Original Article

Lifestyle as a choice of necessity: Young women, health and obesity

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Abstract Sociologists of health have regularly called into question strictly knowledge-based health promotion approaches that focus on individual lifestyle change, claiming preference for collective actions on social determinants of health. These critiques have more recently been directed towards the issue of obesity. Although there is a growing body of work that shows the connection between poverty, obesity and ill health, few studies have focused on the concerns for health and lifestyle of vulnerable populations. In this qualitative study, 15 in-depth interviews were conducted with young underprivileged women in order to capture their dispositions towards health practices by outlining sociocultural factors that do (or do not) incline them to pursue a health regimen and weight control strategies. By drawing on Pierre Bourdieu's concepts of habitus, practical sense and 'choice of the necessary', the results suggest that inclinations to follow normative health guidelines are strongly influenced by family and financial responsibilities and by pressing health concerns rather than a calculation of how the prescribed risk avoidance behaviours will improve personal health and/or prevent illness for one's own sake. In conclusion, this study highlights the limits of prescribed 'solutions' to health improvement that have little to no consideration of embodied social knowledge and lived experiences.
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Introduction

Most current health promotion initiatives linked to obesity encourage people to take up a healthy lifestyle in order to decrease the risk of developing a range of chronic diseases (for example, diabetes, high blood pressure) thought to be associated with obesity (WHO, 2013). At the basis of such initiatives is the

intention to educate and vest responsibility over one's health (Brownell *et al*, 2010). The sociology of health inequalities has provided many criticisms of this approach for its over-simplistic understanding of people's health and lifestyles, notably for its neglect of social structure and social inequalities as important determinants of health. It has also called into question strict knowledge-based or behavioural approaches to lifestyle in health policy, instead calling for more inclusive strategies that embrace collective action on various social determinants of health (Frohlich and Poland, 2007).

Although individual-based and structure-based approaches stem from separate research foci that have been associated to the biomedical and the social models of health respectively (Germov, 2005), a neat separation between them misrepresents the complexity of efforts to promote healthy lifestyles. Even if it is clearly not flawed to accept individual-centred strategies to improve health by changing lifestyle, as Cockerham reminds us (2013, p. 150), 'it seems very rare that agency ever truly frees itself from structure'. Hence the importance of investigating the interactions between these two positions.

Although there is a growing body of work demonstrating the connection between poverty, obesity and ill health (Levine, 2011), few studies have focused on the concerns for health and lifestyle of socio-economically deprived populations by using an elaborate theory of practice. In this qualitative study, 15 in-depth interviews were conducted with young underprivileged women in order to capture their dispositions towards health practices by outlining sociocultural factors that do (or do not) incline them to pursue a health regimen and weight control strategies. By drawing on Pierre Bourdieu's concepts of habitus, practical sense and 'choice of the necessary', results show the manner in which the participants' health and weight management practices were influenced by their immediate needs and responsibilities, as well as their embodied social knowledge for how to cope with stress and responsibilities – despite their awareness of normative health guidelines. Such conclusions promise to contribute by informing policy makers of the hierarchy of priorities of young underprivileged women.

Women, Lifestyle and Obesity. A Critical Approach

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 that restated the health risks associated with obesity and issued warnings about the repercussions of

neglecting generic health guidelines (see Doctors of Weight Loss, 2011). These forums regularly present mortality and morbidity notes associated with the social and economic impacts of obesity on Canadian society. These publications, public health bulletins and accompanying newspaper editorials are part of an array of obesity-related messages so vast that any adult female living in North America would be hard-pressed to miss the alarm about the obesity epidemic or the common health prescription for women at 'risk' of overweight or obesity: weight loss through lifestyle change (diet and exercise).

However, a growing number of scholars and activists question the claims of mainstream obesity science as well as the related anti-obesity health promotion discourses. There is a diversity of perspectives within this group (see Gard, 2011), with some challenging the validity of mainstream obesity science (namely the idea that obesity and overweight cause ill health) (Gaesser, 2002; Campos, 2004; Oliver, 2006), and others urging fat acceptance (see Rothblum and Solovay, 2009). Most relevant to our analysis are those scholars who criticize the so-called neo-liberalization of obesity-related health promotion and the manner in which various organizations have uncritically positioned individuals as solely responsible for changing their lifestyles to ensure an appropriate (and 'healthy') body weight (Burrows, 2009; Fullagar, 2009). The imperative to take responsibility for one's health that is advocated by medical institutions and disseminated by the media has been linked to 'healthism', an ideology that shapes moral frameworks and influences our daily practices in the pursuit of health (Crawford, 1980; Lupton, 1996). As argued by Crawford (1998, p. 84), healthism engenders a 'blaming the victim' discourse, which intimates that '[if] individuals take appropriate actions, if they … adopt life-styles which avoid unhealthy behaviour, may prevent most diseases'. Of particular significance to the present study, healthism pays little to no attention to the impact of social structure, life circumstances and life contingencies, which shape the dispositions and offer opportunities for engaging in health practices (Crawford, 1998; Wright and Harwood, 2009).

The study of social practice has shown that the social variation of health and lifestyles is highly linked to socioeconomic circumstances and to social inequality. For instance, socioeconomically disadvantaged groups often experience a perpetual sense of urgency to respond to immediate needs such as food, shelter and employment (Miller and Brown, 2005; Hankivsky, 2007). They are characterized by a strong present-time orientation (short-termism) and weaker preventative attitudes; living close to economic necessity reduces the ability to invest in future health whereas more affluent socioeconomic groups have greater latitude in this regard (Boltanski, 1971; Dumas and Bournival, 2011; Savage *et al*, 2013). Indeed, social epidemiologists have presented a growing and convincing body of data linking social and material deprivation with ill-health at the population level, thus bringing attention to upstream social determinants of

health (that is, income level, housing quality, job security, early life circumstances) over an exclusive focus on individual (biological) characteristics and lifestyles (Raphael, 2009; Braveman *et al*, 2011). It is crucial to pursue research on these 'upstream' factors that shape the health of vulnerable populations, as well as to explore the social and cultural aspects that account for their engagement in health practices (or lack of).

Research concerning obesity as it relates to women on low income is particularly important given the inverse correlation between income level and obesity in women (PHAC, 2011; Martin and Lippert, 2012) – and the tendency to place blame on women for this situation instead of working towards a more nuanced understanding of the factors that might contribute to this trend. Very little sociocultural research has applied qualitative methodologies to focus on contextual factors influencing the uptake of health practices related to body weight for underprivileged women. One notable exception is the work of Warin *et al* (2008) who located obesity within the lived experiences of two groups of Australian women of differing socio-economic contexts (low and middle/upper class), and found that gender and social class, as well as their role as mothers, played a central role in their participants' health practices as well as their constructions of identity.

This study builds on this existing research in order to better understand the extent to which the life circumstances of young underprivileged women fashion their bodily dispositions to engage in health practices. It also makes a theoretical contribution by drawing upon Pierre Bourdieu's approach to social classes and embodied dispositions. We feel this perspective, which is outlined in more detail below, provides the necessary tools to explore the meanings given to health and the body, and which, with few exceptions, has been underutilized by obesity scholars.

Habitus, Practical Sense and the Choice of the Necessary

Although many English language social scientists have used Foucauldian perspectives to examine discourses on obesity, health and the body, including how they shape individual subjectivities (for example, Chase, 2008; Harwood, 2009; Warin, 2011), Pierre Bourdieu's theory of habitus has also been proposed as a valid framework. As argued by Allen Luke (1992) discourse (that is, 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 sociocultural environment (Dumas and Turner, 2006).

The bodily habitus points to a set of socially constructed and embodied schemes of dispositions that generate actions, practices and preferences related to the management of the body (Bourdieu, 1984). As argued by Bourdieu (1984, p. 90): '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'.

The terms instrumental and reflexive relations to the body have been used in this framework in order to highlight the habitus of working class and upper class women (Bourdieu, 1984); underprivileged and working class conditions bring about a conception of the body as a tool or a means to an end in order to fulfil imminent necessities (for example, acquiring food and shelter, taking care of their children). As such, the tastes and preferences in food, physical activity and bodily appearances of underprivileged groups have a tendency to 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 itself.[1]

In furthering his explanation of lifestyle, Pierre Bourdieu (2000) refers to people's *practical sense* as it calls attention to the socialized 'know-how' that allows the coordination of actions in accordance with the constraints and opportunities, characteristic of their living conditions: 'The practical sense is what enables one to act as one "should" … without positing or exercising a … rule of conduct' (2000, p. 139). As a dispositional concept, it refers to the spontaneous adjustment of people's actions to their objective possibilities and beliefs (Bourdieu, 1990). It provides embodied and practical explanations for actions, rather than intellectual or rational; each person has a practical knowledge that is a function of one's social position in society (Bourdieu, 2000).

Finally, this theory also includes the 'choice of the necessary' as one of the key explanations for lifestyles of people in disadvantaged living conditions and with limited opportunities. In this context, lifestyles are the result of a 'taste for necessity which implies a form of adaptation to and consequently acceptance of the necessary' (Bourdieu, 1984, p. 372). In other words, conditions of necessity undermine concerns for health improvement 'when there are so many things that come first' (1984, p. 375). In this study, the 'choice of the necessary' allows an understanding of the hierarchy of incentives of underprivileged women, their priorities and practices in regard to health and weight management.

Methodology

This study is part of a larger research project on young Canadian women's social construction of health and obesity.[2] It specifically targeted underprivileged young women because they face several structural, gendered and personal

barriers to health practices. Fifteen women took part in a 90-min semi-structured interview aimed at capturing their perceptions of health and weight. Participants were recruited within low-income neighbourhoods in the Outaouais region (Québec, Canada), primarily through community organizations that intervene with vulnerable populations (for example, low-income organizations, work insertion programmes, adult education). These organizations either allowed us to display recruiting posters in their facilities or to speak directly with their members. Participants were selected by the following criteria: female, French speaking, aged between 18 and 29 years, no post-secondary diploma and residing in an underprivileged geographic area as defined by Statistics Canada (that is, median income below US$22 000) (Statistics Canada, 2009). Participant characteristics are listed in Table 1. The participants (average age of 23 years old) were generally unemployed with little or no post-secondary education (average years of schooling was 10.5) and had worked in various part-time occupations (that is, nurse's aid, cashiers, personal and home care aids, waitresses or counter attendants). None of the participants were employed at the time of the study and their income was entirely or partially provided by financial aid, government grants or family allocations. Seventeen participants were interviewed but two were disregarded because they ultimately did not conform to the sample criteria.

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 socioeconomic environment, for example, their background and past experiences; (b) the importance given to health and obesity; (c) their perceptions,

Table 1: Participant 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

attitudes, tastes and dispositions regarding lifestyle; and (d) their perception of human and financial resources available, for example, access/barriers to quality food, physical activity services, health professionals and weight loss programmes. 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, each interview was thoroughly read to gain familiarity with the data. All interviews were translated from French to English by the authors. Attempts have been made to preserve the language level used by the interviewees to illustrate the women's expressions. The names used in this article are fictitious. The University of Ottawa Ethics Board approved this study.

Each interview was analysed using data management software NVivo. Data were analysed through a thematic analysis to identify patterns within the interviews. The information provided by the participants was regrouped into themes and categories according to semantic affinities found within the interviews. As suggested by Rubin and Rubin (2005), data were analysed vertically in order to consider the participants' unique experiences, that is, to verify the relation between participants' life circumstances and their own life trajectory. In addition, a horizontal analysis was also performed in order to find similarities and differences between the interviews. Although participants each had a unique biography, their life circumstances were similar and were a determining factor of their social position and lifestyle.

Results

Overall, results indicate that the life circumstances of the participants incite them to negotiate a hierarchy of priorities based on their proximity to conditions of necessity. Although their perspectives on health, body weight and lifestyle were not entirely homogeneous, none of the women engaged in health practices and weight management with their future health in mind (that is, managing their individual risk factors); they were concerned with living 'day by day' or 'within the moment'. They prioritized economic stability, family needs or healing of highly debilitating illnesses. These orientations to the body illustrate the diversity of priorities that are connected to one's responsibility and needs, and in what follows, we further explore how they take action when confronted with the desire to seek upward mobility for themselves and/or their family, motherhood and pressing health concerns that threaten physical autonomy.

Prioritizing imminent necessities to seek upward mobility

One's social and material living conditions structure a hierarchy of priorities and fashion a relation to the body (Bourdieu, 1984). According to Hankivsky (2007), lack of time and low income are major constraints experienced by unemployed Canadian women; many remain in a precarious economic equilibrium while they are involved in demands related to unpaid labour (mothers and caregivers). Similarly, in this study, imminent necessities (for example, increasing one's income and completing basic educational training) and lack of free time act as significant barriers in their lives. Among 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 before the interview, her partner became unemployed, and since then, the entire family has been living off of social security. During the interview, she expresses her struggles with drug addiction and economic difficulties that limited her opportunities to engage in a balanced lifestyle:

> I don't have the will nor the guts to do exercise or anything. 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. But I find I have no will, no energy. (…) I'm a little ashamed to say that our drug consumption is also enough to harm our budget. We are trying to stop.

In another interview, Solange, a 20-year-old single mother, explains her past struggles with drug addiction and her 2 years of treatment and rehabilitation. Although she showed a keen interest in exercising and eating well, her priority is to finish school in order to be able to provide for herself and her daughter. For this young mother, well-being is achieved through education as self-fulfilment rather than typical health behaviours.

> My health and weight are more or less my priority. I can't say that it is. 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 … 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.

From another point of view, economic and childbearing priorities also have an impact on one's social networks, a condition often required to adopt and

maintain an active lifestyle. For example, Karine, 22 years old and a mother of one child, indicated her difficulty finding a regular exercising partner:

> I don't want to exercise by myself, and since I gave birth to my daughter I don't really have any friends. I'm trying to get another mother from the Centre to work out with me, but she has to look at her finances too.

In addition to low income, many young women mentioned lack of time as constraining their health. As scarce resources, time and money shape cultural dispositions and lifestyles. As argued in Practical Reason, people tend to act in their 'best interest', that is, in respect to what is meaningful for them and culturally valued in their references group in a given moment in time (Bourdieu, 1998). 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 bedtime. On top of keeping up with this routine, they also had to juggle their household chores and daily errands. Although several claimed to have an interest in pursuing physical activities, their interest in maintaining a healthy lifestyle and monitoring their body weight was most often suppressed by their need to foster more pressing and immediate concerns that impeded on time devoted to personal care and leisure. Jacqueline, for example, is a single mother who attends a community centre once to twice weekly to complete her high school education, adding another responsibility to her agenda, and increasing time constraints.

> 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 do 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!

Underprivileged conditions are also highly disruptive and can lead to a form of social inertia (Charlesworth, 2000). Living under conditions not of one's own choosing and coping with life's daily contingencies often result in dispirited attitudes and lack of focus required to sustain lifestyle change. In a discussion about the difficulties of maintaining a health regimen, Amelie, an 18-year-old mother living in common law with her partner describes the context that underpins her sedentary lifestyle: fatigue, boredom, laziness and lack of time are among the many reasons she provided for not engaging in a healthier lifestyle.

> Well, I'm not doing anything to help myself right now, that's for sure. I'm aware that I have to lose weight and that I'm not at my healthy weight. On top of that, I'm also anaemic. (…) I gained a lot of weight. I often order take-out. It seems like it gives me something to do because I'm bored. You know? It's a bad habit that I took up (…) I also don't have the time, but I don't give it to myself either. I do have the time, you know? It's laziness or a lack of will. I get tired, and then when I eat badly, I get more tired, and I have even less will.

Conversely, for some participants, good bodily health was a means to economic stability, reflecting dispositions of an instrumental relation to the body (Bourdieu, 1984). The participants that were involved in paid work were hired part-time as waitresses, bar maids, nurse's aids, and personal and home care aids in order to increase their income or pursue their education. For example, Cassandra, a 23-year-old young woman, had returned to adult education to acquire her nurse's certificate. Her concerns for a healthy weight are conditioned by the requirement of her job as a nurse's aid. Controlling her body weight allows her to be more efficient because of the physical component of her work. Good health was conducive to earning a better income and her expectations of upward mobility.

> 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!

The above quotes show the connection between poor life circumstances and the primary focus on imminent needs, as well as express the idea that concerns for health improvement were framed within a utilitarian logic – whether they invested or not in their health for the sake of a better job and more secure financial future (as opposed to engaging in health-related behaviours for the sake of their health alone).

Motherhood and its priorities

Eleven out of the 15 participants were mothers of 1–3 children. The interviews showed that they were highly reflective about their role of mothers and that they adjusted their lifestyle in order to manage imminent family needs, priorities and budgets. Childbearing had shaped their degree of interest to pursue health and weight managing practices: as a rupturing event in their life, motherhood initiated a reflexive process which either sensitized them to their own physical health, therefore adopting a health regimen in order to instil healthy practices among their children, or conflicted with such an interest as

they became highly preoccupied with their children's well-being at the expense of their own.

Interview data also testified to their anxiety and sharp sense of accountability towards their children's wellbeing. Inculcating healthy practices by providing 'good examples' arose among many of the participants. For instance, during the interview, many reported consuming tobacco, drugs and alcohol on a regular basis before their pregnancy but became sober once children arrived. In this respect, several mothers express the educational function of breaking from their early socialization by modifying their lifestyle for their child's sake. As expressed by Arielle, a 27-year-old single mother:

> I am more preoccupied with health now. I've become more aware of this since my daughter's birth. I've become aware of things: if I don't take my health to heart seriously, I will become sick quicker. The faster I become sick, the less time I will have to take care of her … My parents did nothing with me because they were always 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 the best for her.

Similarly, Victoria, a 26-year-old mother with two children and Karine, a 22-year-old mother, report that it remains essential to foster a good example by inculcating healthy practices to their 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, 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. (Victoria)

> Well you know, people are really fat now! Even kids are fat, and I wouldn't want my child to become fat like that! And yeah, she is small right now, but it could happen later in her life. So you know, it's not just her nutrition that I have to watch, but mine also. It's better if when I eat I project a good image! Someone who only eats junk food, well their child will be tempted to do the same later, whereas a child who eats well, well they will be used to eating well. (Karine)

While childbearing remains an opportunity for some women to develop accountability for their actions, becoming a primary caregiver also led others to disregard their own health as a consequence of their ethic of care. For instance, Chantal, an 18-year-old mother on social assistance, claims that

mothering in a context of poverty has repercussion on her body weight and health:

> I don't prioritize my health anymore. My son's well-being is more important than mine. Before I gave birth to my son, I took better care of myself because I have hypothyroidism. It makes you gain weight and it's difficult to lose it. I used to take medication and eat three times a day with, one or two snacks. Now I can't buy my medication anymore. I just buy his. I only eat at lunch and supper. That's it! … 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 for my hypothyroidism because I just couldn't afford both. I also stopped renewing my asthma pumps so I can afford his medication. He is by no doubt the priority. I am able to manage without my medication.

These findings resonate with the work of Warin *et al* (2008) who identified the difficulty of acting on health promotion initiatives as a mother on low income; in their study, the participants' relational identity as mothers required them to displace their individual needs for the sake of their children. For instance, Julie-Anne, a 21-year-old mother of three young children, explained how the care for her children shifted her priorities by setting aside her personal investments in health. Additionally she resists the idea that her body weight and lifestyle serve as an unhealthy influence on her children.

> 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. I can't do two things at once … I'll just wait and eat alone. Since I have had my kids, I gained weight, but I don't care about that, I'm still a good mother! I would not say that if I had 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 would tell them 'make your own food'. But no, I get up, I clean, I feed my children, I do everything!

Although Julie-Anne appears to accept the weight gain that came with motherhood, there appears to be a limit to what is acceptable, as illustrated by her insinuation that obese mothers (weighing '300 to 400 pounds') are lazy mothers who do not feed their children properly. This expression of class distinction (Bourdieu, 1984) reflects the work of feminist scholars who have demonstrated the manner in which marginalized women are more often constructed as posing the greatest risk of 'breeding' obesity in their children and by extension being 'bad' mothers in need of a greater level of surveillance and intervention (see Bell *et al*, 2009; McNaughton, 2011). Julie-Anne resists such

messages that would tie her worth as a mother to her present body weight, which would suggest their irrelevance to her. However, the fact that she is aware of – and accepts – such messages when directed at heavier women suggest her susceptibility to such constructions should she gain weight herself, even while she is aware of the constraints on mothers to attend to their own health.

Management of a critical illness

Two of the women interviewed responded more directly to health guidelines because they suffered various forms of physical or psychological complications that limited their opportunity to integrate within the work sphere, participate in social activities or acquire a desired health status. Although they reported wanting to live a 'normal life', they showed greater sensitivity to monitor and prioritize their health to maintain a functional body and gain independence. Avoiding hospitalization and active social participation were some of the benefits expected from their health regimen (for example, eating habits, physical activity, medical appointments and medication). In the following quote, Francine, a 25-year-old woman who is paraplegic and suffering from a series of related complications (for example kidney problems and hypertension) expresses her keen incentives to follow a health regimen.

> I have a lot of health complications. 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 any 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.

Sharing a similar view, Manon, a 25-year-old who has been diagnosed with bipolar affective disorder 3 years before the interview stresses the importance of closely monitoring her health. She believes that without the proper combination of psychological and physical well-being, she would be unable to fulfil ordinary socially oriented activities (shopping, attending school). Manon reported to have gained a lot of weight due to her medication. Although she indicated being slightly preoccupied by her weight gain, she is satisfied that she had sustained her lifestyle change and was able to function independently.

> Exercising and health wasn't really important for me before. I didn't really think about it. But now, it has become a question of well, not life or death, but of my 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. Well, it's awful! It's not only being healthy in your head, but physically too, – I find they go together. So for me it's important now, no drugs, and no alcohol. (…) It's

> important for me because if I let myself go, if I have a little slip, I don't know, going to bed really late, or having a drink, it will derail everything! 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 … Being able to do things I want, well, like it or not, by exercising everyday, it [losing weight] will happen on it's own.

Both of these participants mentioned that their physical and psychological circumstances could jeopardize their well-being and their lives. 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 disabilities distinguished them from the other participants because they triggered a sharper interest to cater to their health. This process is akin to what Dumas and Laberge (2005) observed with increased health concerns of older ill 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). For these young women, 'health' does not appear to be synonymous with body weight and mainstream health promotion messages. It had more to do with immediate physical challenges that impeded on their independence.

Discussion and Conclusion

This study captures the dispositions of young underprivileged women towards their health practices by outlining sociocultural factors that incline them to adopt normative health guidelines – or not. The findings highlight the close connection between these participants' social position, their social and material living conditions, hierarchy of priorities and lifestyle. The results suggest that their health practices are much less a function of their knowledge of health, but rather the outcome of a 'choice of the necessary'. Several women face barriers and pressing concerns, compelling them to fulfil imminent needs and respond to social norms rather than engaging in health practices or weight control strategies in order to avoid future and intangible health complications.

Social scientists have regularly shown that living conditions fashion distinctive preferences and practices of social groups. Generally speaking, the social variations of 'body care' point to people's socialization, and to their ability to gauge their

choices and actions in relation to constraints and opportunities (Boltanski, 1971; Cockerham, 2005, 2013). In this study, the 'instrumental relation to the body' was a useful concept to raise the importance of structural factors impacting the health behaviours of people living in poverty. It illustrates the short-term attitudes and weaker dispositions towards illness prevention and perhaps the tendency to ask 'why invest in illness prevention or in future health when benefits are delayed and uncertain'?

In agreement with many critics of individual-centred approaches to reduce obesity, this study emphasizes a dispositional approach to health practices. It calls into question prescribed 'solutions' to health improvement that have little to no consideration of embodied social knowledge and lived experiences. Theoretical frameworks aiming to study lifestyles can gain in credibility by avoiding over-rational explanations of behaviour by attempting to understand why people adopt unhealthy behaviours when they are knowledgeable about the risks they have on their health (Williams, 1995).

The concepts of habitus, practical sense and 'choice of the necessary' show the complexity of understanding lifestyles by calling attention to the limitations of knowledge-based or strictly individual approaches to behaviour modifications. As Pierre Bourdieu argued, taste (which is part of the habitus) 'continuously transforms necessities into strategies, constraints into preferences, and without any mechanical determination, it generates a set of 'choices' constituting lifestyles' (1984, p. 175). Following this line of reasoning, it is then fallacious to exclude social and material life circumstances in any explanation of behaviours, and irresponsible, from a policy perspective, to place a heavy burden of responsibility on a group with respect to their health. For participants who did not suffer from any debilitating diseases, concerns about weight were only moderately supported by desires of improving long-term health.

When used in conjunction with other analytical categories (gender, ethnicity, age), Pierre Bourdieu's theory of practice contextualizes women's lifestyles in their diverse social and economic circumstances. This study underlines the importance that gender plays in the class habitus. A noticeable example was the influence that motherhood played on lifestyles. Overall, childbearing and care giving either encouraged these mothers to preoccupy themselves with their health and weight management (for the sake of their children) – or constrained them from doing so (also for the sake of their children). Regardless of which, experiences of motherhood fashioned a particular relation to health and weight, which is strongly determined by the well-being of their children.

This heterogeneity *vis-à-vis* their perception of health and lifestyles suggests that more biographical work needs to be done on the personal and social factors that orient young mothers to invest in their health. For example, the weaker health concerns of mothers who had quit (or who were in the process of quitting)

a drug addiction are significant indicators of their personal history. Because the habitus is also an embodied history of personal experiences (Wacquant, 1992), it is likely that one's health standards and lifestyle preference are always modulated by one's perception of 'how far they have come'. To what extent does freedom from addiction bring a sense of happiness and of being healthy despite holding other anti-normative (health) practices? Biographical analysis thus provides valuable insights on the discrepancies between individual concerns and dominant discourses on health and the body.

In certain situations, the experience of motherhood could benefit both children's and mother's health through a reflexive process. This positive observation, however, should be interpreted with caution in health promotion. It may reinforce the idea that woman are the sole actors responsible for their health, reinforcing neoliberal approaches to health. As argued by Miller and Brown (2005), the well-being of mothers is challenged by various moral responsibilities that are thrust upon them. In addition, it risks stigmatizing a woman as a 'bad mother' if she cannot fulfil her duties, bringing associated feelings of self-recrimination and blame in societies characterized by high levels of social inequalities. Mildred Blaxter (1990) argued two decades ago that, despite the good intentions of health promotion experts, publicity regarding health practices reinforce adherence to health standards and bodily ideals by stigmatizing people who do not conform to health guidelines, and by creating unrealistic expectations that are detrimental to the well-being of marginalized populations. Questions regarding the practical and ethical implications of mainstream biomedical framings of obesity are beginning to appear in venues supportive of obesity science, such as *Obesity Reviews*, which recently published an article detailing a host of reasons that existing obesity prevention initiatives and programmes are potentially problematic, including the negative psychosocial consequences, and blaming and stigmatization (Ten Have *et al*, 2011, see also O'Dea, 2005 and Puhl and Heuer, 2010). This conclusion is significant if it is assumed that dominant anti-obesity discourses are framed in an imperative that is centred on self-responsibility, which may over-simplify the relation between health and lifestyle (Fullagar, 2009).

Although social epidemiology has provided valuable measures linking poverty to health, obesity and lifestyles, few frameworks deepen these links by capturing the experiences of underprivileged groups. The merit of drawing Pierre Bourdieu's theory can thus be summarized in the following points. First, it considers the symbolic dimension of the body – it recalls a social constructivist assumption that obesity, health and lifestyles are social constructs. Second, it provides concepts that capture the social signification of practices of people who share common life-worlds. Third, the theory recognizes the impact of power relations and social inequities on health and health practices. All points considered, it shows a process of distinction with respect to 'valued practices' and 'valued

bodies' that are characteristic of hierarchal societies that are strongly defined by socioeconomic variables.

Several results in this study warrant further exploration. First, because the theory of habitus focuses on socially significant practices and aims to understand the 'logic of practice', moralised topics such as obesity and health may have influenced participants to emphasize their health concerns while reproducing official public health rhetoric. Second, the scope of this study cannot explain the inverse statistical relation between obesity rates of women and their socioeconomic status (PHAC, 2009; Poulain, 2009). In fact, the higher interest in weight loss of some participants may point to some characteristics of underprivileged class fractions that are more inclined to conform to normative weight standards. Third, further work on 'age dispositions' as significant variables of the habitus may also be fruitful (Dumas and Turner, 2006). For instance, the seeking of socioeconomic comfort and upward mobility should also be further explored as a factor explaining why illness prevention is somewhat secondary for young underprivileged women. As indicated elsewhere (Walkerdine *et al*, 2001; Walkerdine, 2003), participants in this study also mentioned their aspirations for achieving upward mobility through various pathways (education and professional occupation). To what extent do such aspirations reduce interest to improve their health? Do underprivileged youth experience tensions between the priorities given to 'upward social mobility' and those given to health? The fact that young women hold the optimistic belief that 'all is still possible' for them may nuance the notion of a 'taste of necessity' for underprivileged groups and its negative impact on health. Pierre Bourdieu's concepts of *illusio* could be useful in order to comprehend the concerns age groups have towards specific domains of interests (Frank, 2013) that downplay illness prevention. *Illusio* is a non-utilitarian form of interest that expresses a state of being invested in a social game (Bourdieu, 1998); it refers to the 'fact of being caught up in and by the game', of believing the 'game is worth the candle', or more simply, that playing is worth the effort (Bourdieu, 1998, pp. 76–77). In this respect, is there an *illusio* that is characteristic of youth? If so, how is it played out in the relation to health and the body?

In the short term, health and lifestyle disparities will doubtlessly remain. The persistence of socioeconomic inequalities is likely to be carried over onto people's health (Cockerham, 2005), and there is reason to believe that health promotion programmes can actually participate in widening health disparities because they speak more to middle class sensibilities (White *et al*, 2009); working class and/or poor individuals are less able to benefit from them than their middle and upper class counterparts.

These conclusions support health policies that push for collective actions on multiple fronts rather than a strict individualist approach. Four general recommendations could be forwarded. First, public health promotion

initiatives should act on a structural level by integrating other social policies aimed at reducing social inequality. As argued by the well-known Whitehall studies, much of the variation in health is directly associated to social inequality and its effects on lifestyle. Second, such initiatives that focus on obesity may also prove to be too narrow. As presented in this study, to become concerned about health and health practices, women need to feel that they have the means to respond to their basic necessities and responsibilities, allowing them to devote time to leisure, and to achieve longer-term ambitions. Third, community centres that intervene with underprivileged populations should pursue efforts to offer programmes and interventions which combine an active participation on the parts of both parent and child, given that several participants of this study have exemplified this dimension. Finally, a less judgmental approach, which also considers personal biographies and social position, is needed to better understand the barriers faced by underprivileged populations.

About the Authors

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Notes

1 This trend towards the adoption of a reflexive relation the body (perception of the body as an end in itself) has been discussed preciously (Bourdieu, 1984; Dumas and Laberge, 2005).

2 Rail, G. and Dumas, A. Social sciences and humanities research council of Canada, Young women's discursive constructions of the body and health in the context of obesity discourses and biopedagogies, 410-2008-0043.

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