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Weight-Loss Practices among Working-class Women in France

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Abstract: It has long been known that obesity is inversely associated with one’s occupation category, and women from working-class backgrounds are more widely affected. The aim of this paper is to increase our understanding of the methods working-class women use to implement slimming diets. It uses the results of a qualitative investigation (observations and interviews) conducted among women who participated in a Food Education Programme in the north of France, the region where obesity is most widespread. We illustrate that the women interviewed use three types of techniques (physical, dietary or culinary) in order to lose weight, revealing three different ways of envisaging weight-loss – interventions upon the body (including weight-loss surgery) without any modification of food intake / severely restricting food intake / adapting culinary practices. These differences reflect the effects of class belonging and the subdivisions of that class, combined with the effects of social trajectories. More generally it should be highlighted how some of our interviewees go through a predictable order of different techniques in parallel with their social trajectory. Conceptions of dieting and its implementation can be understood in light of the somatic cultures particular to each subdivision, which reproduce internally the more general differences dividing social groups concerning disease, health and eating habits. Social and family trajectories tend to reinforce these differences, especially when the social mobility of daughters acts as inverse socialisation when they encourage their mothers to adopt their own standards for body weight. As opposed to Great Britain (Department for Environment, Food and Rural Affairs eg) there is in France an important debate among policy makers to know whether one should target messages at particular groups, but for the moment nothing has been decided in this way. The results of our study bring one more evidence that the same policy should not be expected to work universally.

Keywords:

France, Obesity, Weight-loss, Working-class, Women, Eating habits
Introduction

In Western societies where a slim body is currently the norm, controlling and managing body weight has become a major issue as much from a public health perspective as an individual one (Offer, 2001; Warde, 1997: 88 sq.). Obese people have long been subject to social stigmatisation (Cahnman, 1968; Poulain, 2009). More recently, they have also been subject to moral condemnation, sparked off by the “war on obesity” - “those who are medically categorised as obese are frequently characterised as being morally weak, lacking in willpower and as seeking a weight-loss ‘quick-fix’ which will enable them to duck the bodily work of diet and exercise”, (Throsby 2009: 203; see also Counihan, 1999: chapter 5). However, it has been shown that obesity and practices to control weight are inversely associated with one’s occupation category, and women from working-class backgrounds are more widely affected (Sobal and Stunkard, 1989; Ball and Crawford, 2005). They are more tolerant regarding weight-gain than upper or middle-class women, intervene later to start dieting once a gain in weight has been observed, and receive less social support to have a healthy diet and partake in physical exercise (Jeffery and Simone, 1996; Wardle and Griffith, 2001; McLaren and Gauvin, 2002; de Saint-Pol, 2007). Based on this observation, various interpretation elements have been put forward. A slender body as a sign of social distinction seems to be more common among the higher social classes (Bourdieu, 1979; Mac Laren and Kuh, 2004; Régnier, 2006), and the level of education appears to increase the amount of attention paid to media images and health education messages (Mac Laren and Kuh, 2004), and social environment seems to be a vector for body norms (McLaren and Gauvin, 2002).

The aim of this article is to acquire a fuller understanding of the ways to implement weight-loss diets used by working-class women. There is very little literature to enable us to understand this. Qualitative investigations on weight-loss practices mainly concern women from the middle or upper classes (Duboys Delabarre, 2004; Chapman, 1999; Throsby, 2007). Studies including the working class concentrate mostly upon the representations and practices of healthy eating, without specifically addressing the question of dieting (McKie and Wood, 1991; Wardle and Steptoe, 2003; Backette-Milburn et al., 2006)\(^1\). Quantitative surveys do not help us achieve our objective either, for two main reasons. By reasoning on the principal differences between social groups, they do not allow us to understand differences within the working classes. While the relationship to food remains highly distinct between social environments, this is also true within each social group (Halbwachs, 1912; Bourdieu, 1979; Grignon and Grignon, 1999). Above all, however, these surveys rely on the dominant (i.e. medical) conception of slimming diets, essentially based on the modification of food intake (Williamson et al., 1992; Jeffery and French, 1996; Wardle and Griffith, 2001; Masson, 2004). Only the questionnaire devised by French, Perry, Leon and Fulkerson (1995) and taken up by Markey and Markey (2005) incorporates elements such as the practice of taking emetics or laxatives\(^2\).

Using a qualitative survey conducted by interviewing and observing working-class women, we demonstrate that weight-loss practices do not always occur through changing one’s eating habits. Not only is the connection between dieting and food not always established for the working class, it may even be antinomic. Schwartz (1990) points out that “the question of food is firmly rooted in resisting the establishment. Many women who are advised to go on a diet refuse to stick to it because food is a vested right, a victory over frustration, and giving this up is hard to accept” (p. 479). Assuming a direct link between food and dieting is to deny that food may correspond to other social functions which are in direct competition with the diet.
Method and Materials Used

This article uses data obtained by observing a food education programme designed for obese women in unstable circumstances. It took place in the north of France, the region with the highest prevalence of obesity in the country (14% compared with 10% for French people overall in 2003). Generally, in France, obesity is significantly over-represented in the poorest households in comparison with wealthier ones, and this is even more so for women than for men (Régnier, 2005). However, despite these findings, surveys show that it is not those affected by obesity who follow the most diets – this practice is more developed among women from intermediary or higher social categories: in 2003, 7.5% of employees and 6% of lower and higher managers and professionals said they had tried dieting compared with 3.4% of farmers and 3.5% of manual workers - in other words, those less affected by weight problems, who dieted to maintain their figures or as a preventative measure (de Saint Pol, 2007).

The food education programme I studied – funded as part of a national nutrition policy – consisted of a series of 12 sessions spread over three months, aiming to give participants the means to be independent in their approach to losing weight. It alternated between nutritional education from a dietician, awareness of the importance of physical exercise from a sports’ counsellor and advice from a psychologist on how to combat cognitive restriction. Participation in the programme was free, although certain conditions applied: those interested had to complete two questionnaires beforehand (on health and food consumption, which were also completed at the end of the programme to assess its effectiveness) and provide a letter from their GP in which he or she agreed to the patient’s participation (the aim of this request was to involve doctors more personally in their patients’ diet). The programme took place in a social centre, responsible for publicising the event widely. However, the women who enrolled heard about the programme through various different means (neighbours, hospital staff, general practitioners and the local press).

The survey consisted of participant observation and interviews. Based on the hypothesis that these educational sessions offered a privileged position from which to observe the encounter between two distinct normative systems – that of the organisers and that of the participants - the combination of these two techniques proved to be very effective. In this way, we were able to carry out a precise investigation into the methods of appropriating nutritional advice in a dual context: that of the sessions (interacting with the counsellors) and that within the domestic framework (interacting with household members). I observed the sessions of two groups held between January and September 2003. I was introduced during the first session as someone monitoring the programme to help its functioning, as it was a pilot experiment. I gradually found a way to make myself useful, serving coffee, setting up the hall, fetching equipment and so on. A kind of trust developed, due to the fact that I was always present at each session (while the organisers took it in turns to run sessions), and I ended up playing a liaison role in the participants’ eyes. In addition to these observations, 18 individual interviews were held, some with the women who had participated in the two groups, and others with women who had participated in subsequent groups which I had not observed. In terms of domestic and professional situations, the women I encountered were divided between a majority of single-parent households (13 out of 18) and couples. A third’s income came from employment (this included retired people), a third’s income was from disability allowances and a third’s income was from “minima sociaux” (State welfare support). In this article, we shall see that weight is not the determining factor in understanding their approach to and practice of dieting. For this reason, we have not listed their BMI as a descriptive trait of the surveyed population. It is not pertinent as it is not a category familiar to them, and none of them, with one exception, defined herself as obese or overweight.
Findings

An analysis of the findings shows that the women interviewed used three types of techniques in an attempt to lose weight: physical techniques (taking action on one’s body), dieting techniques and culinary techniques, and these will be discussed further in the following three sections. The relative distinction between the techniques allows us to take the opposing view to that of literature on the “war on obesity”, which presupposes a certain linearity between methods used to lose weight, as Throsby (2009) has emphasised. The body-weight trajectories and diets of the women interviewed show that their approaches follow less a gradation in their practice (from conventional 'life-style interventions' to weight-loss drugs and finally weight-loss surgery), than a fairly strict separation in ways of doing this. At the same time, the dividing lines between each of these techniques are not totally clear-cut, and we shall examine more closely the profiles of people who oscillate between one approach and another.

Physical Techniques (Taking Action on One’s Body)

For some of the women observed, dieting consisted of turning to techniques which act upon the body (rather than through eating habits). Their final goal was surgical procedures. This was situated in the continuity of practices intervening on the body (Mauss 1950) which they had been using until then to diet. Nathalie was 30 years old and married with no children. She had a problem with her knee, so was partially disabled. She had been dieting for about ten years and claims to have tried “almost everything. I even tried cabbage soup, hyper-protein sachets; I’ve tried them all (...) That thing with the cabbage soup they show on telly, I did that too. I’ve done loads of things. I even wanted to buy the special trousers4; I even bought the slimming cream with the roll of cellophane to wrap yourself in. I wrapped myself in it, but it didn’t do anything at all! I wrapped myself up for nothing [she laughs]. Then I wanted to buy those clogs they’re advertising at the moment, with the 8° heels5. I’m tempted, but not tempted because I know they won’t work”. Having dieted for around twenty years, Naïma, 45, who owned an ambulance company with her husband, explained that she, too, had tried countless techniques and therapies, “I took so many appetite-suppressants and things like that when I was younger (...). Later I tried acupuncture, homeopathy – I think I tried everything”. But, like Hélène, 37, unemployed and without qualifications, and dieting for twenty years, they had all come to the same conclusion that “in the end (...), none of it does any good.”

Confronted with the ineffectiveness of these techniques, the women interviewed saw surgery as the ultimate and definitive action on the body to rectify their weight problems. Relatively far from the idea of a slimming diet, to them, weight-loss surgery appeared instead as a remedy. This can be understood as a conception of the body and disease typical of the working class, where disease is perceived as an accident which only a “remedy” can cure (Boltanski, 197; Bourdieu, 1979; d’Houtaud, 1984; Nettleton, 2006). Eating habits are not seen as a mode for prevention (Boltanski, 1971; Régnier, 2009a; Depecker, 2009). Although surgery should be accompanied by dietary precautions, this did not appear to be a priority in the interviews. The only connection those interviewed made between disease and diet – the question was asked during the interview – concerned the unpleasant side effects of their medical treatments on their appetite or digestion6. For example, when I questioned Hélène about possible connections between her diet and her health, she replied without hesitation, “Yes, when I eat too much I feel bloated and then I feel guilty.”
Similarly, Nathalie was mainly concerned about the effect her medication (taken for her knee problem) had on her appetite or when preparing meals, telling me “Sometimes, with my treatment, it’s very difficult to manage, too. So sometimes I can’t taste things, sometimes I don’t feel like preparing food because I’m too tired.”

The relationship with food was also linked to the place food had in their individual and family trajectories. For some, food and, more specifically, the act of cooking recalled earlier, premature learning “on the job”, related to family separations; Hélène learnt to cook for herself on her own in the children’s home to which she was sent as an adolescent; Fabienne learnt at the age of 13 as a servant in a doctor’s house. As a result, the programme’s recommendations did not always reach their target when concerning cooking. With my survey, the war on obesity would appear to focus mainly on cooking. In line with the ideas of the national campaign whose recommendations are based on lifestyle advice (healthy eating and physical activity), those running the group spread reasonably general messages more closely related to a healthy diet and home economics than slimming diets. However, this type of message presupposes an interest for home economics that was absent in the women in this group. In particular, they did not have the necessary social and emotional conditions to make a family meal exist as seen in the abundant literature on ‘proper meals’ (Mennell et al., 1992). The women running the group, married and mothers responsible for several children, were accustomed to cooking and spending time on the family meal. Their advice indirectly conveyed a normative approach of marital structure to women who were mostly separated or divorced. In France, the war on obesity also appears to be a class war. The women who participated in this group belonged to the lower strata of the working class. Coming from working-class families where mothers do not work, they had no qualifications and for all of them, their previous employment was in very low-skilled jobs; Nathalie defined herself as a “former cleaning technician”, Hélène as a “home-help”, and Fabienne successively as a “servant” and “childcare provider”. At the time of the survey, they were receiving income support, and despite being relatively young, (born in the 1960s and 70s), they appeared to be far from (re)joining the labour market.

**Dietary Techniques**

Some of the women interviewed saw slimming diets as severely restricting food over a limited period. This is how it was considered by Sandrine, 28, who had an Advanced Vocational Training Certificate in “social and domestic economy”, and claimed that “going on a diet means limiting your eating”. For Jenifer, 21, educated to A-level, going on a diet implied, above all, knowing “which foods you really shouldn’t eat”. This conception of dieting is based on a traditional model of nutrition which advocates establishing menus and rations, weighing foods and a series of taboos and forbidden food. This is why the programme did not suit them as the advice given was not restrictive enough. As Sandrine explained during our interview, “I’m here to lose weight, not just to sit here listening and that’s it”. Colette, 52, an occupational therapist’s assistant on a disability allowance, expressed her reservations regarding the effectiveness of the programme; “I think maybe that when it’s finished I’ll have lost 2 kilos (...) but I wouldn’t say ‘I’m going to go to it and lose those 15 kilos’”. As they did not find what they were looking for in the programme, most of the women left before completing the course. They chose instead to consult an endocrinologist in the hope of being prescribed a personalised and restrictive diet plan, corresponding to their conception of dieting. This perception of dietetics as a discipline for losing weight is characteristic of the intermediate categories. It “is particularly manifest within ascending subdivisions and can be seen
as a desire to avert the spectre of relegation through ostentation of the appropriation of dominant standards” (Depecker, 2009). The women in this group did indeed belong to the upper strata of the working class. Most of them held qualifications and worked in social or paramedical jobs. They were from families of which one member also worked in this sector (many had parents or grandparents who worked as auxiliary nurses).

The notion of relegation stressed by Depecker is important as it enables us to understand partially why these women all left the Food Education Programme before it was finished. On one hand, they did not receive the advice they had been expecting, but above all, they perceived it as stigmatising, referring to the social distance they wished to keep with regard to the obese people who were part of the group. Some of them insisted upon the fact that they did not recognise themselves in the excesses described by other participants. This is how Jenifer described her neighbour during the first session; “Even the girl in front of me, I can’t remember her name, who must have eaten – I can’t remember what she ate in the mornings, I was shocked. That’s it, she ate ham and I don’t know what else. Well, she really ate a lot in the mornings – I don’t eat breakfast, and it really shocked me”. Colette, when talking about the other participants during our interview, made it clear that “They aren’t really my kind of people, I have to say”, thus emphasising the distance she kept from other members of the group (and controlling the image she wanted to give of herself to the interviewer). In this instance, the Food Education Programme played the opposite role from the one intended – instead of creating a mutual-support group it began to act as a repellent.

Their relationship to work supplies a key to understanding these women’s approach to weight loss. As Bourdieu (1979) has pointed out, a major divide exists in every social class between women who work and women who do not, resulting in fairly differentiated relationships to their bodies. Here, their weight gain was recent. They saw it as an aesthetic problem which needed to be remedied quickly. Their rapid response to this weight gain, characteristic of middle and upper categories, can be understood with respect to their professional trajectories and aspirations. They held or had held very feminised jobs, more highly-valued socially than the jobs held by the women from the previous group, and for some, this illustrated the fact that they were qualified to secondary or higher levels. Having obtained her Advanced Vocational Training Certificate, Sandrine worked for 5 years as an assistant primary-school teacher until her contract ended a year earlier. Unemployed at the time of the interview, she was considering the possibility of taking up her studies again to become a nurse or to fulfil her dream of becoming a midwife. Régine, 44, a former supermarket cashier, and her daughter Jenifer, 21, had no qualifications. When I met them for the interview, they were unemployed but were embarking on a secretarial course with the hope of returning to the labour market. Colette, 52, had always worked as an occupational therapist’s assistant until she was obliged to stop working following a lung operation. She received a disability allowance, but missed her job and was being monitored for depression. Their approach to dieting came, therefore, at a critical stage in their professional trajectory where each of them was confronted with problems in entering, maintaining their position in or even leaving the labour market. All of them shared the same type of approach to take themselves in hand by formulating professional, training or retirement projects – personal development which also included modifying their appearance and figure.

Culinary Techniques

Other women expressed clearly in the interviews their concern to lose weight on condition that they did not have to deprive themselves of food. They did not set themselves short-term targets and
expressed their aspired clothing size rather than the number of kilos they wanted to lose. Nevertheless, two distinct profiles can be seen among this group; women who were embarking upon a diet for the first time, and those who had experienced “yoyo dieting”. We shall return to this distinction in the following section. When they evoked their earlier attempt(s) to lose weight, they all specified that this did not involve “dieting”. Karima, a home-help in her forties, said “I don’t need to go on a diet. I simply cut out sugar and fat, and started off like that, on my own”. This was also the case for Geneviève, 55, a former medical sales rep who was working for the city council at the time of the survey; “I used the Montignac method for six months, but it’s not really a diet”. By this they meant that for them, the notion of dieting involved a restrictive approach, and they did not perceive their own approach in this way. These statements were the inspiration for this paper – they drew my attention to the fact that the notion of dieting was not socially shared, and encouraged me to continue analysing the interviews from this perspective.

Their conception of dieting was, above all, illustrated by their relationship to cooking. They spent much time cooking, enjoyed eating and had no intention of depriving themselves. The activity of cooking provided the key to understanding their relationship to food and dieting. The importance of cooking may be understood with regard to the close relationships these women, among the oldest of those surveyed, [born between 1935 and 1960] and mostly single (widowed, divorced or separated), continued to have with their children, grandchildren, parents and even ex-partners. In addition to other services (including looking after grandchildren), they continued to take charge of meals at which family members regularly participated, including those who no longer lived at home. For example, Martine, 48, a home-help, lived near her daughter. They regularly invited each other to share meals, and Martine often looked after her grandchildren. Her daughter had a car and took Martine to the shops every fortnight. Geneviève lived alone but went to her son’s house each morning to bring him a meal. Marie-Rose cooked most evening meals for her husband and the two children still living at home, meals at which her elder daughter often joined them with her two young children, whom Marie-Rose looked after. Food served as intergenerational transmission and enabled the continuity of relationships between family members, especially when they were no longer living under the same roof.

With regard to cooking, the women in this group evoked the culinary legacy of their mothers or grandmothers, both in their taste for cooking and in their culinary repertoire. While some of them agreed in thinking that their repertoire was outmoded in terms of nutrition, they claimed to have managed to reconvert to a type of cooking more in line with dominant nutritional standards. For example, Martine explained, “So for years I cooked with butter like my grandmother used to. (...) he [the family’s doctor] told me ‘you’ve got to stop using butter’ (...) so I used margarine, or he told me to use olive oil.” It was also through cooking that they managed to reappropriate and implement some of the information they received during the sessions. Geneviève explained that it was through cooking that she managed to incorporate the information from the Programme into her eating habits, integrating “tips”, methods and recipes. She thus immediately adopted the recipe for “light” béchamel sauce, “for example in the winter, with leeks – instead of making a béchamel sauce with milk, you add a little cornflour into the juice from cooking the leeks and stir it, and it’s true that makes a very good béchamel sauce”. Cookery was the principal vector for incorporating nutritional advice. When they turned to the slimming market, this essentially involved purchasing cooking products – special equipment9 from Weight Watchers and “healthy” cookery books. Some of the women had worked in customer service jobs as medical sales reps or product managers in supermarkets, and this could be observed in their consumption of techniques and body care products, more often the prerogative of higher social classes (Boltanski, 1969).
Discussion

The three types of techniques (physical, dietary and culinary) highlighted in this article thus reveal a certain number of differences in the way in which the women envisaged weight loss – taking action on one’s body (including weight-loss surgery) with no modification of eating habits / strictly limiting food consumption / adapting culinary practices. The three techniques translate in different ways of turning to the slimming market – purchasing products to apply to the body or ingest / consulting a doctor / purchasing cooking utensils and cookery books. They also shape the different relationships within the group and towards the Food Education Programme – perceived as a mutual-support group and used with a view to surgery / rejected as perceived as stigmatising / perceived for what it was – a support.

The three techniques were informative of the different relationships to their bodies, health and food. They may be understood in the light of the social qualities of the women interviewed, who reproduced on their own levels a more general difference between the somatic cultures pertaining to the working class and higher classers. As shown in the work of Boltanski (1969, 1971), the working classes’ use of treatment is of a curative type, and this is how the request for surgery should be understood here. It is required to correct the human body and the weight “problem” with which these women are confronted. Those from higher social classes, on the other hand, consult earlier and more frequently as a preventative measure. Doctors are there to provide “lifestyle guidelines”, in other words, to give advice which may, above all, prevent disease. These two social definitions of health and disease can also be applied to food: “Recognising that there are foods which preserve good health and others which gradually affect it adversely, in a certain way breaks down the boundaries, apparently well-defined for the working class, separating health and disease, by accepting the progressive rather than brutal and accidental transition from one state to another” (Boltanski, 1969: 97). Class belonging, however, does not enable us to understand all the practices connected with dieting. Some of the women in the survey did not fit into this pattern of explanation. In the next two sections we shall demonstrate that in order to understand the different relationships to implementing an approach to weight loss, it is necessary to take into account the effects of social mobility and family relationships.

Class and Social Mobility

Mac Laren and Kuh (2004) have demonstrated the way in which studies of social status in connection with satisfaction with one’s body weight have concentrated on the subjects’ current social status without taking into consideration either the family’s original socio-economic position or social mobility during the subjects’ lifetime. They concluded, notably, that there was no link between midlife body esteem and the adult or childhood social class. This investigation suggests that this relationship should be examined more closely. The case of Naïma provides a very interesting example. Naïma was from an immigrant family from Algeria, aged 45 and married with two children. Her dieting techniques changed along with her upward social mobility as she adopted the techniques and (body) values of the group of which she became a member. The history of her body weight trajectory is distinguished by a period before her marriage, when she worked in a factory. Without qualifications, she gradually rose through the ranks. During this first phase she tried out, from the age of 16, the various physical techniques and therapies mentioned in the first section of this article. She then entered a 2nd phase, marked by rapid social ascension related to her
marriage to a civil engineer. She stopped working and began to consult dieticians and nutritionist doctors, and started to attend Weight Watchers meetings, through which she managed to lose weight. At the time of the interview, she and her husband were running an ambulance transport company. Despite her knowledge of nutritional rules and her applying them to her everyday eating habits, she could not lose weight and hoped to undergo surgery. This is the main reason for which she joined the Programme, on the advice of the surgical team. The successive mobilisation of diverse dieting techniques thus appears to echo her ascending social trajectory. In her case, resorting to a surgical procedure does not come under the category of our initial pattern. Among the candidates for surgery, however, Naïma was the only woman who underwent the operation. Her example would seem to give credence to criticism regarding the moral war on obesity, suggesting that the operation is a reward for those who follow the established rules. Indeed, progressively throughout her experience of dieting and her social ascension, she moved away from her former beliefs about “dieting” as a means to slimming to knowledge about healthy eating as a more appropriate way to control her weight (Chapman, 1999). This is how she described what she had learnt with Weight Watchers: “Actually, it taught me to eat properly; it’s a diet– well, I shouldn’t really call it a diet anymore, but eating habits which I really appreciate because it’s really about eating properly over the long term.” She appropriated the recommendations after an active approach experimenting and acquiring knowledge (Régnier, 2009b).

The case of Martine brings into play the question of intergenerational mobility. We have already discussed Martine in relation to culinary techniques. She worked as a home-help and her mother had been an auxiliary nurse and her father a workman. During the interview she talked a lot about her daughter Ève, with whom she had a very close relationship. Ève, 30, was an executive in an IT company. This represented significant upward social mobility, establishing her as a model for her mother, in particular with regard to the question of eating habits and weight control. Being slim was an essential value for Ève, who thus conformed to the standards of the group of which she was a member and which distinguished her from her original group. We discovered from Martine that Ève watched her figure. After having dieted with Weight Watchers the previous year, she regularly went to a sports club; “She went for a while because she’d put on weight – she weighed 75 kilos and didn’t feel good about herself (…) she had a complex about it, but she’d gone from a size 12 (UK sizes) to a size 16 and she couldn’t stand it. Now she’s a size 10, and she still weighs 63 kilos (…). She wouldn’t wear a swimming costume anymore.” The pressure Ève put on her mother to watch her weight was a driving force and a support in Martine’s approach. It was Ève who persuaded her to enrol in the Food Education Programme; “And one day my daughter said to me ‘well, haven’t you got in touch with the association yet?’”. She had a major influence on regulating Martine’s eating habits, in the form of inverse socialisation. She persuaded her mother to pay attention to her eating habits and transmitted the idea of watching her weight, her knowledge and “culinary tips” such as steaming vegetables and using Weight Watchers’ utensils for fat-free cooking. This example of Martine and her daughter does not only indicate the positive effect of the daughter’s social mobility on the mother’s nutritional standards. This model is made possible by the complicity between the two women. We encountered other women whom the upward social mobility of their children led, on the contrary, to the breakdown of relations between them. In this instance, the conflictual relationships had negative repercussions on culinary practices and the relationship with food and body weight.
**Marital Status and Family Relationships**

It is accepted that family trajectories, particularly changes in marital status, can affect body weight (Sobal et al., 1992, 2003; Lewis et al., 2006). Sobal et al. (2003) have shown, notably, that marital trajectories involving separation or widowhood are associated with weight loss in men but not in women, and they recommend examining more closely “the question of the link between changes in marital roles and body weight” (p.1552). A qualitative approach enables these general trends to be clarified.

In the account of her weight fluctuations, Muriel, 54 and divorced, a former home-help who had been living for several years with a disability allowance, revealed her entire history. During the interview she described the variations in her weight, superimposing the chronology of her body weight history with that of her family history. “At 12, when I went on my first diet, I weighed 55 [kilos], afterwards when I got married I went back to 75; later I lost two little boys and I must have weighed at least 100 kilos. Then I had my daughter and I got even fatter, when I arrived in L**** I weighed at least 130 kilos. Then I slimmed down (…). Then I put on weight again. Then my mother died and I got thinner. Then my father died and I was eating almost nothing. And I felt really bad about myself – that’s when I went through a really bad depression. And now, well, I think I’m a bit better as I’ve put on weight again”. Her account points to two periods. The first, her youth, in which she describes her weight in kilos as it follows the developments of her life – marriage, pregnancies and the death of young children. The second corresponds to her life as a divorced woman, living alone with her daughters; separation, moving house, the death of her parents and depression. Here she no longer describes her weight in kilos but in clothing size (which could be interpreted as a sign of modesty or as a sign of less medical monitoring and a less strict observation of her weight). Unlike the example of Martine described earlier, her relationship with her elder daughter, aged 33, did not motivate her to watch her figure. They did not have a close relationship, even though Muriel looked after her grandchildren on a regular basis. “My elder daughter is 5’9”, and weighs 130 kilos. She never says how much she weighs, but I can see she’s a bit like I was. She’s a size 30. I told her she should ‘be careful’, but she goes ‘Oh, I’m fine, I’m not diabetic or anything.’ She’s young, she’s only 33”.

The example of Muriel reflects numerous other situations revealed in interviews where fluctuations in body weight depending on family incidents were not offset by the intensity of the women’s relationships with their children. In the “Culinary Techniques” group, with similar social and family trajectories, positive or negative relationships with children, particularly daughters (who differentiate themselves, or do not, by their social mobility) help us understand approaches to weight loss. Beyond social origins, these examples show that other criteria come into play, which only a qualitative approach can bring to light. Using case studies, this involves uncovering more general characteristics which could contribute to the understanding of anomalies in body weight.

This investigation would appear to show the prevalence of the medical conception of dieting, based on modifying everyday eating habits. This conception tends to impose a practical framework which may, in certain cases, be opposed to the function and social implications of food for diet candidates. For working-class women, this means denying that food is a vested right which conflicts directly with the principle of restricting food in order to lose weight. The study shows that these differences reflect the effects of belonging to a social class and subdivision of that class, combined with the effects of social trajectory. More generally it should be highlighted how some of our interviewees go through a predictable order of different techniques in parallel with their social trajectory. These
conceptions of dieting and its implementation can be understood with regard to the somatic cultures particular to each subdivision, which reproduce internally the more general differences dividing social groups concerning disease, health and food. Social and family trajectories tend to reinforce these differences, especially when the social mobility of daughters acts as inverse socialisation when they encourage their mothers to adopt their own standards for body weight. As opposed to Great Britain (Defra eg) there is in France an important debate among policy makers to know whether one should target messages at particular groups, but for the moment nothing has been decided in this way. The results of our study bring one more evidence that the same policy should not be expected to work universally.

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References


I will not cite here the huge amount of literature relating to commercial groups such as Weight Watchers. Most articles address how these organisations are run rather than how dieting is managed once the participants have returned home; neither will I discuss the countless surveys and studies on poorer households’ eating habits, as they respond to specific questions which differ from the mines.

However, used to identify deviant behaviour with regard to teenage eating habits, this does not necessarily apply to the population as a whole.

According to the National Institute for Statistics and Economics Studies, a single-parent household includes a single parent and one or more unmarried children (without children of their own).

Type of calf-length trousers made with special material which is supposed to encourage perspiration and drainage.

Shoes, the heels of which are angled in a way that is supposed to work essential muscles to hone the figure.

According to McKie, Wood et Gregory (1993), working-class women in the North East of England made an immediate connection between health and eating habits. While this was not the case for the women I met, they could, however, accurately determine which foods were good and which bad for their health.

Since 2001, a policy of nutritional health has been in operation in France to encourage physical exercise and healthy eating habits, notably with the campaign recommending “5 fruits et légumes par jour”, very similar to the British “Five-a-day” campaign.

This age group is relatively young in comparison with the women interviewed in general. Could this be linked to selection with regard to criteria for weight-loss surgery, or simply to their presence in the marriage market?

This enables food to be cooked without adding fats.

These are products to wear or apply to the body, or ingest in liquid or solid form. They are not foodstuffs, and thus differ from so-called “light” products such as yoghurt or biscuits which are eaten during a meal.

Her autistic son went to a special school every day, several miles from their home. In the course of the interview, she explained having set up this business as essentially to supervise these journeys and the (road) safety of their son.

But could this not merely be a guarantee for doctors that there will not be post-operative complications?
2010


2009


2008


