she is satisfied with herself because she is now physically active on a daily basis, and is able to function independently.

Exercising and health wasn't really important for me before. I didn't really think about it. But now that it has become a question of- well, not life or death- but independence, it's part of my life now! Health is what makes me go day after day. Because I know what it is not to have it [health]. Since I've been diagnosed, I gained a lot of weight because of the medication. But I tell myself that if I have to stay this size, but that I'm mentally and physically sane and able to do the things I want, losing weight is the least of my worries. I won't preoccupy myself with it. It's just nice being able to go to school, to go to the grocery store, being with friends, going to the movies and all those things. I couldn't even do those things before.

Manon and Francine mentioned that their physical and psychological circumstances could jeopardize their well-being and their lives at any given time. They are prompt to consume medication, to monitor their nutrition, to engage in physical activity in order to be able to live a 'normal' life, and to engage more closely with health and health care services. Their disability distinguished them from the other participants because it generated an interest and obligation to cater to their health. This process is akin to what Dumas & Laberge (2005) observed with increased concerns over specific health contexts of older women with chronic illness: "Increasing uncertainty about future health states was also tied to the rise in consciousness of body finitude. If the consequences of illness were once perceived as abstract ideas, they now became tangible" (p. 196).

Discussion and Conclusion

Health Canada, along with several other leading nationwide public health initiatives are encouraging a range of health practices in order to avoid the adverse ‘effects’ of obesity on health: “achieving and maintaining a healthy weight is important to reduce the risk of those diseases and improve overall health” (Health Canada, 2006). Such sweeping statements neglect the structuring power of social and material deprivation on lifestyle, and that those experiencing underprivileged circumstances are more driven by immediate and practical concerns to increase their quality of life. The findings presents in this article support the idea that certain groups adopt health practices for reasons other than those widely promoted by public health institutions. In the spirit of health promotion, it is crucial that we tailor messages that will target the interests of broader groups - may it be to prevent future complications, to find independence, or to instill health practices to their progeny.

The aim of this study was to provide empirical data to illustrate the underlying circumstances which shape underprivileged young women incentives to adopt health practices. It provides an understanding on how the living conditions of underprivileged young women shape their dispositions regarding health practices, as well the importance given to weight maintenance. Everything considered, their life circumstances incite them to negotiate a hierarchy of priorities bared on their proximity to their conditions of necessity. While participants’ perspectives were not entirely homogeneous, none of the women engaged in health practices and weight management with their future health in mind; they were concerned with the living ‘day by day’ or ‘within the moment’.

From a theoretical standpoint, Bourdieu’s sociocultural theory has been useful to explain how underprivileged young women’s needs and responsibilities fashion their relation

to health. These life circumstances require them to make decisions according to realistic achievements. As discussed by Bourdieu, the relation to the body, shaped by life's opportunities and constraints "(...) continuously transforms necessities into strategies, constraints into preferences, and without any mechanical determination, it generates a set of 'choices' constituting lifestyles (...) (Bourdieu, 1984: p. 175). Their degree of interest to adopt health and weight management practices relies strongly on the availability of the different opportunities offered, that is, their perspectives, attitudes, and dispositions with regards to health and weight are dependent upon their constraints and opportunities (Bourdieu, 1984; Swartz, 1997).

Several social scientists have also followed Bourdieu's approach to health, and concur that differences in living conditions have been shown to fashion distinctive practices and preferences amongst social groups, such as their preferences in food, physical activity, or hobbies. These social variations in body care, (i.e. the way people feed, exert, dress, and treat their body) have been described as a way for people to gauge their choices and actions in function of their constraints and opportunities (Cockerham, 2005; Boltanski, 1971; Williams, 1995). Findings support the use of Pierre Bourdieu's concepts which consider the effects of various aspects of underprivileged living conditions on lifestyles. Results show the value of understanding the 'instrumental relation to the body' of social groups in order to identify upstream factors of health. In addition, the use of this concept also shows the difficulties for underprivileged women to adopt health practices since the benefits of investing in health are not immediate.

From a practical standpoint, our study is useful for public health initiatives that promote healthy living among Canadian women. It provides detail on underprivileged young

women's relation to the body, and the constraints of living in proximity to conditions of necessity. Results show that the participants' sensitivity towards health was not only a function of their knowledge of health, but rather a 'choice of the necessary'. Several women face barriers and pressing concerns, compelling them to fulfill imminent needs rather than engaging in health practices to avoid future and intangible complications. Drawing on this approach, because social groups possess different amounts of income, education, material goods, and are faced by different responsibilities, health and lifestyle disparities between social groups are likely to persist (Cockerham, 2005; Poulain, 2009).

In agreement with previous authors who have criticized lifestyles approaches (Blaxter, 1993; Williams, 1995), health interventions should strive to target a broader range of populations by adapting their interventions and actions in accordance with the life circumstances of a given group. For example, underprivileged women would benefit strongly from social interventions which seek to secure basic necessities. In sum, this study suggests that for underprivileged women to become concerned about their health practices, they need to feel that they have the means and the support to respond to their needs and responsibilities, allowing them to devote time to leisure, and to achieve longer-term ambitions. We suggest that social structure should change in order to provide the necessary resources the pursue health enhancing practices.

With respect to population living precarious living conditions, the translation of this message into actual practice remains a fundamental stumbling block for those concerned with the promotion of 'positive' change to a 'healthier' lifestyle" (Williams, 1995: p. 578). The need to intervene and understand marginalized populations remains a difficult task. More interviews with underprivileged young women in other contexts (i.e. working-class

women, disabled women, ethnically and racially marginalized women, women classified as ‘obese’) are needed. It would therefore be valuable to pursue the study of the underlying reasons why different underprivileged groups do not engage in health practices. Such information would allow public health interventions to alter their approach accordingly, rather than producing general and universal strategies for society at large.

Chapter VII

Conclusion

By focusing on women's experiences and their social signification of health, the body, and obesity, this qualitative research helped to develop a better understanding of underprivileged young women's perception of health and the body. Results highlight that participants were aware of the dominant obesity discourse, but were also aware of the constraints associated to their social and material living conditions which led them to attend to more pressing concerns.

The results of this study make two important contributions toward developing a better approach to class and health promotion initiatives. First, findings suggest that these young women experience many forms of social suffering, especially through bodily responses such as shame, humiliation, frustration, and exasperation which shaped a relation to health and the body. In light of the intimate connection between health norms and body weight standards, this research highlights the various repercussions experienced by underprivileged women who are involved in a struggle for social acceptance and social value. The women interviewed were well aware of the omnipresence of socially valued norms of the body (e.g. health, thinness, beauty), and expressed feeling pressured to conform to feminine bodily norms in order to gain status. As argued in this thesis, underprivileged women already face several social, material, and personal barriers to health and social status. Given their lack of disposable income, they also have fewer opportunities to cultivate their bodies for health purposes.

Second, despite their awareness of socially valued bodily norms, underprivileged young women are aware of their limits imposed by their social position. Findings show that

participant's incentives, or lack of, to engage in health and weight management were strongly influenced by their immediate needs and responsibilities. Underprivileged living conditions generated other sets of priorities, such as motherhood, achieving economic stability, completing education, and gaining physical independence which were far greater preoccupations. More importantly, this research highlights the role of motherhood as a major time constraint that fashioned these women's relation to the body. The analysis revealed that participants were reflexive about their health practices and aware of the long-term health consequences. However, given their needs and responsibilities, women attended to their immediate necessities in order to maintain stability and comfort. Underprivileged young women's 'choice of the necessary' is based on optimizing resources and channelling them towards their priorities.

Contributions

A class-based analysis drawing on Pierre Bourdieu's socio-cultural theory of habitus was used to analyze how social position orients bodily dispositions. Sub-concepts such as 'the choice of the necessary', 'the instrumental relation to the body', 'symbolic violence', 'social suffering', and 'physical capital' were additionally used in order to provide a more intricate analysis. Findings support the use of Pierre Bourdieu's sociocultural theory in order to better understand the effects of underprivileged living conditions on the relation to the body. Results show the value of understanding the instrumental relation to the body of social groups in order to identify up-stream factors of health. Andrew Sayer's (2007) refinement of Bourdieu's concept of social suffering further included a framework which allowed us to include the participants' responses to inequality and its possible effects on health.

Despite underprivileged women's apparently adequate knowledge of health, it is through their relation to the body and their condition to necessity that their low adherence to health lifestyles appears to be best understood. This research further makes an important contribution to Pierre Bourdieu's concept of 'instrumental relation to the body'. This concept has traditionally been used by health and lifestyle sociologists in order to illustrate the weaker inclinations of working class populations towards improving health and illness prevention.

However, this study exposes another application of this concept, one which suggests that depending on life circumstances and context, the instrumental relation to the body can be beneficial for some of the participants' health. For example, the experience of motherhood generated an approach to the body which could benefit both their children and the mothers. Bearing responsibility for their children's well-being engendered a reflexive process over healthy practices. Several underprivileged women who became mothers viewed their children's health and well-being as an imminent necessity and responsibility. In this case, their conception of the body modulated itself to consider their children's health.

On a practical standpoint, this research provides additional information for public health policies and smaller scaled organizations that intervene with the issue of class and health. On the one hand, this study confirms the findings of many past researches who have attempted to understand the relation between life circumstances and the up-take of health practices (Miller & Brown, 2005; Lee & McDonald, 2010; Williams, 1995). Indeed, underprivileged young women often face sociocultural barriers which inhibit them to develop and adopt practices. On the other hand, this research highlights the important role of motherhood as a generator of amended schemes of dispositions, perceptions, and

appreciations which shaped the approach to health and lifestyle of women who have come upon this responsibility.

As such, those involved in decision making in the fields of public health policies and health promotion interventions are encouraged consider social class as the most influential social determinants of health. Public health promotion initiatives must account for social inequalities and the complexity of social determinants of health. The integration of this approach into other social policies could eventually ripple through other spheres of society, thus intervening on the structural level rather than adopting an individualistic approach to change. To become concerned about health practices, underprivileged women need to feel that they have the means, the resources and the support to respond to their needs and responsibilities, allowing them to devote time to leisure, and to achieve longer-term ambitions. Interventions must target this particular group by adapting their current approach to an inviting setting. Third, health promotion initiatives and community centres who intervene with underprivileged populations could offer programs and interventions which combine an active participation on the parts of both parent and child, given that this dimension has been exemplified by several participants of this study. Lastly, it is essential to consider socioeconomic, cultural, material, and personal conditions in order to offer services and primary health care to underprivileged women who have fewer outlets to support healthy living. An unbiased and guiltless approach, which also considers social positioning and past experiences that are potentially contra health norms, is needed to better understand the barriers faced by underprivileged populations. This conclusion is in line with health policy approaches that vouch for collective actions on multiple social determinants of health rather than a strict individualist approach.

The connection between lifestyle, social class, and gender is a broad topic, and this research primarily focused on underprivileged young women's struggle over social value, as well as contextual influences on the up-take of health practices. Pierre Bourdieu's (1984) concepts of symbolic violence, social suffering, relation to the body, and the conditions to necessity have been used as lenses to analyze, interpret, and understand these issues. Bourdieu has often been critiqued for neglecting gender as an important aspect which fashions acquired experiences and social positioning, however, this study draws from the works of Bourdieusian feminists, such as Beverly Skeggs (1997; 2004), Kate Huppatz (2009), Leslie McCall (1992), Suzanne Laberge (2002; 2005) and Alex Dumas (2005; 2011) to understand the inflicting sociodemographic dimensions which fashioned the bodily habitus and the relation to the body.

An intersectionality approach to Bourdieu, could be employed in a study with a greater and broader sample. This analytical model provides the tools and guidelines to contextualize "women in their diverse social and economic circumstances and understand[s] gender as inseparable from other forms of social difference such as race, ethnicity, culture, class, sexual orientation, gender identity and ability" (Morrow et al., 2007; p. 9). Social scientists wanting to broaden the spectrum of this research could use this approach to understand the impact of social circumstances which engender the emergence of particular perspectives regarding any given issue (Denzin & Lincoln, 2000; McCall, 2005). For instance, certain aspects relating to underprivileged women's ethical dispositions towards practices should be studied in greater depth in order to develop a better understanding of the different sociocultural aspects influencing the up-take of health practices.

An important methodological challenge was to establish a productive contact with women at the margins of society and convince them of the value of participating in a study on health. Why would these women participate in a study on health and the body when, depending on life circumstances, health and bodily preoccupations themselves have become secondary to a multitude of pressing concerns and responsibilities? Socioeconomically disadvantaged groups need to feel like they have a voice, valid perspectives and opinions, as well as have the opportunity to engage in the proposed health lifestyles in order to participate in these studies, which is where the role of public health policy makers and health promotion interventions come in hand.

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APPENDIX A

Identification file and Conversation Guide (français)

Étude sur les pratiques de santé des femmes
FICHE D'IDENTIFICATION

No d'identification : _____
 Région : _____
 Pseudonyme : _____
 Nom véritable : _____
 Quartier : _____
 Date de l'entrevue : _____
 Lieu de l'entrevue : _____
 Durée de l'entrevue : _____
 Intervieweuse : _____

Caractéristiques démographiques

Âge : _____
 Lieu de résidence : _____
 Lieu de naissance : _____
 Scolarité : _____
 Statut civil (a été marié ou non) : _____
 Si marié, occupation du conjoint : _____
 Occupation antérieure : _____
 Proximité et présence de la famille : _____

Origines des idéologies par rapport à la santé

Sources d'information principales (médias, revues, médecins, etc) : _____

Physiquement active (fréquence, intensité, type, durée) : _____

Nutrition (diète particulière) : _____

Revenu annuel :

- Moins de 25 000\$
- Entre 25 000\$- 35 000\$
- Entre 35 000\$- 50 000\$
- Entre 50 000-70 000\$
- Plus de 70 000\$

Code

A: Physiquement actif

I: Physiquement inactive

01 à 10 : numéro chronologique de réalisation de l'entrevue selon la catégorie

GUIDE D'ENTRETIEN QUALITATIF
Étude de l'importance accordée à la santé et aux
pratiques corporelles des jeunes femmes

Ci-dessous se trouve une liste de questions qui pourraient être posées. Étant donné la méthode d'entrevue (conversation informelle) et étant donné que la participante a le choix de discuter ce qu'elle veut, les questions peuvent être posées dans un ordre différent d'une entrevue à l'autre et, dans certaines entrevues, des questions peuvent être mises de côté.

(1) Introduction et caractéristiques de l'environnement socio-économique de la participante (ex., conditions sociales et matérielles). (10 minutes)

- Est-ce que vous pouvez me parler d'où vous venez?
- Votre milieu?
- Votre emploi?
- Status (matrilial status)
- (Interviewé (INT): Explorer les conditions d'existence et les trajectoires sociales)

(2) Perception, pratiques et importance accordées à la santé et le poids.

SANTÉ (10-15 mintes max)

Construction de santé

- Qu'est-ce que « la santé » veut dire pour vous ?
- Peux-tu décrire à quoi ressemble une personne en bonne santé ?
- Quelles qualités est-ce qu'elle a ?
- Est-ce qu'être en santé est différent ou similaire pour les hommes et les femmes ? Comment ?

Sources de construction de santé

-
- D'où viennent vos idées sur la santé ? (Médecins, autres professionnels, professeurs, média, famille, amies, etc.)
- Est-ce qu'il y a beaucoup d'information disponible dans la société ? Est-ce que tu t'intéresses à cette information ? Pourquoi/ Pourquoi pas ?
- Est-ce que tu as confiance en cette information ? Dans quelles sources as-tu le plus/moins confiance ?
- Est-ce que ces sources d'information influencent vos pensées, actions, et pratique de santé ? Lesquelles ? Comment ? Pourquoi ?

Santé et vie quotidienne

- Est-ce que votre santé est une priorité dans votre vie ? Pourquoi/Pourquoi pas ? Quels sont les actions adoptés afin de prioriser votre santé ? (Quels aspects de la santé ?)
- Est-ce que vous vous préoccupez de votre santé ? Pourquoi ?
- Est-ce que tu prends soin de ta santé ? Comment ?
- Est-ce que tu penses que tu es en santé ? Qu'est-ce qui te fais dire ça ?
- Pourquoi est-ce que tu penses que tu es en bonne/mauvaise santé ?
- Que faites-vous pour être en santé/rester en santé ?
- Quelles sont les choses qui vous empêchent de prendre soin de votre santé ?
- Que pensez-vous que vous pourriez faire pour améliorer votre santé ?
- Discuter des contraintes à l'accessibilité aux services de santé (contrainte de temps- prix- horaire, degré d'appréciation).

« Culture » et constructions de la santé

- a) Est-ce que tes parents, tes amies, et les gens de ton environnement voient la santé de la même façon que toi ? Pourquoi ?
- b) Leurs perceptions sont-elles pareilles/différentes ? Pourquoi est-ce que tu penses qu'ils voient les choses comme ça ?
- c) En ce qui concerne ta communauté: est-ce que les gens pensent à la santé de la même façon ? Pourquoi ?

OBÉSITÉ ET LE POIDS (60-75 minutes)

Construction de l'obésité (15 min)

- Qu'est-ce que l'obésité pour toi ? Que veux dire l'obésité pour toi ?
- Est-ce que l'obésité est différente ou similaire pour les hommes et les femmes ? Comment ? Pourquoi ?
- Comment te sens-tu face à l'obésité ? Face à une personne qui a du surpoids ?
- Est-ce que le surpoids ou l'obésité te préoccupe ? Pourquoi/Pourquoi pas ?
- Est-ce que tes parents voient l'obésité de la même façon que toi ? Pourquoi ?
- Est-ce que leurs perceptions sont pareilles ou différents ? Pourquoi ?
- En ce qui concerne ta communauté : est-ce que les gens pensent au surpoids de la même façon ? Pourquoi ?

Source de construction sur l'obésité (15 min)

- D'où viennent tes idées sur l'obésité ?
- Est-ce qu'il y a beaucoup d'information sur l'obésité dans la société ? Es-tu intéressée à cette information ? Pourquoi/Pourquoi pas ?
- Comment te sens-tu par rapport à l'information qui existe sur l'obésité et sur sur l'importance de réguler son poids ?
- Est-ce que tu as confiance en cette information ? Quelles sont les sources dans lesquelles tu as plus/moins confiance ?
- Les médias touchent à l'obésité. Comment est-ce que tu sens par rapport à ça ?

- Est-ce que les professionnels de santé, c'est-à-dire, les médecins, les enseignants d'éducation physique, et autres intervenants ont une influence sur vos actions et pratiques vis-à-vis le poids ?
- Est-ce que ces sources d'information influencent vos pensées, actions, et pratique pour réguler votre poids? Lesquelles ? Comment ? Pourquoi ?

Corps, poids, et pratiques (20 min)

- Est-ce que vous accordez de l'importance à votre poids ? Pourquoi? Qu'est ce que vous faites pour perdre/maintenir/prendre du poids? Pourquoi est-ce que vous pensez que vous devez faire ça ?
- Qui ou quoi a le plus d'influence sur votre corps et votre poids?
- C'est quoi pour toi le poids idéal d'une femme de ton âge ?
- En ce moment, de façon générale, es-tu satisfaite de ton poids ? Pourquoi/pourquoi pas?
- Est-ce que quelqu'un vous a déjà fait sentir que vous n'aviez pas le 'bon poids' ou un corps approprié? Explicitez (sentiments et actions entreprises, contexte, etc.) ?
- Est-ce qu'il y a des aspects qui vous dérangent dans la manière que certaines femmes discutent de leur poids/ leurs corps?
- Est-ce qu'il y a des aspects qui vous dérangent dans la manière que certains hommes discutent du poids/du corps des femmes?

Perceptions des avantages et des désavantages du poids

Pratiques alimentaires (10 min)

- Avez-vous déjà suivi un régime ? Lequel ? Pourquoi ? (Poser des questions pour obtenir des informations sur les bénéfices escomptés qui sont internes par rapport au corps (santé, performance, confiance en soi, etc.) ou externe au corps (esthétique, appréciation d'autrui, amitié, acceptation sociale, etc.)
- Quel régime avez-vous suivi afin de perdre/contrôler votre poids? (clinique, seule, avec une amie, etc?)
- Est-ce que vous évitez certaines nourritures? Lesquelles? Pourquoi? Est-ce que vous limitez la quantité de nourriture ingérée?
- Où achetez-vous votre nourriture, habituellement (vérifier la distance de l'installation, les prix, degré d'appréciation)?
- Discuter de l'accessibilité à une alimentation saine (prix, location, temps de préparation).

Pratiques d'activités physiques (10 min)

- Pratiquez-vous de l'activité physique? Explicitez? Avez-vous déjà fait de l'activité physique afin de perdre/contrôler votre poids? Il y a-t-il des endroits à proximité où vous pouvez vous engager à l'activité physique (vérifier le degré d'intérêt, l'accessibilité des services, distance, prix, horaire)?
- Discuter des contraintes à l'accessibilité à pouvoir participer à l'activité physique (contraintes de temps, autres exigences et priorités, soutien social)

Bénéfices/conséquences du capital physique (15 min)

- De quelle (s) façon votre environnement (milieu de travail, milieu familial et d'amis) influence-t-il l'importance que vous accordez à votre santé et votre corps?
- Croyez-vous qu'il y a des bénéfices associés à un poids corporel/ corps désirable? Lesquels? Pourquoi?
- Croyez-vous qu'il est plus important de maintenir un bon poids pour un homme ou une femme (ou les deux). Pourquoi? Explicitez.
- Est-ce que votre milieu de travail vous incite à vouloir un poids et un corps désirables? Pourquoi? Dans votre milieu de travail, est-il bénéfique d'avoir un poids et un corps désirable? Pourquoi?
- Quels sont les bénéfices/conséquences que vous pouvez retirer d'un poids et d'un corps désirable? Explicitez.
- Adoptez-vous des pratiques corporelles particulières afin de pouvoir bénéficier de votre corps? Lesquels? Pourquoi?

APPENDIX B

Presentation Letters (français)

Date

Objet : Lettre d'information aux organismes au sujet d'une étude sociologique sur les pratiques de santé des femmes francophones

Nom et adresse du récipiendaire

Je suis étudiante de 2^e cycle à la Faculté des sciences de la santé de l'Université d'Ottawa et j'aimerais vous signaler le commencement d'une étude subventionnée par le Conseil de Recherche en Sciences Humaines du Canada. Pour bien mener à terme cette étude, nous avons besoin de votre coopération pendant notre période de recrutement de participants de recherche.

Nous cherchons donc votre collaboration pour soit obtenir le droit d'exposer nos affiches de recrutement dans votre établissement, ou d'obtenir votre permission de faire de courtes présentations au sein des élèves.

L'étude requiert aux participantes de se présenter à une entrevue de 90 minutes traitant de leurs perceptions de la santé et du corps. Notre stratégie de recrutement consiste à (1) afficher nos formulaires (feuilles 8 ½ x 11) dans certains lieux de travail où nous pourrions retrouver cette population cible, et (2) d'obtenir la collaboration d'organismes d'aide sociaux pour nous suggérer des noms de participantes (préalablement consultés) qui pourraient être intéressées à participer à une entrevue.

Cette étude de type sociologique vise : (a) à mieux cerner les perceptions de santé du corps et du poids corporel chez les jeunes femmes canadiennes et ; (b) à mieux comprendre la relation entre les discours et les pratiques de santé adoptées par ces jeunes femmes. Les résultats contribueront au développement de programmes et de politiques sociales plus efficaces en matière de promotion de la santé.

À noter que ce projet sera assujéti aux règles du Comité de déontologie en recherche de l'Université d'Ottawa.

Je vous prie d'agréer l'expression de mes salutations distinguées.

Jeanne Robitaille
Étudiante de 2^e cycle
École des sciences de l'activité physique
Université d'Ottawa

Lettre d'information aux participantes
Étude sur les pratiques de santé des femmes

Bonjour,

Je suis une étudiante à la maîtrise à l'Université d'Ottawa. Je participe présentement à une étude dans le cadre de ma thèse sur le thème des perceptions de la santé des femmes de la région d'Ottawa-Gatineau. Ce projet est mené par Alexandre Dumas, professeur à l'École des Sciences de l'activité physique de l'Université d'Ottawa.

Je suis à la recherche de femmes francophones âgées de 18 et 25 ans et voulant se prêter à une entrevue de 90 minutes pour discuter des questions relatives à la santé.

L'entrevue prendra forme d'une conversation informelle qui sera enregistré. L'objectif de l'étude est de mieux comprendre vos perceptions sur la santé et les habitudes de vie.

Ces entrevues seront confidentielles. Je vous identifierai par des pseudonymes (faux noms) et tous éléments qui pourront vous identifier comme participante seront supprimés. Les données collectées seront utilisées pour cette recherche seulement. Si vous désirez participer, le moment et le lieu de l'entrevue seront choisis par vous. Votre participation est de base volontaire, et vous êtes libre de vous retirer de cette recherche à tout moment.

Chaque participante recevra une compensation de 40 \$.

N'hésitez pas à me contacter si vous avez des questions.

Au plaisir,

Jeanne Robitaille
Étudiante de 2^e cycle
École des sciences de l'activité physique
Université d'Ottawa

APPENDIX C

Consent Form (français)

FORMULAIRE DE CONSENTEMENT

Étude de l'importance accordée à la santé et aux pratiques corporelles des jeunes femmes

Chercheur principal:

Alexandre Dumas, Ph. D.
Faculté de sciences de la santé
Université d'Ottawa
Ottawa, Ontario, K1N 6N5

Assistante de recherche:

Jeanne Robitaille, B.Sc
Faculté de sciences de la santé
Université d'Ottawa
Ottawa, Ontario, K1N 6N5

Note

Les recherches avec des sujets humains requièrent le consentement écrit des sujets de recherche. Cette exigence ne signifie pas que le projet dont il est question comporte nécessairement un risque. En raison du respect auquel ont droit les personnes qui participent à la recherche, l'Université d'Ottawa et les organismes de subvention de la recherche ont rendu obligatoire ce type d'accord.

Je, Mme/Mlle _____, suis intéressée à collaborer volontairement et librement à cette recherche menée par le Professeur Alexandre Dumas et Jeanne Robitaille de l'Université d'Ottawa. L'objectif de cette étude est de mieux comprendre comment l'environnement des participantes (lieu de travail, quartier, cercle social, famille, et expériences antérieures) forge les normes et les valeurs du corps et comment celles-ci influencent le régime de santé de ces femmes. Elle vise également à mieux saisir les facteurs socioculturels qui peuvent inciter ces femmes à approprier (ou non) des pratiques de santé (activité physique, alimentation, régulation du poids). Les résultats contribueront au développement de programmes et de politiques sociales plus efficaces en matière de promotion de la santé.

Ma participation consistera essentiellement à prendre part à une entrevue individuelle d'une durée approximative de 90 minutes, dans un lieu de mon choix et à une heure et une date que j'aurai choisie moi-même. Pendant l'entrevue, je serai invitée à répondre à des questions ouvertes sur: (a) mon milieu socio-économique et mon environnement social; (b) les ressources matérielles et humaines qui me sont disponibles en matière de loisirs; (c) mon histoire personnelle en matière de pratiques corporelles quotidiennes telle que : pratique d'activité physique, pratique alimentaire, contrôle du poids; (d) mes perceptions face à ces pratiques en matière de santé, régulation du poids, l'importance du corps; et (e) les façons que mon environnement (lieu de travail, mon quartier, cercle social) forge ce régime quotidien.

J'accepte que mon entrevue soit enregistrée et qu'elle soit retranscrite. Si je le désire, je recevrai la transcription de mon entrevue afin de lui apporter des modifications si nécessaire. Cette transcription me sera lue ou encore, je pourrai la lire moi-même si je le désire. À ce moment, je pourrai changer ou enlever des passages de l'entrevue et corriger les erreurs de transcription s'il y a lieu.

Je m'attends à ce que la transcription corrigée de mon entrevue ne soit utilisée que pour des fins de recherche et qu'elle soit conservée pendant une période de 5 ans par le Professeur Alexandre Dumas et selon le respect de la confidentialité. Ainsi, l'enregistrement et la transcription de mon entrevue seront conservés dans un classeur barré à clé dans le bureau de recherche du Professeur Dumas. L'enregistrement de mon entrevue sera détruit à la fin du travail de recherche.

J'ai l'assurance des personnes effectuant la recherche que l'information que je partagerai avec eux restera strictement confidentielle. L'anonymat sera aussi garanti. On me demandera donc de me choisir un pseudonyme (faux nom) et c'est ce dernier qui sera utilisé pour la transcription de mon entrevue. Si on cite des parties de mon entrevue dans la recherche, ce même faux nom sera utilisé et toute information pouvant mener à mon identification sera enlevée.

Je comprends que, étant donné que ma participation à cette recherche requiert que je donne certains renseignements personnels, il est possible qu'elle crée un léger inconfort émotionnel à certains moments. J'ai reçu l'assurance des personnes effectuant la recherche que tout sera fait en vue de minimiser ce risque d'inconforts. Entre autres, je ne serai pas tenue de répondre à une ou à des questions qui m'apporteront un certain inconfort. Je peux à tout moment décider de ne pas répondre aux questions qui me sont posées, voire me retirer de l'étude. L'entrevue sera faite de façon décontractée et informelle. La personne effectuant l'entrevue utilisera un langage simple et les questions seront reformulées autrement si je ne les comprends pas bien. Il est bien clair que je suis libre de me retirer de la recherche en tout temps, avant ou pendant l'entrevue, sans encourir de préjudice sous aucune forme.

Si j'accepte de participer à la recherche, l'entrevue sera une occasion de partager mes expériences en matière de pratiques de santé et de régulation du poids. À la fin de la recherche, je recevrai une copie du résumé des résultats de l'étude, un résumé qui me sera lu si je le désire.

Il y a deux copies du formulaire de consentement, dont une que je peux conserver. La personne effectuant l'entrevue m'a demandé si j'avais des questions concernant le formulaire de consentement ou la recherche et a accepté de répondre à toutes mes questions.

Pour tout renseignement additionnel, j'ai été informé du fait que je pouvais communiquer avec le professeur Alexandre Dumas à l'Université d'Ottawa au numéro de téléphone indiqué au début du formulaire. Pour toute plainte concernant la conduite éthique du projet de recherche, j'ai été informée que je pouvais m'adresser au responsable de la déontologie en recherche par courriel (ethics@uottawa.ca), par téléphone (613 - 562-5800 poste 5387) ou par la poste (Subventions de recherche et déontologie, Pavillon Tabaret (159), 550 rue Cumberland, Ottawa, ON, K1N 6N5).

Je, _____, consens de façon volontaire et libre à prendre part à ce projet de recherche.

Sujet de recherche : _____
SIGNATURE **DATE**

Je, _____, déclare avoir expliqué les objectifs, la nature et les inconvénients de l'étude à la participante ci-haut mentionnée. Je m'engage à assurer la stricte confidentialité des informations reçues au sein de cette étude.

Chercheur(e): _____
SIGNATURE **DATE**