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Bodies, mothers and identities: rethinking obesity and the BMI

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Abstract Despite the intense level of attention directed towards obesity, there has been limited success in addressing the rising rates of this public health phenomenon. This paper argues that current approaches to obesity fail to consider concepts of embodiment, and in particular, that gendered and class-based experiences of embodiment are ignored in health promotion practices and policies. Drawing on Bourdieu's concept of *habitus*, this ethnographic study sought to locate obesity within the biographies and everyday experiences of two groups of women from differing socio-economic settings. Rather than identify with the clinical category of obesity, these women constructed identities that were refracted through a gendered and classed *habitus*, and in particular, through their role as mothers. Food provision and practices were central to constructs of mothering, and these relational identities were at odds with the promotion of individual behavioural changes. Moreover, these women's daily lives were shaped by different class-based aspects of *habitus*, such as employment. In demonstrating the ways in which obesity is enmeshed in participants' taken-for-granted, everyday practices, we problematise the universality of health-promotion messages and highlight the integral role that the critical theory of *habitus* has in understanding the embodiment of obesity.

Keywords: obesity, embodiment, gender, class, constructions of mothering

Introduction: locating obesity within social structures

It is well documented in the medical literature that those who are obese experience greater mortality and morbidity, particularly from chronic diseases such as cardiovascular disease, non-insulin dependent diabetes and hypertension (*cf*. Kim and Popkin 2006, Olshanksy *et al.* 2005). There is, however, a growing body of work that critiques the seemingly 'neutral' and 'natural' facts which support the language and evidence of scientific discourse. As argued in the recent *International Journal of Epidemiology* and *Social Theory and Health*, the language of the obesity epidemic is 'loaded with ideology and cultural beliefs

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about how we view "fatness"' (Rich and Evans 2005: 347, Campos *et al.* 2006, and for an overview of these debates and their moral assumptions, see Saguy and Riley 2005). In this paper we recognise the importance of critiquing and deconstructing essentialist categories, but also recognise that dissolving categories erases experiences that are produced by these very terms in the daily lives and social networks of many people. Our focus is not on the epistemological debates of biological 'fact' versus social constructionism in obesity discourses, but on the ways in which largeness is embodied, experienced and articulated within gendered and class-based lifestyles.

Despite advances in understanding the physiology and psychology of obesity, prevention and intervention programmes continue to fail. Moreover, as Summerbell *et al.* (2003) state in their meta-analysis, there is very little research evidence of the effectiveness of interventions, thus making it difficult to encourage and economically sustain local initiatives (*cf*. The Social Development Committee of the Parliament of South Australia 2004: 7).

The limited success of many current initiatives, health promotion interventions and treatment strategies may be due to the adoption of a behaviouralist approach to lifestyle modification based on evidence that ignores socioeconomic and lifecourse variables. As Aphramor (2005) argues, the promotion of weight loss 'fails to integrate people's lived experience as gendered, situated bodies in an inequitable world' (2005: 315). In most current approaches, food, bodies and eating are disembodied and disengaged from the social contexts in which people live their lives.

To place food in a social context resonates with Bourdieu's (1979/1984) study of food and social class in France. In *Distinction: a Social Critique of the Judgement and Taste*, Bourdieu argues that food and eating is much more than a process of bodily nourishment; it is an elaborate performance of gender, social class and identity. This performance is central to the *habitus*, a concept which encompasses the implicit practices and routines that structure the logic of everyday life (Bourdieu 1977: 72). Embodiment is central to *habitus*, for it is through the body that one learns the taken-for-granted dispositions of everyday life, such as accents, gestures, and preferences for food, fashion and entertainment (Crotty and Germov 2004: 252). Bodies are thus socially informed, in that the very ways in which people treat and relate to their bodies 'reveal the deepest dispositions of the *habitus*' (Bourdieu 1979/1984: 190).

As Lupton (1996) and other commentators examining the *habitus* of food and eating note (De Vault 1991, Warde and Hetherington 1994), any discussion of food and bodies in the context of families must incorporate an analysis of the meanings around motherhood and femininity, for in 'western societies, the purchase and preparation of food for the family is the major responsibility of women' (1994: 39). While Pocock (2001: 4) argues that motherhood has undergone a 'paradigm shift', and the model that positioned mothers firmly at the centre of the domestic sphere is no longer relevant to some women, women continue to be raised in many societies to be nurturers and are, in heterosexual relationships, taught to first tend to the needs of others and only then of themselves (Counihan 1999: 96, Hartley 2001: 69). Counihan (1989) suggests that food itself is coded as feminine[1] because of this strong association and women's capacity to produce food with their own bodies during pregnancy and lactation – hence the saying 'mother's milk' (1989: 360, cited in Lupton 1996: 109). In addition, the vast literature on the relationships between women, weight and food (see, for example, Bynum 1987, Bordo 1993, Counihan 1999) surely alerts us to the gendered meanings and practices that women give to food and eating. These taken-for-granted practices are learnt and embodied through the internalisation and reproduction of *habitus*. For the women in this project (who were all mothers), food and weight was deeply embedded in their differing everyday worlds.

Habitus is very much determined by the social and economic conditions of its constitution (Bourdieu and Wacquant 1992: 136). In *Distinction*, Bourdieu shows how different classes think differently in relation to food, activity (including different types of exercise) and the body (Bourdieu 1984, cited in Crossley 2004: 240). In terms of food consumption, the French working class were more likely to be involved in physical labour and viewed the body as a machine in which food was a fuel (*cf*. Coveney 2005). The upper classes distinguished themselves by focusing on the tastes and aesthetics of 'light and delicate' foods and styles, a refinement that was reflected in particular bodily dispositions. Class, like gender, is embodied through a socially and spatially located *habitus*, and becomes a marker of identity.

Bourdieu's understanding of the embodiment of class is the reason why we chose two differing socio-economic groups for this project. Understandings of body size, (and indeed the role of food, what constitutes healthy eating, and experiences of mothering) vary amongst differing groups of women. This is demonstrated by epidemiological studies which reveal an inverse relation between obesity and socio-economic status, such that obesity is six times more prevalent among women of lower SES than among those of higher SES (Sobal and Stunkard 1989: 261, Stunkard and Sorenson 1993). This is not to perpetuate the common assumption that people from lower SES necessarily have poorer nutritional status (Crotty and Germov 2004), do not hear health education messages (the so-called 'deaf ears phenomenon'), or do not value education (Crotty *et al.* 1992: 168). Our aim was to compare the dialogical relationship between socio-economic status and obesity across these differing groups of women, in order to explore different embodied dispositions.

Despite what we already know about the prevalence of obesity across differing classes, Najman and Davey Smith (2000) argue that this paradigm is unable 'to be expanded to provide a better account of why these health inequities persist (or, in some instances, are increasing)' (2000: 3). These authors argue for a shift in focus of health inequity research, in which the embodiment of class (a person's historical and socially determined experiences and exposures) takes centre stage. While Najman and Davey Smith take a lifecourse and critical period approach to obesity, their attention to the embodiment of class has striking resonances with Bourdieu's concept of *habitus* and the sociological interrelationships between health, class and the gendered body in the construction of differing lifestyles.

This paper responds to the growing awareness of the need to theorise the relationships between embodiment and obesity. It is via the presentation of two key narratives of women from differing socio-economic locations (and their connections with the other participants), that we demonstrate how obesity is embedded in a complex, relational social structure of gender and class (not to mention location, age, ethnicity and sexuality).[2] Positioning experiences of obesity within a gendered and classed *habitus* is at odds with current health-promotion policies or practices, which do not take account of local and relational worlds. We suggest that this disjuncture is highly problematic for the uptake of health-promotion initiatives and may limit the success of such programmes.

The study

This ethnographic project is part of a broader and ongoing social epidemiology study that is investigating women's health during pregnancy and the growth and development of subsequent children. The cohort comprises 550 women originally selected using a random sampling approach. As a consequence, collectively, the women have a pattern of age, education, family composition and household income which is similar to that seen statewide

for women with babies and young children. In this cohort the participating women had their body mass index (BMIs) recorded.[3] The BMI is calculated by measuring the individual's weight in kilograms divided by the square of the individual's height in metres. A BMI greater than or equal to 25 denotes 'overweight', whereas a BMI of 30 or greater denotes the disease category of 'obesity' (NHMRC 1997: 3).[4] The first 30 women who fulfilled the clinical criteria of obesity were purposively selected from the existing data base and invited (by letter) to participate. Six women declined to participate (stated reasons for refusal included working full time, busy with new baby, house renovations and illness). Women who declined were replaced by the next eligible person. In addition, the group was divided into two differing socio-economic brackets, one group of 15 from lower socio-economic locations, and the other from middle/upper SES (according to standard indicators derived from Census measures (ABS 2001), such as household income, post code, home ownership and education attainment). While there were a number of women from different ethnic backgrounds in the overall group, there was no need to employ interpreters, as their English language skills were excellent.

Women from lower SES households ranged in age from 23–40 years and resided in the outer, northern suburbs of metropolitan Adelaide. Yearly household incomes were less than $25,000. This corresponded to the 25th percentile for household income in Australia (ABS 2003–4). Of the 15 women interviewed, eight were married, two were in de facto relationships and the remainder identified as single parents. A third of the women in this group had three or more children, another third had two children per household and the remainder had a single child. The majority had completed their high school studies at year 10, four participants had completed year 12, and one was currently studying at TAFE. None of these women had attended a tertiary institution. Of the 15 women selected only three were employed in part-time work outside the home. Thirteen culturally identified as Anglo-Australian, with the remaining participants identifying as Lebanese-Australian, and Maltese Australian.

Participants in the second group reported yearly household incomes of $52,000 or above, which corresponded to the 75th percentile for household incomes (ABS 2003–4). Unlike the previous sample group this indicator did not correlate to a specific region of Adelaide, in fact women in this income category were located across the metropolitan area (but with a preponderance to the eastern suburbs). The age of participants in this cohort ranged from 31 years of age to 44 years of age and again the majority of women identified culturally as Australian or Anglo-Australian, with the exception of two; one identified as Greek-Australian and the other Italian-Australian. All were married except for one who classified her relationship as de facto. On average these women had two children per household; two, however, had four children. A key difference in these two groups was highlighted in the education and employment categories. Only one woman had not completed Year 12; all but four had gained a tertiary qualification, and two were currently enrolled in Masters degrees. In our previous group almost all the mothers we interviewed listed their occupation as 'home duties', whereas in this group participants were employed in a range of professions including home duties, university lecturers, nursing, administrative roles, hospitality and research. It was not surprising that this group was more difficult to access as they had extremely active and mobile lives.

Over the course of 18 months we conducted interviews with these 30 women in their own homes (70 interviews in all), collected genealogies and conducted participant observation in their local environments (including grocery shopping, mapping of local neighbourhoods and shopping centres, and joining in on exercise programmes). We often met their children and partners, most particularly in the lower SES group where unemployment was high and

income was often derived from a range of state benefits. Ethnographic methods were particularly suited to this project as they allowed us to explore in detail and at length how people understood and experienced their bodies in a social context.

In summary, we asked participants about the following themes: their memories of food and weight growing up; the embodied experience of eating and being large (including pregnancies); the meanings and symbolic language of food; and the relationships of these experiences to motherhood.[5] Each participant was interviewed twice (and sometimes three times) in order to develop and compare emerging themes. Interviews were taped and transcribed (along with fieldnotes) and thematic and narrative analysis (*cf*. Good 1996: 139) was undertaken. The interviews took the form of narratives, in that we were interested in placing the meanings of food and bodies within discourses of motherhood, rather than decontextualising obesity as an individual behaviour or pathology.

The approach we have taken in presenting this research follows narrative analysis. Unlike the clinical taking of medical histories in which disease is located within body systems only understood by experts (Bury 2001: 266), narratives, and narrative analysis, focus on the relationships between body, self and society. As Good (1996) points out, 'narrative is a form in which experience is represented and recounted, and in which events are presented as having a meaningful and coherent order' (1996: 139). Careful analysis of narratives thus allows one to show how meaning is created . . . [and] how cultural values and social relations shape the experience of the body (1996: 142). While there is considerable attention to narrative analysis in the humanities, social sciences and medicine, the focus is on illness narratives (*cf*. Kleinman 1988, Charmaz 1991, Kelly and Field 1996), and most particularly on chronic disease. As described below, the women in this project did not consider themselves to have a disease or illness, but through narrative revealed how differing discourses of motherhood were directly related to their own experiences of embodiment.

Presenting the detailed narratives of two women (with supporting ethnographic material from other participants) allows us to examine and understand how they interpret and explain their bodies, and the biographical context of these experiences. These particular narratives were chosen as they are typical of other biographies in the study, in that they reveal how biographies and practices are embedded in local contexts. Moreover, these narratives contain crucial, context dependent elements which highlight and support the theoretical premise of this paper, that is, how obesity is embodied differently according to gender and class.

The embodiment of obesity in biography and everyday practices

While all these women had recorded BMIs that located them within the clinical category of obesity, not one of them identified as obese. This may not be surprising considering the profound social stigma attached to obesity (Sobal 2004), yet the small number who were aware that they did fit into this category (having calculated their own BMI), were shocked to think that they might be called obese.[6] To be labelled as obese was at odds with their own experiences of body size and weight. Josephine, a 23-year-old single parent with one child from the lower SES group, had encountered a chart at a doctors surgery that outlined ideal heights and weight. She recounted her horror at realising that she matched the criteria for obesity:

> They've got their ranges of what you should be. Now I'm classed as being obese. If you look at the scale, I'm classed as being obese. At any doctor's surgery they've got posters

> up with the healthy weight range I think it's called, and as far as I'm aware I'm classed as being obese. I wouldn't have thought I was obese until I saw that chart. I would've said overweight but not obese. To me, obese is huge.

Josephine's comments echoed the sentiments of other participants who did not identify with cultural or medical representations of the obese body. Obesity was regarded as the grotesque 'Other', as 'reckless excess, indulgence, lack of restraint, violation of order and space and transgression of boundaries' (Braziel and LeBesco 2001: 3, *cf*. Aphramor 2005: 334). The language that participants preferred to use when describing their own body shape, and which distanced them from the cultural horror of corpulence, was 'overweight', 'chubby', 'fat', 'big boned' and 'cuddly'. Rather than align themselves within a medical discourse of disease or a stigmatised social category, these women placed their experiences of weight within much broader narratives, in which prominence was given to their own life histories and gendered relationships with families, food and changing experiences of embodiment.

Both groups of women located their understandings and experiences of food within their *habitus*, that is, within a particular socio-economic environment. Those from the first group often recounted biographies of food insecurity, poverty and neglect; experiences that profoundly affected the ways in which food and nurturing now featured in their own families. Many of these families were employed by local industries (such as the automotive or food industry) and spent their working lives as shift workers. Coupled with low wages for unskilled and semi-skilled labour, shift work has a significant impact on nutrition and family dynamics, making it difficult to prepare food within a structured time frame. While meanings and experiences of work vary greatly, Devine *et al.*'s study (2003) of the relationships between work and food choices in differing income households in Upstate New York reveals that working conditions associated with lower-paid jobs (such as inflexible hours, multiple jobs and shift work) create barriers to family nutrition and healthy food choices. Similarly, in our study, class was a central factor in people's food choices and histories of obesity. Class-related factors such as workforce participation (and unemployment), number of children, availability of resources, and family roles were all intimately connected to experiences of obesity.

The women from the middle to upper SES did not recount biographies of food insecurity, but lifestyles in which attention to the body was much more paramount. There were constant discussions of the need to modify the body through dietary and exercise regimes (such as trying a range of diets, and attending diet and/or gym groups). As with the first group, their experiences were embedded in class-based *habitus*, but they described their bodies as aesthetic objects that could be consumed as cultural capital. These women, although constrained by an economy of time, articulated a knowledge and desire of the investments required to produce a body that accorded with their lifestyle.

Gender relations: being a 'perfect (and proper)' mother

The relationship between identity, motherhood and bodies was most strikingly exemplified by Tessa. We first met Tessa in her family home in a low income, northern suburb of Adelaide. She greeted us at the door with a cigarette in hand and led us straight down a corridor to the light blue, open plan kitchen. This was her stage for the next two hours, and indeed for every time we met. Tessa would stand one side of the kitchen bench, while we, the audience, sat perched on the other side on a high stool, with the hanging pots and

pans mimicking the stage's curtain. 'This kitchen', Tessa said, 'is my life'. We learnt how her experiences of weight gain and weight loss could not be disentangled from her life history, and her upbringing had a direct relationship to how she sees her own role as a mother, her relationship with food, and with her body.

Tessa spent her childhood with her mother and 2 other siblings. This period was marked by constant moves (32 in all), of being woken in the middle of the night, told to pack her few belongings and being bundled onto Greyhound buses. The family would often be fleeing their estranged father, her mother's abusive boyfriends, or moving to promises of welcoming aunts and uncles (which was never the case). 'No-one ever welcomed us', Tessa lamented, 'we were the 'blow-ins', the kids who didn't belong anywhere and slept in people's lounge rooms or lived in caravans'. She described her mother as a 'fruit loop', a psychiatric nurse high on sedatives and unable to care for herself or her children. She worked night duty, and the children were left to fend for themselves during the day, sneaking into the caravan during the day to grab a packet of Continental chicken soup, jelly crystals, or weetbix topped with tomato sauce. This is what Tessa remembers as being her staple diet, and as a consequence she described herself as a scraggly and sickly child. As Peel (2004) suggests, in providing intimate portraits of hardship, people from lower classes often begin their accounts with the frailties of their impoverished bodies. Through embodiment of *habitus*, bodies tell stories of poverty.

Being the eldest daughter of the three children, Tessa said that she was the one left at home to look after her mother, 'to make sure she didn't burn herself with cigarettes, make sure she didn't pour hot coffee down herself, or burn the place down . . . that was my job and I resented it'. From an early age, Tessa was responsible for caring for her mother.

This backdrop of extreme poverty and lack of care was the platform for Tessa's own experiences of motherhood at 19. Being pregnant was Tessa's new identity, and she was extremely proud of her new-found status as a pregnant woman. It was here that her weight pattern started to change and she overcompensated for her own mother's neglect by taking the adage of 'eating for two' literally, an overcompensation that continued when her first daughter was born. Pregnancy, as Counihan (1999) notes, allows women to 'be ample', and free of the negative societal gaze that comes with being overweight (1999: 201). Still at home with her own mother, Tessa desperately wanted to be what she called 'the perfect mother' (as an antithesis to her own mother), and demonstrated this by pureeing foods for her daughter from scratch, never allowing her daughter to feed herself, nor allowing her to get dirty playing outside.

Several years later when Tessa had moved away from her mother, she met and married an older European man, and they had two more children. Tessa took her role of mothering very seriously; she learnt to cook and found that she was driven to 'stock up the pantry', so much so that it would 'groan' with the weight of food she stored. During this time her weight fluctuated and, as with her experiences of pregnancy, she related it back to her childhood of neglect. In her family, food preparation, eating and weight was symbolic of nurtured, social relationships.

Like all the mothers in this project, with one exception, Tessa is adamant that her role as a mother is *the* first priority, and that she will always provide a stable 'home life' for her children with 'three square' meals a day. She is the 'proper mother', the mother who does not work (and is disparaging of mothers who do), and who is always home when her children return from school. It is through food that Tessa achieves this gendered and relational identity (both cross gender and same gender). She prepares two hot meals a day (one for her husband who comes home from work for lunch and the other each evening). Hot, cooked meals, as Murcott (1983) and De Vault (1991) note, are, through their lengthy

preparation, redolent of emotional caregiving. Unlike her own childhood experiences, Tessa would never serve food to her family from a tin (such as spaghetti or baked beans), and prides herself that her meals are made 'from scratch'. These meals bring the family together around the kitchen table each day, and are symbolic of an identity linked to a lifetime relationship with food. In many ways, Tessa's serving of food reflects Mauss's (1990) classic definition of the gift, in that the food creates and sustains caring relationships between people and displays an ethos of care. Moreover, as Tessa prepares foods for her family in *her* kitchen space, she reaffirms her concept of self and sense of identity as a mother and wife.

Tessa's weight did not feature prominently in her narrative construction of self. In fact, to be worried about her weight was at odds with her relational sense of identity, in which care for herself was at the bottom of a hierarchy of concerns. Clinically Tessa would be labelled as obese, but to suggest to her that she 'eat less and exercise more', ran counter to her own understanding of the symbolic nature of food and her gendered role in caring for the family.

Leanne similarly recounted a biography of itinerancy and disruption, in which her 'alcoholic step-father' would leave her and her sisters in the car on weekends whilst he spent the night at the local pub. He would slip money to them through the car window to buy their dinner at the local hamburger outlet, and the girls would often 'bunk down' in the car until he re-appeared from his drinking. Leanne later told me how this man had sexually abused her, and she fled home at 14 years of age. She describes her large body now as 'resilient and solid', a frame that can provide a safe environment for her own children. For Leanne, Tessa and many of the other women in this project, their bodies held deeply engrained histories and meanings that could not be explained or reduced to biological reasoning (*cf*. Larkin *et al.*, 1996). These bodily dispositions were gendered, and body size was understood and interpreted within a gendered *habitus*. For Tessa and Leanne, to be 'cuddly' or 'chubby' was very much a part of their relational and celebrated identity as a mother, and helps to explain why they did not identify with a decontextualised pathology of obesity.

Classed gender relations: time and the production of aesthetic bodies

As discussed earlier, mothers from differing socio-economic locations had differing commitments in terms of paid work and lifestyles. Those from the middle to upper socio-economic groups did not recount childhood experiences of neglect like Tessa or Leanne, but accounted for their current weight in terms of a different discourse of motherhood – the juggling/balancing act. This is not to suggest that mothers from working class backgrounds did not similarly juggle their family and work lives, but rather that women who had access to other opportunities (such as education) added these commitments to an already full schedule.

Denise exemplified those women who juggled the work/life balance. Our first interview took place shortly before Christmas and she proudly showed us the large Advent calendars that she had just finished making her children. Each calendar had small pockets for each day leading up to Christmas that Denise had filled with an assortment of 'goodies'. Like Tessa, Denise considered being a mother and looking after her kids 'the number one priority'. Being a mother was positioned at the top of a complex hierarchy that required Denise to balance work, relationships and personal time with the needs of her family. Denise is 37 years old, she works and studies part-time, and like Tessa, is highly organised, confident and quick-witted. Denise lives with her husband Richard and her two young

children in the foothills of Adelaide's southern area in a comfortable modern home that they built nine years ago. She has lived in this vicinity all her life and describes it as a 'nice, safe community', where people still walk past you in the street and say hello. It is conveniently located for health services, educational facilities and a major shopping centre, and close enough to both sets of parents to access their help with child care if needed, but not too close 'to be living in their pockets'.

Memories of eating with her own family begin with Denise describing herself as someone who was happy to sit quietly at the dinner table and 'eat everything in sight', while her sister Caroline would 'pick' and 'fuss' over her food. Her family maintained traditional gender roles in the preparation and serving of food – her mother cooked all the family meals and her father made pancakes or cooked barbecues at the weekends. Dinner usually consisted of meat and three vegetables, a tradition inherited from Grandma, and was always eaten at the dinner table, which Denise and her sister would set on alternate nights. Eating dinner together fostered communication and conversation and it was 'the only time they would all be together'. Commensality in this context is 'a sign and an affirmation of intimacy' (Okely 1983: 84), and maintaining this mealtime ritual affords Denise and Richard the opportunity to prioritise their own time together as a family. Previous research conducted amongst large-bodied women found that participants are often excluded from the social world of food (see Carryer 2001: 91); Denise's case, however, demonstrates that food and sociality in a variety of contexts are actually central to her daily relations with her family.

Denise described her role in the family as 'everything' and when asked if she prepared the meals she replied, 'no one else was going to do it'. She keeps a basic food plan in her head because she doesn't have time to write it out, and the type of meal the family eats depends upon the time she arrives home from work. Denise prefers 'quick meals', such as stir fries, to minimise time spent in the kitchen and tries to shop for meals that the 'whole family can eat' to avoid cooking multiple meals.

Paid work outside the home has been central to Denise's identity since she started her first part-time job during high school. Her current position as a part-time lecturer follows a period of unemployment. Previously, a major bank employed Denise, but her position was made redundant shortly after the birth of her first child. Denise described this brief period of unemployment as 'terrible' and a 'big heartache' because she could not contribute financially to the family. Although she cites being a mother as her most important role, she describes herself as not the 'type of person' who can be a full-time mother focusing her whole life on her children. Denise prefers the freedom that working part time affords her so she is able to help at school and go on excursions with her kids. Denise, however, admits that the demands of motherhood and the demands of part-time work are a combination of 'walking the fine balance all the time', and 'juggling lots of balls'. Denise epitomises what Pocock (2003) refers to as the 'work/life collision', where changes in work patterns and family structures have not been met by similar adjustments to the labour market. The result is a lack of time and constrained social relationships.

To 'keep the balls juggling in the air' Denise had developed a systematic hierarchy of roles in descending order of importance to counteract and neutralise the impact 'dropping a ball' would have on her family, work and personal life. This meant placing her role as a mother first, followed by her work, her study, immediate housework (this involves cooking and making beds) and other duties (this is general housework). At the bottom of her hierarchy was three hours a week to herself to attend painting classes, this she noted 'suffers some weeks', and as a final note Denise mentioned that she doesn't exercise as she has 'no time left' (although her husband has time for regular exercise). Although Denise

was comfortable negotiating multiple roles in both public and private spheres, she measures these against the losses of intimate time with Richard, time for herself and the impact this has on her body size.

Having 'no time left' for exercise was what Denise saw as a major hurdle to losing weight, a concern shared by many paid working women in this project. While they acknowledged that they would like to lose weight and they had the financial means to 'just join a gym' or an expensive weight loss programme (unlike the women from the lower SES group), taking time away from their children to exercise was not a priority, and indeed was represented as selfish. This theme was repeated by Kelly, a 33-year-old mother of three, who said that since becoming a mother she had shifted the focus from 'herself' to her children, and worrying about her weight only absorbed 'precious time and energy' she wanted to share with them.

Despite the lack of time, the women from this SES had greater access to the development of particular bodily forms and lifestyles, that is, to the production of cultural capital. This was reflected in their knowledge of nutrition, and public health messages, such as the benefits of 'healthy' foods and exercise. As Williams (1995) notes, this reveals the class-related *habitus* at work where a concern to cultivate the health-orientated body is writ large. Middle to upper class groups, he argues, 'tend to be less concerned with the production of strong, physical bodies, instead seeking to cultivate slim, trim bodies which relate to the chances of material or symbolic profit that can reasonably be expected within a labour market which valorizes physical appearance and presentation of self' (1995: 595). Indeed, for the women from the higher SES in this project, there was strong acknowledgement of what their social milieu expected – the pressure to 'stay thin'. This acknowledgement of the type of desired body was not similarly reflected in the lower SES group.

Despite the pressures and expectations to produce certain bodies, participants in the higher SES group spoke of caveats to producing stylised bodies that related to discourses of ill health. This pressure to 'stay thin', and the gruelling techniques sometimes employed by their friends to remain thin, was described as unhealthy or even dangerous, in that this behaviour might lead to anorexia or bulima. Cassandra, a 44-year-old mother of two observed that the 'ideal beauty' embodied by the thin, young mothers who would arrive in their 'gym gear' to collect their children from the school her daughter attended, only encouraged their children to 'obsess about their weight' at an early age.

Rich *et al.* (2004) have already noted the damaging implications of the obesity discourse and its associated self-surveillance in their research with school-aged children. Echoing Cassandra's concerns, they found that school responses to the 'obesity crisis' actually propelled some young women towards disordered eating, and other forms of ill health and negative body-self relationships (Rich *et al.* 2004). Similarly, Denise felt that teaching her children, and particularly her daughter, to be healthy had more to do with 'eating well' and 'being comfortable with yourself' than with being thin.

For all of the women involved, the foundational mantras of many popular weight loss programmes (which are echoed in national policy directives) of 'eat less and exercise more' do not take into account how an individualistic model fits into women's relational lives. Recounting stories about her struggles with weight loss, Denise told of her experience at *Weight Watchers* that highlighted the unreal expectations of women to conform to particular body sizes. This involved a regular 'weigh in' at which you were 'given a rap over the hands' if you hadn't achieved your target weight. In addition, many commented that not being able to share food with their families at meal times was problematic, as to refuse food or not partake impacted on commensality and set up gendered patterns of family eating which some participants were explicitly trying to avoid.

Carryer (2001) suggests that both the media and medical discourses (in particular genetic discourses) explain and represent body size in particular ways (2001: 91). If we consider Josephine's earlier comments on obesity, and popular representations of obesity, we could conclude that obesity is associated with chronic illness, laziness, disorder and a body out of control. Yet the narratives we collected challenge such stereotypes, particularly for the women from the lower SES locations. Like many women in this project, Denise is highly organised, busy and very much in control of the various demands on her time. Continuing with Pocock's argument, Denise's narrative supports the position that:

> The self sacrificing ideal of traditional motherhood has given way to a much more diverse set of possibilities, but the hangover of the self-sacrificial mother-model means that most of these possibilities are lived out by women amidst an epidemic of guilt . . . and internal and external conflict. (2001: 5)

Conclusion and implications

In this paper we have taken a much broader approach to women's relationships with food and their bodies, and contextualised them within embodied histories and everyday practices of motherhood. Participants directly linked food to what it was to be a mother; of changing body shapes (and indeed their own mother's and grandmother's shapes), of the central and reciprocal role of nurturing through food, and the multiple responsibilities that managing a family entails. Mothering is fundamentally relational, and at odds with the individualistic approach of current health-promotion messages and directives that address energy in/energy out understandings. Participants found it difficult to act on health promotion initiatives as their relational identity put individual needs as a low priority. Finding time to exercise was difficult in a family context where young children and/or work took priority. Moreover, for many women, 'being chubby and cuddly' was seen as inseparable from some very positive aspects of what it was to be a mother.

The low priority of weight loss was not only related to gendered *habitus*, but also to the differing class *habitus*. This was particularly salient for the women from the lower SES group as they did not have the financial resources to join weight loss and exercise programmes, or to purchase more expensive foods that were perceived to aid weight loss (such as lean meats or low fat products). Nor did they feel safe walking alone in neighbourhoods where there were no street lights or pavements. As the very first participant commented, 'when you are struggling to raise a family on your own, weight loss is not a priority.'

It is surprising, given the literature on women's relationship to food and weight (and the ways in which they are judged more on their appearance and weight than men (Sobal 2004)), that there is limited acknowledgement of gender in the obesity literature. Gender, of course, is not simply equated with women, and the growing literature that examines the relationships between men and their bodies also highlights some clear differences in the gendered consumption and embodiment of food and body shapes (Monaghan 2005a, 2005b, 2005c, 2006). In terms of women, popular discourses continue to privilege and validate the slender female body, and the pursuit of bodily perfection in this particular social milieu 'pathologises and stigmatises fatness' (Carryer 2001: 90). Moreover, 'the rich diversity of female shapes, the association of body fat with women's sexuality and the natural increase in weight with age has been rendered inherently problematic' (Carryer 1997: 107) by the medicalisation of obesity.

How then, might a focus on the embodiment of gendered and class-related lifestyles impact on health-promotion practices and policies related to obesity? Currently, gender is

implicit in Australia's latest policy document *Healthy Weight 2008, Australia's Future* (2003). This policy is strategically targeted at children, young people (aged 0–18) and their families in an attempt to focus on prevention and health promotion from an early age – 'starting at the very beginning of life with breast feeding' (*Healthy Weight* 2008: 3). The national strategy aims to support young people and families both in the home and in the wider community, in contexts such as child care, schools, maternal and infant health, and family and community care services. Although not explicitly stated, it is women (as primary school teachers and child care workers), and particularly mothers, who are at the forefront of these strategies, as they are the household and community members who are most actively engaged in, and organising, the day-to-day nutrition and activities of young children.

While this focus on macro-environments is a positive move away from individualistic models of conceptualising obesity there are inherent dangers in positioning women as central to this campaign. Because mothers are at the forefront of the domestic sphere there is potential to blame them for childhood obesity.[7] The recent case in the UK of a group of mothers delivering fast food lunch orders to children through the school fence demonstrates the dynamics (and contradictions) of blame. These mothers were acting in defiance of a healthy canteen initiative and resisting policies that undermined their status as responsible, knowing, primary care givers – in effect, labelling them as 'bad mothers'. When parents (and mothers in particular as primary care givers) show a lack of support for healthy eating practices, one needs to address issues of identity and authority that may be unwittingly undermined by the very health promotion initiatives that are designed to assist them. This case illustrates what we argue in our study; that understanding different constructions of motherhood and the positive values associated with caring and nurturing through food is crucial for health promotion programmes.

Examples such as these suggest that it is no longer possible to ignore the gendered and class dimensions of obesity. A gendered and class analysis of obesity provides a different entry point for examining 'obesogenic environments' (Egger and Swinburn 1997) by pointing to how social meanings and practices are embodied and reproduced in everyday lives. In attempting to change engrained dispositions that are often reproduced over generations, health promotion practices and policies rely on simplistic and individualistic solutions that are unlikely to be effective in the long term (Banwell *et al.* 2005: 567). Obesity is a complex social issue (or as Crossley (2004) suggests: 'fat is a sociological issue'), and we need to seriously consider how health is fundamentally refracted through social structures. It is the task of social scientists to use critical theory in this debate and put the social relations of gender and class (and ethnicity) on the agenda of obesity research and policy.

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Notes

1 However, ethnographic data clearly reveal how masculinity and femininity in cross-cultural contexts are associated with specific foods.
2 Obesity is coded with somewhat different meanings depending of gender. Women, in particular, are subject to stigmatisation and social opprobrium if they are obese, to the point that they are less likely to be employed in high status jobs (Rothblum 1992, cited in Lupton 1996: 139)

3 It is important to note that such a measure is based on a universal Western 'body' and may not be applicable to a range of bodies that are constructed, both biologically and culturally, as different.
4 While we recognise that prevailing understandings of 'overweight' and 'obesity' as measured by the BMI are contested and problematic (*cf*. Campos 2004, Flegal *et al.* 2005, Gard and Wright 2005), for the purpose of this study, BMI measurements were used to select participants from a larger epidemiological sample. As argued, we were not interested in qualifying these biomedical measurements, but rather in unpacking some of the assumptions associated with their predominance, by exploring how participants understood and experienced their own bodies.
5 We did not begin our questions asking participants about their experiences of obesity as the stigma and shame associated with this category meant that sensitivity was required.
6 It is not surprising that people have different understandings of what their body weight or body image is. Flood *et al.* (2000) found that self-reporting overweight and obesity in populations yields inaccurate results, as people tend to underestimate the true prevalence of obesity and overweight.
7 As Rogers (2006) argues, this blaming takes no account 'of the social context in which parenting takes place, such as the pressures exerted by television advertising or the lack of safe, appropriate open spaces' (2006: 353).

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