

Body Dissatisfaction, Concerns about Aging, and Food Choices
of Baby Boomer and Older Women in Manitoba

by

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ABSTRACT

Body image plays an important role in the lives of women. Perceptions and attitudes towards the body can influence one's emotions, health beliefs, self-esteem, and behaviour. Body dissatisfaction (BD) is highly prevalent among women in Western cultures and has been shown to persist throughout the lifespan. Past studies report that 60 – 80% of middle-aged and older women express some degree of BD. As the Canadian population ages and rates of overweight/obesity continue to rise, more and more women will be unable to meet society's narrowly-defined standards of thinness and youth. With the increasing pervasiveness of Western mass media and the continued expansion of the weight loss, dieting, and anti-aging industries, BD among middle-aged and older women is expected to increase. Baby boomers (born 1946 – 1965) are an interesting, unique, and influential demographic group, yet their body image, aging and food experiences remain largely unexplored. The objectives of this research project were to (1) explore perceptions and experiences related to body dissatisfaction, aging, and the use of body work practices among baby boomer and older women; and (2) explore healthy eating attitudes and barriers, food choice influences, dieting behaviours, and food product usage/attitudes among these women. Fourteen focus groups, each with 7 – 12 women, were held in urban and rural areas of Manitoba (n=137). Half were with baby boomer women (ages 45-65) and the other half were with older women (ages 66 and older). Participants also completed a self-administered questionnaire and anthropometric measurements (height and weight).

It was found that body image, aging and food were intimately connected in women's lives. Feelings about the body were closely connected to the experience of aging and perceptions of the body directly influence food choices and attitudes. Overall, BD is a salient issue for baby boomer and older women, especially when framed in terms of weight. In an effort to alter their appearance and/or control their weight, many women were engaging in a variety of body work practices, including dieting. Healthy eating was very important for these women, yet many experienced numerous barriers that interfere with their healthy eating and/or weight loss goals. When it came to their food choices, these women valued natural, wholesome and unprocessed foods and were seeking healthy, simple foods that taste delicious and provide good value for their money. These women held very particular attitudes towards local, organic, functional, and diet food products. Overall, food and eating issues, coupled with concerns about health and aging, caused a fair amount of tension, stress and anxiety in their lives. This thesis adds value and insight to the existing literature by exploring the connections between aging, food, and the body, from the perspectives of baby boomer women and their older counterparts. The findings of this study have important implications for health care professionals, community programming, and the local Manitoban food industry. Overall, there needs to be an increased awareness of the body image issues, aging concerns, and food attitudes of baby boomer and older women.

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List of Copyrighted Material

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LIST OF ABBREVIATIONS

AA	Anti-aging
BB	Baby boomer
BD	Body dissatisfaction
BMI	Body mass index
cm	centimetre
ED	Eating disorder
FF	Functional foods
kg	kilograms
g	grams
m	metre
MWI	Manitoba Women's Institute
OW	Older woman
PHAC	Public Health Agency of Canada

CHAPTER 1

Introduction

Overview of Problem

Women today live in a complex socio-cultural environment that presents many challenges to health and well-being. The surrounding food environment is rapidly changing, roles and expectations of women are evolving, rates of overweight and obesity are increasing, and societal standards of female beauty are becoming increasingly difficult to achieve. These and other societal influences combine to create an environment that promotes body dissatisfaction (BD) and a fear of aging.

Rates of overweight and obesity among Canadian adults have been increasing over the past several decades. From the late 1970s to 2004, obesity rates nearly doubled among both males and females (Tjepkema, 2006). More recent data from the 2008 Canadian Community Health Survey indicates that well over half of the adult population (62.1%) is overweight or obese ($\text{BMI} \geq 25.0 \text{ kg/m}^2$), with approximately one-in-four adults (25.4%) falling into the obese classification (Public Health Agency of Canada [PHAC], 2011). Across the country, the prevalence of obesity seems to be highest among adults in the middle to late stages of life (ages 35 to 74 years) (PHAC, 2011). The high rates of overweight and obesity among Canadian adults is a major public health concern, given that obesity has been associated with many chronic conditions, including cardiovascular disease, hypertension, type II diabetes, and certain cancers, and may increase the risk of premature mortality (PHAC, 2011). It has been estimated that obesity costs the Canadian economy between \$4.6 to \$7.1 billion dollars on an annual basis (PHAC, 2011).

While the causes and contributors of obesity are multifaceted and complex, researchers in the fields of nutrition and public health have long recognized the changing nature of the Canadian food scape as an influential factor. Put simply, Canadians are living in an ‘obesogenic’ food environment that promotes sedentary lifestyles, excessive food intake, and over-consumption of readily available energy-dense, nutrient-poor foods (Slater et al., 2009; Monteiro, Moubarac, Cannon, Ng & Popkin, 2013). Individuals and families are eating more of their meals outside the home and are increasingly relying on ready-to-eat commercially prepared meals and snacks to meet their nutritional needs in a fast-paced, time-crunched lifestyle (Slater et al., 2009; French, Story & Jeffery, 2001). Meanwhile, portion and package sizes continue to get larger, fast food franchises continue to expand all over the country, food advertising has become more seductive and influential, and there has been an explosion of ‘ultra-processed’ foods into the Canadian marketplace (Slater et al., 2009; Monteiro et al., 2013; Moubarac et al., 2012; French et al., 2001). These consumption trends, which are expected to continue, can partly be attributed to “lack of time to prepare food, women working outside the home, waning food preparation skills and aggressive promotion of low-nutrition foods” (Slater et al., 2009, p. 2222).

At the same time, we have seen the emergence of an ‘orthorexic’ society, whereby individuals are encouraged to take charge of their own health and experience profound moral pressure to achieve a healthy diet and an acceptable body weight (Rangel, Dukeshire & MacDonald, 2012; Nicolosi, 2006). Prevailing discourses in nutrition education and health promotion continue to promote an ‘individualistic’ lifestyle approach that places the blame and responsibility for weight/health issues on individuals,

while reinforcing a culture of self-surveillance, slimming and dieting, largely directed at women (Germov & Williams, 1996; Rangel et al., 2012). The message ingrained in Western mass media is that thinness equals better health, happiness, and success, and the way to thinness is through controlling one's food intake. A thin body (which, at one time, signified poverty and lower social status) is now associated with positive characteristics of youth, health, intelligence, self-control, and discipline. On the other hand, fatness is seen as a "sign of moral and physical decay" (Bell & Valentine, 1997, p. 36). Using the terms 'obesity epidemic' and 'war on fat' to promote their message, health reporters inform us that eating is at the heart of disease, obesity is simply caused by self-indulgence, and that our issues with weight result from lack of self-discipline and willpower (Poulton, 1996). In response to these strong sociocultural messages surrounding food and the body, there has been an influx of 'health foods', detoxes, cleanses, natural health products, functional foods, nutraceuticals, diet supplements, and weight loss plans into the consumer marketplace. As new food products splashed with health messaging continue to flood the supermarkets, many women feel overwhelmed by a food system that is "increasingly complex, contradictory, and opaque, and where commercial dietary regimes offer quick yet incomplete solutions" (Rangel et al., 2012, p. 124).

As our food environment evolves and as Canadian women get larger and heavier, the *ideal* female body, as portrayed in media and popular culture, is getting smaller, thinner, younger, and less curvy (Wiseman, Gray, Mosimann & Ahrens, 1992; Stephens, Hill & Hanson, 1994; Fey-Yensan, McCormick & English, 2002; Borland & Akram, 2007). In today's society, individuals of all ages and genders are bombarded with images that glorify youthfulness, messages that tie self-worth to thinness, and products that

promise youth and beauty forever. From a young age, girls are socialized to believe that their body is an aesthetic object that must be constantly monitored and ‘fixed’ in order to be socially acceptable (Franzoi & Koehler, 1998; Paquette & Raine, 2004). Throughout the course of their lives, women learn that youth is beauty, appearance is a crucial component of self-worth, and that their social value is largely determined by their level of attractiveness (Tiggemann & Lynch, 2001). The pervasive nature of Western mass media results in the acceptance and internalization of these gender norms and ageist stereotypes (Tiggemann, 2003; Grippo & Hill, 2008).

All of these strong socio-cultural messages place extreme pressure on middle-aged and older women, who are experiencing age-related changes in appearance (e.g., wrinkles, weight gain) that move them further from the socially-constructed ideal of female beauty. As a result, many middle-aged and older women (60% to 80% in some studies) express some degree of body dissatisfaction (Mangweth-Matzek et al., 2006; McLaren & Kuh, 2004). The rapidly growing beauty, weight loss and anti-aging industries capitalize on women’s body image issues by offering a myriad of solutions to help women ‘fight’ aging and correct bodily ‘imperfections’ associated with getting older (Franzoi & Koehler, 1998; Saucier, 2004). In an effort to maintain their identity and status in an appearance-based society, many middle-aged and older women adopt a variety of body work practices, including cosmetics, skin creams, fashion, surgeries, exercise programs, and fad diets. The concomitant body image issues can lead to social withdrawal, lower self-esteem, mood disorders, and disordered eating, all of which can have a negative impact on the quality of life and nutritional status of aging women (Marshall et al., 2012).

Study Rationale

Baby boomers (individuals born between 1946 and 1965) are Canada's largest demographic group. In 2011, there were 9.6 million baby boomers in Canada, accounting for approximately one-third of the total population (Statistics Canada, 2011). As baby boomers turn 65 years of age, the senior segment of the Manitoban population is expected to swell from 13.2% to 24.5% between 2005 and 2036 (Turcotte & Schellenberg, 2007). Women represent a notable proportion of the Canadian older adult population, partly due to longer life expectancy than men (Statistics Canada, 2012a). In 2001, 60% of adults ages 75 to 84 and 70% of adults ages 85 and older were women (Health Canada, 2002).

Baby boomers were raised in a period of economic expansion and affluence following World War II (Pak & Kambil, 2006). They are generally better educated, more likely to occupy professional and managerial positions, and have larger disposable incomes than previous generations (Adams-Price, Turner & Warren, 2013; Keister & Deeb-Sossa, 2001; Pruchno, 2012; Frey, 2010). Notably, women in this demographic group achieved higher levels of education, greater participation in the workforce, and higher earnings than their mothers (Keister & Deeb-Sossa, 2001). Baby boomers are also very health conscious, aware of nutritional strategies for chronic disease prevention and self-improvement, and are more likely to use alternative and complimentary medicines (Weiss, 2002; Lipschultz, Hilt & Reilly, 2007; Traynor, 2009; Thornhill, 2006; Frey & DeVol, 2000; Mellor & Rehr, 2005). Given the size, economic affluence, and unique characteristics of this cohort, the aging of the baby boomers will have vast implications for Canadian society. In fact, researchers and gerontologists recommend that issues

affecting the health of aging baby boomers be addressed as soon as possible (Wang, Worsley & Cunningham, 2009; Saucier, 2004; Paxton & Phythian, 1999). Despite this warning, there is little research examining the health and food-related beliefs, attitudes and behaviours of the baby boomer demographic group.

Health is a broad term that encompasses many different factors and variables. We now know that body image and health are closely entwined, especially among women (Grogan, 2006; Lewis & Donaghue, 2005). For example, a woman's perceptions and attitudes towards her body can influence her emotional state, self-esteem, self-identify, and health behaviours (Liechty & Yarnal, 2010; Slevin, 2010). It is also clear that body image and food are intimately connected in women's lives. For many women, beliefs and attitudes about health and body weight play a key role in personal food choices (Rangel et al., 2012; Sun, 2008; Brownie & Coutts, 2013). For example, dissatisfaction with one's body may lead to dieting, restriction of certain food groups, or the adoption of a vegetarian or vegan lifestyle.

Baby boomer women may be particularly vulnerable to body dissatisfaction (BD), given their preoccupation with maintaining health and youthfulness (Biggs, Phillipson, Leach & Money, 2007; O'Reilly, Thomlinson & Castrey, 2003), and their heightened media exposure compared with previous generations (Biggs et al., 2007; Wadsworth & Johnson, 2008; Howarton & Lee, 2010). Many of these women are now entering their 50s and 60s and thus, are currently experiencing the undesirable weight gain and wrinkles that coincide with aging. As the population ages and rates of overweight/obesity continue to rise, more and more women are finding themselves unable and unequipped to meet society's narrowly-defined standards of female beauty (Heinberg, Thompson & Stormer,

1996). Thus, body dissatisfaction, concerns about aging, and eating disorders among middle-aged and older women in Canada are expected to increase (Gadalla, 2008; Midlarsky & Nitzburg, 2008; Lewis & Cachelin, 2001).

Despite this prediction, little is known about the body image perceptions and eating attitudes/behaviours of middle-aged and older women. To date, the majority of published studies on the topics of BD and eating disorders among women have utilized adolescent or college-age samples. Some researchers pose that it is Western culture's stigmatism of aging and the unconscious attitude that older adults are 'invisible' that has led to the neglect of older women's experiences and the assumption that concerns about weight and appearance exist only among young women (Tunaley, Walsh & Nicolson, 1999). This study will add to the existing body of literature by exploring body (dis)satisfaction, concerns about aging, dieting behaviours, and food attitudes of baby boomer (ages 46-65) and older (ages 66 and older) women.

Research Objectives

The objectives of this research project are:

1. To explore perceptions and experiences related to body dissatisfaction, aging, and the use of body work practices among baby boomer and older women; and
2. To explore healthy eating attitudes and barriers, food choice influences, dieting behaviours, and food product usage/attitudes among baby boomer and older women.

Research Questions

This research project seeks to answer the following questions:

Questions that will be answered through quantitative analysis (questionnaire data):

1. What is the prevalence of body dissatisfaction among baby boomer and older women in Manitoba? How important is body appearance/weight to women?
2. Are there relationships between level of body dissatisfaction and any of the following factors: age, household income, education level, location of residence, body mass index, smoking status, or self-reported health status?
3. Are baby boomer and older women concerned about the effects of aging on their appearance?
4. What percentage of baby boomer and older women in Manitoba report dieting behaviour?
5. Do baby boomer and older women in Manitoba consume functional, local, organic or diet/weight loss food products on a regular basis?
6. Are there any differences between baby boomer versus older women or urban-dwelling versus rural-dwelling women when it comes to body dissatisfaction, aging concerns, body work practices, or usage of specific food products?

Questions that will be answered through qualitative analysis (focus group discussions):

7. How do baby boomer and older women describe their body and its importance in their lives? Is body dissatisfaction an issue for these women?

8. Do baby boomer and older women experience concerns about aging and its effect on their appearance? In what ways?
9. What body work strategies or practices do women engage in to alter their appearance, prevent aging, and/or control their weight?
10. How do baby boomer and older women describe their current eating patterns?
 - a. What barriers interfere with women's ability to eat the way they would ideally like to?
 - b. What factors influence women's food choices?
 - c. What nutrients and food components/characteristics are women concerned about?
11. What are the attitudes and opinions of baby boomer and older women with respect to functional, local, organic, and diet/weight loss products?

Definition & Operationalization of Key Terms

Human Aging

An individual's age can be defined in chronological (i.e., calendar) years, or in a physiological (i.e., functional capacity), psychological, biological, or social sense (Whitbourne, 2008). Historically, chronological age has been the most common and accepted manner of defining an individual's age (Timiras, 2003), but stating age in terms of psychological or physiological function is becoming more common, accepted, and sometimes, more accurate (Whitbourne, 2008). In a general sense, aging refers to "the process of growing old, regardless of chronological age; it includes all the changes – in

the present context, the physiological changes – that occur with the passage of time, from fertilization of the ovum to death of the individual” (Timiras, 2003, p. 6).

How and when aging occurs is still a matter of debate among researchers and gerontologists, partly due to the indeterminate onset, inconsistent rate of progression, the un-reliable and un-specific biomarkers of aging, as well as the heterogeneous and multi-level nature of age-related changes that are observed across and between individuals (Timiras, 2003). Some researchers pose that aging is caused by programmed or spontaneous cellular dysfunction (i.e., genetic theories), whereas others attribute aging to environmental or socio-cultural causes (e.g., nutritional programming or disengagement theory) (Rosenberg & Sastre, 2002; Whitbourne, 2008).

Despite the many emerging (and increasingly popular) strategies that claim to prevent aging (e.g., cosmetics, surgery), aging is still considered to be universal, progressive, deleterious, and irreversible (Haynes & Feinleib, 1980, as cited in Chernoff, 2006). Recently, the term ‘successful aging’ has been adopted by researchers, referring to “the maintenance of mental and physical function, avoidance of diseases, and enjoyment of life” (Timiras, 2003, p. 29).

Age Categories

In the academic and non-academic spheres, the terms ‘young’, ‘middle-aged’, and ‘older’ are somewhat vague and unspecific, largely due to a “lack of co-ordination among age categories used for data from a wide variety of sources and subject areas” (United Nations, 1982, p. 1). Across publications, these terms are used differently to represent groups of a certain chronological age range (i.e., each author defines ‘young’ and

‘middle-aged’ differently). In general, and somewhat arbitrarily, the age of 65 is often used and accepted as the age at which an individual leaves middle-age and becomes an ‘older adult’ (Chernoff, 2006; Bernstein & Luggen, 2010; Timiras, 2003; Whitbourne, 2008). Older adults can be further divided into more specific categories of age, but these categories differ according to which author or organization is consulted. For example, Whitbourne (2008) classifies adults ages 65 – 74 as ‘young-old’, those ages 75 – 84 as ‘old-old’, and adults aged 85 and older as ‘oldest-old’. Individuals over the age of 100 are referred to as ‘centenarians’. In contrast, the World Health Organization classifies 60 – 75 years as ‘elderly’, 76 – 90 years as ‘old’ and 90+ years as ‘very old’ (Timiras, 2003). However, it is important to note that these categories are narrow, ignorant of individual differences in psychology, physiology and functional status, encouraging of ageist stereotypes, and certainly not applicable in every situation. Before 2007, Statistics Canada categorized adults by age according to life cycle groupings, with ‘adults’ defined as persons ages 25 – 64 years, and ‘seniors’ defined as persons ages 65 years and older, but has since adopted a system of reporting age categories according to pre-determined five-year age range groups (e.g., 50 – 54 years, 55 – 59 years, 60 – 64 years, etc.) (Statistics Canada, 2010).

Baby Boomers vs. Older Women

The population of interest for this study was baby boomer and older women. The following cut-off criteria were used to define these participant groups: baby boomer (BB) women are women born between 1946 and 1964 (ages 45-64 at time of data collection),

and older women (OW) are women born prior to 1946 (ages 65 and above at time of data collection).

Body Image and Body Dissatisfaction

Body image refers to the perceptions and attitudes a person has toward their body, particularly its size and appearance (Cash, 1990). It is a mental representation of the self, encompassing “how we see ourselves and how we feel about what we see” (Kim & Lennon, 2007). Body image is a multi-dimensional construct, in that it involves perceptual, emotional, developmental, sociocultural, and behavioural components (Sarwer & Crerand, 2004; Cash & Henry, 1995). A person’s body image lies on a continuum and is not static; it can fluctuate from positive to negative in a given situation, as a result of certain experiences, or throughout the life span (Paquette & Raine, 2004). Negative or distorted body image is related to BD, which is a negative subjective evaluation of personal appearance (Stice & Shaw, 2002), more concretely measured as the discrepancy between one’s perceived (actual) body and desired (ideal) body (Furnham & Boughton, 1995). Body dissatisfaction is highly prevalent in Western cultures (Rodin, Silberstein & Striegel-Moore, 1984).

Body image and BD have been measured using a wide variety of subjective, objective, perceptual, attitudinal, and behavioural assessment techniques (Thompson, 1996). These assessment techniques, most of which are quantitative in nature, can be categorized into (a) perceptual measures, which assess size perception accuracy; (b) subjective measures, which assess attitudinal, affective, or cognitive components of body image; and (c) behavioural measures, which account for behavioural indices of body

image disturbance (e.g., disordered eating, avoidance and preoccupation behaviours).

Thompson (1996) has identified several methodological limitations of the existing body image assessment instruments. For instance, numerous factors influence perceptual size estimates and personal questions pertaining to food and body image may not always be answered truthfully. Furthermore, many of the questionnaires currently used to assess body image and BD have been developed and validated using a narrow selection of participants (i.e., Caucasian college-age females), which limits their use with varied sample groups. A more comprehensive list and detailed explanation of body image assessment methods can be found in Thompson (1996), Ben-Tovim & Walker (1990), or Cash & Brown (1987).

Recently, qualitative methods, such as focus group discussions and individual interviews, are being used more often in the body image literature (e.g., Hurd, 2000; Halliwell & Dittmar, 2003; Clarke & Griffin, 2007a; Paquette & Raine, 2004; Paulson & Willig, 2008; Reel, SooHoo, Summerhays & Gill 2008). Mixed-methods approaches are also becoming more common and accepted in the field. These methods seek to overcome the inherent limitations of using solely quantitative assessment methods and allow for more complete, in-depth, and descriptive analyses. For this study, BD will be assessed via a pen-and-paper questionnaire. Body image perceptions and attitudes will be more deeply explored through the focus group discussions.

Body Work

Body work (also referred to as ‘beauty work’) is a broad term that refers to the management and modification of one’s body or appearance. It is, in a general sense, any

“work performed on one’s body” (Gimlin, 2007, p. 353). Body work encapsulates any technique, strategy, practice, product, or procedure adopted to maintain, change or alter one’s external appearance. There are many body work practices that have been previously reported in the literature. Some common forms of body work among middle-aged and older women include hair dye, dieting, exercise, make-up, anti-wrinkle creams, fashion/clothing, and non-surgical cosmetic procedures (e.g., Botox[®], microdermabrasion, laser hair removal, chemical peels, etc.) (Clarke & Korotchenko, 2011; Clarke & Bundon, 2009; Ballard, Elston & Gabe, 2005; Winterich, 2007). Over the past decade, cosmetic surgery has been gaining ground as a more commonly used and accepted form of body work among women of all ages (Sarwer & Crerand, 2004).

Body work has long been considered the domain of women, although this is gradually changing, as the objectification and sexualization of male bodies in popular media becomes more commonplace (Burlew & Shurts, 2013; Mellor et al., 2010). As one author states, “women are expected to engage in a large number of body management practices, spend more effort and money on them, and be more concerned about them than men” (Gimlin, 2007, p. 355).

The discourse surrounding body work contains conflicting interpretations of the behaviour. Some researchers argue that women who engage in body work are victims of false consciousness, in that “they participate in these practices of ‘femininity’ in an attempt to achieve standards of beauty constructed within an oppressively patriarchal and ageist society” (Clarke & Korotchenko, 2011, p. 189). In contrast, others postulate that women undertake body work on their own terms “with an understanding of the natural body as a passive material that must necessarily be built upon, overcome or adapted in a

social context that emphasizes youthfulness and physical attractiveness” (Clarke & Korotchenko, 2011, p. 189). According to these authors, by choosing to engage in body work, women are exercising their own agency and free choice over their bodies, and in doing so, they achieve some degree of personal empowerment.

Functional Foods

In response to increasing consumer demand for health-promoting foods, a new category of products, known as ‘functional foods’, has emerged. According to Health Canada (1998), a functional food is similar in appearance to, or may be, a conventional food, which is consumed as part of a usual diet, and is demonstrated to have physiological benefits and/or reduce the risk of chronic disease beyond basic nutritional functions. Dietitians of Canada has adopted a similar definition, stating that functional foods offer unique health benefits that go beyond simply meeting basic nutrient needs. Functional foods contain ‘bioactive compounds’ that offer health and wellness benefits, such as reducing the risk of chronic disease (Duncan, 2012). These bioactive compounds either occur naturally in the food (e.g., sweet potatoes with beta-carotene; tomato products with lycopene; oatmeal containing beta-glucans), or are added to foods to enhance the nutritional properties and potential health benefits (e.g., bread with added flaxseed; granola bars with added omega-3 fatty acids; margarine with added plant sterols, etc.).

Functional foods differ from nutraceuticals in that functional foods are whole foods with beneficial bioactive components, whereas nutraceuticals are purified or isolated compounds demonstrated to have physiological health benefits that are generally

sold in medicinal forms and not associated with whole food products (e.g., probiotics or omega-3 fatty acids sold in capsule form) (Health Canada, 1998).

Local Eating

There is no one commonly accepted definition of local eating, in terms of geographical distance between food production and consumption. In the 2008 Food, Conservation and Energy Act, the United States Congress defined local food as food that travels less than 400 miles from its origin (Martinez et al., 2010). Followers of the 100 Mile Diet consider local to be within 100 miles of one's own home. The 100 Mile Diet is becoming a popular form of local eating that entails eating foods grown within a 100-mile radius of one's home for a period of 100 days. Others may consider local foods as those produced within their country of residence (e.g., checking food labels for the statement 'Made in Canada'). Common sources of obtaining local foods include household gardening, farmers markets, community gardens, community supported agriculture initiatives, pick-your-own (or 'U-Pick') farms, food share co-ops, or farm-to-school fundraisers, among others. In addition, an increasing number of restaurants are choosing to incorporate local or regional foods into their menus.

Aside from geographical distance, there are many other characteristics that may be used by consumers to define or identify local foods (e.g., production methods, social/community embeddedness, short food supply chain, direct-to-consumer marketing, having a personal connection with the grower, etc.). According to one source, a local food movement is "a collaborative effort to build more locally based, self-reliant food economies in which sustainable food production, processing, distribution and

consumption [are] integrated to enhance the economic, environmental and social health of a particular place” (Richardson, 2006, para. 1).

The benefits of local food production and consumption are becoming increasingly recognized and valued among consumers (Martinez et al., 2010). Local food is considered more environmentally friendly, as it uses less fuel for transport, less packaging, and may help reduce greenhouse gas emissions (Food Matters Manitoba, 2012). Furthermore, local food initiatives have been said to build strong communities by creating jobs and supporting community economic development (Food Matters Manitoba, 2012). In a general sense, local eating celebrates the abundance, diversity and taste of locally-grown food and the people that grow it; facilitates participation in the creation and promotion of a more ecologically and socially just way of eating; increases personal self-discipline and collective action around food justice; and fosters direct linkages between consumers and food producers (100 Mile Manitoba, 2014).

For the purpose of this study, local eating refers to the act of consciously purchasing and consuming foods that are grown or produced/processed within one’s broad or narrow location of residence. For instance, local eating for a Winnipeg citizen might entail choosing foods that are grown or produced within the province of Manitoba.

Organic Food

Organic foods are those that are grown, farmed, produced, and processed without the use of chemicals, synthetic fertilizers, pesticides, antibiotics, growth hormones, irradiation, or genetically modified organisms (Dietitians of Canada, 2010a). Organic producers strive to achieve sustainable food production through the use of farming

methods that protect the soil, water, and environment (Ontario Public Health Association, 2002). Such methods, including crop rotation, cover crops, composting, green manures, and balancing of host/predator relationships, enhance soil fertility and increase biological diversity (Dietitians of Canada, 2010a). Previously, organic foods were not strictly regulated, partly due to voluntary standards and numerous certification bodies taking responsibility for approval. In June of 2009, new mandatory labeling guidelines and standards were implemented for organic food that is traded across provinces or internationally. Currently, the Canadian Food Inspection Agency (in cooperation with existing certification bodies) ensures that standards are met and oversees the evaluation and approval of organic food labeling (Dietitians of Canada, 2010b).

Rural vs. Urban

This study seeks to obtain perspectives and opinions from women across Manitoba. As such, data was collected from participants in both urban and rural areas of the province. According to the Government of Manitoba Municipal Act (2013), an urban municipality is defined as “an area with at least 1,000 residents and a population density of at least 400 residents per square kilometer” (p. 7). In contrast, a rural municipality has a population density of less than 400 residents per square kilometer (Government of Manitoba, 2013).

Organization of Thesis

This thesis is structured as a paper-based manuscript and includes the following chapters.

Chapter 2: Literature Review

The literature review chapter is comprised of three parts. Part One consists of a review paper, titled “*Body dissatisfaction among middle-aged and older women*”, which is published (Marshall, Lengyel & Utioh, 2012). Part Two consists of a second review paper, titled “*Body image and body work among older women: A review*”, which is currently under review (Marshall, Lengyel & Menec, 2014). Part Three contains supplementary background information pertaining to food, eating and women’s health.

Chapter 3: Methods

This chapter includes a comprehensive explanation of the methods used for this research project.

Chapter 4: Manuscript #1

This paper, titled “*Body dissatisfaction, concerns about aging, and body work practices of baby boomer and older women in Manitoba*”, presents the mixed-methods results pertaining to body (dis)satisfaction, concerns about and experiences with aging, and the use of body work practices among participants. This paper addresses Research Questions #1 – 4 and # 6 – 9.

Chapter 5: Manuscript #2

This paper, titled “*‘I really try to eat right!’: Healthy eating, food choices, and food product attitudes of baby boomer and older women in Manitoba*”, presents the mixed-methods results pertaining to healthy eating, food choices, and food product attitudes (specifically, local, organic, functional and diet). This paper addresses Research Questions #5 and #10 – 11.

Chapters 4 and 5 were written in publishable format, as stand-alone research papers. Together, these two papers provide an in-depth examination of the body image perceptions, aging experiences and food issues of baby boomer and older women living in urban and rural Manitoba.

Chapter 6: General Discussion

The final chapter in this thesis ties Chapters 4 and 5 together and provides a general summary of the overall research findings. This chapter also identifies the limitations of this study, highlights the implications of this research, presents avenues for future work, and concludes with a list of take away points.

CHAPTER 2

Literature Review

This chapter is comprised of three parts, which are outlined below. Part One consists of a review paper, titled “*Body dissatisfaction among middle-aged and older women*”, which was published in the Canadian Journal of Dietetic Practice and Research (Marshall et al., 2012). Copyright permission has been obtained from the publisher. Part Two consists of a second review paper, titled “*Body image and body work among older women: A review*”, which has been submitted to the Journal of Ethnicities and Inequalities in Health and Social Care, for inclusion in a forthcoming special edition on women’s health (currently under review). Part Three has not been submitted or published in a peer-reviewed journal, and contains supplementary background information pertaining to food, eating and women’s health.

Part 1:	Marshall, C., Lengyel, C., Utioh, A. (2012). Body dissatisfaction among middle-aged and older women. <i>Canadian Journal of Dietetic Practice and Research</i> , 73, e241-e247. (Published Paper)	22
Part 2:	Marshall, C. E., Lengyel, C. O., Menec, V. H. (2014). Body image and body work among older women: A review. <i>Ethnicity and Equalities in Health and Social Care</i> . (Under Review)	50
Part 3:	Health, Eating & Gender	82

PART 1

Body Dissatisfaction among Middle-Aged and Older Women

Citation: Marshall, C., Lengyel, C., & Utioh, A. (2012). Body dissatisfaction among middle-aged and older women. *Canadian Journal of Dietetic Practice and Research*, 73(2), e241-e247.

ABSTRACT

With the growing pervasiveness of mass media, individuals of all ages and genders are bombarded with images that glorify youthfulness, messages that tie self-worth to thinness, and products that promise youth and beauty forever. Aging women are vulnerable to these societal messages and experience strong pressures to maintain their youth and thinness. As the physiological changes that accompany normal aging move these women further from the ‘ideal’ image, body dissatisfaction may increase. These women are confronted with the impossible task of trying to defy the natural process of aging through a variety of means, including fashion, cosmetics, selective surgeries, and personal food choices. The resulting body image issues, weight preoccupation, and eating disturbances can lead to voluntary food restriction, depression, social withdrawal, lower self-esteem, and disordered eating, all of which can negatively impact quality of life and nutritional status. The objectives of this review are to: 1) explore existing research on body dissatisfaction among middle-aged (30-60 years) and older (60 years and older) women; 2) discuss the prevalence of body dissatisfaction, its predisposing risk factors,

and the resulting eating and body maintenance behaviours; and 3) to examine implications for dietetic practice.

INTRODUCTION

By the 1980's, body dissatisfaction (BD) was so prevalent among women in Western culture that one researcher called it a "normative discontent" (1); that is, women seem to accept that disliking their body is a normal part of everyday life. While the majority of studies on body image and BD have utilized adolescent or college-age samples, less is known about the prevalence of BD among middle-aged and older women. Body image and BD among aging women is a worthy discussion, given that middle age often coincides with weight gain and wrinkles (2), which can set the stage for body image issues throughout older adulthood. Today's generation of middle-aged and older women, collectively referred to as "Baby Boomers" (born 1946 to 1965), may be particularly vulnerable to BD, given their heightened preoccupation with maintaining health and youthfulness (3,4) and their relative affluence, educational attainment and heightened media exposure compared with previous generations (3-6). As our population ages and as rates of overweight/obesity continue to rise, more and more women will be unable to achieve the increasingly thin and youthful ideal portrayed by the media (7). Thus, the prevalence of BD and eating disorders among middle-aged and older women is expected to increase (8). This has implications for individual and population health, as body image influences food choices, physical and psychological health, and overall well-being.

This review will explore existing research on BD among middle-aged and older women. The prevalence of BD, its predisposing/associated factors, the resultant eating and body maintenance behaviours, potential nutritional/health consequences, and implications for dietetic practice will be presented.

METHODS

The web-based database, Scopus, was used to locate published, peer-reviewed articles as it covers a wide range of topics in the scientific, medical and social sciences. The following keywords were used: “women”, “older”, “middle-aged”, “midlife”, “baby boomer”, “aging”, “body satisfaction”, “body dissatisfaction”, “body image”, “self-esteem”, “weight preoccupation”, “food”, “diet*”, “eat*”, and “behav*”. The search was limited to original research and review papers, published from 1990 to 2010, and written in the English-language. Over 250 articles were collected from this search. Additional sources were identified from references listed in the retrieved articles.

To our knowledge, there are no studies on this topic that pertain specifically to baby boomers. To highlight our sample of interest (baby boomer women, born 1946-1964), this review uses the terms “middle-aged” and “older” to capture the range of ages that fall into this demographic group. For the purpose of this review, “young” adults are those between 18-30 years of age; “middle-aged” refers to adults ages 30-60 years; and “older” pertains to adults 60 years of age and older.

RESULTS

Body Image and Body Dissatisfaction

Body image refers to the perceptions and attitudes a person has towards their body, particularly its size and appearance (9). It is a mental representation of the self, encompassing “how we see ourselves... and how we feel about what we see” (10, p. 3). Body image is a dynamic and multi-dimensional construct, involving perceptual, emotional, developmental, sociocultural, and behavioural components (11,12). BD is a negative subjective evaluation of personal appearance (13), more concretely measured as the discrepancy between one’s perceived (actual) body and desired (ideal) body (14).

Prevalence of Body Dissatisfaction among Middle-Aged and Older Women

Body Dissatisfaction Persists Throughout the Lifespan

Several studies have found that young and older women experience similar levels of BD, suggesting that body image issues continue to affect women throughout the lifespan (15-20). Approximately 80% of middle-aged women (21) and over 60% of older women (22) report being dissatisfied with their body weight/appearance. Women over 60 years of age have described their bodies as a major source of displeasure (23-25), using words such as ‘ugly’, ‘sagging’, and ‘awful’ (24, p.87). These studies suggest that some women carry insecurities about their bodies and weight throughout life.

A small body of research poses that BD persists into middle and late adulthood, but self-objectification, habitual body monitoring, and appearance anxiety tend to decrease with age (18). One study found that although middle-aged and older women were equally dissatisfied with their bodies, older women (66 years and older) were less

likely to engage in weight-controlling behaviours (17). Older adults may replace behavioural strategies (e.g., dieting) with cognitive strategies, such as lowering of expectations, acceptance of body changes, and the use of age-appropriate social comparisons (18,26).

Changes in Body Dissatisfaction with Age

Some studies have found that, in comparison to younger women, middle-aged women are more dissatisfied with their bodies (27,28) and have increased concern over their appearance (29,30). A study of 1026 middle-aged women revealed that for most participants, BD had increased since young adulthood. Of these women, 60% were dissatisfied with their bodies and 80% wished to lose weight (21).

In contrast, a few researchers have found that BD decreases with advancing age (31,32). Older women may experience less BD due to increased maturity, less sexual objectification, accumulation of life experiences that deepen self-worth (18,33,34), greater tolerance of body diversity (35), and less strict standards regarding physical appearance (33). Aging is often accompanied by a shift in priorities, such that health and other components of identity become more important than appearance (24,36,37).

Factors Associated with Body Dissatisfaction

Media and Societal Pressures

Western culture, fueled by advertisements, movies, and magazines, is thought to be a key factor in the development of BD, weight preoccupation, and eating disorders (EDs) (7,13,38,39). For both younger and older women, media pressure has been found

to be the most significant predictor of BD (16). The current standard of thinness portrayed by the media is narrowly defined, unrealistic, and simply unattainable for most women (31,40-42). Not only do women experience profound pressure to be thin, they are also expected to maintain a youthful appearance. Aging has become stigmatized (29,43), to the point of being a ‘condition’ that most women struggle to prevent through whatever means necessary (40,44-47). Middle-aged women are particularly vulnerable to these sociocultural pressures, as their concerns about aging and weight gain have been exploited by advertisers through the continued use of youthful models, the promotion of products that promise revitalization, and the underlying message that the perfect body is within reach given the right amount of effort, willpower, and financial investment (4,5,44,45).

Female Gender

At all stages of life, women report higher levels of BD and weight preoccupation than men (33,48-51). Girls are socialized to believe that they should monitor/improve their appearance, as attractiveness leads to social acceptance, happiness, and success (18,20,40,52-54). The tendency of older women to select thinner figure drawings as more socially acceptable and beautiful than their male age-counterparts is evidence of the pervasive and lasting effects of these messages (55). Studies with middle-aged and older adults report that in comparison to men, women are less satisfied with their bodies (55,56), more preoccupied with age-related changes in appearance/weight (57-59), and more pessimistic towards their bodies (54,57,60). Middle-aged and older women are also more likely than men to engage in weight loss practices (52) and express anxieties about

eating and/or becoming fat (49,56). This is not surprising, given the ‘double standard of aging’, in which aging women are judged more harshly on their appearance than men (61).

Body Mass Index (BMI)

Among middle-aged and older women, a higher BMI is associated with greater BD (18,21,22,37), more intense drive for thinness (17) and more frequent use of weight control behaviours (62). Importantly, BD is also common among women who are already at a ‘normal’ weight for their age and height (21,22). In one study of older women, more than one-third of normal weight women reported that they experience BD (22). It seems as though “women nearly always perceive they should be lighter than they are, regardless of their weight” (31, p.315).

Biology of Aging

Middle age is associated with age-related changes in physical appearance, including greying/thinning hair, wrinkling/sagging skin, weight gain, and loss of lean muscle mass (26,27,42,43). Unfortunately, these normal signs of aging are viewed as negative and stressful signs of degeneration (27,45,50). For women who place high value on physical and sexual attractiveness, alterations in appearance at midlife may negatively influence body image and self-esteem (47,56).

Menopause

Menopause involves numerous biological and hormonal changes (e.g., lowered metabolic rate), and for some women, weight gain (33,46,63-65). Qualitative research reveals that some women perceive menopause to be a threat to both physical appearance (65) and sexual attractiveness (66). Some researchers pose that these physical and mental ‘symptoms’ may result in body image disturbances similar to those experienced during puberty (17,27,46,63,66).

Life Events and Stress

Significant life events (e.g., divorce, caregiver burden, disability, etc.) may also influence a woman’s body image in mid/late life (2,46,63,67,68). Failure to make smooth transitions or cope effectively with these life events may cause psychological distress that, when combined with existing risk factors, encourages the development of BD and/or EDs (63,67,68). Divorce or widowhood can be particularly stressful, as women who become single at midlife experience pressure to look as youthful as possible as they re-enter the dating world (63,69).

Familial and Social Relationships

Relationships with friends, family, and romantic partners are intimately connected to an individual’s body image and self-esteem. Low marital satisfaction is associated with greater BD, independent of age, gender and BMI (70). Specifically, negative appearance-related comments from a spouse can deeply influence a woman’s body image (39,71,34). Through their attitudes and comments regarding the ‘appropriate’ female body shape,

husbands, friends, and family members can unintentionally perpetuate existing sociocultural messages and exert indirect control over a woman's body satisfaction and eating behaviours (39,72).

Mothers also convey important information regarding body image (73) and can greatly influence their daughters' food and body-related attitudes. Concerns about weight and appearance are easily transferred from one generation to the next (17). As women age, they tend to adopt eating, weight control, and appearance-enhancing behaviours similar to those modeled by their mothers (73).

Ethnicity and Culture

Research examining the relationship between ethnicity and BD has yielded conflicting results (26). While a few researchers have found minimal ethnic differences with regards to BD among adult women (20,74-76), meta-analyses support the notion that BD is more common among Caucasian women (77,78). In the general population, Caucasian women express more negative body image (12), less body satisfaction (79,62,80), higher standards of thinness (81,82), and more dieting behaviours (62,83) than women of different ethnic backgrounds. It is still unclear, whether these differences persist into middle and late adulthood.

Socioeconomic Status

BD and weight preoccupation have been found to increase with higher levels of education and income (21,84,85). Even though middle-aged women of higher

socioeconomic status tend to weigh less, they are more likely to have BD and are trying to lose weight compared to women of lower socioeconomic status (21).

Eating and Body Maintenance Behaviours

Dieting

A common manifestation of BD (across all age groups) is the adoption of dieting (i.e., restricting one's food intake to lose weight) (22,25,86,87). The prevalence of dieting among middle-aged and older women ranges from 30% to 56% (8,35,22). Most of these women evaluate their eating as "normal and healthy" (22, p.585), which again demonstrates the 'normative' culture of BD and dieting among women. Older women have even described dieting as a necessary body maintenance strategy (25).

Body Monitoring and Altering Behaviours

BD among women is associated with habitual body monitoring and self-surveillance (19,25,73). In a study of older women, nearly three-quarters of the sample reported that they weigh themselves regularly (22). A study of women over 50 years of age found that the majority (76%) were preoccupied with a desire to be thinner and 30% were fearful of becoming 'too fat' (8). Women with BD may also invest in self-improvement strategies (e.g., makeup, wrinkle-creams, hair dye, cosmetic surgeries) (4,20,34,46,47,50,88-90). As anti-aging products become more available and affordable, looking old will "become even more culturally unforgiveable" (32, p.633). The preoccupation with maintaining a youthful appearance not only costs time and money; it

also wastes mental and physical energy that could be spent doing other, more productive and health-promoting activities.

Disordered Eating

BD has been identified as a significant risk factor for the development of eating pathology among middle-aged women (46). Middle-aged and older women have reported using herbal supplements, laxatives, diuretics, cigarettes, and diet pills, as well as self-induced vomiting, excessive exercise, spitting out food, fasting, and fad diets as weight control strategies (8,16,21,22). Among middle-aged and older women (ages 45 to 65+ years), the incidence of EDs ranges from 1.8% to 14.8% (8,21,22,46). However, EDs are still over-looked and under-diagnosed in this population (17,63,67,68), partially due to the assumption that EDs are primarily an adolescent issue. The physical signs of EDs in older women are non-specific and may be easily overlooked in the presence of other health issues (67).

DISCUSSION

Consequences of Body Dissatisfaction

BD has been associated with less self-reported happiness (91), avoidance of physical intimacy (21), anxiety (8), depression (8,21) poor self-esteem (15,18,21), and lower overall quality of life (21) among middle-aged and older women. Furthermore, BD promotes body shame and appearance-related anxiety which may lead to social isolation. Women who are dissatisfied with their bodies may avoid various situations, such as

social events with food, engaging in physical activity, or wearing a bathing suit in public (21).

Consequences of Dieting

The consequences of dieting for middle-aged and older women have not been thoroughly examined; therefore, the following discussion references studies conducted with the general population (i.e., adults over 18 years). Although one can speculate that some of the physical, psychological and nutritional consequences of dieting might be seen in middle-aged and older adults, generalizability to this population has not yet been confirmed. Additional studies are needed to thoroughly describe the consequences of dieting for middle-aged and older women.

Weight Cycling

BD appears to be related to dieting behaviour (21,22); however, in reality, diets have a dismal success rate and the majority of adults who lose weight gain it back (87,92-98). This usually results in a continuous, self-perpetuating, and potentially dangerous cycle of 'yo-yo dieting' or 'weight cycling' (99). This pattern of cyclical weight loss and gain has been found to have numerous negative effects on health, including increased blood cholesterol, impaired glucose regulation, decreased lean body mass, higher waist-to-hip ratio, loss of bone density, hypertension, heart disease, and increased mortality risk (87,99-103). Yo-yo dieting also reduces basal metabolic rate, making subsequent weight loss efforts even more difficult (87,92,99). In fact, across the lifespan, former and current dieters tend to be heavier than those who have never dieted at all, regardless of age (35).

Psychological Implications

In the general adult population, chronic dieting is associated with poorer psychological health, depression, increased stress, and lowered self-esteem (92-94,99). Since dieting rarely results in sustained weight loss, many women remain dissatisfied with their bodies and experience profound feelings of disappointment and personal failure (42). Dieting is often accompanied by negative self-talk, dichotomous ('all-or-nothing') thinking, and feelings of guilt and shame when fattening or 'forbidden' foods are eaten (34). Ultimately, eating becomes un-enjoyable and the unsuccessful dieter gets trapped in a constant state of deprivation and emotional turmoil based on a perceived lack of willpower (42).

Eating Disorders

Dieting is involved in the etiology and maintenance of EDs, particularly binge eating and bulimia nervosa (46,94,104). The over-restriction and perceived deprivation that often accompany dieting can lead to over-compensation in the form of binge eating (86,87). EDs are known to have serious health implications, including compromised organ and physiological functions, and psychological symptoms (2,67). Middle-aged and older women who report ED tendencies are more likely to experience depression and/or anxiety and abuse alcohol than women without ED symptoms (8). EDs can potentially become life threatening, especially among older women with compromised immunity, poor nutritional status, and co-morbid illnesses (2,67,105).

Nutritional Implications

Food choices influence an individual's nutritional status and overall health. When dieting involves restriction of certain nutrients, meals, or entire food groups, nutrient deficiencies may result (27,92). This is especially concerning for older women, who may already be at increased risk of malnutrition (105,106). Nutritional adequacy is known to have a significant role in successful aging and improving disease outcomes (107), and thus, dieting may impede healthy aging for middle-aged women and negatively affect overall quality of life for older women (105,108).

Physiological and Physical Complications

Dieting can increase the risk of physiological and physical complications/conditions that tend to coincide with advancing age. By compromising nutritional status, dieting can indirectly contribute to muscle loss, osteoporosis, poor glucose regulation, and reduced immune function (42,104,106). Among middle-aged and older women, dietary restraint has been associated with higher levels of cortisol, a stress hormone which negatively effects bone mass (109). Among older women, inadequate food intake (whether caused by dieting or other behaviours) may worsen nausea, dizziness and poor balance, interfering with activities of daily living and increasing the risk of falls and fractures (42,106). For older adults, excessive caloric restriction is related to the development of gout, gallstones and cardiac complications, as well as gastric, hematologic, neurologic, renal and metabolic abnormalities (2,42). All of these physiological symptoms could negatively affect quality of life (106), interfere with

successful aging (105), and increase risk of premature mortality (110) among middle-aged and older women.

Limitations

BD among baby boomer women has not been thoroughly researched, thus, studies using both middle-aged and older women were included to capture women in this demographic group. Combining these groups of women into one discussion implies that they have the same issues related to body image and food/eating, when in fact, they may have entirely different issues.

Relevance to Practice

Health care professionals, including dietitians, must be aware of BD, weight preoccupation, and dieting among middle-aged and older women, and should be trained to deal with these issues appropriately. Dietitians must consider the risk/benefit ratio of overweight in older women and realize that there is a fine balance between promoting healthy weights and perpetuating weight preoccupation/disordered eating. Among older adults, a BMI of 23-29 may be more appropriate, given that low BMI and malnutrition are risk factors for increased mortality (105,111,112) and extra weight may protect against acute illness and accidental injuries (42).

Women seeking weight loss counseling should be discouraged from restrictive, short-term dieting and encouraged to eat a balanced, healthy diet, with emphasis on enjoyment and variety, not restriction (42). Achieving an 'ideal weight' should not be the primary outcome of nutritional intervention; instead, encouragement of healthy lifestyle

behaviours (e.g. regular physical activity, balanced diet, adequate sleep) should be the focus of client-centered counseling.

Women need to be educated about healthy body weights, the effects of media on body image, the dangers of quick-fix diets, and the negative health outcomes of chronic dieting and weight cycling. Community programs aimed towards middle-aged and older individuals should: promote eating in a positive and relaxing environment; address common nutrition/body concerns; and include media literacy education. Public advocacy groups and government policies should encourage advertisers to focus on the positive aspects of aging, body diversity, and health at every size.

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PART 2

Body Image and Body Work among Older Women: A Review

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ABSTRACT

Purpose: To review the literature on body image and aging among older women. Using existing qualitative research, this paper explores how aging affects body image and how women respond to body image issues as they age. **Methodology:** Multiple databases were used to locate original and review articles on the topics of body image and aging, with a target population of women ages 60 years and older. The findings of the literature search were compiled, summarized and sorted to create themes. **Findings:** Women struggle with body image issues throughout their lives. Women tend to perceive age-related changes in appearance negatively, as a threat to their identity and social value. This is due, in part, to the sociocultural environment, which pressures women to ‘fight’ aging and maintain an ideal (young and thin) image at all costs. Some women do come to terms with their aging body and report increased self-acceptance with age. However, others turn to various forms of body work (e.g., dieting, hair dye, makeup) in order to maintain their value in an appearance-based society. **Practical & Social Implications:** Poor body image can affect older women’s emotional, psychological and physical health and overall well-being. Health care professionals, community workers and policy makers

need to be made aware of these issues so that they can respond appropriately. **Value:**

There has been limited research exploring body image among older women. This paper identifies gaps in the literature and suggests avenues for future research in this area.

INTRODUCTION

“It is in and through our bodies that we most immediately experience the social and physical realities of growing older” (Clarke and Korotchenko, 2011, p.495).

Our bodies are intimately connected to our experience as human beings. It is through our bodies that we feel pain, experience pleasure, communicate our identity, and manifest illness. The body – how it looks and how it functions – is also a means by which we experience and express our age, health and gender. Body image, a more global concept, encompasses more than just the state of our bodies; it involves “an individual’s thoughts, perceptions, feelings, and evaluations of his or her own body” (Liechty, 2012, p.71). In other words, body image encompasses “how we see ourselves and how we feel about what we see” (Kim and Lennon, 2007, p.3). It is a multi-dimensional construct, in that it involves perceptual, affective and behavioural components (Cash and Henry, 1995). Body image is integral to one’s sense of self, and it plays an important role in well-being and quality of life, especially among women (Lewis and Donaghue, 2005; McCormick, 2008; Liechty and Yarnal, 2010; Slevin, 2010). For instance, a woman’s relationship with her body can affect her emotional state and health behaviours (Price, 2010; Grogan, 2006). There are many different factors that influence body image,

including illness, menopause, and familial relationships, among others (Peat, *et al.*, 2008; Chrisler and Ghiz, 1993; Ferraro *et al.*, 2008).

Body image issues seem to affect women to a greater degree than men (Halliwell and Dittmar, 2003; Algars *et al.*, 2009) although this gender gap is likely narrowing, due to shifts in our socio-cultural environment that place increasing pressures on men's bodies (Burlew and Shurts, 2013; Mellor *et al.*, 2010). Thus, historically, research on body image has focused on young (adolescent and college-age) women, who were thought to be particularly vulnerable to body image disturbances. It is now well accepted that poor body image among young women is a serious and important issue, with implications for nutritional health and psychological well-being (Cash and Henry, 1995; Moore, 1993). Until recently, much less was known about body image issues among middle-aged and older adults.

A few academics have addressed this gap by studying body image among middle-aged women (approximately 40 to 60 years old). We now know that middle-aged women experience similar levels of body dissatisfaction as younger women, which suggests that body image issues persist into later life (Lewis and Cachelin, 2001; Tiggemann and Lynch, 2001; Grippo and Hill, 2008; Pruis & Janowsky, 2010). Weight preoccupation, dieting, and eating disorders also appear to be an issue among this age group (Reel *et al.*, 2008; Mangweth-Matzek *et al.*, 2006; Midlarsky and Nitzburg, 2008; Brandsma, 2007). The body image and eating issues among middle-aged women have been reviewed previously (e.g., Marshall *et al.*, 2012; Saucier, 2004; Tiggemann, 2004).

While these are important findings that have laid the groundwork for research in this area, our knowledge of body image issues among older women is still in its early

stages. Thus, this review seeks to summarize the current state of knowledge, with a focus on the qualitative experiences of older women. Qualitative research in this area is particularly valuable, as it helps to deepen our understanding of the meanings and relationships between body image and aging. This review will focus on research pertaining to the two components of body image, as proposed by Szymanski and Cash (1995): (1) cognitive appraisal of one's body and the associated attitudes, emotions and meanings, and (2) the nature and extent of body investment (i.e., the behavioural responses to body image, also termed 'body work'). The implications of these findings will be discussed, and the strengths and limitations of the existing literature will be addressed.

METHODS

The purpose of this paper is to review the existing literature on body image among older women (60 years of age and older), with a focus on qualitative research. More specifically, we wanted to explore how older women experience and respond to body image issues. Initially, the web-based database *Scopus* was used to find relevant articles. Multiple keywords (e.g., 'body image', 'women', 'older', 'aging', 'body dissatisfaction', 'appearance', 'body work') were used in various combinations to locate original and review articles published between 2000 and 2012. Additional sources were obtained by reviewing the reference lists of key articles. Important or key articles were included, even if their publication date preceded 2000. PubMed, Google Scholar, and the University of Manitoba Libraries one-stop search engine were also used to locate articles (using the same search terms listed above), and while a few additional articles were

retrieved, we found that there was significant duplication among these databases. In the end, we compiled nearly 100 original and review articles broadly related to body image among aging women. This list was narrowed further by reviewing each abstract for relevance, and including only those articles that included older women (60 years of age and older), took place in developed nations (e.g., North America, Europe, Australia), and employed a qualitative or mixed-methods approach. In the end, this resulted in a collection of 30 relevant articles. These papers were read and important findings/discussion points were highlighted, summarized and compiled in table format, which facilitated the identification of recurring themes. The major themes that arose from this review process (and therefore, provide the outline for this paper) are: (1) socio-cultural influences on women's body image; (2) negative body image perceptions/body dissatisfaction; (3) conflicting feelings surrounding the aging body; (4) acceptance/coming to terms with the aging body; (5) use of body work practices/techniques; (6) natural aging as the ultimate goal; and (7) the relationship between body image and health. Throughout the writing process, additional articles on related topics were retrieved and reviewed, as needed.

RESULTS

Body Image among Older Women

It is worth acknowledging upfront that there is great diversity among older women's perceptions, opinions, attitudes, experiences, and behaviours (Krekula, 2007). Many researchers in the field of gerontology have noted the heterogeneity that exists among the older adult population, when it comes to health and other factors (Chappell *et*

al., 2008). Each woman's experience of body image is uniquely individual, and as a result, there is a wide range of attitudes and experiences reported in the literature.

Socio-cultural Influences on Women's Body Image

One of the most commonly cited factors affecting women's body image is the socio-cultural context in which they live (Bedford and Johnson, 2006; Paquette and Raine, 2004; Bakhshi, 2011; Swami *et al.*, 2010). In Western cultures, women are constantly surrounded by images that glorify youthfulness, messages that tie self-worth and success to thinness, and products that promise eternal youth and beauty (Saucier, 2004). These media messages promote an ideal image of female beauty – one that is increasingly young and thin (Fey-Yensan *et al.*, 2002; Borland and Akram, 2007). The pervasive nature of Western mass media results in the acceptance and internalization of gender norms and ageist stereotypes (Tiggemann, 2003; Grippo and Hill, 2008). From a young age, girls are socialized to believe that their body is an aesthetic object that must be constantly monitored and 'fixed' in order to be socially acceptable (Franzoi and Koehler, 1998; Paquette and Raine, 2004). Through this self-objectification, women learn that appearance is a crucial component of self-worth and that their social value is largely determined by their level of attractiveness (Tiggemann and Lynch, 2001). These images and messages also promote the idea that to be beautiful, one must be young. This perpetuates ageist beliefs that 'old' bodies are ugly, asexual and unproductive (Altschuler and Katz, 2010; Montepare, 2006; Calasanti, 2005). In response, the rapidly growing beauty, weight loss and anti-aging industries offer a myriad of solutions to help women 'fight' aging and correct bodily 'imperfections' associated with getting older (Franzoi

and Koehler, 1998; Saucier, 2004). According to Oberg and Tornstam (1999), as anti-aging products and cosmetic surgery procedures become more available and affordable, looking old will “become even more culturally unforgiveable” (p.633). These strong socio-cultural messages place extreme pressures on middle-aged and older women, who are experiencing age-related changes in appearance (e.g., wrinkles, weight gain) that move them further from the socially-constructed ideal of female beauty.

Negative Body Image among Older Women

For many women, body image is a complex construct that encompasses a combination of perceptions, attitudes, and outcomes (Liechty, 2012). In most studies with older women, aging is perceived to have a largely negative impact on appearance and overall body image evaluation (Clarke and Korotchenko, 2011; Hurd, 2000). For instance, the wrinkles, sagging, and greying hair that accompany aging are viewed as undesirable changes that threaten one’s appearance and social value (Halliwell and Dittmar, 2003; Winterich, 2007). Women over 60 years of age commonly describe their bodies using derogatory terms, such as ‘ugly’, ‘awful’, and ‘a disaster’ (Hurd, 2000). Older women also tend to compartmentalize their bodies into discrete parts, focusing on ‘problematic’ areas such as their ‘big belly’, ‘sagging bum’, ‘thick legs’, or ‘flabby arms’ (Liechty, 2012; Hurd, 2000; McCormick, 2008; Clarke *et al.*, 2009). Of particular concern to older women are issues of body weight (Clarke, 2002a; Winterich, 2007). Women carry insecurities about weight gain throughout life and many describe their weight as a major source of displeasure and self-criticism (Clarke, 2002a; Hurd, 2000). Anxieties about being or becoming overweight are extremely common (Baker and

Gringart, 2009; Mangweth-Matzek *et al.*, 2006), and many women report wanting to lose weight (Tunaley *et al.*, 1999; Winterich, 2007).

Interviews with women aged 60-69 years revealed that appearance remains important outside the home and is a significant source of self-confidence (Liechty, 2012). In general, women “understand that our society values youthfulness and [they] are keenly aware of both the positive cultural capital that accompanies youthful images and the negative capital that comes with being old or looking old” (Slevin, 2010, p.1009). These findings are in contrast to the male experience, where signs of aging can enhance appearance and societal value (Sontag, 1997). Several researchers support this idea of a ‘double standard’ of aging whereby women are more negatively affected by social constructions and physical realities of aging than are men (Slevin, 2010). Others claim that older women are plagued by a double jeopardy, in that they experience both ageism and sexism when it comes to their bodies (Krekula, 2007).

Conflicting Feelings Surrounding the Aging Body

Women’s perceptions of and experiences with the body can be, at times, contradictory. In other words, it is not uncommon for women to hold both negative and positive feelings about their bodies. Through one-on-one interviews with 13 women aged 60 to 69, Liechty (2012) found that women express dissatisfaction with their bodies and desire changes in their appearance, yet simultaneously report overall contentment. Krekula (2007) concluded that women experience stress related to age-related changes in appearance, but also see their bodies as a source of pleasure in relation to sexuality and physical activity. Life events and transitions such as menopause, retirement and

widowhood/divorce can be seen as threats to the maintenance of positive body image (Liechty & Yarnal, 2010; Hurd, 2000; Midlarsky and Nitzburg, 2008); however, women also see later life as a time for opportunity, creativity, freedom, and personal growth (Tunaley *et al.*, 1999). Lastly, a major source of tension in women's lives is the discrepancy between the aging physical body and the youthful inner spirit. Some women report that their subjective ("felt") age is much younger than their chronological (actual) age, and this causes feelings of conflict when it comes to body/appearance expectations (Oberg and Tornstam, 2001; Hurd, 1999; Paulson and Willig, 2008).

Body Acceptance: Coming to Terms with the Aging Body

While some women do continue to struggle with body image issues later in life, other women seem to come to a place of self-acceptance regarding their bodies and its appearance. That is, as some women age, their level of body acceptance increases, which results in a more positive state of body image and overall well-being. In most studies, many older women report at least some degree of body acceptance, even if they also report mild dissatisfaction with their weight or a specific feature (Liechty, 2012). In one study with women ages 60-92, participants expressed pragmatism about their aging bodies, acknowledging that changes in appearance are part of the natural process of aging (Hurd, 2000, p.88). At the same time, the importance attributed to appearance also seems to decrease with increasing age (Tiggemann, 2004), which may be a protective buffer against the potential negative outcomes of poor body image, such as low self-esteem, depression, and eating disorders (Webster and Tiggemann, 2003).

Women who are able to reach a more positive state of body image may do so through a variety of cognitive adjustments (Price, 2010; Liechty and Yarnal, 2010). For instance, some women come to accept age-related changes in appearance as being inevitable and outside of their personal control (Tunaley *et al.*, 1999). Other women re-evaluate physical signs of aging as evidence of a life well lived. For example, in one study with 22 women ages 61-92, wrinkles were considered a ‘badge of honour’ (Clarke, 2002a). Other cognitive strategies that older women may use to improve their body image include lowering their appearance-related expectations and goals (Tiggemann, 2004) and comparing themselves to same-age peers who are ‘worse off’ (Price, 2010). Furthermore, aging is often accompanied by a shift in priorities, such that health and functioning become more important than appearance (Hurd, 2000; Liechty and Yarnal, 2010; Baker and Gringart, 2009). After finding a partner and establishing a career, older women may be less concerned with external expectations and more focused on building their self-worth and identity through other means (Tunaley *et al.*, 1999). Some participants in Liechty’s study (2012) had accepted their ‘flawed’ bodies because they felt that characteristics of wisdom, personality and inner beauty were more important than appearance, as was the case with one 62 year old woman who stated, “There’s more to me than how I look” (Liechty, 2012, p.81).

Older Women and Body Work

As discussed above, older women hold varied, complex, and somewhat contradictory views of their bodies. While some women come to accept the physical realities of growing older, others experience persisting body image issues and believe

they must resist aging at all costs (Clarke and Griffin, 2007a). Some feel they can ‘retire’ from feminine beauty work in old age; these women emphasize the importance of ‘growing old gracefully’ (Clarke and Korotchenko, 2011; Clarke and Griffin, 2007a). For others, moving further from the ideal of feminine beauty means that they must engage in increasing efforts to counteract the effects of aging. These women may choose to engage in body work practices that minimize or prevent signs of aging in an effort to maintain a youthful appearance, or at least, not look ‘old’. Body work has been defined as, “any practice undertaken that aims to modify or maintain some aspect of the body” (Coffey, 2013, p.4).

Body Work Practices of Older Women

Among women who do engage in body work, there are many techniques, products and regimes that are used. Hair dye, face creams, make-up, and lipstick are commonly reported as important to older women’s beauty routines (Clarke and Bundon, 2009; Clarke and Korotchenko, 2010; Winterich, 2007; Paulson and Willig, 2008). Women also understand that their clothing choices are a “cue to age” (Slevin, 2010) and many use fashion to hide imperfections and present a ‘put-together’ image to others (Clarke *et al.*, 2009; Paulson & Willig, 2008). Restrictive eating, or dieting, is also a common behavioural response to poor body image (Stice, 2002; Mangweth-Matzek *et al.*, 2006). In a study of women aged 61-92, dieting was seen as a ‘necessary’ body maintenance strategy, with most women reporting some kind of restrictive eating behaviour (Clarke, 2002b). Many women also engage in exercise as a way to maintain health, function and appearance as they age (Hurd, 1999; Paulson and Willig, 2008). According to several

authors, cosmetic surgery is becoming a more commonly used and accepted form of body work among older women (Sarwer and Crerand, 2004), and these procedures are seen as a “very viable way to resist aging” (Slevin, 2010, p.1013).

Regardless of the method(s) used, more and more women are investing time, money and effort into maintaining a youthful appearance, as evidenced by the increasing consumer demand for anti-aging products (Muisse and Desmarais, 2010; Smirnova, 2011). These body work behaviours are highly encouraged by the beauty, weight loss and anti-aging industries, which have much to gain from making women feel inadequate and unattractive (Paquette and Raine, 2004). In essence, women’s concerns about aging and body image are being exploited and manipulated by companies through the use of youthful models, the promotion of products that promise rejuvenation, and the underlying message that the perfect (i.e., young and thin) body is within reach given the right amount of effort, willpower, and investment (Bordo, 1993; Calasanti, 2005).

Motivations for Undertaking Body Work

The decision to conduct body work is likely influenced by many different factors, some more subconscious than others. Whereas some women undertake body work to lose weight or maintain their appearance, others see this as vain, citing ‘health’ as the reason for intervention (Clarke, 2002b). Some women engage in body work to avoid negative stereotypes and distance themselves from those they perceive as ‘old’ (Slevin, 2010). Others are more concerned with moulding their external image to reflect their ‘true’ inner sense of youthfulness and vitality (Clarke and Griffin, 2007a). It has also been found that women’s body work practices may be greatly influenced by the body image issues and

beauty routines modeled by their mothers (Paulson & Willig, 2008; Clarke and Griffin, 2007b).

A woman's decision to engage in body work may also be determined by the extent to which she views her body as modifiable. According to Ballard *et al.* (2005), women perceive their aging bodies as both private and public. Private aspects of aging (the internal physiological changes that are largely undetectable by others) are inevitable and un-modifiable, whereas the public aspects of aging (physical and appearance-related changes that are visible to others) are 'malleable' and should be monitored and corrected as necessary (Ballard *et al.*, 2005). The value placed on a youthful appearance and the desire to conform to the ideal further influences the decision to undertake body work.

It is predicted that as baby boomers (individuals born between 1946-1965) enter late life, the use of body work practices and anti-aging regimens among older women will increase (Smirnova, 2012). Unlike previous generations of older adults, this generation grew up in a culture of mass media and persuasive advertising and they are "fascinated with the body and its malleability" (Ballard *et al.*, 2005, p.172). It is expected that baby boomers will continue to invest in body work practices that not only help them maintain a socially acceptable appearance, but also close the perceived gap between their external (aging) body and their inner (youthful) spirit (Ballard *et al.*, 2005).

'Natural' Aging as the Ultimate Goal

One priority that seems to be consistent among older women is the achievement of a 'natural' look that is socially acceptable amongst their peers (Clarke and Griffin, 2007a). Some women believe that to age naturally is to accept the inevitability of age-

related changes in appearance. From this standpoint, the ‘natural’ body is one that has aged without modification, untouched by anti-aging products or beauty interventions (Clarke and Griffin, 2007a). In contrast, others contend that “technological youth and beauty enhancing practices are becoming increasingly normalized and are a natural requirement of feminine body work” (Clarke and Griffin, 2007a, p.190), and therefore, engaging in body work is simply a ‘natural’, ubiquitous part of aging in today’s world.

This pursuit of a ‘natural’ look plays itself out through the body work practices and beauty routines of older women. In one study, women wanted to disguise the signs of aging (e.g., by using hair dye to cover grey hair), but they were also careful not to overdo it, out of fear they would look ‘fake’ (Ballard *et al.*, 2005). These women are also very conscious of choosing age-appropriate fashions and in order to avoid looking like “mutton dressed as lamb” (Ballard *et al.*, 2005, p.180). These examples demonstrate that through their cosmetic and fashion choices, older women strive to look authentic – the product of good genes and ‘graceful’ aging (Clarke and Griffin, 2007a).

Implications for Well-Being

Given that body image is intimately connected to one’s identity and sense of self (Lewis and Donaghue, 2005), changes in body image as one ages has potential implications for health and well-being (Roy and Payette, 2012). Studies have found that among older adults, poor body image is associated with low self-esteem (Baker and Gringart, 2009), psychological distress and depression (Miller *et al.*, 1991). The age-related changes in appearance and body functioning that move women further from their socially ingrained notion of ‘feminine beauty’ can also result in identity confusion and a

feeling of losing control over their lives (Saucier, 2004). Researchers have found that when women “are no longer viewed as young and desirable, they begin to struggle to regain a sense of self” (Saucier, 2004, p.422). For women who have always based their identity and self-worth on physical attractiveness, changes in appearance with age may be particularly traumatic, resulting in significant emotional and psychological consequences (Winterich, 2007; McCormick, 2008).

Health-Related Behaviours

The desire to achieve a certain image may motivate healthy behaviours (e.g., physical activity, healthy eating), but may also result in negative behaviours that pose serious health risks. For instance, habitual body monitoring can create appearance anxiety and an avoidance of social situations (Reel *et al.*, 2008; McLaren and Kuh, 2004). Body issues can also lead to restrictive eating or dieting (Stice, 2002; Anderson *et al.*, 2002; Grogan, 2006) and dieting is known to negatively impact women’s health and well-being (French and Jeffery, 1994). Diets have a dismal success rate and many individuals who diet end up regaining any lost weight (Maclean *et al.*, 2011; Lowe and Timko, 2004; Mann *et al.*, 2007). This can lead to a destructive cycle of chronic dieting and weight cycling that has significant long-term health implications, including muscle loss, reduced bone density, cardiovascular abnormalities, and increased risk of mortality (Lee *et al.*, 2010; Folsom *et al.*, 1996; Olson *et al.*, 2000; Montani *et al.*, 2006). Dieting may also result in nutrient deficiencies, especially among older women who are already at increased risk of malnutrition (Miller and Wolfe, 2008). Since dieting rarely produces the desired result (sustained weight loss), many women who diet remain dissatisfied with

their bodies and experience profound feelings of disappointment, guilt, and personal failure (Thomas *et al.*, 2008). Dieting has also been associated with disordered eating attitudes and behaviours, depression, and lowered self-esteem (Cachelin and Regan, 2006; French and Jeffery, 1994). In fact, eating disorders (and associated psychiatric disorders) among older women appear to be on the rise (Harris and Cumella, 2006; Gadalla, 2008; Brandsma, 2007).

Body Work: Empowering or Oppressive?

Among women who spend a considerable amount of time on body work, the preoccupation with outward appearance can consume mental and physical energy that could be spent doing other, more productive and health-promoting activities. There is also the question of whether women's body work is empowering or oppressive (Winterich, 2007; Slevin, 2010). In many studies, women declare that by choosing to engage in beauty work, they are exercising personal agency, which improves their body image, increases their self-confidence, and results in feelings of empowerment (Muisse and Desmarais, 2010). By maintaining a socially acceptable appearance, these women are "fighting invisibility", "resisting exclusion", and retaining their "positive cultural capital" (Slevin, 2010, p.1017). However, some argue that body work is ultimately oppressive for women, as it not only consumes a great deal of personal resources (time, effort, money, etc.), but also perpetuates ageist consumer culture and unrealistic norms of female beauty (Winterich, 2007; Slevin, 2010).

DISCUSSION

Strengths and Limitations of Existing Literature

There are several strengths within the body of literature pertaining to older women and body image. As evidenced by the growing number of articles in the qualitative realm, researchers are recognizing the value of qualitative inquiry for capturing the richness and complexity of older women's body image experiences. The use of different techniques to capture women's perceptions, attitudes and behaviours (e.g., interviews, focus groups, narratives, photo diaries, etc.) has enhanced the depth and breadth of investigation. Another strength is that many authors are adopting a feminist approach to their inquiry (e.g., Hurd, 2000; Winterich, 2007; Slevin, 2010). Feminist researchers recognize that "each person exists within a matrix of socially ascribed privileges and oppressions that can shift in importance and meaning depending upon context" (Mitchell and Bruns, 2011, p.122), and that ageism, sexism, commercial interests, and power differentials within our society devalue and disparage older women (Clarke, 2002a). The feminist approach is valuable because it considers social inequalities, respects human diversity, utilizes "theories and methods that accurately depict the everyday life experiences of older people and women" (Covan, 2005, p.6), and advocates for social change.

Despite these strengths, there are several limitations within the existing body of literature on this topic. Among qualitative studies, there is insufficient attention to sample diversity. Study participants are consistently white, middle-class, heterosexual, and from Western cultures, which represents a neglect of other populations and leads to a narrow interpretation of reality. There appears to be a limited number of researchers doing

qualitative work in this area. In Canada, for instance, one author is particularly prominent, having produced approximately 60% of the existing literature on this subject (Roy & Payette, 2012). While replicability is not necessarily a goal of qualitative research, these findings would carry greater weight and meaning if they were reproduced (and perhaps, reinterpreted) by other research groups.

Future Research

There are many avenues and opportunities for future research in this area. In the quantitative realm, there is a need for consensus on the definition of body image for older adults. This may be achieved through the development and validation of measurement tools and investigative techniques that are appropriate for older adults, and therefore, more conducive to capturing the unique body image experiences of this group (Roy and Payette, 2012). There is also a need for longitudinal studies to trace developmental changes in body image across the life course. In addition, future research in this area should strive to include diverse population groups to explore ethnic and cultural differences in body image experience. While there is a growing body of literature examining older men's body image, more studies are needed to explore men's body image issues and body work investment. Other potential topics that would contribute to this field are exploring the relationship between body image and illness/disability and the intersection of body image and sexuality in later life. Lastly, in continuing research on this topic, it will be important to move beyond an assessment of the problem to potential solutions. We already know that body image is a serious and relevant issue among women, young and old alike. We now need to explore how and why certain people are

able to maintain a positive body image into old age. In other words, what are the protective factors that prevent some women from experiencing poor body image and its consequences? These research efforts can guide the development of effective intervention strategies that promote healthy lifestyles, improve body image experiences, and enhance quality of life for aging women.

Societal Implications

Body image among this population has implications for various sectors of society. Health care workers should be aware of potential body image issues among the older women they serve and should be trained to deal with these issues in a sensitive and empathetic manner. Health professionals should also consider the effects of aging, illness, and chronic conditions on women's body image and should be aware that life events, such as menopause and widowhood/divorce, can influence a woman's body image and health/eating behaviours (Brown *et al.*, 2012). An appreciation of these issues can lead to counseling and intervention strategies that promote healthy lifestyles and positive body images. In discussing healthy aging with clients, health professionals should "help women to focus on positive self-evaluations that are based less on physical appearance and more on maintenance of health, functional ability, and overall quality of life" (Fey-Yensan *et al.*, 2002, p.71). Lastly, it is important that all professionals working with older adults take the time to examine their own age and gender-related biases and stereotypes, and consider how these attitudes influence their interactions with and expectations of older clients.

Individuals working in community agencies and senior centres are also in a position to address older women's body image issues. Community-based programs should focus on age-appropriate activities that facilitate choice, creativity, personal fulfillment, and values clarification. Social opportunities and group discussions can provide women with the opportunity to share their body image experiences with others in a safe environment that encourages self-reflection and mutual support. Meaningful and effective educational and support services can help women to "problematize the context rather than themselves" (Mitchell and Bruns, 2011, p.122) and develop strategies of resistance and empowerment. If women are able to develop a sense of self that is based on personal goals, priorities and abilities, rather than outward appearance, this could have a positive impact on body image and self-esteem. When women feel good about themselves and their bodies, they are better able to take care of themselves and lead productive, meaningful lives (Saucier, 2004).

Advocacy groups are needed to encourage and promote media and advertising campaigns that not only use healthy, diverse and realistic images, but also focus on the positive aspects of aging, while reducing the amount of harmful images and messages directed towards women's bodies. In addition, government initiatives should promote media literacy for all ages and genders. Media literacy can help women become aware of the impact that unrealistic beauty ideals can have on their body image and can encourage women to "view media and its emphasis on youth and beauty with a more critical eye" (Saucier, 2004, p.423).

Conclusion

Women struggle with body image issues throughout their lives. These issues are expressed through perceptual evaluations, cognitive interpretations, and attitudinal and behavioural responses. Body image is a vital part of one's identity and discussions surrounding the aging body are fraught with emotions and contradictions. Among older women, age-related changes in appearance are generally viewed negatively and are seen as a threat to beauty, self-identity and social value. However, the importance of appearance does seem to diminish over the lifespan, partially due to the fact that health and physical functioning become more salient components of body image as one ages. Over time, most women come to terms with the natural course of aging and, through a variety of cognitive adjustments, many learn to accept their bodies as beautiful and resilient. Some women, however, do experience continued body issues as they age and in an effort to maintain a youthful appearance, choose to engage in a variety of body work practices that are, arguably, both empowering and oppressive. The implications of poor body image are varied and profound, affecting older women's emotional and physical health, self-esteem, and overall well-being. There needs to be increased awareness of the body image issues affecting older women and appropriate responses from the health care, community, and public sectors.

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PART 3

Health, Eating & Gender

Obesity and Health

Rates of overweight and obesity among Canadian adults have been increasing over the past several decades. From the late 1970's to 2004, obesity rates nearly doubled among both males and females (Tjepkema, 2006). More recent data from the 2008 Canadian Community Health Survey indicates that well over half of the adult population (62.1%) is overweight or obese ($BMI \geq 25.0 \text{ kg/m}^2$), with approximately one-in-four adults (25.4%) falling into the obese classification (Public Health Agency of Canada [PHAC], 2011). Across the country, the prevalence of obesity seems to be highest among adults in the middle to late stages of life (ages 35 to 74 years) (PHAC, 2011). According to one report, approximately 44% of annual provincial health care spending is allocated to the needs of adults over 65 years of age (Duncan, 2012). The high rates of overweight and obesity among Canadian adults is a major public health concern, given that obesity has been associated with many chronic conditions, including cardiovascular disease, hypertension, type II diabetes, and certain cancers, and may increase the risk of premature mortality (PHAC, 2011). It has been estimated that obesity costs the Canadian economy between \$4.6 to \$7.1 billion dollars on an annual basis (PHAC, 2011).

Complex Food Environment

While the causes and contributors of obesity are complex and multi-factorial, there is no denying that food and eating are intricately related to health and disease. For

many years, researchers in the fields of nutrition and public health have been raising concerns about the changing nature of the Canadian food scape. Put simply, Canadians are living in an increasingly ‘obesogenic’ food environment that promotes sedentary lifestyles, excessive food intake, and over-consumption of readily available energy-dense, nutrient-poor foods (Slater et al., 2009; Monteiro et al., 2013). Individuals and families are eating more of their meals outside the home and are increasingly relying on ready-to-eat commercially prepared meals and snacks to meet their nutritional needs in a fast-paced, time-crunched lifestyle (Slater et al., 2009; French et al., 2001). Meanwhile, portion and package sizes continue to get larger, fast food franchises continue to expand all over the country, food advertising has become more seductive and influential, and there has been an explosion of ‘ultra-processed’ foods into the Canadian marketplace (Slater et al., 2009; Monteiro et al., 2013; Moubarac et al., 2012; French et al., 2001). Ultra-processed foods are ready-to-eat products made from processed substances (e.g., refined flour, hydrogenated fats) that are typically high in fat, sugar, sodium and calories, and low in fibre, vitamins and minerals (Monteiro et al., 2013). They are very appealing to consumers because they are not only cheap and easy to access, but also “have a long shelf-life, dispense with culinary preparation and the need for dishes and cutlery, and are intensely palatable and appealing to the senses” (Moubarac et al., 2012, p. 2242). These consumption trends, which are expected to continue, can partly be attributed to “lack of time to prepare food, women working outside the home, waning food preparation skills and aggressive promotion of low-nutrition foods” (Slater et al., 2009, p. 2222).

At the same time, we’re seeing the emergence of an ‘orthorexic society’, whereby individuals are socialized to take charge of their own health and experience profound

moral pressure to achieve a healthy diet and an acceptable body weight (Rangel et al., 2012; Nicolosi, 2006). Prevailing discourses in nutrition and health promotion continue to promote an individualistic lifestyle approach that places the blame and responsibility for weight/health issues on individuals, while ignoring the societal, psycho-social and socio-cultural influences that influence food and eating. These health messages also reinforce a culture of self-surveillance, slimming and dieting that is largely directed at women (Germov & Williams, 1996; Rangel et al., 2012). The message ingrained in Western mass media is that thinness equals better health, happiness, and success, and the way to thinness is through controlling one's food intake. A thin body (which, at one time, signified poverty and lower social status) is now associated with positive characteristics of youth, health, intelligence, self-control, and discipline. In contrast, fatness is seen as a "sign of moral and physical decay" (Bell & Valentine, 1997, p. 36). Using the terms "obesity epidemic" and "war on fat" to promote their message, health reporters inform us that eating is at the heart of disease, obesity is simply caused by despicable self-indulgence, and that our issues with weight result from lack of self-discipline and willpower (Poulton, 1996). In response to these strong sociocultural messages, there has been an influx of 'health foods', detoxes, cleanses, natural health products, nutraceuticals, diet supplements, and weight loss plans into the consumer marketplace. All of these products claim to offer quick and easy solutions to our body, weight and eating problems. In essence, our concerns about weight and food have been exploited by advertisers through the continued use of stick-thin models, the promotion of products that promise thinness, and the underlying message that the perfect body is within reach given the right amount of effort, willpower, and financial investment. The business of weight loss is incredibly lucrative, even though its success is

built on its customers' failures. Yet, North American women are buying what they're offering, collectively squandering over 50 billion dollars (per year) in an effort to meet their weight loss goals (Poulton, 1996).

Research suggests that consumers are becoming increasingly conscious of their food choices and are selecting food products that promote health, but also address their concerns regarding body shape and weight (Agriculture & Agri-Food Canada, 2004; Agriculture & Agri-Food Canada, 2009a; Mehrotra, 2004; Hasler, 2002; Siro, Kápolna, Kápolna & Lugasi, 2008). Consumers are making more of an effort to consume fruits and vegetables, reduce their salt and sugar intake, look for nutritional information at restaurants, and choose foods with perceived health benefits (Dietitians of Canada, 2014). Women are particularly interested in nutrition; they tend to have greater nutrition knowledge and seek nutrition counseling more frequently than men (Kiefer, Kunze & Rathmanner, 2005). For many women, especially, beliefs and attitudes about health and body weight play a key role in personal food choices (Rangel et al., 2012; Sun, 2008; Brownie & Coutts, 2013). In fact, women perceive food choices to be one of the most important factors influencing personal health (Hargreaves, Schlundt, Buchowski, 2002; Blake & Bisogni, 2003; Lindeman & Stark, 1999). In North America, women are becoming increasingly concerned about what is in their food and are spending a great deal of time researching, organizing, selecting, and obsessing over food (Rangel et al., 2012; Nicolosi, 2006). Furthermore, an increasing number of women are turning to diet plans and programs to help structure and guide their food choices in our increasingly complex and confusing food environment (Rangel et al., 2012).

Gendered Food

On top of the complexities ingrained in the Canadian food system, there are also socially-constructed expectations of what and how much women should eat (Germov & Williams, 1996; Ristovski-Slijepcevic et al., 2010). In stark contrast to masculine expectations surrounding food, the feminine way of eating encourages control, delicacy and restraint. Even in the Victorian era, elite women were warned of “the dangers of indulgent and over-stimulating eating and advised how to consume in a feminine way (as little as possible and with the utmost precaution against unseemly show of desire)” (Bordo, 2003, p. 112). In contrast, men tend to have a relaxed, uncomplicated and pleasure-oriented attitude towards food (Kiefer et al., 2005). Men are allowed, even encouraged, to eat heartedly and voraciously, for pleasure, strength, and fullness (Bordo, 2003; Wardle et al., 2004). We even associate certain foods with specific characteristics in order to satisfy these gender expectations. For example, meat is considered to be a ‘manly’ food, and a man who wants to appear strong and masculine is more likely to eat foods described as strong and masculine (Shah, 2010). On the other hand, foods assigned qualities of ‘lightness’ and ‘delicacy’ (e.g., salads, fruits, yogurt) are considered to be more appropriate for women (Varney, 1996). Studies of actual food intakes confirm gender differences in consumption: women tend to eat more fruits, vegetables, dairy products, whole grains, and vegetarian meals, whereas men tend to prefer red meats, sausages, eggs, alcohol, and potatoes (Kiefer et al., 2005). Food cravings also appear to differ between the genders; men tend to desire protein-rich foods such as steak and sandwiches, whereas women tend to crave carbohydrate-rich foods, sweets, chocolate and ‘comfort foods’ (Shah, 2010; Kiefer et al., 2005). Whereas men tend to have good feelings after indulging a craving (Kurzer, 1997),

women are more likely to report negative emotions, such as guilt and shame (Kiefer et al., 2005). According to Varney (1996), “Men eat food. Women also conduct a courtship and discourse around it” (p. 273).

The expectations and (silent) rules surrounding the gendered nature of foods have consequences, particularly for women. That is, the ‘feminine’ way of eating ultimately serves to reinforce concerns about body image and weight among women. In comparison to men, women tend to exhibit more restrained eating, obsessive calorie counting, dieting, and disordered eating (Kiefer et al., 2005). They also tend to report more issues with emotional eating and food cravings (Kiefer et al., 2005; Kurzer, 1997). According to Chernin (1985), “[women] discharge tension by turning to food... we eat and vomit, fast and eat again, plan new diets, come up with new nutritional schemes, all in an effort to manage life’s complexities” (p. 149).

In addition to their anxieties surrounding body weight, many women experience additional pressures related to the provision and consumption of food within the home. Although gendered role expectations are gradually shifting, women are still the primary nutrition gatekeepers and food providers in the majority of Canadian households (Heslop, Madill, Duxbury & Dowdles, 2006; Beagan, Chapman, D’Sylva & Bassett, 2008; Polegato & Zaichkowsky, 1999). In general, women acknowledge the value of home cooked family meals and feel ultimately responsible for providing nutritious and satisfying meals to their families (Beagan et al., 2008; Slater, Sevenhuysen, Edginton & O’Neil, 2011). As such, food-related activities (including meal planning, budgeting, grocery shopping, food preparation and cooking, serving, and clean-up) consume a large portion of women’s time and mental energy, and can result in a great deal of stress,

especially among working women who are simultaneously trying to pursue a productive and fulfilling career (Heslop et al., 2006; Slater et al., 2011). According to Chernin (1985), “food has defined female identity through the domestic routine of daily means – that endless, tedious round of supermarket, refrigerator, table, and kitchen sink from which we are so legitimately eager to free ourselves” (p. 197). Amidst their other roles and responsibilities, women use different strategies and coping mechanisms to get food on the table every day, with some women succeeding more than others (Heslop et al., 2006; Johnson, Sharkey, Dean, McIntosh & Kubena, 2011). For example, women tend to accommodate the preferences of other family members in order to prevent conflicts and ensure everyone is satisfied, even if it means neglecting their own preferences and healthy eating goals (Charles & Kerr, 1988; McKie, Wood & Gregory, 1993). Despite the disproportionate amount of time spent on food-related tasks, these skills often go unrecognized and undervalued in the home.

Being constantly surrounded by and involved with food can make it difficult for women to achieve their weight loss goals. That is, women are expected to be around food all day and feed their families delicious and satisfying meals, while simultaneously controlling their own appetites and denying food to themselves (Charles & Kerr, 1988; Tunaley et al., 1999). Put simply, “eating food [is] a great deal less feminine than preparing it” (Varney, 1996, p. 272). Thus, women’s relationship with food in the home is inherently problematic and precarious, fraught with contradictions and anxiety. At the same time, they feel pressure to model healthy eating behaviours in an effort to prevent concerns about weight and dieting from being transferred to their impressionable, equally objectified, daughters (Abraczinskas et al., 2012).

Food Advertising

Food companies normalize gendered nature of food by developing products and marketing campaigns that reinforce a feminine way of eating. An example is the blatant use of certain words to differentiate products geared towards men versus women (Wiseman, 2010). For example, Nestlé[®] has produced two different versions of essentially the same chocolate bar: *Kit Kat Chunky*[®] (manly) and *Kit Kat Senses*[®] (more lady-like). In the case of cold cereals, Kashi[®] Berry Blossoms[™] (“*a tasty and nutritious way to prepare your family for a good day*”) is for women, whereas Kellogg’s[®] Vector[®] (“*with Vector you’ve got the right attitude to be in the game*”) is a man’s breakfast.

Food companies are acutely aware of the fact that many women engage in dieting behaviour, and advertisers are experts at exploiting the conflicting feelings and inevitable frustrations that female dieters experience. These commercials and print advertisements resonate with female audiences by normalizing the experience of dieting, acknowledging that dieting is difficult and frustrating, and assuming that most women are familiar with the bland, flavourless foods that often accompany dieting. Advertisers reinforce the notion that high-calorie, high-fat (i.e., tasty) foods are ‘sinful’ and promote the message that women will be successful in their pursuit of thinness if they just buy the right products (Wilson & Blackhurst, 1999). The most dangerous element of food advertising is that they do an outstanding job of normalizing body dissatisfaction and weight preoccupation, evoking guilt and shame about women’s appetites, and inducing “fear and anxiety about the potential consequences of unrestrained eating” (Wilson & Blackhurst, 1999, p. 113).

If women are not being depicted as overly concerned about their bodies and anxious about giving in to their temptations, then they are being portrayed as the responsible,

unconditionally loving mother who is busily preparing or serving a satisfying and nutritious meal to her family. This is evidenced in the recent proliferation of advertisements promoting pre-made meals and convenience products that offer to help working women manage the conflicting responsibilities of home and work life. Thus, not only do food advertisers target the body and food concerns of women, they also reinforce role expectations by portraying women as nurturing homemakers, confined to the kitchen.

In the context of this complicated and confusing environment of mixed messages and competing expectations, eating can become a source of stress and substantial worry for many women (Lindeman & Stark, 1999). All of these messages surrounding health, gender, food and the body reinforce body image issues and disordered eating among women.

CHAPTER 3

Methods

Methodological Approach

This study is guided by the theoretical perspective of pragmatism. The defining feature of pragmatism is that the main focus is on the research problem. The pragmatic perspective is also concerned with finding applications and solutions to problems. To this end, pragmatism recognizes the practical value of using a variety of approaches to understand the problem (Creswell, 2009). In other words, researchers are free to select the methods and procedures that best address the research question(s) at hand. This worldview is common among mixed-methods researchers, as it is “not committed to any one system of philosophy and reality... Inquirers draw liberally from both quantitative and qualitative assumptions” (Creswell, 2009, p. 10). According to Creswell (2009), “for the mixed-methods researcher, pragmatism opens the door to multiple methods, different worldviews, and different assumptions, as well as different forms of data collection and analysis” (p. 11). With this in mind, it is worth noting that this project is also heavily influenced by the constructivist worldview, as evidenced by the priority given to qualitative data. Constructivism seeks to understand the world in which participants live by collecting subjective meanings of their experiences (Creswell, 2003). The goals of this form of inquiry are to (a) rely on participants’ views of the situation being studied, (b) accept and appreciate varied and multiple meanings of a phenomenon, (c) understand the historical and cultural settings that influence individuals, (d) make sense of, or interpret,

the meanings others have about a phenomenon, and (e) inductively develop patterns of meaning (Creswell, 2003, p. 8).

Guiding Framework

The framework used to guide this research project is included in Appendix A. This visual framework was drafted after conclusion of the literature review and aims to portray the various relationships and interactions of factors related to the topic of interest, that is, BD. In essence, this framework depicts the multiple pathways and relationships between body image, BD, and food and body related attitudes/behaviours. Other influential, associated, interacting, and mediating variables also appear throughout the diagram. For instance, factors that influence body image appear on the left-most side of the diagram and are categorized into biological, environmental, social, health-related, and individual factors. The level of importance attributed to body/appearance appears as a mediating variable between BD and eating and body related attitudes/behaviours. On the right-most side of the diagram (stemming from eating and body related attitudes/behaviours) appears a list of the various health and nutritional consequences that may result. Most of the variables that appear within the framework (i.e., the associated/predisposing factors, resultant food-related behaviours, and health consequences) have been described linearly during the literature review portion of this paper. Bolding and shading were used to highlight the topics and relationships that are of particular interest to the researcher. In other words, the bolded areas of the diagram emphasize the variables that this study seeks to explore. Some of the bolded areas (e.g.,

the relationship between BD and consumption of functional foods) remain unexplored in the academic literature and represent an area of novel research.

Study Design

Research Approach

Currently, there is a lack of research examining the body image issues, aging concerns, and food choices/attitudes of baby boomer women. This study narrows this gap through the use of both qualitative (focus group discussions) and quantitative (questionnaire) methods. A concurrent mixed-methods design, with a greater focus on qualitative data collection and analysis, was used to explore the body satisfaction, concerns about aging, and food choices/attitudes of urban and rural-dwelling baby boomer women in Manitoba.

Mixed methods research has been defined as, “a systematic integration of quantitative and qualitative methods in a single study for purposes of obtaining a fuller picture and deeper understanding of a phenomenon” (Johnson, Onwuegbuzie & Turner, 2007, p. 119). This research approach seeks to overcome the inherent flaws and capitalize on the strengths of other approaches. According to Creswell & Plano Clark (2007), “the use of quantitative and qualitative approaches in combination provides a better understanding of research problems than either approach alone” (p. 5). For this research study, both open-ended and close-ended questions were used to collect different forms of data (text and numeric), which allowed for both thematic and statistical analyses. In this way, “different but complementary data on the same topic” was obtained (Creswell & Plano Clarke, 2007, p. 62). Ultimately, this procedure enabled the researcher to more

deeply and accurately explore the topic of interest (i.e., the body and food-related experiences and attitudes of baby boomer women).

When planning a mixed-methods study, consideration must be given to the following factors: Timing, Weighting and Mixing (Creswell & Plano Clarke, 2007).

1. Timing

According to Creswell & Plano Clarke (2007), timing “refers to the temporal relationship between the quantitative and qualitative components within a study” (p. 81) and can be classified as concurrent or sequential. For this study, a concurrent procedure was used, in that both forms of data (qualitative and quantitative) were collected simultaneously.

2. Weighting

According to Creswell & Plano Clarke (2007), “weighting refers to the relative importance or priority of the quantitative and qualitative methods to answering the study’s questions” (p. 81). In other words, priority can be given to either the quantitative or qualitative data, or both can be treated equally. Some factors that may influence the weighting decision include the researcher’s theoretical drive; which data collection method is best suited to the study’s purpose; resource allocation; the researcher’s experience with each method; and the intended audience (Creswell & Plano Clarke, 2007). For this study, the qualitative data (from focus group discussions) was given slightly higher priority, due to the richness of data obtained via this method.

3. *Mixing*

The third component of planning a mixed-methods study is deciding how the different methods will be mixed. Some common forms of mixing include integrating (also called merging), connecting or embedding. Integrating involves transforming one data type into the other type in order to merge the results, whereas connecting “occurs when one type of data leads to the need for the other type of data” (Creswell, 2009, p. 84), as is often the case in sequential (two phase) designs. This particular study employs an embedded design, whereby one form of data (in this case, qualitative) is the primary method, with the secondary form of data (quantitative) providing supporting information.

When all of these design factors are considered, this study can be described as Concurrent Mixed-Methods using an Embedded Design. For a visual overview of the mixed methods procedure used in this study, including all aspects of quantitative and qualitative data collection, analysis and interpretation, please refer to Appendix B.

Qualitative Strategy of Inquiry

For the qualitative strategy of inquiry, this study includes elements of phenomenology. Phenomenology involves studying participants’ subjective opinions and interpretations in order to develop patterns and relationships of meaning. That is, the researcher seeks to collect participant experiences and attitudes concerning a phenomenon (in this case, BD) in an effort to understand the true lived experience (Creswell, 2003). Qualitative data, encapsulating the views, values, beliefs, feelings,

assumptions, attitudes, and ideologies of baby boomer women, was collected through the use of open-ended questions in a focus group setting. Focus groups were chosen as the most appropriate method of collecting qualitative data, as they are designed “to obtain perceptions on a defined area of interest in a permissive, nonthreatening environment” (Krueger & Casey, 2000, p. 5) in order to more deeply “understand how people feel or think about an issue, product or service” (p. 4). Following qualitative data collection, meanings, themes, and patterns were derived through the use of categorical coding and thematic analysis.

Quantitative Strategy of Inquiry

For the quantitative strategy of inquiry, a non-experimental approach was employed. The researcher collected cross-sectional data from a group of participants. Quantitative data was collected through the use of a paper-and-pen questionnaire. The purpose of this questionnaire was to collect important demographic/descriptive information (e.g., household income, education level, etc.) and more concretely measure certain variables of interest (e.g., level of body dissatisfaction, dieting frequency, use of functional foods, etc.). The quantitative data also serves to supplement the more exploratory qualitative data, in order to provide a comprehensive analysis of the topic at hand.

Methods

The following sections will outline the details of the proposed study, with respect to population of interest, participant recruitment and eligibility criteria, quantitative and

qualitative data collection and analysis procedures, anonymity and confidentiality, potential risks, and compensation.

Population of Interest

The population of interest for this study was baby boomer and older women living in rural and urban areas of Manitoba. The following cut-off criteria were used to define these participant groups: ‘baby boomer women’ are women born between 1946 and 1964 (ages 45-64 at time of data collection), and ‘older women’ are women born prior to 1946 (ages 65 and older at time of data collection).

Fourteen focus groups, each consisting of seven to twelve women were conducted in rural and urban communities within Manitoba (n=137). Seven focus groups were with baby boomer women (n=68), and the remaining seven focus groups were with older women (n=69).

To be eligible to participate in this study, potential participants had to meet the following inclusion criteria: (a) female, (b) born between 1946 and 1965 *or* prior to 1946, (c) live in Manitoba, (d) speak fluent English, and (e) be able to attend a two hour focus group session. Only one participant per household was permitted to participate.

Participant Recruitment

Convenience and snowball sampling techniques were used to recruit baby boomer and older women living in rural and urban areas of Manitoba. Participants were recruited from a variety of environments to emphasize their diverse backgrounds and experiences within rural and urban Manitoban communities.

The principal researcher recruited participants in Winnipeg by putting up posters at the University of Manitoba and in various community places (libraries, churches, recreation facilities, community centres, senior centres, etc.) across the city. (See Appendix C for a sample of the recruitment poster). Additional participants were recruited by emailing personal and professional contacts to spread the word and through word-of-mouth. A total of 51 potentially interested participants were recruited.

The Manitoba Women's Institute (MWI) assisted with participant recruitment as well as focus group logistics in the urban municipality of Brandon and in various rural communities across Manitoba (Russell, Reston, St. Pierre and Hamiota). The research study was mentioned at one of the MWI board meetings, and willing MWI Representatives voluntarily agreed to advertise the study and recruit eligible participants in their respective areas. These MWI Representatives were contacted by the principal researcher to thank them for their time and to provide them with necessary information for carrying out recruitment (see Appendix D for letter sent to MWI representatives). They were also given copies of the recruitment poster (Appendix C) to put up in various places in their communities (e.g., recreation centres, churches, grocery stores) as well as a brief recruitment letter (Appendix E), which they were encouraged to distribute to any interested participants who wanted more details about the study. This letter explained the study objectives and methods, and included contact information for the principal researcher should they have any further questions. After approximately one month, the MWI Representatives forwarded a list of interested women (including their names and contact information) to the principal researcher. With the help of these MWI Representatives, a combined total of 147 interested participants were recruited from the

urban municipalities of Winnipeg and Brandon, as well as the rural municipalities of Hamiota, Pipestone (Reston), Russell and De Salaberry (St. Pierre).

All interested participants were mailed a package containing a final participant information letter (Appendix F) and a consent form (Appendix G). The information letter outlined the purpose of the study as well as all data collection procedures. The information letter also described the process of voluntary consent and outlined measures taken to ensure anonymity and confidentiality. The letter also contained details regarding the date, time, and location of their scheduled focus group session. Participants were asked to read the enclosed consent form at home, sign it, and bring it with them to their scheduled focus group session. Extra copies of the consent form were made available at each focus group session, in case any participants forgot to bring their signed consent form with them. Each participant was also given a second copy of the consent form for their own reference and records.

Of the 147 interested participants, nine decided not to participate. Reasons for declining participation were varied, but bad weather on the day of the scheduled focus group and unforeseen illnesses were influential factors. One participant completed the questionnaire, but was excluded from data analysis because she could not complete the other two components of data collection (anthropometric measurements and the focus group). In the end, a total of 137 women participated in all components of the study.

Data Collection Procedures

Data collection took place over a three month period (October to December 2011) and involved the following procedures: (1) Focus Group Sessions (qualitative); (2)

Questionnaire (quantitative); and (3) Anthropometric Measurements (quantitative). From arrival to departure, data collection for each site took approximately 1.5 to 2 hours in total, which allowed 30 minutes for completion of the questionnaire and anthropometric measurements, with 1 to 1.5 hours remaining for the group discussion.

1. Focus Group Sessions

Fourteen focus group sessions were held in the following Manitoban communities: Winnipeg (urban), Brandon (urban), Hamiota (rural), Reston (rural), Russell (rural), and St. Pierre (rural). In each town, two focus group sessions were held (one with baby boomer women and the other with older women), with the exception of Winnipeg, where there were four focus groups in total (two with baby boomers, two with older women). Seven focus groups were with baby boomer women (n=68), and the remaining seven focus groups were with older women (n=69). These focus group sessions were used to more deeply explore the body, aging and food related experiences and attitudes of participants. The principal researcher acted as the moderator for all fourteen focus groups. A semi-structured Moderator's Guide (Appendix H) was used to facilitate group discussion on the following topics: (1) body image perception/body satisfaction, (2) concerns about aging and appearance, (3) dieting/weight loss, (4) barriers to healthy eating and food choice influences, and (5) attitudes/perceptions towards certain types of food products. Several prompting, probing and clarifying questions were used to help elicit responses, as needed.

All focus group discussions were digitally recorded on audio tape to facilitate transcription and data analysis. At each session, three different recording devices were placed around the room to capture the discussion. This ensured that all voices were captured equally and provided a sense of reassurance in case one piece of equipment should fail or run out of battery. Furthermore, a trained and experienced note taker was present at each focus group to record any non-verbal behaviour or interactions that took place, as well as any individual or group dynamics that were not conducive to audio recording. The principal researcher (who served as the moderator for all groups) also took field notes throughout the course of data collection.

2. Questionnaire

Upon arrival at their focus group session, all participants were asked to complete a self-administered pen-and-paper questionnaire (Appendix I). The principal researcher was present at all times to address any items of concern/confusion and ensure completeness upon submission. Using this questionnaire, demographic and health information (e.g., age, marital status, household income, education level, self-reported stress level), as well as information pertaining to variables of interest (body/weight satisfaction, attitudes and concerns about aging/appearance, dieting/weight maintenance behaviours, food choices, and use of local, organic, functional, diet and anti-aging products) was collected for each participant.

3. Anthropometric Information

After completing and submitting the questionnaire (but before the focus group discussion began), participants' height and body weight were measured. Weight was measured using a bathroom scale, and height was measured against a flat wall using a ruler, marker, and measuring tape. The collection of anthropometric information was completed by a trained research assistant in a separate room so that participants could not see or comment on each other's measurements. This ensured that anthropometric measurements were not easily observable by others, thus helping to prevent the sharing of personal information, avoid possible embarrassment, and uphold the dignity of participants.

The purpose of obtaining anthropometric information was to calculate the BMI of each participant. This allowed the researchers to discern whether women who are at a 'normal' weight for their height, that is, women who fall within the BMI range of 18.5 – 24.9 (Health Canada, 2003), experience BD and/or report dieting behaviours to the same extent as women who fall within the higher BMI categories (e.g., 'overweight' or 'obese'). Several other studies have discovered that BD is an issue not only among overweight women, but also among a high proportion of normal weight women (McLaren & Kuh, 2004; Mangweth-Matzek et al., 2006).

Collecting anthropometric data also allowed the researchers to determine the amount of desired weight loss by calculating the discrepancy between desired weight (reported in the questionnaire) and actual weight (measured by the researcher) for each participant. Past studies have used this method to quantitatively assess BD among middle-aged and older women, with a larger discrepancy between actual and

ideal body weight indicating greater BD (Allaz et al., 1998; McKinley, 2006; McLaren & Kuh, 2004).

Research Materials

1. Questionnaire Development

The questionnaire was developed by the principal researcher in consultation with the primary advisor, following a lengthy in-depth literature review process. Questions were stated as simply as possible, with consideration as to what question format would be (a) most appropriate for the variable of interest and (b) most understandable for the target group. Prior to use with the study participants, the questionnaire underwent expert review as well as pre-testing with a sample group from the target population. The feedback obtained from both groups was very valuable and enabled the researchers to improve the questionnaire's readability, clarity and format. These procedures are described in more detail below.

A) Expert Review Group: The questionnaire was first reviewed by a group of experts in the fields of body image, older adults, and community nutrition. A total of ten experts, primarily nutrition professors and registered dietitians working with body image and/or older adults, reviewed the questionnaire for relevance and clarity. The expert reviewers were given a consent form, the questionnaire, and space for written feedback (all contained in Appendix J). The consent form explained the study purpose and methods and gave instructions as to their role as an expert reviewer. The items on the

questionnaire remained the same, but the format was modified slightly to allow room for the reviewer to assess the relevancy and clarity of wording for each item using a rating scale of one to five. A space for written feedback was also provided so that expert reviewers could provide any additional comments and/or suggestions for improvement. Based on their feedback, some slight modifications to the questionnaire were made. This expert review process improved the content validity of the questionnaire and helped to ensure that the questions were relevant to the issue being studied.

B) Pilot Testing of Questionnaire: The questionnaire was pre-tested by a sample group of women (n=10) from the target population (i.e., women over 46 years of age). These women were asked to complete the questionnaire and then provide written feedback regarding the wording, clarity, length, and structure. These women were given three documents: a consent form, the questionnaire, and a feedback form (see Appendix K). The consent form briefly explained the study and provided instructions as to their role. They were told that their responses would not be included in data analysis or results. The feedback form asked a couple of specific questions, for example: How many minutes did it take you to complete the questionnaire?; Was the font type and size easy to read?; Were there any words in the questionnaire that you didn't understand?; and allowed room for additional comments/suggestions at the end. A total of ten women completed and provided feedback on the questionnaire. Based on their responses and comments, some minor

modifications to the format and wording of the questionnaire were made. This procedure helped the researchers ensure that the questionnaire would be understandable and appropriate for women in the target population group.

2. Focus Group Sessions & Moderator's Guide

The focus group sessions were planned using the textbook 'Focus Groups: A Practical Guide for Applied Research' (Krueger & Casey, 2000) as a guiding reference. The principal researcher acted as the moderator for all fourteen focus groups. According to Krueger & Casey (2000), "the role of the moderator is to ask questions, listen, keep the conversation on track, and make sure everyone has a chance to share" (p. 9). The moderator must also be careful to control his/her own verbal responses and body language in order to remain neutral and non-judgmental, while still showing interest in what the participants are saying (Krueger & Casey, 2000). Prior to the focus groups, the principal researcher prepared for this role by reading a variety of texts and papers on the subject of moderating focus groups, attending a professional development workshop on qualitative data collection, and completing moderator training by the primary advisor. Among other things, this training provided valuable tips and tools for managing group dynamics and dealing with unforeseen/unexpected issues.

The Moderator's Guide (Appendix H) was created by the principal researcher, based on the steps outlined in Krueger & Casey (2000), with ongoing assistance and feedback from the primary advisor. The questions were broadly based on the research questions and the overarching research objectives. The moderator's guide opens with

a welcome and introduction, a brief overview of the research study, a list of ground rules, a group ice breaker activity, and then proceeds into the general discussion questions. Twelve open-ended questions were used to guide discussion on four general topics: (1) body image/body satisfaction; (2) experiences of and attitudes towards aging; (3) healthy eating and food choices; (4) food product attitudes. Several prompting, probing and clarifying questions were listed under each question to help elicit responses, if needed. These prompting questions were basically a re-statement of the initial question using different words or a different approach. At the end of every discussion, participants were given the opportunity to add extra comments/opinions or clarify previous responses. The moderator's guide ended with a statement of thanks, a note of encouragement to promote positive body image among participants, and distribution of a resource list and the \$25 grocery store gift card.

Data Analysis

As is the case with a Mixed Methods Concurrent Embedded Approach, one form of data was given greater weight than the other. In this particular study, the qualitative data analysis was emphasized in the reporting of results, due to the richness of data obtained via this method. The quantitative data serves as supplementation to the qualitative results.

1. Qualitative Analysis

The primary method of collecting and analyzing data and interpreting results was via the qualitative approach. After each focus group, field notes and personal reflections were recorded by the principal researcher. Some of these thoughts were shared, discussed and reflected upon with the research assistant, in a sort of informal process of peer debriefing. Upon completion of all fourteen focus groups, the audiotapes were transcribed to text. The principal researcher transcribed the first focus group; all other focus group recordings were transcribed verbatim by a trained and experienced transcriptionist. All audio-to-text transcriptions were double-checked for accuracy by a research assistant.

Following transcription, the principal researcher read through all the transcriptions in their entirety, to obtain a general sense of the data and reflect on overall themes and meanings. From this, a list of preliminary themes was developed. Throughout this process, the researcher recorded notes, first impressions, and general thoughts in the margins of each document. These preliminary themes were presented to the participants at the MWI annual convention in April, 2012 and through a printed newsletter distributed to all MWI members. Through this process of ‘member checking’, participants were able to provide feedback on the preliminary themes that had been identified.

Thematic analysis using a coding procedure, as described in Creswell (2009), was used to analyze the qualitative (focus group) data. According to Creswell (2009), “Coding is the process of organizing the material into chunks or segments of text... It involves taking text data or pictures gathered during data

collection, segmenting sentences (or paragraphs) or images into categories, and labeling those categories with a term, often a term based in the actual language of the participant” (p. 186). To begin the coding process, a preliminary list of coding words was developed from the research questions. Additional code words and sub-categories were inductively generated upon re-reading the transcripts. This rough list was then sorted into categories, based on the hierarchies and relationships between code words. This list was revised and re-organized several times, based on reflection by the principal researcher and feedback from the research assistant, note taker, and advisor. This coding schematic was then applied to a subset of the transcripts. Four focus group transcripts (two with baby boomer women, two with older women) were randomly selected in order to ‘test’ out the preliminary coding structure. Both the principal investigator and the research assistant carried out pen-and-paper coding for these four transcripts. That is, code ‘names’ were written next to the appropriate segments of text. The results of this preliminary coding were compared to assess inter-coder reliability. Based on this comparison, a few codes were deleted, added and re-organized and our final ‘code list’ was established (Appendix L).

All transcripts were first coded by the principal researcher using pen and paper. All transcripts were then input into NVivo8 QSR International software (2008) for final content analysis. The NVivo8 platform was used to organize codes and categories, run a series of queries (e.g., word frequencies) and assist in generating overall themes and patterns. Once all of the coding was completed in NVivo8, each code was printed out and reviewed by the principal researcher to

identify and pull out overarching themes, meanings, and important quotes within each 'category' of text. This process resulted in a table of final themes and sub-themes (with columns for their detailed meanings and exemplary quotes) as well as visual hand-drawn diagrams demonstrating the relationships between themes and sub-themes. This entire process, which involved re-reading, re-coding and re-analyzing the transcripts several times over allowed the principal researcher to become completely immersed in and intimately familiar with the qualitative data.

2. *Quantitative Analysis*

Quantitative data obtained from the questionnaire and anthropometric measurements was compiled and analyzed using the statistical analysis program SPSS (Statistical Package for Social Sciences) release #20.0 for Windows. The primary researcher entered all data into SPSS and data entry was checked for accuracy by a research assistant. Descriptive statistics (i.e., means, standard deviations, frequencies, and percentages) were used to describe the variables of interest. Additional analyses (i.e., ANOVA, Chi-square tests) were used to compare data across age, BMI, location of residence (urban vs. rural), level of body satisfaction, and other variables. The normality of the data determined if parametric or non-parametric tests should be used. A p -value ≤ 0.05 was used to signify statistical significance.

Study Ethics & Logistics

Participant Consent

Informed voluntary consent was obtained from all participants prior to their involvement in the study. As stated in the information letter, participants were asked to read the enclosed consent form at home, sign it, and bring it with them to their scheduled focus group session. Extra copies of the consent form were made available at the session, in case some participants forgot to bring their consent form with them. Each participant was given a second copy of the consent form to take home for their own reference and records.

Anonymity & Confidentiality

Participants' confidentiality and privacy was maintained through the use of numeric data to code responses, perceptions, opinions, and anthropometric information obtained from the focus group sessions and questionnaire. Before the start of the study, each participant was assigned a randomly generated number. During the focus group discussion, participants identified their responses using their name (i.e., by preceding their comment with their name). When this data was transcribed from audio tape to text, participant names were replaced with their assigned number. The numerical code was also assigned to the participant's questionnaire and anthropometric data. From this point forward, all participant information was identified and referred to by numerical code only. None of the data collected was identifiable by name or other personal information and reporting was done on a total group basis only.

All of the data collected, including consent forms, contact information, audio recordings, transcripts and questionnaires, were stored in a locked cabinet in a locked room (418 Human Ecology Building) that was accessible to the researchers only. The audio tapes and all paper documents (including consent forms) will be destroyed within five years or one year after initial publication, whichever comes first. All electronic documents and data were encrypted and password-protected, and thus, were accessible by the principal researcher only.

Potential Risks & Measures Taken to Minimize Risk

Prior to embarking on this study, a thorough assessment of the potential risks to participants was conducted. Participants were asked to share their attitudes, opinions and perceptions of body image, dieting, aging, and body weight. Thus, there was the potential risk that participants may become self-conscious or embarrassed by sharing information of this nature. Personal questions regarding body satisfaction (or dissatisfaction) and concerns about aging/appearance were also asked, and this could have made some participants feel vulnerable or exposed. Given the personal and subjective nature of the questions, the possibility that some participants will have differing views and opinions was anticipated. Thus, there was the risk of verbal disagreement or outright challenging of opinions from members of the group, which could make certain participants feel criticized, wrongly judged or personally attacked.

The researchers and moderator present at the focus group session took special measures to avoid all of these potential risks from occurring. An ‘ice breaker’ (opening question) was used at the start of the session to build rapport, put participants at ease, and

create an open and relaxed environment. The moderator also outlined ‘ground rules’ to the group before starting the focus group session, in an effort to prevent the occurrence of judgmental comments and encourage respectful listening (see Appendix H). For example, participants were reminded of the importance of listening to and respecting each other’s comments and opinions. The moderator stressed that there are no right or wrong answers to any of the questions, and that participants should feel free to share their opinions/thoughts without any prejudice or judgment. Participants were also reminded that their responses will be kept strictly confidential and that no identifying information would be linked to their comments. Participants were also asked to keep others’ statements and opinions confidential; however, the researcher cannot guarantee that all participants abided by this request. The moderator also emphasized that participants are free to withdraw from the study at any time and may refrain from answering any questions that they are uncomfortable with or prefer to omit.

The moderator was trained in group dynamics and management and was prepared to deal with issues and confrontations that may arise in group settings. For example, if any participant were to express judgmental or prejudice comments or directly ‘put down’ another participant, they would be kindly asked to return to the topic at hand. If a participant continued to express judgmental comments or directly attack another participant’s opinion, they would be reminded of the ground rules, as stated at the beginning of the session. The moderator may also offer to speak privately with the person regarding their issue/concern once the focus group has come to an end. Expulsion was not considered a useful option, as this would nullify the differences in perspective,

experience, and opinion that focus groups are designed to elicit. Fortunately, none of these types of issues took place during the focus group sessions.

Given that the moderator was also a Registered Dietitian, another potential issue was the risk of power relations within the focus group setting. That is, if participants knew they were speaking with a dietitian, they might not be as honest or forthcoming as they would otherwise. They might withhold their true thoughts and feelings, out of fear that they would feel judged or embarrassed for certain behaviours or lack of nutrition knowledge. In light of this, the moderator was extremely aware of keeping all responses neutral and non-threatening. For each session, the moderator strived to create a welcoming, non-threatening environment so that participants felt comfortable sharing their personal experiences, attitudes and opinions.

Another important issue worth discussing is the concept of ‘Double Agency’ in qualitative health research (Edwards & Chalmers, 2002), which occurs when the boundaries between the therapeutic and research relationship are blurred. More specifically, the researcher feels an inner conflict between his/her role as a researcher and his/her responsibilities as a health professional. The moderator was prepared for this situation to arise during the focus group sessions (e.g., a participant needing answers to an ongoing nutrition problem), and was equipped with strategies for handling it appropriately.

To end each focus group session, the moderator gave a brief motivational talk about the beauty and uniqueness of individual bodies. This closing statement was intended to give participants a self-esteem ‘boost’ and encourage them to be healthy, but more importantly, love themselves and their bodies as they are. In this closing statement,

self-acceptance and respect of body diversity was emphasized, and a focus on living a healthy, balanced and personally-fulfilling life was encouraged. This closing statement ended the focus groups on a positive note and encouraged participants to speak lovingly and positively about themselves and others.

In addition, each participant received a list of helpful resources, phone numbers and websites where they could access more information on body image, healthy eating, and eating disorders, should they want to seek out more information or help in these areas (see Appendix M). This resource list included toll-free numbers for the Provincial Eating Disorder Prevention & Recovery Program, Health Links, the Women's Health Clinic, and the free provincial Dial-A-Dietitian service. The Dial-A-Dietitian program and the 'Find a Dietitian' service through the Dietitians of Canada website enable participants to seek nutrition information and/or counseling services in their particular area of residence. The Women's Health Clinic and the Provincial Eating Disorder Prevention & Recovery Program provide individual counseling and group programs on a variety of issues.

As a result of the aforementioned precautions, the overall level of risk associated with this study was considered to be minimal.

Potential Benefits to Participants

Many authors have previously commented on the therapeutic benefits of qualitative research for participants, noting that the sharing of stories can be quite therapeutic for those involved (Barbour, 2007; Jones & Neil-Urban, 2003; Burman, Batchelor & Brown, 2001; Duggleby, 2005). Certainly, the focus group sessions conducted as part of this study did appear to be valuable and enlightening for the

participants. The sharing of perceptions, attitudes and experiences surrounding body image appeared to build the women up, bringing them insight into their own experiences and comfort in knowing that others shared their thoughts. The sharing of what turned out to be very similar experiences seemed to bring the women together, forming a social bond of shared meaning and understanding. Many of the women commented afterwards that they thoroughly enjoyed getting together with other women of the same age and talking about these body- and food-related experiences that were so universal, yet somehow hidden. The women seemed relieved and validated by the fact that others shared similar attitudes and experiences. For this reason and others, the focus group format proved to be the perfect medium through which to explore the issues of body image, aging, and food choices.

Compensation

Beverages and snacks were made available to all participants at the focus group sessions. After completion of all study components (questionnaire, collection of anthropometric information, and focus group), each participant received a \$25.00 gift certificate for a local grocery store as a token of appreciation for their time and participation. In addition, the main findings will be summarized in the form of a newsletter and will be distributed to all participants that requested a copy on their consent form.

Researcher Reflexivity

As is normally the case with qualitative research, the principal investigator engaged in a process of self-reflection prior to data collection. This involved an in-depth analysis of how personal experiences, biases, values, upbringing, and culture may shape or influence interpretations formed throughout the course of research. As a result of this process, the principal researcher adopted a variety of practical strategies to prevent bias and undue influence on the results. These strategies included personal reflection, journaling, note taking, peer debriefing with a research assistant, and ongoing frequent conversations with an advisor.

A research assistant accompanied the principal investigator on all focus groups trips (many of which were outside of Winnipeg). The research assistant was present during the focus groups to take notes and provide assistance as needed. The research assistant also engaged the principal researcher in reflective discussion after each session concluded. This allowed the principal researcher to verbally review the session and share any initial thoughts. As is important in qualitative research work, these discussions also prevented the principal researcher from unintentionally skewing or misinterpreting the data to fit any sort of preconceived notions, biases or expectations. These discussions also helped the principal researcher to reflect upon and unwind from what were, usually, very intense and draining focus groups.

Ethics Approval

This research study was approved by the Joint-Faculty Research Board of Ethical Review at the University of Manitoba.

CHAPTER 4

Body Dissatisfaction, Concerns about Aging, and Body Work Practices of Baby Boomer and Older Women in Manitoba

INTRODUCTION

Women today live in a complex socio-cultural environment that presents many challenges to health and well-being. Roles and expectations of women are evolving; rates of overweight and obesity are increasing; the anti-aging, beauty and weight loss industries are rapidly growing; and societal standards of female beauty are becoming increasingly difficult to achieve. These and other societal influences combine to create an environment that promotes body dissatisfaction and a fear of aging.

In Western cultures, women are constantly surrounded by images that glorify youthfulness, messages that tie self-worth and success to thinness, and products that promise eternal youth and beauty (Saucier, 2004). These media messages promote an ideal image of female beauty – one that is increasingly young and thin (Fey-Yensan et al., 2002; Borland & Akram, 2007). The pervasive nature of Western mass media results in the acceptance and internalization of gender norms and ageist stereotypes (Tiggemann, 2003; Grippo & Hill, 2008). From a young age, girls are socialized to believe that their body is an aesthetic object that must be constantly monitored and ‘fixed’ in order to be socially acceptable (Franzoi & Koehler, 1998; Paquette & Raine, 2004). Through this self-objectification, women learn that appearance is a crucial component of self-worth and that their social value is largely determined by their level of attractiveness (Tiggemann & Lynch, 2001). These images and messages also promote the idea that to

be beautiful, one must be young. This ultimately perpetuates ageist beliefs that ‘old’ bodies are ugly, asexual and unproductive (Altschuler & Katz, 2010; Montepare, 2006; Calasanti, 2005). In response, the rapidly growing beauty, weight loss and anti-aging industries offer a myriad of solutions to help women ‘fight’ aging and correct the bodily ‘imperfections’ associated with getting older (Franzoi & Koehler, 1998; Saucier, 2004). According to Öberg and Tornstam (1999), as anti-aging products and cosmetic surgery procedures become more available and affordable, looking old will “become even more culturally unforgiveable” (p. 633). These strong socio-cultural messages place extreme pressures on middle-aged and older women, who are experiencing age-related changes in appearance (e.g., wrinkles, weight gain) that move them further from the socially-constructed ideal of female beauty.

Poor body image and more specifically, body dissatisfaction, is becoming an increasingly prevalent issue among women of all ages. Body image refers to the perceptions and attitudes a person has towards their body, particularly its size and appearance (Cash, 1990). It is a mental representation of the self, encompassing “how we see ourselves and how we feel about what we see” (Kim & Lennon, 2007, p. 3). Body image is a multi-dimensional construct, in that it involves perceptual, affective, and behavioural components (Cash & Henry, 1995). Body image is integral to one’s sense of self, and it plays an important role in well-being and quality of life, especially among women (Lewis & Donaghue, 2005; McCormick, 2008; Liechty & Yarnal, 2010; Slevin, 2010). For instance, a woman’s relationship with her body can affect her emotional state and health behaviours (Price, 2010; Grogan, 2006). Body dissatisfaction is a negative subjective evaluation of personal appearance (Stice & Shaw, 2002), more concretely

measured as the discrepancy between one's actual (perceived) body and desired (ideal) body (Furnham & Boughton, 1995).

Middle age is associated with age-related changes in physical appearance, including greying/thinning hair, wrinkling/sagging skin, weight gain, and loss of lean muscle mass. Unfortunately, for many women, these normal signs of aging are viewed as negative and stressful signs of degeneration (McKinley, 2006; Beyene, Gilliss & Lee, 2007; Halliwell & Dittmar, 2003). For women who place high value on physical and sexual attractiveness, alterations in appearance at midlife may negatively influence body image and promote feelings of body dissatisfaction (Baker & Gringart, 2009; Algars et al., 2009). We now know that middle-aged women experience similar levels of body dissatisfaction as younger women, which suggests that body image issues do persist into later life (Lewis & Cachelin, 2001; Tiggemann & Lynch, 2001; Grippo & Hill, 2008; Pruis & Janowsky, 2010). Some studies report that up to 60 – 80% of middle-aged and older women express body dissatisfaction (Mangweth-Matzek et al., 2006; McLaren & Kuh, 2004). Weight preoccupation, dieting, and eating disorders also appear to be an issue among this age group (Reel et al., 2008; Mangweth-Matzek et al., 2006; Midlarsky & Nitzburg, 2008; Brandsma, 2007). The body image and eating issues among middle-aged women have been reviewed previously (e.g., Marshall et al., 2012; Saucier, 2004; Tiggemann, 2004).

Less is known about the body image issues of older women (ages 65 and older), although this is gradually changing as more and more researchers take up interest in this area. In most studies with older women, aging is perceived to have a largely negative impact on appearance and overall body image evaluation (Clarke & Korotchenko, 2011;

Hurd, 2000). Like middle-aged women, many older women perceive the wrinkles, sagging, and greying hair that accompany aging to be undesirable changes that threaten their appearance and social value (Halliwell & Dittmar, 2003; Winterich, 2007). In addition, many older women experience issues related to body weight (Clarke, 2002; Winterich, 2007). Body weight is a major source of displeasure and self-criticism, and many women carry insecurities about weight gain throughout their lives (Clarke, 2002; Hurd, 2000). Anxieties about being or becoming overweight are extremely common among both middle-aged and older women alike (Baker & Gringart, 2009; Mangweth-Matzek et al., 2006), and many women report wanting to lose weight (Tunaley et al., 1999; Winterich, 2007).

Despite ongoing feelings of BD and tensions surrounding weight, some researchers have reported that BD decreases with age (Borland & Akram, 2007; Öberg & Tornstam, 1999). Older women may experience less body image issues due to increased maturity, less sexual objectification, accumulation of life experiences that deepen self-worth (Tiggemann & Lynch, 2001; Tunaley et al., 1999), greater tolerance of body diversity (Hetherington & Burnett, 1994), and less strict standards regarding physical appearance (Peat, Peyerl & Muehlenkamp, 2008). For example, some women accept their ‘flawed’ bodies because they feel that characteristics of wisdom, personality and inner beauty are more important than external appearance (Liechty, 2012). In one study with women ages 60-92, participants expressed pragmatism about their aging bodies, acknowledging that changes in appearance are part of the natural process of aging (Hurd, 2000, p.88). The importance attributed to appearance also seems to decrease with increasing age (Tiggemann, 2004). This decline in relative importance might be due to

the fact that aging is often accompanied by a shift in priorities, such that health and functioning become more important than appearance (Hurd, 2000; Liechty & Yarnal, 2010; Baker & Gringart, 2009).

Some researchers suggest that while BD may persist into middle and late adulthood, other moderating factors such as self-objectification, habitual body monitoring, and appearance anxiety tend to decrease with age (Tiggemann & Lynch, 2001). One study found that although middle-aged and older women were equally dissatisfied with their bodies, older women (66 years and older) were less likely to do anything about it (Lewis & Cachelin, 2001). It may be that some older adults replace behavioural strategies (e.g., dieting) with cognitive strategies, such as lowering of expectations/goals, acceptance of body changes, and the use of age-appropriate social comparisons (Tiggemann & Lynch, 2001; Thompson, Thomas & Rickabaugh, 1998). These compensatory attitudes and behaviours may act as a protective buffer against the potential negative outcomes of poor body image, such as low self-esteem, depression, and eating disorders (Webster & Tiggemann, 2003).

A common manifestation of BD (across all age groups) is the adoption or maintenance of body work. For some women, moving further from the ideal of feminine beauty means that they must engage in various types of body work in order to counteract or minimize the effects of aging. Body work has been defined as, “any practice undertaken that aims to modify or maintain some aspect of the body” (Coffey, 2013, p.4). Some of the most common body work techniques used by middle-aged and older women are hair dye, face creams, fashion/clothing choices, make-up, and lipstick (Clarke & Bundon, 2009; Clarke & Korotchenko, 2010; Winterich, 2007; Paulson & Willig, 2008).

According to several authors, cosmetic surgery is becoming a more commonly used and accepted form of body work among older women (Sarwer & Crerand, 2004); these procedures are seen as a “very viable way to resist aging” (Slevin, 2010, p.1013). Regardless of the product or method(s) used, more and more women are investing time, money and effort into maintaining a youthful appearance, as evidenced by the increasing consumer demand for anti-aging products (Muisse & Desmarais, 2010; Smirnova, 2011). Furthermore, body work is highly encouraged by the beauty, weight loss and anti-aging industries, which have much to gain from making women feel inadequate and unattractive (Paquette & Raine, 2004).

Restrictive eating, or dieting, is also a common behavioural response to poor body image (Stice, 2002; Mangweth-Matzek et al., 2006; Anderson, Eyler, Galuska, Brown & Brownson, 2002; Grogan, 2006). The prevalence of dieting among middle-aged and older women is estimated to be around 30% to 60% (Gadalla, 2008; Hetherington & Burnett, 1994; Mangweth-Matzek et al., 2006). In one particular study with 1000 women ages 60-70 years, 56% of participants reported restricting their eating, yet most of them evaluated their eating as “normal and healthy” (Mangweth-Matzek et al., 2006, p.585), which demonstrates the ‘normative’ culture of BD and dieting among women. In another study of women aged 61 – 92, dieting was seen as a ‘necessary’ body maintenance strategy, with 64% of the sample reporting some kind of restrictive eating behaviour (Clarke, 2002). These statistics are concerning, given that dieting is known to have a potentially negatively impact on health and well-being (French & Jeffery, 1994). Diets have a dismal success rate and many individuals who diet end up regaining any lost weight (Maclean, Bergouignan, Cornier & Jackman, 2011; Lowe & Timko, 2004; Mann et al., 2007). This

can lead to a continuous, self-perpetuating, and potentially dangerous cycle of ‘yo-yo dieting’ or ‘weight cycling’ (Brownell & Rodin, 1994). Since dieting rarely produces the desired result (sustained weight loss), many women who diet remain dissatisfied with their bodies and experience profound feelings of disappointment, guilt, and personal failure (Thomas, Hyde, Karunaratne, Kausman & Komesaroff, 2008). Dieting is also involved in the etiology and maintenance of EDs, particularly binge eating and bulimia nervosa (Midlarsky & Nitzburg, 2008; Lowe & Timko, 2004). Eating disorders are known to have serious health implications, including compromised organ and physiological functions, and psychological symptoms (Harris & Cumella, 2006; Lapid et al., 2010). A concerning finding is that eating disorders (and associated psychiatric disorders) among older women appear to be on the rise (Harris & Cumella, 2006; Gadalla, 2008; Brandsma, 2007).

Given that body image is intimately connected to one’s identity and sense of self (Lewis & Donaghue, 2005), changes in body image as one ages may have potential implications for health and well-being (Roy & Payette, 2012). The age-related changes in appearance and body functioning that move women further from their socially ingrained notion of ‘feminine beauty’ can result in identity confusion and a feeling of losing control over their lives (Saucier, 2004). For women who have always based their identity and self-worth on physical attractiveness, changes in appearance with age may be particularly traumatic, resulting in significant emotional and psychological consequences (Winterich, 2007; McCormick, 2008). Studies have also found that among middle-aged and older adults, poor body image is associated with low self-esteem (Baker & Gringart, 2009; Webster & Tiggemann, 2003; Tiggemann & Lynch, 2001), psychological distress, and

depression (Miller, Morley, Rubenstein & Pietruszka, 1991; Gadalla, 2008). Body dissatisfaction, specifically, has also been associated with avoidance of physical intimacy (McLaren & Kuh, 2004), lower self-reported happiness (Stokes & Frederick-Recascino, 2003), anxiety and mood disturbances (Gadalla, 2008), and lower overall quality of life (McLaren & Kuh, 2004) among middle-aged and older women.

From the existing literature in this area, it is clear that BD is an important issue among women of all ages. While a great deal more research is already being done to explore the complex relationship between aging and the body among women in mid and later life, few authors have focused specifically on the baby boomer demographic group (individuals born between 1946 and 1965). Baby boomers may be particularly vulnerable to BD, given their heightened preoccupation with maintaining health and youthfulness and their relative affluence, educational attainment and heightened media exposure compared with previous generations (Biggs et al., 2007; O'Reilly et al., 2003; Wadsworth & Johnson, 2008; Howarton & Lee, 2010). Furthermore, baby boomer women may have distinct attitudes and experiences with regards to body image, aging and body/beauty work. In fact, it is predicted that as baby boomers enter late life, the use of body work practices and anti-aging regimens among older women will increase (Smirnova, 2012). Unlike previous generations of older adults, this generation grew up in a culture of mass media and persuasive advertising and they are “fascinated with the body and its malleability” (Ballard et al., 2005, p.172). It is expected that baby boomers will continue to invest in body work practices that not only help them maintain a socially acceptable appearance, but also close the perceived gap between their external (aging) body and their inner (youthful) spirit (Ballard et al., 2005).

This research study seeks to address these gaps by exploring the perceptions and experiences related to body dissatisfaction, aging, and the use of body work practices among baby boomer and older women. As part of a larger research project exploring the body image, aging and food choices of Manitoban women, this paper focuses on a subset of the data pertaining to body dissatisfaction, concerns about and experiences with aging, and the use of body work practices/anti-aging products. The results pertaining to healthy eating, food choices, and food product attitudes will be discussed in Chapter 5.

METHODS

Study Design

This study used a concurrent mixed-methods design to explore the body satisfaction, concerns about aging, and food choices/attitudes of urban and rural-dwelling baby boomer women in Manitoba. Mixed methods research has been defined as, “a systematic integration of quantitative and qualitative methods in a single study for purposes of obtaining a fuller picture and deeper understanding of a phenomenon” (Johnson et al., 2007, p. 119). According to Creswell & Plano Clark (2007), “the use of quantitative and qualitative approaches in combination provides a better understanding of research problems than either approach alone” (p. 5).

Participants

The population of interest for this study was baby boomer (born 1946 – 1964) and older women (born prior to 1964) living in rural and urban areas of Manitoba. Potential participants had to meet the following inclusion criteria: (a) female; (b) born between

1946 and 1965 (ages 45 – 64 at time of study) *or* prior to 1946 (ages 65 and older at time of study); (c) live in Manitoba; (d) speak fluent English; and (e) be able to attend a 2 hour focus group session. Only one participant per household was permitted to participate.

Convenience and snowball sampling techniques were used to recruit eligible participants. Participants were recruited through posters and word-of-mouth from a variety of environments within rural and urban Manitoban communities. The Manitoba Women's Institute (MWI) assisted with participant recruitment in rural areas.

Data Collection

Data collection took place over a three month period (October to December 2011) and involved the following procedures: (1) Focus group sessions; (2) Questionnaire; and (3) Anthropometric measurements. From arrival to departure, data collection for each site took approximately 1.5 to 2 hours in total, which allowed 30 minutes for completion of the questionnaire and anthropometric measurements, with 1 to 1.5 hours remaining for the group discussion.

Focus Group Sessions

Qualitative data was collected through moderator-led semi-structured focus groups. These focus group sessions were used to more deeply explore the body, aging, and food related experiences and attitudes of participants. A total of fourteen focus groups, each consisting of seven to twelve women, were conducted in the following Manitoban communities: Winnipeg (urban), Brandon (urban), Hamiota (rural), Reston (rural), Russell (rural), and St. Pierre (rural). In each town, two focus

group sessions were held (one with baby boomer women and the other with older women), with the exception of Winnipeg, where there were four focus groups in total (two with baby boomers, two with older women). Seven focus groups were with baby boomer women (n=68), and the remaining seven focus groups were with older women (n=69). Beverages and snacks were provided at all focus group sessions.

A semi-structured moderator's guide was used to guide the focus group discussions. Open-ended questions were used to guide discussion on the following topics: (1) body image perceptions/body satisfaction; (2) concerns about, experiences of, and attitudes towards aging; (3) dieting/weight loss; (4) healthy eating barriers and food choice influences; and (5) food product attitudes. Several 'prompting', probing and clarifying questions were used to help elicit responses, as needed. At the end of every discussion, participants were given the opportunity to add additional comments/opinions or clarify previous responses. The focus group ended with a statement of thanks and distribution of a resource list.

All focus group discussions were digitally recorded on audio tape to facilitate transcription and data analysis. A trained and experienced note taker was present at each focus group to record any non-verbal behaviour/interactions that took place as well as any individual or group dynamics that were not conducive to audio recording. After each focus group, field notes and personal reflections were recorded by the researcher. Some of these thoughts were shared and discussed with the research assistant and the primary advisor, in an informal process of peer debriefing.

Questionnaire & Anthropometric Measurements

Upon arrival to the focus group session, participants' height and body weight were measured by a trained research assistant. The collection of anthropometric information took place in a separate room so that participants could not see or comment on each other's measurements. Following this, all participants were asked to complete a self-administered pen-and-paper questionnaire. The purpose of the questionnaire was to collect demographic information as well as information pertaining to certain variables of interest (e.g., body/weight satisfaction, concerns about aging, dieting, use of certain food products). The principal researcher was present at all times to address any items of concern/confusion and ensure completeness. The questionnaire was developed by the principal researcher, in consultation with the primary advisor, following an in-depth literature review process. Questions were stated as simply as possible, with consideration as to what question format would be most appropriate for the variable of interest and most understandable for the target group. Prior to use with the study participants, the questionnaire underwent expert review as well as pre-testing with a sample group from the target population.

Data Analysis

For this study, we chose to emphasize the qualitative data analysis due to the richness of data obtained via this method. The quantitative data serves as supplementation to the qualitative results.

Qualitative Analysis

The primary method of collecting and analyzing data and interpreting results was via the qualitative approach. Upon completion of all fourteen focus groups, the audiotapes were transcribed to text and double-checked for accuracy by a research assistant. The principal researcher read through all transcriptions in their entirety, to obtain a general sense of the data and reflect on overall themes and meanings.

Thematic analysis using a coding procedure was used to analyze the focus group data. To begin the coding process, a preliminary list of coding words was developed from the research questions. Additional code words and sub-categories were inductively generated upon re-reading the transcripts. This code list was then sorted into categories, based on the hierarchies and relationships between code words. This coding schematic was then ‘tested’ for inter-coder reliability. Based on this comparison, a few codes were deleted, added and re-organized and the final ‘code list’ was established.

All transcripts were first coded by the researcher using pen and paper. NVivo8 QSR International software (2008) was used to organize codes and categories and assist in generating overall themes and patterns. Once all of the coding was completed in NVivo8, each code was printed out and reviewed by the principal researcher to identify and solidify overarching themes, meanings, and important quotes within each ‘category’ of text. This process resulted in a table of final themes and sub-themes (with columns for their detailed meanings and exemplary quotes) as well as hand-drawn diagrams demonstrating the relationships between themes and sub-themes. Throughout the qualitative data collection and analysis process, the principal

researcher adopted a variety of practical strategies to prevent bias and undue influence on the results. These strategies included personal reflection, journaling, note taking, peer debriefing with a research assistant, and ongoing frequent conversations with an advisor.

Quantitative Analysis

Quantitative data obtained from the questionnaire and anthropometric measurements was compiled and analyzed using the statistical analysis program SPSS (Statistical Package for Social Sciences) release #20.0 for Windows. The researcher entered all data into SPSS and data entry was checked for accuracy by a trained research assistant. Descriptive statistics (i.e., means, standard deviations, frequencies, and percentages) were used to describe the variables of interest. Additional analyses (i.e., ANOVA, Chi-square tests) were used to compare data across age, body mass index, location of residence (urban vs. rural), level of body satisfaction, and other variables. The normality of the data determined if parametric or non-parametric tests were used. A p -value ≤ 0.05 was used to signify statistical significance.

Ethics & Compensation

This research study was approved by the Joint-Faculty Research Board of Ethical Review at the University of Manitoba. Informed voluntary consent was obtained from all participants prior to their involvement in the study. Each participant received a \$25.00 gift certificate for a local grocery store as a token of appreciation for their time and participation.

RESULTS

Participant Characteristics

A total of 137 community-dwelling women, ranging in age from 46 – 84 years, participated in this study. A summary of participant characteristics is presented in Table 4.1. The average age was 65.2 (± 9.1) years. Approximately half (49.6%) of the participants were in the baby boomer group (ages 46 – 65 at time of study) and the other half (50.4%) were in the older women group (ages 65 and older at time of study). There was a fairly even split between the number of participants living in rural (small town) Manitoba (52.6%) and those residing in the larger urban centres of Winnipeg and Brandon (47.4%). Sixty-nine of the participants had a partner (married, common-law or engaged), 22.6% were widowed, and 8.1% were divorced. There was diversity among the women with respect to marital status, household size, educational attainment, income level, and smoking status. Nearly all participants (92.6%) rated their health as excellent, very good or good, with only 7.3% rating their own health as fair or poor. Body mass index (BMI) ranged from 18.2 kg/m² (underweight) to 53.3 kg/m² (obese class III). Nearly three-quarters of the sample (72.8%) fell into the overweight or obese category. The average BMI was 28.7 (± 5.8) kg/m² (overweight).

Table 4.1: Participant Characteristics

Demographic Variable	All (n=137) Percent (%)	BB (n=68) Percent (%)	OW (n=69) Percent (%)
Age Group			
Baby Boomers	49.6	100	0
Older Women	50.4	0	100
Mean Age (SD)	65.2 ± 9.1 yrs	57.7 ± 5.9 yrs	72.5 ± 4.6 yrs
Age Range	46 – 84 yrs	46 – 65 yrs	66 – 84 yrs
Location of Residence			
Urban	47.4	48.5	46.4
Rural	52.6	51.5	53.6
Relationship Status			
Married or Common-law	67.9	75	60.9
Engaged	0.7	1.5	0
Single	0.7	1.5	0
Divorced or Separated	8.1	7.3	8.7
Widowed	22.6	14.7	30.4
Number of People in Household			
1 (self / live alone)	29.6	22.1	37.3
2	54.8	48.5	61.2
≥ 3	15.6	29.4	1.5
Household Income			
< \$20,000	7.6	5.1	10.2
\$20,000 - \$39,000	23.7	10.2	37.3
\$40,000 - \$59,000	24.6	20.3	28.8
\$60,000 - \$79,000	21.2	27.1	15.2
\$80,000 - \$99,000	9.3	11.9	6.8
≥ \$100,000	13.6	25.4	1.7
Highest Level of Education			
Less than High School	11.1	7.4	14.9
High School Graduate	18.5	14.7	22.4
Vocation/Trade/College	46.7	52.9	40.3
University (undergraduate/graduate)	23.0	23.5	22.4
Other	0.7	1.5	0
Smoking Status			
Current Smoker	5.2	2.9	7.4
Ex-Smoker	38.2	47.1	29.4
Have Never Smoked	54.4	45.6	63.2
Other (socially, occasionally)	2.2	4.4	0
Self-rated Health			
Excellent	8.1	11.8	4.4
Very Good	43.4	39.7	47.1
Good	41.2	44.1	38.2
Fair	6.6	2.9	10.3
Poor	0.7	1.5	0
Self-Reported (Estimated) Weight			
Mean Estimated Weight (SD)	74.5 ± 16.4 kg	78.1 ± 16.6 kg	71.1 ± 15.6 kg
Estimated Weight Range	47.6 – 152.0 kg	47.6 – 140.6 kg	48.5 – 152.0 kg

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Table 4.1: Participant Characteristics

Demographic Variable	All (n=137) Percent (%)	BB (n=68) Percent (%)	OW (n=69) Percent (%)
Measured Weight			
Mean Measured Weight (SD)	75.1 ± 16.2 kg	78.0 ± 16.6 kg	72.3 ± 15.4 kg
Measured Weight Range	47.4 – 144.3 kg	47.4 – 137.5 kg	51.7 – 144.3 kg
Measured Height			
Mean Height (SD)	161.8 ± 5.5 cm	163.5 ± 5.4 cm	160.1 ± 5.1 cm
Height Range	143.5 – 178.0 cm	152.0 – 178.0 cm	143.5 – 172.8 cm
Body Mass Index (BMI)			
Underweight (BMI < 18.5 kg/m ²)	0.7	1.5	0
Normal (BMI 18.5–24.9 kg/m ²)	26.5	26.9	26.1
Overweight (BMI 25.0–29.9 kg/m ²)	41.9	31.3	52.2
Obese (BMI ≥ 30.0 kg/m ²)	30.9	40.3	21.7
Mean BMI (SD)	28.7 ± 5.8 kg/m ²	29.2 ± 6.0 kg/m ²	28.1 ± 5.6 kg/m ²
BMI Range	18.2 – 53.3 kg/m ²	18.2 – 52.5 kg/m ²	20.8 – 53.3 kg/m ²
Daily Stress Level (on a scale of 0-100)			
Mean Stress Level (SD)	39.7 ± 22.9	43.8 ± 23.8	35.7 ± 21.2
Stress Level Range	0 – 96	0 – 95	0 – 96

Questionnaire Results

A summary of the questionnaire results pertaining to body dissatisfaction, aging, and body work is provided in Table 4.2.

Table 4.2: Questionnaire Results – Body Dissatisfaction & Aging

Variable	All (n=137) Percent (%)	BB (n=68) Percent (%)	OW (n=69) Percent (%)
Satisfaction with Overall Appearance			
Very satisfied	8.1	7.4	8.8
Moderately satisfied	58.1	52.9	63.2
Neutral	19.8	22.1	17.7
Moderately dissatisfied	14.0	17.6	10.3
Very dissatisfied	0	0	0
Satisfaction with Current Body Weight			
Very satisfied	6.7	6.0	7.5
Moderately satisfied	34.3	28.4	40.3
Neutral	15.7	14.9	16.4
Moderately dissatisfied	36.6	40.3	32.8
Very dissatisfied	6.7	10.4	3.0
Concern about Aging <i>(I am worried about the effects of aging on my overall appearance)</i>			
Strongly Agree	5.1	2.9	7.3
Agree	28.7	36.8	20.6
Neutral	44.1	47.1	41.2
Disagree	18.4	10.3	26.5
Strongly Disagree	3.7	2.9	4.4
Importance of Appearance <i>(on a scale of 0-100)</i>			
Mean Level of Importance (SD)	60.9 ± 21.2	59.6 ± 21.5	62.2 ± 21.0
Range	0 – 100	0 – 96	0 – 100
Appearance Preoccupation <i>(During a typical day, how often do you think about your appearance?)</i>			
Always	2.9	1.5	4.4
Often	14.6	16.2	13.0
Sometimes	58.4	61.7	55.1
Rarely	20.4	16.2	24.6
Never	3.7	4.4	2.9

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Table 4.2: Questionnaire Results – Body Dissatisfaction & Aging

Variable	All (n=137) Percent (%)	BB (n=68) Percent (%)	OW (n=69) Percent (%)
Appearance Anxiety (Do you feel self-conscious about your body shape/size in the company of others?)			
Always	9.7	13.4	5.9
Often	13.3	16.4	10.3
Sometimes	49.6	46.3	53.0
Rarely	23.7	19.4	27.9
Never	3.7	4.5	2.9
Feelings about body prevent participation in activities you enjoy			
Yes	12.6	17.9	7.4
No	87.4	82.1	92.6
Desired Weight Loss (difference between estimated and ideal weight)			
Mean Desired Weight Loss (SD)	-8.8 ± 8.6 kg	-10.8 ± 10.2 kg	-6.9 ± 6.4 kg
Range	-59.0 to +3.4 kg	-59.0 to +3.4 kg	-31.8 to +0 kg
Dieting Behaviour (Within the past year, have you ever controlled, restricted or reduced your food intake in an effort to lose weight?)			
Yes	54.1	58.8	49.3
No	45.9	41.2	50.7
Use of Diet Plans/Programs (Have you participated in a formal weight loss program or diet plan within the past 5 years?)			
Yes	21.3	29.4	13.2
No	78.7	70.6	86.8
Use of Anti-Aging Products			
Daily	28.7	23.5	33.8
3-5 times per week	9.6	14.7	4.4
1-2 times per week	5.1	5.9	4.4
2-3 times per month	2.9	2.9	3.0
Once a month or less	6.6	8.8	4.4
Never	39.0	41.2	36.8
Not sure	8.1	3.0	13.2

Body & Weight Dissatisfaction

According to the questionnaire, most women (66.2%) were very or moderately satisfied with their overall appearance. When body satisfaction was framed in terms of weight, however, only 41.0% of women said they were very or moderately satisfied. There was a significant relationship between body weight dissatisfaction and BMI. That is, women who said they were very or moderately dissatisfied with their body weight had a higher BMI, on average, than those who stated they were very or moderately satisfied ($p < 0.05$). For example, women who said they were very *dissatisfied* with their body weight had a mean BMI of $35.0 (\pm 6.16) \text{ kg/m}^2$, whereas women who stated they were very *satisfied* had a mean BMI of $22.9 (\pm 1.98) \text{ kg/m}^2$. There were also relationships between degree of body weight dissatisfaction and body self-consciousness, avoiding participation in activities, dieting, and the use of diet plans/programs (see Table 4.3 for statistically significant results pertaining to body dissatisfaction, aging, and dieting).

According to the questionnaire, women wanted to lose $8.8 (\pm 8.6) \text{ kg}$, or $19.4 (\pm 19.0)$ pounds, on average. A higher BMI was associated with a greater amount of desired weight loss ($r = 0.8, p < 0.001$). As would be expected, greater degree of body weight dissatisfaction was also associated with greater desired weight loss ($F = 23.4, p < 0.05$). That is, women who reported they were very dissatisfied with their weight also reported greater discrepancy between their current and ideal weight than those who stated they were very or moderately satisfied. There was also a mild linear association between age and weight discrepancy ($r = -0.3, p < 0.001$), suggesting that as age increases, amount of desired weight loss decreases. Only two women (one of whom had an ‘underweight’

BMI of 18.2) wanted to gain weight, and six women (4.7%) reported no desired weight change.

Appearance: Importance, Preoccupation & Anxiety

When asked to rate the importance of appearance on a scale of 0 to 100, the responses ranged from 0 to 100, but the average response was 60.9 (± 21.2). To assess appearance preoccupation, we asked: “During a typical day, how often do you think about your appearance?” In response, 17.5% of women selected ‘always’ or ‘often’, 58.4% selected ‘sometimes’, and 24.1% selected ‘rarely’ or ‘never’. Women who were more preoccupied with their appearance tended to be less satisfied with their overall appearance ($p < 0.05$) and to be more concerned about the effects of aging on appearance ($p < 0.001$).

Almost half of the women (49.6%) reported that they sometimes feel self-conscious about their bodies in the company of other people, and another 23.0% reported that they always or often feel self-conscious about their bodies. Women who were more self-conscious about their bodies tended to also have stronger appearance dissatisfaction ($p < 0.05$), more concerns about aging ($p < 0.05$), and greater desired weight loss ($p < 0.001$).

For some women (12.6%), negative feelings about their body size/shape prevented them from participating in activities they enjoy. The types of activities that women avoided due to body issues were varied, including water aerobics, walking, yoga, dancing, curling, fitness classes, and team sports.

Concerns about Aging & Use of Anti-Aging Products

About a third (33.8%) of women agreed or strongly agreed with the statement: “I am worried about the effects of aging on my overall appearance”. Over a quarter (28.7%) of women reported using AA products (i.e., products that claim to minimize the signs of aging) on a daily basis. Another 14.7% of women reported using these types of products at least once per week. There was no significant difference in the use of anti-aging products between baby boomer and older women.

Body Work: Dieting

Over half of the women in this study (54.1%) said they had dieted within the past year, when dieting was defined as: “controlling, restricting, or reducing food intake *in an effort to lose weight*”. When asked to elaborate as to how often they diet, many women reported that they had dieted frequently over the past year, using words like ‘weekly’, ‘constantly’, ‘all the time’, ‘continuously’, ‘ongoing’, or ‘daily’. Those women that reported dieting over the past year had a higher average BMI ($30 \pm 5.5 \text{ kg/m}^2$) than those that didn’t diet ($27 \pm 5.8 \text{ kg/m}^2$) ($p < 0.05$).

According to the questionnaire, about a fifth of the women (21.3%) had used a formal diet plan or had participated in a formal weight loss program within the past five years. Baby boomer women were significantly more likely to have used a formal diet plan/program than older women (29.4% vs. 13.2%, $p < 0.05$). Women in urban households were also significantly more likely to have used a formal diet plan/program than women in rural households (29.2% vs. 14.1%, $p < 0.05$).

**Table 4.3: Statistically Significant Findings related to
Body/Appearance Satisfaction, Aging and Dieting**

Variables of Interest	Statistic	df	P-Value
Overall appearance satisfaction and Relationship status	$\chi^2 = 32.481$	18	0.019
Overall appearance satisfaction and Self-rated health	$\chi^2 = 42.922$	12	<0.001
Overall appearance satisfaction and Measured BMI	$F = 14.191$	3, 131	<0.001
Overall appearance satisfaction and Appearance preoccupation	$\chi^2 = 23.573$	12	0.023
Overall appearance satisfaction and Body self-consciousness	$\chi^2 = 25.292$	12	0.013
Overall appearance satisfaction and Avoid participating in activities	$\chi^2 = 14.775$	3	0.002
Body weight satisfaction and Desired weight loss	$F = 23.415$	4, 120	<0.001
Body weight satisfaction and Measured BMI	$F = 12.290$	4, 128	<0.001
Body weight satisfaction and Body self-consciousness	$\chi^2 = 43.132$	16	<0.001
Body weight satisfaction and Avoid participating in activities	$\chi^2 = 21.674$	4	<0.001
Body weight satisfaction and Dieting	$\chi^2 = 23.595$	4	<0.001
Body weight satisfaction and Use of diet plans/programs	$\chi^2 = 11.171$	4	0.025
Desired weight loss and Measured BMI	$r = 0.808$	124	<0.001
Desired weight loss and Age	$r = -0.281$	125	0.001
Desired weight loss and Body self-consciousness	$F = 5.531$	4, 120	<0.001
Desired weight loss and Avoid participating in activities	$t = 2.220$	123	0.028
Desired weight loss and Dieting	$t = 3.876$	123	<0.001

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**Table 4.3: Statistically Significant Findings related to
Body/Appearance Satisfaction, Aging and Dieting**

Variables of Interest	Statistic	df	P-Value
Concern about aging and Relationship status	$\chi^2 = 45.222$	24	0.005
Concern about aging and Self-rated health	$\chi^2 = 36.349$	16	0.003
Concern about aging and Appearance preoccupation	$\chi^2 = 49.940$	16	<0.001
Concern about aging and Body self-consciousness	$\chi^2 = 29.985$	16	0.018
Self-rated health and Smoking status	$\chi^2 = 42.450$	12	<0.001
Self-rated health and Importance of appearance	$F = 2.482$	4, 130	0.047
Self-rated health and Measured BMI	$F = 2.989$	4, 130	0.021
Dieting and Measured BMI	$t = 3.028$	132	0.003
BB vs. OW and Desired weight loss	$t = 1.995$	125	0.048
BB vs. OW and Use of diet plans/programs	$\chi^2 = 5.724$	1	0.017
Urban vs. Rural and Use of diet plans/programs	$\chi^2 = 4.640$	1	0.031

Focus Group Results

Table 4.4 provides a summary of the qualitative results pertaining to body dissatisfaction, concerns about aging, and body work practices. Each of the major themes and sub-themes are described in detail below.

Table 4.4: Qualitative Themes – Body Dissatisfaction & Aging

Major Theme	Sub-Themes
1. Body Perceptions	1a. Body dissatisfaction (BD) <ul style="list-style-type: none">- BD related to aging- Temporal/situational nature- Dissatisfaction with specific body parts 1b. Body satisfaction/acceptance
2. Weight Issues	2a. Weight tied to body image 2b. Desire to lose weight
3. Attitudes & Experiences of Aging	3a. Feelings towards the aging body <ul style="list-style-type: none">- Negative attitudes/experiences- Positive attitudes/experiences 3b. Concerns about aging <ul style="list-style-type: none">- Appearance- Function/Mobility- Health
4. Importance of Appearance	4a. Confidence comes from looking good 4b. Looking good in public
5. Body Work Practices	5a. Dieting <ul style="list-style-type: none">- Diet plans/programs- Dietary restraint- Unenjoyable and unsuccessful- Chronic yo-yo dieting 5b. Anti-Aging Products 5c. Other Body Work Practices <ul style="list-style-type: none">- Skin care- Hair dye- Cosmetics and make-up- Clothing/Fashion- Exercise- Food and supplements 5d. Influence of Family 5e. Maintaining a Natural Look

1. Body Perceptions

1a. Body Dissatisfaction

When asked about their current feelings about their bodies, a wide range of responses were received, with some women on one end of the body dissatisfaction spectrum and others on the complete opposite end of the spectrum. While some women were very dissatisfied with their body, some were very satisfied, and many others fell somewhere in the middle of those two extremes. Body dissatisfaction seemed to be more of an issue among the baby boomer groups, where statements like “I absolutely hate my body” (BB, Urban) and “I’m disappointed with the way I am right now” (BB, Urban) were fairly common. It was apparent that many women had struggled with body image issues throughout their entire lives, and that aging was making things even more complicated, as exemplified by this comment:

I’ve always struggled with my body image. I can’t remember when I haven’t and I still struggle with it. I’m finding it even harder as I’m aging.
(BB, Urban)

Body Dissatisfaction Related to Aging

Feelings of body dissatisfaction were often tied in to the experience of aging. In talking about their body issues, age-related changes in appearance were often the source of much dissatisfaction and frustration. As one woman explained,

When I get out of the shower and look at myself? Hmm, yeah, I don’t like that my body’s sagging. I don’t like that things are shifting. I don’t like that my grown daughters look at me saying, ‘Mom, you’re shrinking!’.
(BB, Urban)

These women were very aware of the constant changes that their bodies were going through with each advancing year, and they often commented on how things

seemed to be changing ‘all at once’. For many women, menopause was seen as a transition point, where body image issues seemed to worsen:

I always used to be thin, skinny, until I hit menopause. And then I put on weight, and I just can’t seem to lose it. So I’m dissatisfied. (OW, Rural)

Dissatisfaction with Specific Body Parts

When talking about their body dissatisfaction, many women fixated on a specific body part. A few body parts, in particular, seemed to be very problematic for most women in the study, namely the stomach/belly area, the hips/butt region, and the breasts.

One woman explained her ongoing frustration with sagging breasts:

You see all these ladies with beautiful and perky boobs, and it seems as you get older, all of a sudden, you’ve got the boobs, but what do you do with them because they’re just hanging! It’s like, okay, not such a hot item! (BB, Rural)

The stomach area, sometimes referred to as the ‘muffin top’, was another area of strong dissatisfaction and frustration:

I’m unhappy with my middle. Everything goes around the middle. Maybe that’s for all us women, I don’t know. Everything wants to settle there and it just doesn’t want to come off. (OW, Urban)

For some women, changes in these specific body parts were attributed to aging and were considered to be largely outside of one’s personal control. One woman stated:

I guess my biggest thing is I wish I didn’t have my little paunchy stomach. But I think maybe it goes with age. (OW, Rural)

Temporal/Situational Nature of Body Image

Some women commented on the temporal and situational nature of body image. These women described their body image as dynamic, in that it could fluctuate based on the day or a particular situation:

Sometimes you absolutely hate yourself and feel like you don't even want to go outside because you don't have anything that makes you look like those magazines or nice. But then, other times, you know, you feel okay. (BB, Urban)

The women described certain situations that tend to prompt, or stir up, negative feelings towards the body, such as going to the beach, shopping for clothing, or even a simple comment from a family member. One woman explained how shopping for clothes can be particularly stressful:

I don't usually worry about it until I have to go and try on clothes. And then I think, 'Oh gee, it would be nice to be six feet tall and skinny. (BB, Rural)

As soon as one woman started talking about her frustration with finding clothes, others chimed in with similar experiences:

I'm like the rest, I didn't really notice it till I went to go and put on some of my clothes, particularly when you're going out to something important and you know, you really don't have anything that looks good. And you don't want to buy the size that maybe looks alright because you think you're not going to stay there. (BB, Rural)

Some women also commented on how comments from friends and family can influence their body image:

A lot of times too, you may think you're feeling great about yourself until somebody says, 'Oh you look like you've put a little bit of weight on', or maybe the other way, 'It looks like you've lost a few pounds'. But it's what other people say to you that might change your mind about how you're feeling about yourself that day. (BB, Urban)

1b. Body Satisfaction/Acceptance

On the whole, the majority of women did experience some degree of body dissatisfaction, but this was, at times, coupled with sentiments of overall acceptance. In other words, body issues and concerns were still a part of their everyday lives, but they

were doing their best to look past external appearance and reach some level of self-acceptance. This was especially evident among women in the older age group. The following sentiments demonstrate this mixture of dissent and acceptance:

I'm pretty satisfied with my weight, although I could probably stand to lose a few pounds, or at least have everything redistributed somehow. I used to be a lot lighter when I was young, but there's been periods when I've been a lot heavier too. So now I seem to be staying just in around the same weight. So like I say, I'm pretty happy with it, other than it would be nice to have it redistributed. (OW, Urban)

It is worth acknowledging that there were some women who were overtly positive and very satisfied with their bodies. These women, many of whom were in their 60s and 70s, had come to accept themselves as they are. Even though most of them said they would like to lose some weight, they were also thankful that their bodies were healthy and in working order:

I'm happy. Yeah, I know I should lose a few pounds, but I'm healthy. I think at my age, if I can stay this way, I'll be very happy. (OW, Rural)

Most of these women had gone through a period of body dissatisfaction earlier in life, but reported that their level of acceptance had increased with age. These women wished that they hadn't been so hard on themselves when they were younger, and looking back, wished they had been happier with their bodies as young adults:

I'm okay with my weight right now... I just wish that I had been as happy with my body in my teens as I am now, because I could have worn all those really cute things that I didn't think I could wear. Like, the older I get the happier I am with who I am and how I look. (BB, Urban)

Another woman put it this way:

Your body image is like your license picture. Like, as bad as you thought you were years ago, you now think, 'Oh my god, I looked great!'... You have to look back to appreciate it, and you know you didn't appreciate it

then and you never will, so that's a mental attitude... Looking back, you think, 'Oh good Lord, why wasn't I nude?!' (BB, Urban)

Some women were satisfied with their bodies, but had only reached this point after losing some weight:

I'm actually quite happy with my body. I used to be much, much heavier so I'm very pleased with where I'm at right now. I wish I had looked after myself earlier on, cause then I would have been even happier with myself at that time. So right now, I'm actually quite pleased with where I'm at. (BB, Urban)

A small minority of women had never had any sort of body image issues. This was largely attributed to good genetics and family values:

I grew up in a family where your appearance wasn't a big value, and because of that, I've never really had much body image issues or anything. It was always what you do and the kind of person you are. (BB, Urban)

For many, the road to self-acceptance was a long journey that they were still navigating into later life. They recognized that they were their own harshest critics and would always find something to be dissatisfied about. They knew that in order to become more at peace with themselves, they would have to work at it:

I would say that in the last year my body image has improved. You know, I look in the mirror and I'm not so critical of myself... but it's something that I have to continue to work on. You know, I wasn't terribly upset when I saw my weight on the scale today. I've taken the scale away from my house and I feel much better about myself because it was one of those things that would determine how I felt. Like, oh my god, I'm up two pounds, or whatever. So I feel better now in that respect, but it's something I have to work on, and I have to remind myself to look for some good qualities instead of looking in the mirror and thinking, oh I don't like my legs. (BB, Urban)

I'm actually very satisfied with my height and my weight and my appearance. I've come great strides in the last five years... I believe that you have to have a love of yourself and then I think that as you have a love for yourself and you cleanse your mental health, you become a lot more confident in yourself. I am still learning. In the same way, I think that everybody's on a journey and I believe that there's so much to learn about

good health. Age is only a number, and I've always believed in that. (BB, Rural)

2. Weight Issues

Weight issues were a common thread among all of the focus groups, regardless of age group or location of residence (urban versus rural).

2a. Weight Tied to Body Image

Weight was a major component of women's body image evaluation, in that feelings of body dissatisfaction were often related to weight. When asked about their bodies, many women immediately brought up their issues with weight:

I haven't been happy, having just gained about 10 pounds, and I'm not at all happy with that. It's been quite distressing to me because what I've usually been able to wear, I don't feel comfortable in and so it has been an issue. I've always, I guess, been fairly critical. I don't think I've had a great self-image throughout my life, so it's always been a struggle for me. (OW, Urban)

Well, lately I've been highly dissatisfied with my appearance. I know I put a lot of weight on this last year. I told my doctor that I was fat, happy and healthy and he said I couldn't be all three! So I guess that was his hint that I needed to do something about my weight. But I guess I've been fighting it since I was a child. (BB, Rural)

As this last statement suggests, many women had struggled with weight throughout their entire lives:

I've had a lifelong battle with my weight too, probably since I was 13 or 14. I can't even remember. (BB, Rural)

I've always been big, even as a kid. I've always been, you know, losing 50 pounds, gaining, losing 20, you know, and that kind of thing, back and forth. (BB, Urban)

In general, weight was considered to be central to one's overall health, self-identity, and happiness, and many women reported being concerned about gaining weight or becoming fat. Weight surveillance was a common practice, with some women weighing themselves every day:

Once I turned 60 I felt, at that point, I want to try to look my best, you know. And I find it's even more important, you know, to step on those scales every morning, just to keep yourself in line. (BB, Urban)

It's a very conscious effort to maintain my weight. It's a 24 hour effort. (BB, Urban)

2b. Desire to Lose Weight

Most women, regardless of current weight status, wanted to lose weight or be thinner. They believed that if they could lose a little bit of weight, they would feel healthier and happier:

I would like to be just a little bit thinner than I am, but it's mainly because I [would] feel a little bit better. About five pounds less and I'd be happy. (BB, Urban)

The reasons for wanting to lose weight were varied. At one point, one baby boomer woman simply stated, *"I don't want to be fat, frustrated, and forty!"* Even though weight was closely tied to appearance, many women cited health as their primary motivation for weight loss:

I know that if I lost weight that would improve my health and that would be my motivation, not appearance. [Appearance] would be a by-product of that. (OW, Rural)

Among older women especially, weight loss was seen as a way to improve or mitigate existing health issues:

I think my knees would do better if I lost about 10, 15 pounds, because I find sometimes when I go up and down stairs an awful lot, I feel it on my knees. So I think 10 pounds lighter would be good. (OW, Rural)

Part of the reason I watch my weight is not just for my body image, but it's also health wise, because I am on blood pressure pills and also I've had high cholesterol and high blood sugar at times. (OW, Rural)

Among women who wanted to lose weight, there was an obvious disconnect between their thoughts and behaviour. That is, most women claimed they wanted to lose weight, but very few seemed to be actively doing anything about it. The most common reason for this was simply a lack of motivation or laziness:

Right now I am dissatisfied. But not dissatisfied enough that I can get myself moving to actually get back on the treadmill. (BB, Rural)

Yeah, the weight issue does bother me. But not on a daily basis enough to make me take action. (BB, Rural)

The women often blamed themselves for their inability to lose weight, citing lack of willpower as their main problem:

It should be important [to lose weight], but I don't know how important it is. My laziness trumps the importance of it. Like so many of the women around this table, I have the knowledge of what one should do to lose weight and get better body tone and all the rest of it, and yet, I'm just not willing to put that effort into it. (BB, Rural)

3. Attitudes and Experiences of Aging

3a. Feelings towards the Aging Body

Like body image, attitudes towards aging were complex and deeply individual. As was expected, each woman had her own perceptions, attitudes and experiences of aging. This section will attempt to summarize some of these attitudes and experiences as they relate to the body, ranging from the negative to the positive.

Negative Attitudes and Experiences

Some women viewed aging negatively, as a threat to appearance, health, self-identity, and self-worth. These women were finding it hard to cope with age-related changes and were quite worried about how age would affect their appearance and well-being. One baby boomer explained her troubles with aging in the context of the bodily changes she was experiencing:

As you get older there's more issues and I'm afraid to suffer. I've always been very healthy, and so yeah, that kinda scares me [that] things can go wrong... I think the biggest thing has been, in the last couple of years, I've felt very different cause I've entered that peri-menopausal period and that is when I really started to feel like I'm getting old. I feel different. My body feels different. I feel like certain things are falling apart because, you know, like I didn't have to pee constantly like I do now or you know, or things like that where you notice, hey I'm not 20, 30, 40 even anymore, you know and it's different, so it's kind of an eye opener... I'm middle aged now and it's gonna be harder... You're just aware that you're not like you used to be. (BB, Urban)

Several women commented that bodily changes seem to happen all at once. For these women, aging was seen to be a fairly overwhelming and negative experience:

I really think that this aging, it requires, I'm not exactly sure, but it is a considerable adjustment to this changing appearance... I'm all stiff, and you know, I used to be able to squat down to do an exercise on the floor, no problem. Now I have to do it very carefully and it's a really big adjustment, I find. And I guess we're all in the middle of it and it's difficult. I find the biggest problem for me, aside from all I've mentioned so far, is choosing clothes... It's just a lot of things are happening. (OW, Urban)

The women often commented on how hard it is to accept your body aging when you still feel young on the inside. They described a sense of dissonance between their objective (chronological) age and their subjective (felt) age. As one woman explained:

The actual aging of the body is not fun, and well, my head doesn't accept the fact that my body is, my knees are going. I have arthritis. I have to have surgery on them. So are this, so are that. I have fibromyalgia with my

arthritis and so, I'm pretty well in pain, not a lot of pain, but in pain most every day. But my head doesn't accept that this is my body getting older. I'm still young up here [pointing to head] and that, to me, is the hardest part. Your body is betraying you. (OW, Urban)

Others shared similar sentiments:

I don't feel old. Inside I feel young. And maybe that's why I stopped looking in the mirror, because every now and then, when I do, it's like, oh goodness, you know?! (BB, Urban)

We all don't feel any different inside ourselves and I think that's where the problem is, is that we still feel like we're 30 or 40, or whatever the age might be, and yet our body won't do those things anymore... So I guess I look at myself and I think, well, oh my goodness, in 10 more years, you know, I'm gonna be looking at 80, and well, I don't like that much. And I think it's that acceptance of the fact that, yes it is an aging process and I guess we're lucky to be as well as we are, but it's hard to feel like that some days. It's hard in our heads to think that we're aging... Like, totally, yes, I'm getting older, but it doesn't really sink in, I don't think. (OW, Urban)

These women were very aware of how aging affected their place in the world.

They had noticed a difference in attitudes towards them and worried about becoming invisible in their old age. As one woman explained:

A friend of mine said, it seems as she's getting older, she noticed the difference in attitudes of other people towards her. She said suddenly you're invisible! I thought that was most fascinating, and you know, it does happen. It actually is very true because you're being discounted just because you're beyond a certain age. (BB, Urban)

A few others commented on the poor representation of older women in media, and how they felt that the media promotes a double standard of aging that disadvantages older women:

I mean, when you look at a magazine and watch the TV now, you're old! You know, I hear it from my kids and their wives, you know, we're getting old! And that's so wrong, but that's the way it is now. I mean, you're considered a senior citizen at a certain age and you just, you may not feel that way inside but that's the way you're labeled and that's the way you're looked upon. Men don't seem to have those same issues. They can look the

way they want. They can act the way they want. Women are under a microscope all the time. (BB, Urban)

Positive Attitudes and Experiences

A fair number of women had come to accept the inevitability of aging and spoke positively about the experience. These women seemed to be in a positive place in their lives and their stories were filled with acceptance, self-love, and laughter. These women recognized the importance of a positive attitude:

I think age is a matter of attitude. You can feel old and you will act old and you will look old. But if you think, 'Hey, I'm not too bad', it helps being positive about what you've got. (OW, Rural)

In general, these women believed that worrying is a waste of time and that you've got to do the best with what you've been dealt:

I think you have to realize that aging is a part of life and do the best you can with it and try to stay as healthy as you can. It's gonna happen. There's no way around it. (OW, Urban)

These women acknowledged that their bodies were changing, but had decided to just accept it. There was a shared belief that as an aging woman, you just have to 'smile and go on'.

You look different, things are different, they hang differently, they move differently. And you can't help that, and that's okay. (BB, Urban)

The fact that my hair is grey and my face is a bit wrinkled has not concerned me at all. But when I look in the mirror and see my posture and realize that because of my problems with my spine, that I don't stand as erect as I used to, that bothers me for a second. But then I just smile and go on. But yes, as you say, aging is not for sissies! (OW, Urban)

For these women, changes in weight were not viewed as negatively. Several of them spoke of the idea of a 'grandma figure' that had been reinforced by friends and family:

One thing that my kids said to me is, 'But grandmas are supposed to be soft!' So sometimes, maybe we need to just embrace where we're at. (BB, Urban)

My children, when they were very little, they had a healthy grandma and a not healthy grandma and it had to do with the weight. My mother was plump, had a cuddly hug and they called her the 'healthy grandma'. My husband's mother wasn't healthy... she always kind of restricted her intake and kept herself thin and she just didn't feel warm and safe to them. So, the image of a plumper older person is actually more attractive than the idea of a scrawny, unhealthy-looking older person. (BB, Rural)

Some women commented on the joy and freedom of being older, saying that they felt happier and more content now than they had been when they were younger:

I'm not having a problem with getting older. In fact, I quite enjoy the stage I'm at right now, free to come and go as you please, and to travel or whatever. (BB, Rural)

I wouldn't want to be 20 again. I wouldn't want to go back there. I like knowing everything I know at this age, it's really cool. I just hope that the body holds it together long enough to enjoy this time! (BB, Urban)

Some women were simply thankful to still be alive and well:

I'm very glad to be the age I am because I never thought I was gonna make it to this age. It was never on my radar, never mind being a grandmother. I feel totally blessed. (BB, Urban)

For these women, age-related changes in appearance were viewed as badges of honour; a sign of a life well lived:

I think we all have a concern with what age does to our body.... Everything just seems to drop a little as we age. And the crinkly face also bothers me. I look in the mirror and they say, 'every last line tells a story'. I'm beginning to think I have a big story to tell! (OW, Urban)

As these quotes demonstrate, stories and experiences of aging were spotted with a healthy dose of humour. In fact, it seemed as though humour was a common coping mechanism for dealing with the ups and downs of aging.

3b. Concerns about Aging

A small proportion of women in this study were not concerned about the effects of aging on their bodies. These women had a carefree attitude towards life and believed that worrying makes things worse. The majority of women, however, did have concerns about the aging process and how it might influence their lives. Some of these concerns pertained to appearance, but health and functioning also emerged as significant sources of worry in the women's lives.

Appearance Concerns

In general, women expressed concerns about certain aspects of their appearance and how they would change as they got older. One woman referred to what she called the 'three horrible S's of aging': sagging, shifting and shrinking. Another joked about the sagging issue, saying:

I've got all the proper bits and that's really the most important thing. I'm not missing anything, it's all here, it's just lower than it used to be... I hope this won't offend anyone, but if I [got] my nipple pierced, I could do my belly button at the same time! It's sagging, lots of sagging. (BB, Urban)

Wrinkles were also a common concern among women. As this quote demonstrates, wrinkles were sometimes discussed along with conflicting feelings about weight:

Like everybody else, I'm concerned about the wrinkles, especially with losing weight, I've noticed I'm getting more wrinkles. So I've been beginning to wonder if maybe I should put the weight back on and get rid of some wrinkles! (OW, Urban)

Another issue that was of great concern to these women was changes in hair colour. Most women in the study had experienced some degree of greying and/or thinning hair, and this caused a fair amount of distress for them:

I don't know what I would do with grey hair. I got my hair dyed the other day and [the hairdresser] says, 'You know, you're almost white!'. I said, 'Yeah, but I'm not ready', you know? I just can't. (BB, Rural)

Most women agreed that grey hair serves as a clear symbol of age, and that dying their hair to cover the grey automatically made them look and feel younger. One woman shared a personal story of how white hair could define a person's age:

When my daughter was in kindergarten, I was 35 maybe, and the kids would say, 'Oh here comes grandma' because I had white hair. When I was 40, in the same year, I was carded at a drinking establishment and I was offered my first unsolicited senior's discount! That's what white hair can do! (OW, Urban)

These age-related changes in appearance were largely viewed as inevitable and outside of personal control, and this was hard for some women to come to terms with. These women struggled with the fact that they were concerned about elements of their appearance, but could do little to change it:

I find as I'm getting older it's harder and harder to keep it the way I want it. Some of it is out of my control, of course, and some of it is within my control. But yeah, the wrinkles and so on, and the health issues that come that prevent you from looking as good as you want to look, yeah, that's what I find." (OW, Urban)

I think that's my biggest concern, is the skin, you know... And sagging of the face too. I think that's something I will be concerned about as years go on, but there's not much you can do about it. (OW, Rural)

Functional/Mobility Concerns

Aside from appearance, women also shared concerns about reduced function and mobility. This was particularly common among women in the older age group. In

general, women were very concerned about losing strength, function and mobility and what impact this would have on their daily activities. Pain was an issue for some women and several were already noticing increasing difficulties with activities of daily living:

I dropped something or whatever, got down on my knees to get a hold of it, there's no way I could get up again, though. What's going on here? My head is saying 'Up, up!', but my knees aren't doing it. So that part gets very upsetting. Or when you're trying to do something at home, get the lid off of a jar, and you can't do it. I just take it to my grandson and say, 'Can you undo this for me?' cause I can't do it. So things like that sometimes get very upsetting. (OW, Urban)

Now at my age I'm going, 'Yeah, but I can't lift a bale of hay!' I used to be able to lug the hay and now I've got this [pointing to arm]. What used to be muscles is now hanging. So there's a point where, no, I can't lift above the shoulder. This one's got tendonitis. It's just, those things just happen. And so, there's things that I can't do that I used to be able to do without even thinking. (BB, Urban)

Maintaining a sense of independence was very important to these women, and many were fearful of a time when they might have to be dependent on others:

Maybe why I worry more is because what I did two years ago, I can't do today. You know, what's it gonna be two years down the road? I have osteoporosis and, yeah, that's what worries me, being dependent and having to rely [on others] when I've always been an independent person. (OW, Urban)

As I'm getting older, I'm finding it more difficult to walk and do things for myself when the arthritis really strikes up... They're not like they used to be, so it's kinda scary for me, the whole aging and getting so that I'm gonna be dependent on somebody else. And I like personal care homes because I worked in one for a long time, and they're a great place to go, but for somebody else! (OW, Rural)

Women want to continue doing activities they enjoy well into later life and worried that their aging bodies might prevent them from doing so. Staying active and engaged well into later life was seen as very important for overall well-being:

I really haven't thought about it too much other than, you know, I would want my health to be so that I could be mobile and continue to do the

things that are fun... in order to meet those goals of keeping as active as you can be and engaged, both physically and mentally. (BB, Rural)

Health Concerns

Women in this study were also very worried about how aging might change or influence their overall health status. For some, concerns about changing health far outweighed concerns about appearance:

I think health now is more important than your appearance. If I go to the doctor and he gives me concerns, then I think that's worse than having some appearance problems, you know? (OW, Rural)

Many worried about developing debilitating health issues later in life, particularly dementia, osteoporosis, heart disease/cholesterol, pain, stroke, and general fatigue. When talking about their health concerns, women often acknowledged the influence of genetics and talked about their 'good' or 'bad' genes as a main determinant of their health later in life:

My father is suffering from memory loss, and my grandmother suffered from memory loss... I don't know if you'd say worry, but you're certainly aware of it, and you think, you know, I hope I didn't get that genetic strain in myself. So I mean, we're certainly aware of what can happen to you. (BB, Rural)

Several of these women had been involved in the care of their own parents and had witnessed how health can deteriorate with age:

It's only been three years since my mother passed away, and I went through the aging process with her, through strokes and dementia and what not. And so sometimes, I see myself heading in that direction and I find that quite frightening. And I'm having a birthday this week and it's even more frightening! I had this horrible realization that I am getting old! (OW, Urban)

When it came to discussions surrounding health, a common priority was wanting to stay well enough to be able to interact with young grandchildren. Whenever longevity

was mentioned, it was in the context of wanting to be around as their grandchildren grow older:

To me, it's not the appearance as much. I think it's more the health thing. I worry about aging, you know. I've got high cholesterol and I just want to be there for my grandchildren and I want to be healthy. (BB, Rural)

I have to agree with the health issues. And I would add that I have a two year old granddaughter that I want to still be able to, you know, be active with. And there might be others too, soon. But I start thinking of my own health, well, I want to last a longer time here. (BB, Urban)

4. Importance of Appearance

4a. Confidence Comes from Looking Good

During the focus group discussions, it became clear that for most women, appearance is a highly important aspect of self-identity and self-worth. Both baby boomer and older women spoke about the importance of looking good and how maintaining a nice appearance can translate into self-esteem and confidence:

Appearance, yeah, I must say, I do check myself out in the mirror. I make sure that my hair is done. I make sure I'm wearing makeup and I look put together, because that gives me more confidence to greet the day. So yeah, looking good, appearing well put together, it's important, absolutely. (BB, Urban)

4b. Looking Good in Public

Appearance outside the home seemed to be particularly important to these women. In general, the women were very cognizant of the fact that others judge them on their appearance. Several women spoke about the pressure to look good in front of others:

Isn't our body weight and appearance uppermost? Because, I mean, we have to wear clothes, we have to go out, we have to see people... at least in my opinion, it's uppermost in every woman our age... The person who sees you has got like two seconds to make an opinion on you and if you don't look half decent then they're not even gonna bother with you, you

know. Like, at least that's been proven, you know. So everybody wants to make a nice, good impression. (BB, Urban)

It seems like you're more accepted in today's world if you've got that complete look. (BB, Rural)

I never leave my bedroom until I have my hair combed or curled and I have my face 'put on' for the day. When you step out the door, you meet somebody right away! (OW, Rural)

Several women commented on how maintaining a nice appearance is very important while in the workforce. They spoke of wanting to 'look their best' at work and were keenly aware of how their external image could influence their work:

I think when you have an off-the-farm job and you're in the public, you kind of represent whatever organization you work for, and so you want to look your best." (BB, Rural)

I worked in a bank and we were always taught that if we were dressed properly and we looked nice, people would have more respect for you, and so that kind of stuck with me. (OW, Urban)

One woman, who had recently retired, explained how her appearance had been much more important during her career:

When I was working, though, I was very concerned about how I looked and was dressed every day and all of that. Now, I still like to dress nicely and look nice, but it's not as important to me. Like, I'm letting my hair go grey, you know, stuff like that. Like, it's just not as big of a deal to me as it used to be. (BB, Rural)

In general, most women felt that it is okay to look 'sloppy' at home, as long as you look presentable and put-together when you step outside:

Fifteen years ago, when I worked in an office, appearance was more important to me than it is now... And then when I retired, I found, unfortunately, when I get up in the morning, a lot of times I'm still in my pajamas at noon... When I was home by myself for a year and a half, it didn't matter what I looked like. Now, my husband's retired and so I do try a little bit more, for his benefit, cause I don't think he particularly likes to see me in slouchies [sweat pants]... When I go out, I like to be dressed up, not quite as I used to be, but I do like to wear the earrings and

the necklace and the rings and stuff. So I try a little bit more if I'm going someplace, but at home, it's not a big deal. (BB, Rural)

Yes, it's important to me. For many years, I got up in the morning, put makeup on, was ready for the day. I've kind of fallen off that a little bit, but it's still, I think it's important to be presentable when you go out. It's okay to go around sloppy at home, but when you go out, I think it's important. (OW, Urban)

The phrases 'neat and tidy', 'put together', and 'not too old' were often used to describe how they wanted to appear to others outside the home:

I feel that yes, it definitely is important to me. As you get older, your body changes, even your face changes, the wrinkles come. But it still is very important to me to look as put together as I possibly can. (OW, Urban)

I like to look neat and tidy and presentable. Not too old. I've got two daughters who keep me on my toes! (OW, Urban)

Some women had reached a healthy balance of being attentive to appearance, but not being overly concerned or preoccupied. One woman explained:

You like to put your best foot forward, but I don't dwell on the fact that I don't look so good. You've got to put up with what you've got. But you know, your face and that, you try to dress as neatly as you can. So I guess it is a little important, but it isn't, I don't spend a lot of time worrying over it. (OW, Rural)

A small minority of women reported that they don't care what others think, and therefore, refuse to worry about their appearance:

There's nobody to impress, just me, so I'm fine with what I look like. It doesn't worry me. It doesn't take up any space in my brain. (BB, Rural)

I really could care less about what other people think about my body image. Unless they're a body builder or look perfect themselves, I don't think they should have any right to tell you what they think of your body image. Definitely I would like to be toner, you know, but weight to me – a number – isn't a big deal to me. I would like the rolls to be smoothed out a little bit better or a little tighter, but it's just a number. (BB, Urban)

I'm getting to the point now where I'm saying 'Okay, you don't like it? Too bad', you know? This is me, this is how I am, and this is how you have to accept me. (OW, Urban)

5. Body Work Practices

Many of the women in this study were engaging in some sort of body work in order to maintain or control their external appearance. The types of products and practices used varied, but some were more common than others. The most commonly used practices were anti-aging/wrinkle creams, makeup/cosmetics, hair dye, fashion/clothing, and dieting. Exercise and supplements were also mentioned as a way to maintain health and appearance as one ages.

5a. Dieting

Diet Plans & Programs

The most commonly used diet programs were Weight Watchers[®], TOPS[®] (*Take Off Pounds Sensibly*), and Atkins[™]. Jenny Craig[®], LA Weight Loss[®], and The South Beach Diet[™] were also mentioned, but less frequently. Some women had tried them all:

My experience is the same with [hers], where I tried all the different diets, the grapefruit diet, the milk diet. If there is such a thing, I tried it! (BB, Urban)

Weight Watchers[®] was the most common diet program, and while their efforts on the program were not always successful, several women reported that they had learned something valuable from the Weight Watchers[®] experience:

I joined Weight Watchers, which was very good, and if I were really serious about losing weight, I'd go back to Weight Watchers because I think they are an excellent program and they do teach you to make healthy choices and to exercise. So you never know, I might break down sometime and go back to Weight Watchers. (BB, Urban)

I used to go to Weight Watchers, well I'm a lifetime member of Weight Watchers, but I only go when I'm really desperate or there's a goal where I want to lose some weight. But I've learned a lot from Weight Watchers and I incorporate that into my lifestyle... just watching the kinds of foods that we eat and only buying healthy food, like not even having it in the house. (OW, Urban)

With the exception of Weight Watchers[®], most other diet plans were considered to be difficult and unpractical:

Well, five or so years ago, I went on the South Beach Diet, and I lost 20 pounds, which has all returned, by the way. But I found that it wasn't a practical diet. (OW, Rural)

Yes, I've done Weight Watchers a couple times. I've also done, can't remember what in the world it's called, Nutri-System? I did well on that, but then, all the food is there, ready. You just eat their food! But once you get going on your own food again, forget it! (OW, Urban)

Dietary Restraint

Aside from the use of formal diet plans and programs, many women exhibited some form of self-imposed dietary restraint, using words such as 'trying to limit', 'watching what I eat', or 'cutting back'. These women exhibited a more subtle form of restriction – an ongoing, underlying sense that they should always monitor and restrict their intake as much as possible. For some women, it was simply a matter of becoming more conscious and making healthier choices:

In the last few years, I really have tried to, you know, be more conscious of how much of that I eat every day... On a daily basis, I think about the way I eat. (BB, Rural)

I know that I have to make healthy food choices and I just can't eat the things that I was eating before or I'll be putting the weight back on, so I have to have some discipline, and it is helping. I think a lot of it's here [pointing to head]. (OW, Rural)

Others, however, had adopted a more restrictive approach and seemed to be caught up in the potentially dangerous dieting mentality that promotes all-or-nothing thinking and negative self-talk. One woman explained her daily struggles with watching her diet:

I'm really trying, like I watch my weight every single day and I really try to eat right, but then I get up in the morning and I'll say, 'Okay, today you can't eat anything!' But then, this chocolate bar is calling me. And then I finally eat it, just to get it out of there so it won't be calling me anymore. And that's the way it is, you know? (BB, Urban)

Unenjoyable and Unsuccessful

Regardless of whether the dieting was program-led or self-imposed, nearly all women who had dieted or restrained their eating perceived the experience as being unenjoyable. In addition to being 'no fun', dieting was seen to be all-consuming in that it requires a lot of effort, will power, and a substantial time commitment. The women spoke of how analyzing every bite takes the fun out of eating and makes it hard to enjoy even occasional indulgences because they always feel guilty about what they're eating:

What I eat is for my health and it takes out a lot of the enjoyment. Like, I can't say that I ever get terribly excited about eating anymore... Every so often my husband says, let's go to A&W. And so we do. But saying that, like it's not exactly, like, I don't get any enjoyment out of dipping in to a hamburger because, well, it's white bun and it isn't gonna work for me, and so I eat half the bun because I don't want to eat the whole frigging thing. Well, I'm not enjoying my hamburger... I'd like to eat a hamburger without ever having to analyze what I'm eating. So it does take the fun out of it. (BB, Urban)

Very few women had been successful in their dieting attempts. Not only was dieting considered to be difficult, unenjoyable, and restrictive, it also didn't appear to work. The vast majority reported that while dieting may work in the short term, it simply doesn't result in long-term sustained weight loss:

I tried all kinds of different diets, and the only one that every really worked for me was the Dr. Atkins, the low-carb diet, and that one seemed to work. I did take a lot of the weight off, but then I think I put it all back on again. (OW, Urban)

I had joined Weight Watchers, and I know this is terrible, but all I lost is \$200! (BB, Urban)

Yo-Yo Dieting & Weight Cycling

The weight rebound that came from dieting would often result in greater feelings of BD and a desire to diet again. As a result of this pattern of loss and regain, some women had found themselves caught up in a continuous cycle of yo-yo dieting. A fair number of women had been dieting for most of their lives:

I've been on a diet all my life. I have been since I was 18, 19 years old. But it's off and on, off and on... You know, I'll be on it for, you know, a month, two months, six months, and then all of a sudden, something changes in your life, you know, an emotional problem or whatever, and it's gone. And then all of a sudden, the weight is back up again. (BB, Rural)

As I've said before, I've had a weight problem all my life and like [she] said, I tried many, many diets and they never worked. You take the weight off, but then you put twice as much back on! (OW, Urban)

Of these women, many had experienced the chronic rebound effect of dieting, and after many years of dieting, found themselves heavier than ever before:

I have dieted off and on throughout my life. I've done calorie counting, I've done the fad diets, like Scarsdale, and I've done a couple of sessions with Weight Watchers... But there is a bit of a pattern, and I think this is documented in other places that, you know, you weigh a certain amount and then you cut calories and you lose weight, and then you gain more weight than you had previously, and you know, gradually. At one time, I weighed 120 pounds and now, I weigh considerably more, and it's sort of gone up, you know, over the decades. (BB, Rural)

Women tended to blame themselves for their inability to lose weight, citing lack of willpower as the main reason for their failure:

I believe that, ultimately, it does come down to yourself to try and control, but it's also very difficult. Every day, the consumer world is flashing things at you constantly and you have to have very strong willpower to say no to whatever they might be flashing at you, and I don't have that willpower, basically. But again, that comes down to me then. I need to improve my willpower! (OW, Rural)

Especially late at night – that is my bad time. Cause I love night, I'm not an early to bed person. I'll do crosswords, I'll go on the computer and I can't sit there without having something to nibble on. I know it's a horrible thing to do and I keep doing it! Why am I doing this, you know? I know what I'm supposed to be doing, and just don't do it! I have very little willpower. (OW, Urban)

Others believed that dieting itself is the problem and the reason for their repeated failures.

These women had come to the general conclusion that dieting is not healthy, and just results in unproductive feelings of deprivation, failure, guilt, and shame. These women had realized that if they just avoid the negative dieting mentality, they're better able to control their intake in a healthier, more moderate way:

I did try all kinds of things and you know, I finally realized like, hey, I'm not going there anymore! I'm not doing that yo-yo dieting. It threw my metabolism off for years! (BB, Urban)

I don't diet. I think dieting has the opposite effect. So now I'm trying to work out more, you know, three or four times a week. So that's my plan, as opposed to trying to diet, and also trying to just eat healthy, but not dieting. (BB, Rural)

Some women had sworn off dieting completely because of negative personal experiences or as a result of witnessing others' unsuccessful attempts:

Dieting can really, you know, I've watched family and friends go through these diet cycles and that just crashes, you know, and then they have all these other health issues that come from not being, well eliminating. Like, I'll use my sister. She eliminates fat from her diet as much as she can and she has so many health issues and I'm saying it's like trying to run a car without oil. If you don't put some fat in your body, your motor will stop working, you know. (BB, Rural)

As someone who before didn't have to think about any of those things when I was eating, it really is abnormal to think about those things when you're eating. It makes eating all the more difficult. It's kind of crazy, and that's why I gave that up, and just exercise now. Because really, how do you eat normally when you're worried about how you're eating? I mean, to me, it's crazy.... It's really, it's very difficult, you know? And all the games we play with, you know, it makes you think more about food! It makes you want to eat more, frankly... It's very stressful. (BB, Urban)

Despite the overwhelming majority of women not achieving success on their diets, a small number had been successful and were able to keep the weight off. Of these women, several reported that they had been able to maintain the weight loss by making small changes in their behaviour and/or attitude:

I do the portion control and basically it was what my doctor suggested. I did one pound a month. That was my goal, my only goal. And I went down, down, down, and I have been able to keep it off because I went down real slowly and changed everything about what I was doing. I exercise more too. My goal was one pound a month and everybody says, 'That's ludicrous!' But I said, no, that's where I'm headed, and I ended up losing a substantial amount, one pound a month. (BB, Urban)

Before 2004, I was really heavy, like a lot heavier. And I just decided that this was no good and I started to really watch what I ate. And I lost probably close to 30 pounds and I kept that off. (BB, Rural)

5b. Anti-Aging Products

Attitudes towards anti-aging products were mixed. One of the most common reasons for using these products was to increase self-esteem or inner confidence. When describing her beauty routine, one woman stated:

You use everything you can to look a little better, to feel better... To feel like you look half decent, to give you more confidence. (BB, Urban)

A few women mentioned that they use anti-aging products even though they're aware that the products probably don't really make a notable difference. These women didn't seem to care that the products weren't working; they continued to use them simply

because it made them feel like they were taking action to do something about their appearance:

I think I've become more aware of wrinkles now, on my neck and down here. So I am using a cream, although, intellectually, I don't think creams work. But I'm still using it in order to try and reduce. (BB, Rural)

Among women who did not use anti-aging products, the reasons varied. For some, it was a matter of effort and cost. They simply didn't have the time or money to invest in such products. Other refused to use these types of products because they believed that anti-aging claims are largely unsubstantiated. These women viewed the whole beauty/anti-aging industry as a money grab, filled with empty promises and designed to make women feel bad about themselves:

Face creams and the products, it's the same as dieting, really. Like, they promise eternity and it's a waste of time, unless maybe if you really stuck to it and creamed yourself from head to toe every day of your life, but you know. (BB, Urban)

I don't use the products and things. Like to me, that's sort of life your head's up in the clouds if you think you can put stuff on your face and make the lines go away. Or rub yourself one way or the other and your lumps are gonna go away. Like, I've been around the block a few times, it doesn't happen. (BB, Urban)

5c. Other Body Work Practices

Aside from dieting and anti-aging products, the most commonly used body work practices included skin care, hair dye, clothing/fashion choices, and cosmetics/makeup. Exercise and vitamin supplementation were also occasionally mentioned as valuable 'strategies' for maintaining a nice appearance. There were also some less common practices mentioned, such as using Preparation H[®] (hemorrhoid cream) to reduce under-eye circles, covering the entire body in Vaseline[®] to retain moisture while sleeping, and

bathing in olive oil to keep skin looking youthful. When discussing their various beauty products and routines, there was a great deal of ‘sharing’ among the group, in that women were eager to pass on their tips/techniques and learn about what others were doing to keep up their appearance.

Skin Care

The use of skin care products was incredibly common among the women in this study. Almost all of the women reported using some kind of skin care product on a daily basis. Most women had started these routines when they were younger and had just kept it up as a normal part of their daily routine. Many of them acknowledged the fact that youthful skin is an important aspect of beauty and as a result, aging requires a higher level of skin care in order to maintain that fresh and youthful appearance. To this end, many women mentioned that they are choosing higher quality skin care products as they get older:

I would say yes [to using anti-aging products]. I did that all the time when I was young, but now I find the ones that I’m choosing are the ones that will say ‘anti-aging’, cause I assume I’m at that level of skin care. I used to use them all the way through to look after the skin, but now it says right on it: ‘anti-aging’, as opposed to what I used 10 years ago. (BB, Urban)

A common problem for these women was increasing dryness of the skin with advancing age. Many commented on their problems with dry skin and emphasized the importance of keeping the skin moisturized in order to prevent wrinkles:

I think that’s my biggest concern, is the skin, you know. You try to keep your skin moisturized so maybe it’ll help that you don’t get as many wrinkles. (BB, Rural)

I use a good night cream. It’s supposed to get rid of these [pointing to wrinkles], or prevent more from coming! (OW, Urban)

Hair Dye

Hair dye was another commonly used beauty routine among the women in this study. Many of the women were bothered by any signs of grey hair, saying it made them look older. A few women went so far as to say that they were ‘disgusted’ at the thought of grey hair. These women viewed greying hair as a clear sign of their advancing age and did whatever they could to cover it up:

I am just really glad that I live in an age where highlighting is normal, you know, because otherwise, I would be turning grey and I wouldn't want to because I had a mother who was a twin and my mother always dyed her hair and her twin didn't. And her twine looked 10 years older than she did! (BB, Urban)

Several women also commented on the different kinds of greys that exist, stating that certain kinds of greys are more beautiful or desirable than others. They explained that they are generally okay with grey hair, as long as it looks a certain way. Of course, these women were never quite satisfied with their own shade of grey:

I've been doing all I can to keep the hair colour. And if my hair could just be a beautiful grey as some of you are, I would. (BB, Rural)

Cosmetics and Makeup

While less common than skin products and hair dye, makeup was still used among some of the participants. In particular, applying makeup was seen as an important step in getting ready to go out, as it not only enhanced appearance, but also made them *feel* more attractive:

Every time I go out, I'm wearing make-up, or if somebody's coming in, I always try and spruce myself up a little bit. I think it just, I don't know, it perks you up, makes you feel better. At least it does for me, anyway. (BB, Rural)

I think it's important in the sense that, like I don't want to go out if, you know, I haven't combed my hair and dressed appropriately, and you know, just for my own self-esteem just to look as good as I can for the occasion, you know, like going out for the evening, you put more make-up on or things like that, just to feel good. (BB, Urban)

Makeup was not without problems, though. Several women commented on the increasing difficulty they were experiencing when trying to apply makeup:

This morning I was putting eyeliner on and I thought, man, I hate that my eyelids are so baggy, and it's really hard to put eyeliner on. They move and they shift and you can't do it properly... And I looked in the mirror and I thought, oh yeah, you are getting older... I used to be able to put on my make-up when I was driving the car and I cannot do that anymore. Impossible! (BB, Urban)

Clothing/Fashion

Clothing came up in all of the focus groups, as both a blessing and a curse. As mentioned previously, choosing and shopping for clothing was considered to be a huge hassle and a major headache. Women talked at length about the difficulties in finding appropriate and attractive clothing that looks and feels good. In short, clothing was a huge source of distress for many women and the reason for many disparaging comments about the body. However, at the same time, clothing was also mentioned as a way to improve appearance or 'hide the imperfections' associated with aging. In one focus group, a couple women spoke of wearing turtlenecks specifically to hide their double chin or neck fat. Another said she specifically wore jackets or sweaters in order to hide her mid-section:

[I] hide it as much as we can. [I] don't like to wear tight things and when I do, I usually have a jacket or sweater over top. (BB, Rural)

These women were also very aware of how clothing can have the opposite effect and make you look bigger than you really are:

You can wear things that are really tight and it just makes you look even bigger than what you are. And sometimes wearing something that's too big makes you look bigger than you are too. So it's important for me to look decent. (OW, Rural)

Like makeup, clothing was also seen as a way to increase confidence and feel better about oneself in the world:

I'm wearing a new pair of pants today and some heels, rather than a pair of running shoes, and that makes me feel good when I walk down the hallway. And I feel better about everything. (BB, Urban)

Exercise

The women in this study spoke of exercise as a way to not only lose weight, but also maintain an overall youthful and attractive appearance. Exercise was seen to have many benefits for the self, such as reducing aches and pains, relieving stress, improving mood, increasing energy, building strength, losing weight, and just generally feeling better. Several women commented on how exercise can help prevent the sagging that comes with aging:

You need that exercise. Everyone talks about keeping things in place and things dropping... If you were just to exercise, that does such a world of good for your, mentally and physically. It just keeps everything kind of in the same place, you know. (BB, Urban)

I'm concerned about gravity. Everything seems to go south. I think the older we get, the more we have to exercise to keep muscle tone and to have bones stronger and muscles stronger. So that, like, if you lift things and you have stronger muscles, apparently your bones are stronger, so that will help for aging. So that's a good reason. (OW, Rural)

Despite these known benefits, women struggled to maintain a routine of exercise.

Many different barriers, such as lack of time and poor motivation, interfered with their ability to stay active on a regular basis. At times, exercise was viewed as yet another 'job' that they had to somehow fit into their day:

All of a sudden, this roll appeared out of nowhere and I know, like my doctor has told me that it's stress weight, or what they call stress weight, and the only way to get rid of it is to really exercise and, you know, do all kinds of stuff like this. And I'm thinking, oh god, there's another thing to add to the pile! (BB, Urban)

I had been going to Curves, either in Virden or Souris, and really enjoyed it, but it got to be a job, like you know, instead of... and maybe if you had somebody to go with, you might continue. But I don't know what my excuse is for not walking, but I just haven't done that either. (BB, Rural)

Women also complained about the difficulty of being active in the winter season and in light of increasing functional limitations:

I'd like to do more walking, which isn't easy when you've got icy streets like we have and when you have arthritis. So these things sort of play a big role in your exercising. (OW, Urban)

Food & Supplements

Food and nutrition was also seen as a way to help manage the aging body.

Healthy eating was seen as a very viable way to stay young and healthy for as long as possible:

Last Christmas, I was in Coles and I ran into this book called 'Younger Next Year', and I thought, what the heck, I had just turned 50 and thought, oh, I better read that. So picked it up and what it talked about is the importance of healthy choices. We all know fruits and vegetables, and that's what you got to eat, and you're supposed to eat lean proteins, and you're supposed to have whole grain instead of white. We all know that, but this made so much sense. And it's an amazing amount of diseases and problems you can eliminate! (BB, Urban)

Women were also very interested in what foods or vitamin/mineral supplements could help them feel better and look younger. Several were taking vitamin or mineral supplements in order to prevent or delay the 'ravages' of old age:

I strongly believe that what you eat is what you are. What you take to help minimize whatever ravages happen to your body is important: anti-

oxidants, omega-3's are important. Those are two things off the bat that I think alone help combat aging. (OW, Rural)

5d. Influence of Family

When talking about anti-aging products and other body work routines, a common theme that arose from all the focus groups was the influence of family members. Some of the women in this study reported being influenced by the beauty work practices modeled by their own mothers, as was the case with this woman:

Yes, I do [use anti-aging products], I do a lot, have for many years. [I] haven't seen my hair for about 40 years, the colour of it. My mom was very conscious of her appearance and we learned that from a young age. I have three sisters who also are very conscious of their appearance. I spend a fair amount on skin care and appearance products, anti-aging. My husband tells me I'm high-maintenance, but I figure I'm worth it. (OW, Urban)

The above quote suggests that young girls may observe and learn how to monitor and manage their appearance from their mothers. However, the influence of children (particularly daughters) was also quite strong. Several women described how their daughters encouraged them to stay 'on top of' their appearance:

I have a daughter that's a hairdresser. She won't let me go down the street unless I look just like this. And the rest of the girls in the family have Arbonne parties, and so I'm forced into spending all my pension on Arbonne. I have anti-aging makeup, creams... (OW, Rural)

My girls are still pushing me to do what you need to do to feel youthful, mom. So you know, the pedicures... and a little bit of Olay too, to help those wrinkles that I was blessed with from my mother's side. (BB, Rural)

I'll have to admit to colouring my hair, which I have done for so many years. But I try to tell myself it's the colour it used to be! I kept saying that at a certain age, I'd stop doing it. But my daughters say, 'Heavens, no, mother! You'd look awful!' (OW, Urban)

5e. Maintaining a Natural Look

Among women who engaged in body work, the achievement of a ‘natural’ look was paramount. In general, the women in this study were very aware of the danger of looking ‘unnatural’. They wanted to use beauty products to enhance or maintain their appearance, but were very careful not to overdo it, out of fear of looking ‘too young’ or being seen as ‘trying too hard’:

I don’t think there’s anything worse than seeing an older woman with a lot of wrinkles with caked on makeup. I think it is just awful, so the more natural, the better. Just moisturizer and a little lipstick. (OW, Urban)

If you put it [makeup] on too thick, it just looks like you’re filling in cracks! (BB, Urban)

I started to go grey when I was 10. I put on a black wig one time and there is nothing uglier!... My daughter just thought it was a real hoot, so I just let it go. You can really draw attention to yourself! (OW, Rural)

DISCUSSION

General Discussion

This paper has explored the body perceptions, aging concerns/attitudes, and body work practices of baby boomer and older women living in urban and rural areas of Manitoba. To date, little attention has been given to the body image and aging issues experienced by baby boomers. This paper adds to the existing literature by exploring the connections between aging and the body, from the perspectives of baby boomer women and their older counterparts. It also examines the meanings that women construct and ascribe to their aging bodies, and the behaviours they adopt in an effort to manage their bodies.

Body Image & Aging

Based on the findings, BD does appear to be an issue for women as they age. However, during the focus group discussions, it became clear that body image is more than just a simple statement of satisfaction or dissatisfaction for these women. It is much more complex, involving different interlocking and overlapping thoughts, perceptions, opinions, attitudes and experiences. Each woman's body image perceptions were unique, a result of her own personal circumstance and experiences. Although there were similarities in experience and opinion among the group, it is clear that body image is clearly a deeply personal and individual construct. There was great diversity and complexity in the body image perceptions of baby boomer and older women, with responses ranging from very negative to extremely positive, and everything in between. Furthermore, even within one individual, body image evaluations weren't stable or static – it was clear that body image is temporal and situational in nature, fluctuating in response to certain external situations or stimuli. For example, shopping for and trying on clothing seemed to be one situation in which body image issues would resurface and feelings of intense dissatisfaction would emerge.

When talking about their issues with BD, many women fixated on a specific body part. Other researchers have also found that women tend to compartmentalize their bodies, evaluating them not as a whole, but as a series of distinct parts (Halliwell & Dittmar, 2003). This focus on specific problematic body parts may explain the discrepancy between the questionnaire results (which found that 66% of participants were satisfied with their *overall* appearance) and the focus group discussions, in which feelings of BD were common. In addition to their dissatisfaction with specific body parts, many

women were also struggling with ongoing weight issues. Through their comments, it was clear that body weight is intimately connected to self-esteem and overall appearance evaluations. This observation was confirmed by the questionnaire results, which found that nearly half the women were very or moderately dissatisfied with their weight. This was not entirely surprising, given that nearly three-quarters (72.8%) of the women in this study were overweight or obese. It is worth pointing out that the rate of overweight and obesity in our sample was higher than the national average. For comparison, Statistics Canada reported that in 2012, just under half (45%) of Canadian women were overweight or obese (Statistics Canada, 2012b).

Some of the women in this study had been fighting their weight throughout their entire lives. For others, excess weight had only become an issue once they reached middle-age, prompted by the gain or redistribution of weight that tends to coincide with menopause. Previous studies have also found that issues with and concerns about weight are very common among middle-aged and older women, and that most women want to lose weight or be thinner (e.g., Clarke, 2002; Hurd, 2000; Baker & Gringart, 2009; Mangweth-Matzek et al., 2006). It is unclear whether the drive for weight loss is due to higher levels of BD among women, or simply because more and more women are overweight or obese and therefore, find themselves further from the socially accepted standard of thinness. In this study, even women who fell into the 'normal' BMI range (18.5 to 24.9 kg/m²) wanted to lose weight, which may suggest that women always want to be thinner than they are, regardless of their current weight. In general, the women were very attuned to the sociocultural influences that dictate what female bodies should look like, and were explicitly aware of social expectations and pressures surrounding age and

femininity. Furthermore, these women acknowledged that their appearance can determine their social value and worth in society, and thus, they were very concerned with how others would perceive them outside the home.

Feelings towards the body were often closely related to the experience of aging, which suggests that aging and body image are intimately linked. For many women, negative feelings towards the body were related to age-related changes in appearance that moved them further from the ideal standard of female beauty. Similar to the findings of Halliwell & Dittmar (2003) and Winterich (2007), wrinkles, sagging skin and greying hair were seen as major threats to the maintenance of a youthful appearance. Furthermore, the women who were experiencing body image issues and body dissatisfaction tended to be the ones who were struggling to come to terms with aging. Similar to the findings of Rubinstein & Foster (2013) and Strauss (2013), menopause was mentioned as a crucial transition point, where issues surrounding age and the body seemed to emerge and entwine. When talking about their bodies in the context of aging, several women commented on how everything seems to change all at once, which is not only difficult and overwhelming, but also results in feelings of losing control over one's body. They were finding it hard to accept the changes that coincide with aging and felt that aging was threatening not only their appearance, but also their identity, self-worth, and social value. Many women commented on how difficult it is to accept that your physical body is aging when you still feel young inside. It was almost as if they felt their body was 'betraying' them, and this caused a lot of tension and stress in their lives. This sense of cognitive dissonance between chronological age and subjective (felt) age was also found in the work of Öberg & Tornstam (2001) and Hurd (1999), among others.

Concerns about aging applied not only to external appearance, but also to changes in functioning, mobility and health. The older women in particular, seemed more concerned with age-related changes in health that might affect their lifestyle and independence. This finding agrees with previous studies, where it was found that as women age, health and functioning become more important than appearance (Hurd, 2000; Liechty & Yarnal, 2010; Baker & Gringart, 2009). These women worried that reduced function and mobility that would impact their ability to do everyday tasks as well as leisure activities. They valued their freedom and independence and worried about a time when they might have to rely on others for help. Some women were especially concerned about certain diseases such as dementia, arthritis, hypercholesterolemia/heart disease, and osteoporosis. These fears often stemmed from an awareness of the genetic tendency of disease and from seeing their own parents deal with worsening health conditions later in life. When it came to their health, a key priority was their desire to remain actively involved with their families. They wanted to live long enough and well enough to be able to interact with their grandchildren.

Some women in this study were not concerned about their appearance and were generally very satisfied with their bodies. These women, many of whom were over the age of 65, felt blessed to be alive, grateful for their health, and generally positive about the future. A common thread that tied these women together was that they had come to accept aging. That is, they considered age-related changes in appearance to be an inevitable part of life and were doing their best to manage the ongoing changes to their bodies. These women had truly reached a place of inner strength and acceptance by starting to embrace their imperfections and accept themselves as they are. They felt that

age is a matter of attitude and you can choose to be happy with where you're at. A commonly shared sentiment was that you 'smile and go on'. This observation aligns with previous work, in which older women reported greater self-acceptance due to a shift in priorities/values and a rejection of external expectations (Liechty, 2012; Tunaley et al., 1999; Paquette & Raine, 2004). Overall, these women were in a positive place in their lives and their stories were filled with acceptance, self-love, and laughter. Some of them went so far as to say that things were getting better with age; they were relishing in the freedom and wisdom of later life and reported being happier now than they ever had been in their youth. Many of the younger (baby boomer) women who were still struggling with BD were striving for this sort of happiness. They realized that, when it comes to their bodies, they are their own worst critics. They recognized that the path to self-acceptance was a long one that they would have to continually work towards.

Body Work & Dieting

Despite individual differences in how women perceived and dealt with the aging of their bodies, many were engaging in some sort of body work. The types of products/techniques and frequency varied, but essentially all women were doing something to try to improve their external image and/or mitigate the effects of aging. Skin care products (e.g., anti-aging/wrinkle creams), hair dye, and makeup were all commonly used among both baby boomer and older women. These products have been previously reported as important to women's beauty routines (Clarke & Bundon, 2009; Clarke & Korotchenko, 2010; Winterich, 2007; Ballard et al., 2005; Paulson & Willig, 2008). Clothing, despite all of its troubles, was also seen as a useful way to enhance

appearance or cover up imperfections. Other authors have previously commented on the strategic use of clothing among middle-aged and older women (Liechty, 2012; Clarke, Griffin & Maliha, 2009).

Dieting was also a common behavioural response to BD; over half of the women in this study had dieted within the past year alone. The prevalence of dieting in this study is consistent with previous studies of middle-aged and older women (Gadalla, 2008; Mangweth-Matzek et al., 2006; Hetherington & Burnett, 1994; Germov & Williams, 1996). Among the women in this study, dieting took several forms; 21% had used a formal diet program (Weight Watchers[®] being the most common), and many others had adopted their own personal diet plans based on popular diet books or on their own ideas of weight loss. In all of the groups, an underlying thread of cognitive dietary restraint was apparent, as demonstrated by phrases like ‘attempting to cut back’ and ‘trying to limit’. It became clear that even when women aren’t ‘dieting’, per se, most of them are still monitoring or restricting their intake in some way, shape or form. This observation is perhaps indicative of a broader ‘orthorexic’ trend in Western society that upholds individualistic responsibility for health and promotes dieting as a path to improvement, particularly for women (Rangel et al., 2012). On the other hand, this sort of behaviour may be a perfectly healthy mechanism of self-management and control. In fact, some researchers argue that some degree of self-regulation is absolutely essential for preventing weight gain in the context of the obesogenic Western environment, and that dietary restraint signifies “an adaptive way to respond to a plentiful, palatable and energy-dense food supply” (Johnson, Pratt & Wardle, 2012, p. 665).

Unfortunately, most women who embarked on diets had not experienced long term success. The overwhelming majority of dieters had been able to lose some weight in the short term but had experienced the classic weight rebound that is characteristic of restrictive dieting (Maclean et al., 2011; Lowe and Timko, 2004; Mann et al., 2007). Not only was dieting seen to be ineffective for long-term weight maintenance, it was also perceived to be a largely unenjoyable practice. Many women spoke of the overwhelming feelings of deprivation that accompany dieting, as well as the intense feelings of guilt, shame, frustration, and personal failure that result. Many women were caught up in a continuous, self-defeating, viscous cycle of yo-yo dieting, where each diet would lead to loss, and then subsequent regain and greater BD. Some women who had struggled with weight throughout their lives said that they had tried ‘every diet in the book’ and had ended up heavier than ever before. This was confirmed by the questionnaire results; those women that reported dieting over the past year had a higher average BMI than those that didn’t diet. This may suggest that women with higher BMIs simply feel more need to diet, or that dieting itself leads to a higher BMI, as has been suggested previously (Neumark-Sztainer et al., 2012; Provencher et al., 2004).

The sort of repetitive weight cycling observed in this study has been shown to have significant long-term health implications, including muscle loss, reduced bone density, cardiovascular abnormalities, and increased risk of mortality (Lee et al., 2010; Folsom, French, Zheng, Baxter & Jeffery, 1996; Olson et al., 2000; Montani, Vieceili, Prévot & Dulloo, 2006). Furthermore, dieting has been associated with depression, lowered self-esteem, nutrient deficiencies, and eating disorders, all of which can have a

negative impact on women's overall health and well-being (Cachelin & Regan, 2006; French & Jeffery, 1994; Miller & Wolfe, 2008).

Regardless of the product, technique, or diet plan used, the main goal of body work was to achieve a 'natural' look that would be socially acceptable amongst their same-age peers. Through their body work, they wanted to appear 'neat and tidy', 'put together', and 'not too old'. Similar to the findings of Clarke & Griffin (2007a) and Ballard et al. (2005), the women in this study were cognizant of the potential to appear 'fake' and didn't want to look like they were trying 'too hard'. It was important for them to maintain a youthful appearance, while still looking an 'appropriate' age. In sharing their body work routines, cosmetic surgery was barely mentioned at all, likely because it didn't align with the pursuit of natural beauty. The few times it did come up, it was referred to as an extreme and 'unnatural' procedure that only other people did. Among the few women who chose not to engage in body work, a common reason was distrust of the beauty, weight loss, and anti-aging industries, and a refusal to spend money on products designed to make women feel bad about themselves.

It is worth noting that all the time, money and effort spent on body work served a greater purpose in the women's lives. The endless products, shopping trips, and diet plans were not only helping them achieve a sought-after appearance, but also gave them a tangible sense of inner confidence, agency, and improved self-esteem. Even if they knew the products weren't making much of a difference, they continued to use them because the simple action of doing so gave them a greater sense of control over their appearance. This speaks to earlier observations that body work can simultaneously be empowering for

middle-aged and older women, while still reinforcing unrealistic societal standards of beauty and ageist consumer culture (Winterich, 2007; Slevin, 2010).

Another theme that emerged was the social nature of body work. Several women commented that they had picked up their body work practices from their mothers or their daughters. Indeed, other researchers have suggested that women's body work practices seem to be greatly influenced by the body image issues and beauty routines modeled by family members (Paulson & Willig, 2008; Clarke & Griffin, 2007b). Furthermore, the women who took part in this study were eager to share their body work routines and practices with one another. In almost every focus group, there was an aura of enthusiasm surrounding the sharing of beauty tips; the women were eager to pass on their tried and tested techniques. In fact, the sharing of personal beauty routines seemed to foster social connections among women who had never met before. For example, in one group, the discussion about anti-aging techniques led a handful of women to start making plans to go to a hair salon together. In this way, engaging in body work appears to be a shared experience among today's generation of middle-aged and older women; it is something that each and every woman can relate to.

A Comment on the Benefits of Focus Group Methodology

Many authors have previously commented on the benefits of focus group research for participants, noting that the sharing of experiences and stories can be quite therapeutic for those involved (Barbour, 2007; Jones & Neil-Urban, 2003; Burman et al., 2001; Duggleby, 2005). Certainly, the focus group sessions conducted as part of this study did appear to be valuable and enlightening for the participants. Hearing about others' body

image and weight struggles appeared to build the women up, bringing them insight into their own experiences. The sharing of similar experiences seemed to bring the women together, and in many groups, the women formed a social bond of shared meaning and understanding. Many of the women commented afterwards that they thoroughly enjoyed getting together with other women of similar age and talking about body, aging, and food-related experiences that were so universal, yet somehow always kept private. The women seemed relieved and validated by the fact that others shared similar attitudes and experiences, and they communicated this by actively supporting one another through their gestures and comments. Even when someone in the group expressed a different opinion or attitude, the women were keen to listen and always showed signs of respect and appreciation of individual differences. For this reason and others, the focus group format proved to be the perfect medium through which to explore these deeply personal issues of body image, aging, and eating.

Implications

The findings of this study have several important implications for health care, dietetic practice, as well as community programs/organizations.

Health Care

All health care professionals must be aware of body dissatisfaction and aging concerns among baby boomer and older women, and should be trained to deal with these issues appropriately. In all areas of practice, health care professionals should be sensitive and empathetic to women's needs, concerns, and circumstances as they age. Physicians

and dietitians who work with middle-aged and older adults must consider the effects of aging, illness, menopause, disability, and chronic conditions on health. If health care professionals are made aware of the body image and aging issues experienced by women, they will be more equipped to recognize potentially dangerous attitudes/behaviour and provide effective counseling/treatment in an empathetic and appropriate manner. When providing any sort of education or counseling to baby boomer and older women it is important for health professionals to maintain a positive, non-judgmental practice environment that respects the uniqueness, diversity, and body sensitivities of each and every client.

Dietetic Practice

Since body image is intimately connected to one's food choices and attitudes, dietitians and nutritionists have an important role to play in addressing the dieting attitudes and behaviours of middle-aged and older women. It is important for dietitians to recognize that many clients have struggled with weight their entire lives, have tried repeatedly to lose weight without success, are caught up in self-defeating cycles of yo-yo dieting, and have developed dysfunctional relationships with food. Dietitians should be trained to recognize and address any signs of dieting mentality, negative self-talk, or dichotomous (all-or-nothing) thinking. In general, and whenever possible, nutrition practitioners should focus on promoting healthy lifestyle behaviours instead of achieving an 'ideal' weight. By taking the focus off of weight, body dissatisfaction, self-objectification, weight preoccupation, and habitual body monitoring can all be reduced.

Community Health Promotion

Community-based organizations, including senior centres, could utilize the results of this study to help develop nutrition resources and community programs that address healthy aging, provide appropriate and meaningful nutrition education, and ultimately, promote healthy lifestyles and body attitudes among baby boomer and older women. Older women need to be educated regarding healthy body weights, ‘normal’ aging, the dangers of quick-fix diets, and the negative health outcomes of chronic dieting and weight cycling. These programs should promote all aspects of health (spiritual, emotional, social, and physical), as well as functional ability, skill development, and personal growth. Community programs may be the perfect place to provide this type of education, since health professionals often have very limited time to discuss these sorts of deeper issues in the clinic setting.

Group workshops and activities that allow participants to share personal stories, experiences and opinions among a group of women who are at similar life stages may be very ‘therapeutic’ for those involved. By discussing commonly experienced issues in a social environment, women may realize that they are not alone in their thoughts about body image, concerns about appearance, and fears of aging. This sense of community could serve as a valuable social support network for vulnerable women who are struggling with BD. Community programs that adopt a holistic, health-centered approach can help women to develop a sense of self-esteem and self-worth that is based on more than their outward appearance. These sorts of community initiatives can have major positive impacts on the body image and quality of life of baby boomer and older women.

Limitations

This study is somewhat limited by its sampling techniques and sample composition. As is usually the case with qualitative and mixed-methods research, a combination of convenience and snowball sampling techniques were used to recruit participants. Thus, the sample was not randomly selected, and therefore, may not be representative of the general population. There is also the possibility of sampling bias, in that women who volunteered to participate in this study may have been those with a pre-existing interest in or experience with body image issues. Given that the eligibility criteria excluded male participants, this study only represents the female perspective. In addition, while participants were not asked to specify their ethnic background, it was fairly obvious that the majority of participants in this study were Caucasian. Thus, the experiences and voices of visible minorities were not well represented in this study.

CONCLUSION

In conclusion, each woman's experience of aging is unique and deeply personal. While there are definitely similarities, there is also great diversity and complexity when it comes to body dissatisfaction, aging and body work. In general, it was discovered that aging is intimately connected to one's body perceptions and evaluations, and that age-related changes in appearance and functioning can cause a lot of tension and stress in women's lives. Furthermore, many women engage in various forms of body work in an effort to disguise imperfections of age and maintain a youthful appearance. Skin care, hair dye, and makeup are particularly important to women's body work routines. Dieting was also seen as an important, albeit frustrating, method of altering body shape/size. The

ultimate goal of body work is to look ‘naturally’ beautiful. Beyond the benefits to appearance, these products provide the women with a sense of control and inner confidence. The sharing of body work practices has social significance for baby boomer and older women and they are eager to learn from others’ tried and tested routines. Despite their ongoing issues with body image and weight, many women are striving to become more self-accepting. Some older women have truly reached a place of inner strength by accepting the inevitability of aging and embracing their imperfections. These women had positive attitudes towards aging, felt blessed to be alive and well, and viewed later life as a time for freedom, wisdom and personal growth. Overall, there needs to be an increased awareness of the body image issues affecting baby boomer and older women. The findings of this study have important implications for health care professionals and community programs.

CHAPTER 5

‘I really try to eat right!’: Healthy eating, food choices, and food product attitudes of baby boomer and older women in Manitoba

INTRODUCTION

Baby boomers (individuals born between 1946 and 1965) are Canada’s largest demographic group. In 2011, there were 9.6 million baby boomers in Canada, accounting for approximately one-third of the total population (Statistics Canada, 2011). As baby boomers turn 65 years of age, the senior segment of the Manitoban population is expected to swell from 13.2% to 24.5% between 2005 and 2036 (Turcotte & Schellenberg, 2007). Due to longer life expectancy, women represent a notable proportion of the Canadian senior population. In 2001, 60% of adults ages 75 to 84 and 70% of adults ages 85 and older were women (Health Canada, 2002).

Baby boomers were raised in a period of economic expansion and affluence following World War II (Pak & Kambil, 2006). They are generally better educated, more likely to occupy professional and managerial positions, and have larger disposable incomes than previous generations (Adams-Price et al., 2013; Keister & Deeb-Sossa, 2001; Pruchno, 2012; Frey, 2010). Notably, women in this demographic group achieved higher levels of education, greater participation in the workforce, and higher earnings than their mothers (Keister & Deeb-Sossa, 2001). Baby boomers are also very health conscious, aware of nutritional strategies for chronic disease prevention and self-improvement, and are more likely to use alternative and complimentary medicines (Weiss, 2002; Lipschultz et al., 2007; Traynor, 2009; Thornhill, 2006; Frey & DeVol,

2000; Mellor & Rehr, 2005). According to one author, “the sheer size of the baby boom generation has given members of this age cohort considerable cultural power and influence” (Adams-Price et al., 2013, p. 2).

Researchers in the field of gerontology are starting to recognize the impact that the aging of the baby boomers will have on the Canadian health care system (Duncan, 2012; Health Canada, 2002). According to one report, approximately 44% of annual provincial health care spending is allocated to the needs of adults over 65 years of age (Duncan, 2012). Across the country, the prevalence of obesity seems to be highest among adults in the mid to late stages of life (ages 35 to 74 years) (PHAC, 2011). The high rates of overweight and obesity among Canadian adults is concerning, given that obesity has been associated with several chronic health conditions (PHAC, 2011). Indeed, many baby boomers are living with chronic diseases, such as hypertension, arthritis, heart disease, and diabetes (Health Canada, 2002).

Diet plays an important role in health and prevention of disease, and adequate nutrition is essential for successful aging (Duncan, 2012). The type and amount of food we eat affects our nutritional status, and indirectly, influences our overall well-being. However, food choice is a complicated (yet largely unconscious) mental process that involves many different cognitive, psychological, social, cultural, environmental and experiential elements (Blake & Bisogni, 2003). For example, individual factors (e.g., age, gender, knowledge, beliefs), socio-economic factors (e.g., income, education, location/type of residence), cultural factors (e.g., religious practices, ethnic traditions), social supports (e.g., family, peers), and the built physical environment (e.g., accessibility of grocery stores) are all known to influence food choices and eating behaviours (Popkin, Duffey &

Gordon-Larsen, 2005; Booth et al., 2001; Nestle et al., 1998). Hargreaves et al. (2002) found that women choose, prepare, and eat foods based on a variety of different motivators, such as personal and family preferences, appetite, time constraints, convenience, taste, habits, price, emotions, stress, social occasions, and cultural traditions. For many women, ideas about ‘health’ also play a key role in personal food choices. In fact, women perceive food choices to be one of the most important determinants of overall health status (Hargreaves et al., 2002; Blake & Bisogni, 2003; Lindeman & Stark, 1999).

The surrounding food environment plays a major role in influencing the food choices and decisions of individuals. However, for many years, researchers in the fields of nutrition and public health have been raising concerns about the changing nature of the Canadian food scape. Put simply, Canadians are living in an increasingly ‘obesogenic’ food environment that promotes sedentary lifestyles, excessive food intake, and over-consumption of readily available energy-dense, nutrient-poor foods (Slater et al., 2009; Monteiro et al., 2013). Individuals and families are eating more of their meals outside the home and are increasingly relying on ready-to-eat commercially prepared meals and snacks to meet their nutritional needs in a fast-paced, time-crunched lifestyle (Slater et al., 2009; French et al., 2001). These consumption trends, which are expected to continue, are attributed to “lack of time to prepare food, women working outside the home, waning food preparation skills and aggressive promotion of low-nutrition foods” (Slater et al., 2009, p. 2222).

At the same time, we are seeing the emergence of an ‘orthorexic society’, whereby individuals are socialized to take charge of their own health and experience profound moral pressure to achieve a healthy diet and an acceptable body weight (Rangel

et al., 2012; Nicolosi, 2006). Prevailing discourses in nutrition and health promotion continue to promote an individualistic lifestyle approach that places the blame and responsibility for weight/health issues on individuals, while ignoring the socio-cultural environments that influence food and eating. Using the terms “obesity epidemic” and “war on fat” to promote their message, health reporters inform us that eating is at the heart of disease, obesity is simply caused by self-indulgence, and that issues with weight result from lack of self-discipline and willpower (Poulton, 1996). In response to these strong sociocultural messages, there has been an influx of ‘health foods’, detoxes, cleanses, natural health products, nutraceuticals, diet supplements, and weight loss plans into the consumer marketplace.

Research suggests that consumers are becoming increasingly conscious of their food choices and are selecting food products that not only promote health, but also address their concerns regarding body shape and weight (Agriculture & Agri-Food Canada, 2004; Agriculture & Agri-Food Canada, 2009a & 2009b, Mehrotra, 2004; Hasler, 2002; Siro et al., 2008). Consumers are making more of an effort to consume more fruits and vegetables, reduce their salt and sugar intake, look for nutritional information at restaurants, and choose foods with perceived health benefits (Dietitians of Canada, 2014).

Local, organic, and functional food products, in particular, have seen a substantial increase in consumption among Canadians (Agriculture and Agri-Food Canada, 2004; Agriculture and Agri-Food Canada, 2009a; Hasler & Brown, 2009). According to Health Canada (1998), a functional food is similar in appearance to, or may be, a conventional food, which is consumed as part of a usual diet, and is demonstrated to have

physiological benefits and/or reduce the risk of chronic disease beyond basic nutritional functions. Past research suggests that functional food acceptance and consumption is associated with certain demographic characteristics, including female gender and older age (Dogan et al., 2011; Siegrist, Stampfli & Kastenholz, 2008; Herath, Cranfield & Henson, 2008; Agriculture & Agri-Food Canada, 2009b). Organic and local foods are also gaining popularity among female consumers (Bellows, Alcaraz & Hallman, 2010). One study reports that sales of organic produce have risen dramatically since the 1990s, and that this rapid growth is “related to environmental and moral concerns and recent food scares related to food safety and health outcomes” (Bellows et al., 2010, p. 540). The increased consumption of local foods may be related to their perceived safety, health benefits, environmental and ethical value, and improved taste (Autio, Collins, Wahlen & Anttila, 2013).

While the knowledge gap may be closing, historically, women have tended to be more interested in and knowledgeable about nutrition than men (Wardle, Parmenter & Waller, 2000; Hendrie, Coveney & Cox, 2008). With the continued expansion of the internet, social media, food blogs, diet books and other media, nutrition and health information is more easily accessible than ever before. In North America, women are becoming increasingly concerned about what is in their food and are spending a great deal of time researching, organizing, selecting, and obsessing over food (Rangel et al., 2012; Nicolosi, 2006). Furthermore, many women recognize the value of home-cooked meals and feel a responsibility to provide nutritious and satisfying meals to their families (Beagan et al., 2008; Slater et al., 2011). As such, food-related activities (including meal planning, budgeting, grocery shopping, food preparation and cooking, serving, and clean-

up) consume a large portion of women's time and mental energy. Despite a high level of nutrition knowledge and a disproportionate amount of time spend on food-related activities, many women still struggle to meet their healthy eating and weight loss goals (Welsh et al., 2012; Williams, Thornton & Crawford, 2012). Previous research has concluded that women experience many different barriers that interfere with healthy eating, including a lack of time, family preferences, emotional eating, cravings, and the increasing cost of healthy foods, among others (e.g., Whiting, Vatanparast, Taylor & Adolphe, 2010; Kearney & McElhone, 1999; Kiefer et al., 2005). In addition to these barriers, women often feel overwhelmed by the amount of nutrition and health information they receive and get confused and frustrated when they try to make sense of conflicting nutrition research and dietary advice (Rangel et al., 2012). As women juggle competing priorities of home, work and health, many feel overwhelmed by a food system that is "increasingly complex, contradictory, and opaque" and as a result, experience anxiety about what is right and wrong (Rangel et al., 2012, p. 124). In the context of this complicated and confusing environment of mixed messages and competing expectations, eating can become a source of stress and substantial worry for many women (Lindeman & Stark, 1999).

While there are many studies that explore specific nutrition issues among women, few have qualitatively probed the deeper relationships that middle-aged and older women have with food and eating. And yet, the high level of education, media exposure, and health consciousness exhibited by baby boomer women suggests that this cohort of women may have distinct attitudes and experiences with regards to food choices and attitudes. This study seeks to address these gaps by examining the healthy eating attitudes

and barriers, food choice influences, dieting behaviours, and food product usage/attitudes of baby boomer and older women living in Manitoba. As part of a larger research project exploring the body image, aging and food choices of Manitoban women, this paper focuses on a subset of the data pertaining to healthy eating, food choices, and food product attitudes.

METHODS

Study Design

This study used a concurrent mixed-methods design to explore the body satisfaction, concerns about aging, and food choices/attitudes of urban and rural-dwelling baby boomer women in Manitoba. For more details on the methods used, refer to Chapter 4 (pg. 117).

Participants

The population of interest for this study was baby boomer women (born between 1946 and 1965) and older women (born prior to 1946) living in rural and urban areas of Manitoba. Potential participants had to meet the following inclusion criteria: (a) female, (b) born between 1946 and 1965 *or* prior to 1946, (c) live in Manitoba, (d) speak fluent English, and (e) be able to attend a two hour focus group session. Only one participant per household was permitted to participate.

Convenience and snowball sampling techniques were used to recruit eligible participants. Participants were recruited through posters and by word-of-mouth from a

variety of environments within rural and urban Manitoban communities. The Manitoba Women's Institute (MWI) assisted with participant recruitment in rural areas.

Data Collection & Analysis

Data collection involved the following procedures: (1) Focus group sessions; (2) Questionnaire; and (3) Anthropometric measurements. Data collection for each site took approximately 1.5 to 2 hours in total, which allowed 30 minutes for completion of the questionnaire and anthropometric measurements, with 1 to 1.5 hours remaining for the group discussion.

Fourteen focus groups, each consisting of seven to twelve women, were conducted in rural and urban communities within Manitoba. Seven focus groups were with baby boomer women (n=68), and the remaining seven focus groups were with older women (n=69). Upon arrival at the focus group session, all participants were asked to complete a self-administered pen-and-paper questionnaire. The purpose of the questionnaire was to collect demographic information as well as information pertaining to certain variables of interest (body/weight satisfaction, concerns about aging, dieting, use of certain food products). Anthropometric information (measured height and weight) was also collected for each participant. The focus group discussions were led by a trained moderator, with the assistance of a trained note taker. A semi-structured moderator's guide was used to guide discussion on the following topics: (1) body image perceptions/body satisfaction; (2) concerns about, experiences of, and attitudes towards aging; (3) dieting/weight loss; (4) healthy eating barriers and food choice influences; and (5) food product attitudes. All focus group discussions were digitally recorded on audio

tape. Beverages and snacks were provided at all focus group sessions.

All focus group audiotapes were transcribed to text and checked for accuracy by a research assistant. Thematic analysis using a coding procedure was used to analyze the focus group data. After developing and refining a list of codes, all transcripts were coded by the researcher, first on paper, and later, using NVivo8 QSR International software (2008). The NVivo8 platform was used to further organize codes and assist in generating overall themes and patterns. Data obtained from the questionnaire and anthropometric measurements was compiled and analyzed using the statistical analysis program SPSS (Statistical Package for Social Sciences) release #20.0. Descriptive statistics and additional analyses (i.e., ANOVA, Chi-square tests) were run, using a p -value ≤ 0.05 to signify statistical significance.

Ethics & Compensation

This research study was approved by the Joint-Faculty Research Board of Ethical Review at the University of Manitoba. Informed voluntary consent was obtained from all participants prior to their involvement in the study. Each participant received a \$25.00 gift certificate for a local grocery store as a token of appreciation for their time and participation.

RESULTS

Participant Characteristics

One-hundred thirty seven community-dwelling women, ranging in age from 46 to 84 years, participated in this study. A summary of participant characteristics is presented

in Table 5.1. Approximately half of the participants were in the baby boomer group (ages 46 – 65 at time of study) and the other half were in the older women group (ages 65 and older at time of study). The mean age was 65.2 (± 9.1) years. Fifty-three percent of participants lived in rural (small town) Manitoba, and 47% resided in the larger urban centres of Winnipeg and Brandon. There was diversity among the women with respect to marital status, household size, educational attainment, income level, and smoking status. Nearly all participants (92.6%) rated their health as excellent, very good or good, with only 7.3% rating their health as fair or poor. Body mass index (BMI) ranged from 18.2 kg/m² (underweight) to 53.3 kg/m² (obese class III). Nearly three-quarters of the sample (72.8%) fell into the overweight or obese category. The average BMI was 28.7 (± 5.8) kg/m² (overweight).

Table 5.1: Participant Characteristics

Demographic Variable	All (n=137) Percent (%)	BB (n=68) Percent (%)	OW (n=69) Percent (%)
Age Group			
Baby Boomers	49.6	100	0
Older Women	50.4	0	100
Mean Age (SD)	65.2 ± 9.1 yrs	57.7 ± 5.9 yrs	72.5 ± 4.6 yrs
Age Range	46 – 84 yrs	46 – 65 yrs	66 – 84 yrs
Location of Residence			
Urban	47.4	48.5	46.4
Rural	52.6	51.5	53.6
Relationship Status			
Married or Common-law	67.9	75	60.9
Engaged	0.7	1.5	0
Single	0.7	1.5	0
Divorced or Separated	8.1	7.3	8.7
Widowed	22.6	14.7	30.4
Number of People in Household			
1 (self / live alone)	29.6	22.1	37.3
2	54.8	48.5	61.2
≥ 3	15.6	29.4	1.5
Household Income			
< \$20,000	7.6	5.1	10.2
\$20,000 - \$39,000	23.7	10.2	37.3
\$40,000 - \$59,000	24.6	20.3	28.8
\$60,000 - \$79,000	21.2	27.1	15.2
\$80,000 - \$99,000	9.3	11.9	6.8
≥ \$100,000	13.6	25.4	1.7
Highest Level of Education			
Less than High School	11.1	7.4	14.9
High School Graduate	18.5	14.7	22.4
Vocation/Trade/College	46.7	52.9	40.3
University (undergraduate/graduate)	23.0	23.5	22.4
Other	0.7	1.5	0
Smoking Status			
Current Smoker	5.2	2.9	7.4
Ex-Smoker	38.2	47.1	29.4
Have Never Smoked	54.4	45.6	63.2
Other (socially, occasionally)	2.2	4.4	0
Self-rated Health			
Excellent	8.1	11.8	4.4
Very Good	43.4	39.7	47.1
Good	41.2	44.1	38.2
Fair	6.6	2.9	10.3
Poor	0.7	1.5	0
Self-Reported (Estimated) Weight			
Mean Estimated Weight (SD)	74.5 ± 16.4 kg	78.1 ± 16.6 kg	71.1 ± 15.6 kg
Estimated Weight Range	47.6 – 152.0 kg	47.6 – 140.6 kg	48.5 – 152.0 kg

Continued on next page...

Table 5.1: Participant Characteristics

Demographic Variable	All (n=137) Percent (%)	BB (n=68) Percent (%)	OW (n=69) Percent (%)
Measured Weight			
Mean Measured Weight (SD)	75.1 ± 16.2 kg	78.0 ± 16.6 kg	72.3 ± 15.4 kg
Measured Weight Range	47.4 – 144.3 kg	47.4 – 137.5 kg	51.7 – 144.3 kg
Measured Height			
Mean Height (SD)	161.8 ± 5.5 cm	163.5 ± 5.4 cm	160.1 ± 5.1 cm
Height Range	143.5 – 178.0 cm	152.0 – 178.0 cm	143.5 – 172.8 cm
Body Mass Index (BMI)			
Underweight (BMI < 18.5 kg/m ²)	0.7	1.5	0
Normal (BMI 18.5–24.9 kg/m ²)	26.5	26.9	26.1
Overweight (BMI 25.0–29.9 kg/m ²)	41.9	31.3	52.2
Obese (BMI ≥ 30.0 kg/m ²)	30.9	40.3	21.7
Mean BMI (SD)	28.7 ± 5.8 kg/m ²	29.2 ± 6.0 kg/m ²	28.1 ± 5.6 kg/m ²
BMI Range	18.2 – 53.3 kg/m ²	18.2 – 52.5 kg/m ²	20.8 – 53.3 kg/m ²
Daily Stress Level (on a scale of 0-100)			
Mean Stress Level (SD)	39.7 ± 22.9	43.8 ± 23.8	35.7 ± 21.2
Stress Level Range	0 – 96	0 – 95	0 – 96

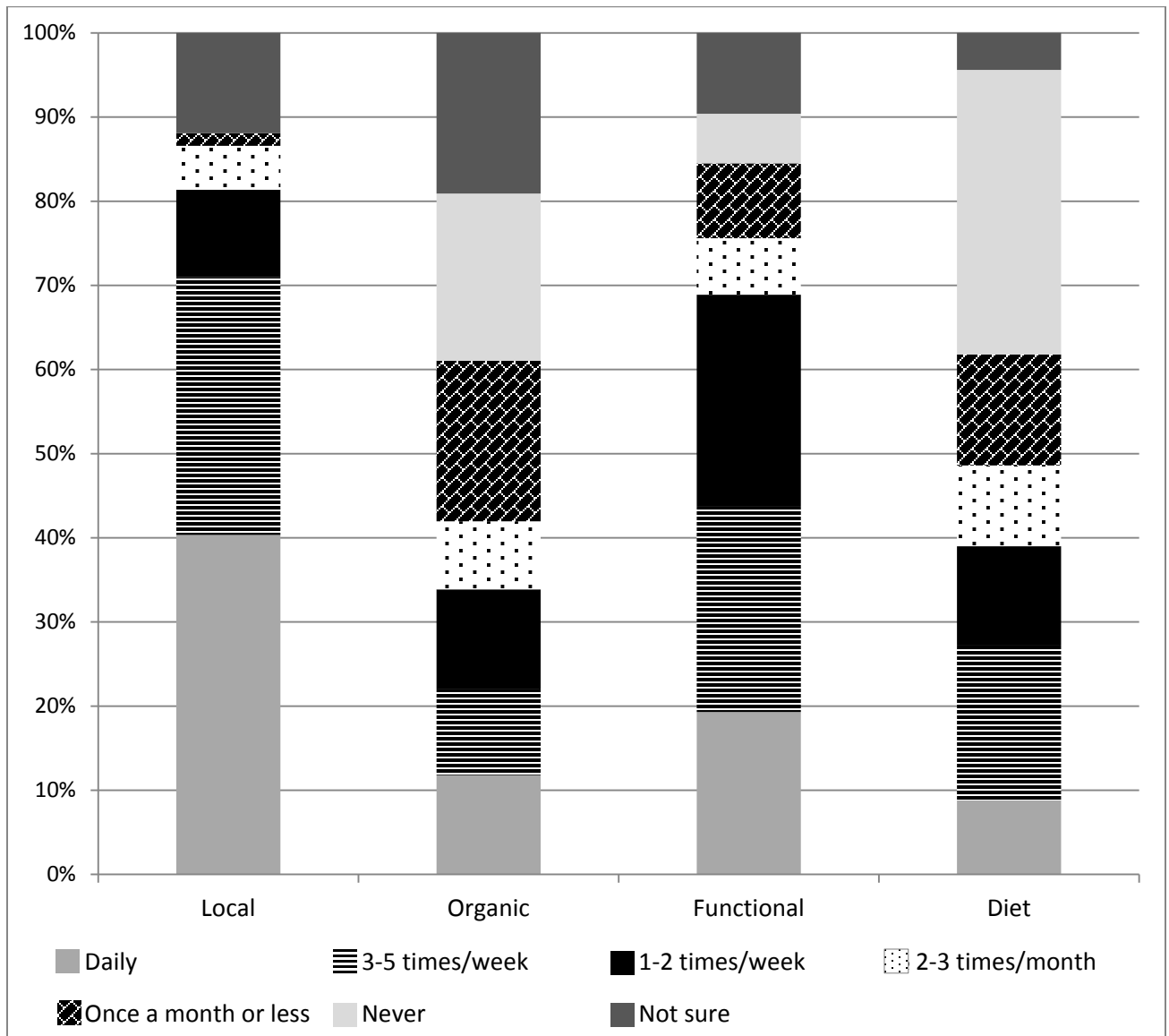
Questionnaire Results: Consumption of Specific Food Products

This study explored women's usage of and attitudes towards certain categories of food products. On the questionnaire, participants were asked to indicate how often they consumed local, organic, functional, and 'diet' products. A functional food (FF) was defined as any product that claims to offer health benefits and/or reduce the risk of disease, and a 'diet' product was defined as any product that is labelled to suggest it could help with weight loss, including those products with the terms 'low-calorie', 'diet', 'low-fat' or 'light' on the label, as well as those labelled with specific weight loss brands (e.g., Weight Watchers[®], Slim Fast[®]). The results pertaining to food product usage are presented in Table 5.2 and Figure 5.1.

Table 5.2: Questionnaire Results – Consumption of Food Products

Variable	All (n=137) Percent (%)	BB (n=68) Percent (%)	OW (n=69) Percent (%)
Consumption of Local Food Products			
Daily	40.3	42.6	37.9
3-5 times per week	30.6	26.5	34.9
1-2 times per week	10.5	10.3	10.6
2-3 times per month	5.2	5.9	4.5
Once a month or less	1.5	2.9	0
Never	0	0	0
Not sure	11.9	11.8	12.1
Consumption of Organic Food Products			
Daily	11.8	10.3	13.2
3-5 times per week	10.3	16.2	4.4
1-2 times per week	11.8	13.2	10.3
2-3 times per month	8.1	5.9	10.3
Once a month or less	19.1	25.0	13.2
Never	19.8	13.2	26.5
Not sure	19.1	16.2	22.1
Consumption of Functional Food Products			
Daily	19.3	17.7	20.9
3-5 times per week	24.4	27.9	20.9
1-2 times per week	25.2	26.5	23.9
2-3 times per month	6.7	8.8	4.4
Once a month or less	8.9	8.8	9.0
Never	5.9	2.9	9.0
Not sure	9.6	7.4	11.9
Consumption of ‘Diet’ Foods			
Daily	8.8	11.8	5.9
3-5 times per week	18.4	13.2	23.5
1-2 times per week	11.8	7.3	16.2
2-3 times per month	9.6	14.7	4.4
Once a month or less	13.2	16.2	10.3
Never	33.8	35.3	32.3
Not sure	4.4	1.5	7.4

Figure 5.1: Frequency of Food Product Usage



According to the questionnaire, eighty-one percent of the women in this study consume local products at least once per week, with 40.3% of women reporting that they consume local foods on a daily basis. There were no notable differences in local eating among baby boomer versus older women; however, women in rural areas were significantly more likely to consume local foods on a regular basis ($p<0.05$). Compared to local eating, organic eating was not as big of a priority among the baby boomer and older women in this study. Approximately one-third (33.9%) of the women reported that they eat organic food at least once per week, but only 11.8% reported eating organic food on a daily basis. One-fifth of the women (19.1%) stated they eat organic less than once per month, and another 19.8% said that they never eat organic food products. Baby boomers and women in rural areas were significantly more likely to consume organic foods on a regular basis (three or more times a week), compared with older women and women in urban areas ($p<0.05$). As a point of comparison, just over one-third of rural women (33.8%) reported that they eat organic three or more times a week, whereas just 9.3% of urban women reported the same frequency of consumption.

A large proportion of women (68.9%) said they use FF products at least once per week, with one-fifth of participants (19.3%) reporting that they consume FF on a daily basis. While there were no differences between the two age groups, we found that urban women were more likely to consume FF on a regular basis compared to rural women ($p<0.05$). Lastly, over one-third of women (39.0%) used diet products on a weekly basis, with 8.8% using these products daily. There were no differences in frequency of consumption of diet products between baby boomer and older women and those living in urban versus rural areas.

The results pertaining to differences among age groups (baby boomers versus older women) and location of residence (urban versus rural) are presented in Table 5.3.

**Table 5.3: Differences in Food Product Use between
Baby Boomer vs. Older Women and Urban vs. Rural Location**

Variables of Interest	Chi-Square Statistic (χ^2)	df	p-value
BB vs. OW and Use of local products	2.827	5	0.727
BB vs. OW and Use of organic foods	12.690	6	0.048*
BB vs. OW and Use of functional foods (FF)	5.945	6	0.429
BB vs. OW and Use of diet products	11.082	6	0.086
Urban vs. Rural and Use of local products	17.183	5	0.004*
Urban vs. Rural and Use of organic foods	19.219	6	0.004*
Urban vs. Rural and Use of FF	14.170	6	0.028*
Urban vs. Rural and Use of diet products	5.927	6	0.431

*Indicates statistical significance at $p\text{-value} \leq 0.05$

Focus Group Results: Healthy Eating, Barriers, Food Choice

The following section presents the results pertaining to healthy eating, barriers, and food choice influences. Table 5.4 provides a summary of the qualitative themes and sub-themes that will be discussed in detail below.

Table 5.4: Qualitative Themes – Food & Eating

Major Theme	Sub-Themes
1. Healthy Eating	1a. Relationship between eating and health 1b. Balance and moderation 1c. Importance of homemade meals 1d. Eating the good and limiting the bad 1e. Certain nutrients of concern
2. Barriers to Healthy Eating	2a. Cooking for one 2b. Family preference/influences - Husbands 2c. Dislike of cooking 2d. Time/busy lifestyle 2e. Availability/access to nutritious foods - Cost 2f. Personal preferences and habits 2g. Social situations 2h. Emotional eating issues
3. Food Choice Influences	3a. Cost 3b. Convenience 3c. Quality (taste) 3d. Brand loyalty 3e. Family influences - Upbringing - Preferences of others 3f. Nutritional value - Reading food labels 3g. Health issues 3h. Media/Information Sources - Confusion about nutrition information

1. Healthy Eating

1a. Relationship between Eating and Health

Baby boomer and older women consider healthy eating to be very important for health, prevention of disease, weight maintenance, and overall well-being. These women were very aware of the connection between food and nutrition and overall health and disease. On an individual level, they were very aware of how what they ate could affect how their body feels and they believed that choosing healthy foods could help them feel better, whereas unhealthy choices could make them feel worse:

What I've been learning in the last month or two months, is that the choices I make actually are being lived out in my life and in my body. And I don't like it that I have to bear the consequences to my actions... So I don't eat at night anymore because I don't like to have high blood sugars in the morning and, so those are things that I, you know, purposely have to choose. I don't always succeed, but yeah. I could eat, you know, bread or raisin buns from the Crusty Bun [a local bakery] and that would be like really nice every day, but not a good idea. (BB, Urban)

In our family, because my mom has had issues and stuff, we've kind of started now looking at food as medicine and really trying to read up on that as much as possible. And we've noticed that if we really pay attention to how we feel after we've eaten something, that there are some foods that one person can't tolerate that another person can. (BB, Rural)

Healthy eating was also seen to be important in the context of weight management. The women often alluded to the connection between diet and weight. Many of them saw food as a means to control or alter their weight:

I know that I have to make healthy food choices and I just can't eat the things that I was eating before, or I'll be putting the weight back on. So I have to have some discipline, and it's helping. (OW, Rural)

The motivation to eat healthier in order to prevent disease was sometimes prompted by a significant life event, as was the case with this older woman whose husband had recently died:

I had a lifestyle change this year when my husband passed away, so I thought it was a good time to change my eating habits. I try to eat healthier, more fruits and veggies, and things that are good for me. (OW, Urban)

Many of the women had been motivated to change their eating habits when grandchildren entered into the picture. They wanted to lead a healthier lifestyle in order to be around and involved with their grandchildren's lives for as long as possible.

I have a two-year-old granddaughter that I want to still be able to, you know, be active with. And there might be others too, soon. But I start thinking of my own health; well, I want to last a longer time here. (BB, Urban)

Another important priority was wanting to model a healthy lifestyle and pass down good habits to their grandchildren:

Now, my husband and I are retired, and we're trying to be healthy grandparents. We want to be there for our grandkids as much as we are now. We're part of their lives and we want to be as healthy as we can be, so we do watch a lot more. And baking isn't one of those things that enters into the picture too much anymore. (BB, Urban)

I'm a grandparent and a parent, and you know, you want to give good habits, good eating habits to your kids and your grandchildren. (BB, Rural)

1b. Balance & Moderation

When talking about their efforts to eat healthier, balance and moderation emerged as key priorities. In general, the women believed that a healthy diet is one that is balanced and varied, allowing for all foods in moderation:

I think I eat healthy. I don't sit at home and eat a bunch of junk food. I like to have a glass of wine with supper, but I don't think I indulge in anything excessively. I think everything's kind of in moderation, which has kept my weight at the same for years now. (BB, Urban)

I'm a firm believer [that] common sense is what you need to go by. Hit the middle of the road, don't go crazy overboard and don't go crazy under.

Try to stay as healthy as you can and eat as well as you can, but don't deprive yourself completely either. (OW, Urban)

Several women spoke about their efforts to be more flexible with their eating and allow treats in moderation. They had realized that if they take a more relaxed and non-restrictive approach, that they were better able to control their cravings:

I'm not eating exactly the way that I would like to, but I also don't deny myself. And I find that I can, if I have a little bit of something, I'm actually pretty good at then not wanting it so much. If I don't have that something, I just start obsessing about that, whatever it is. So if I want chocolate, I'll have a piece of chocolate and I'm good for the next while because I had the chocolate and I was okay with it. (BB, Urban)

I think I'm eating what I'd like to eat and making good choices... I've gotten away from the 'bad' food and the 'good' food labelling. It's just, you know, and I can recognize when I'm full as well. And if I want some taco chips, I'll have some taco chips. It's not a forbidden food and it's just so much more joyful. (BB, Urban)

A few women were caught up in the belief that healthy eating is inherently restrictive and unenjoyable. Women with this sort of view point tended to be the ones that had experienced lifelong issues with weight and had dieted repetitively over the course of their lives. As this statement demonstrates, these women saw healthy eating as an all-or-nothing behaviour that isn't particularly enjoyable:

I would ideally love to have lasagna, spaghetti, and perogies and all that stuff, okay, but I know it's bad, so I eat chicken and fish and salads... I really don't love the way I eat. I don't find the stuff I eat really that good, you know. I mean, anything good's got fat in it, you know, and I love food and that's sort of gone by the wayside. And so I will eat the way I eat for certain lengths of time and then I'll get to one week or something where I have to eat other things, you know, and then I do that and then I go back and eat the way I'm supposed to eat again. So, I'm having a hard time with it, you know... I don't really love what I'm eating, you know. (BB, Urban)

Other women recognized the danger of this sort of over-obsessive and restrictive attitude that is characteristic of the dieting mentality:

I think all of us have a pretty good indication of what good food is. I mean, it's the less processed stuff, it's well balanced. There's no one great food, you know... I couldn't imagine spending time worrying about all that stuff. It would just be so stressful, and I think that is what really causes emotional eating... I see how people agonize over that and what it does to them, so I don't want any part of that... I'm talking about just making, like just spending so much time worrying about every little thing and what's in food and this and that and whatever. I just, for me, I don't know, maybe because I've seen the stress that it causes so many people... I don't want any part of that. (BB, Urban)

1c. Importance of Homemade Meals

The women considered homemade meals to be at the root of healthy eating. When it came to feeding their families and themselves, making homemade meals from scratch was a main priority. It was clear that women feel responsible for the nutritional health of their families. They wanted to make sure that dinner was enjoyable for all and that everyone had enough good quality food to eat. They also felt responsible for instilling healthy habits in their children and grandchildren. A desire to pass along, or model healthy behaviours was an important aspect of family meals:

I feel very responsible for the food choices that I make for my husband, and before, with my family. So I did try to sort of balance food and the kinds of foods used. Through the 4-H program or Home Ec programming, it's foremost in my mind. So I really feel that I'm responsible for teaching my kids, my grandkids. (BB, Urban)

They valued wholesomeness, 'real' foods, and natural ingredients and spoke of avoiding processed foods as much as possible. In fact, there was a sort of nostalgia around home cooking, with many older women speaking fondly of the 'olden days', when processed foods were not as abundant or readily available:

The way my mother and father... our food choices when we were really young. There was not a lot of money and we ate very, very plainly. We lived on a farm, my mother preserved everything in her garden. There were no tin foods in our house as long as I grew up, maybe Campbell's

soup, you know... We just didn't have, we didn't [drink] Coke, we didn't eat chips. (BB, Urban)

In general, attitudes towards processed foods were very negative. Processed foods were viewed as very unhealthy and as these comments demonstrate, women were trying their best to avoid using these products:

I don't like excessively processed foods. I'm a label reader, very much so. Mostly just healthy food, and we really don't eat a lot of processed-type foods. If anything, I'll buy frozen vegetables or frozen fruit. (BB, Urban)

We're not using packaged foods and things with too much salt in them, and I don't even go near them. We're pretty basic – meat, potato, vegetables and fruit. When I shop, you buy the basics you know, like flour and sugar. (OW, Rural)

Overall, these women were doing everything in their power to make homemade meals as often as possible:

I'm pretty much a scratch cook, and serve the comfort foods. And so I would say, taste and just good wholesome food. Like, we don't eat a lot of, I try to stay away from prepared foods that have a whole lot of extra stuff in them. I like the real food and so that's mainly what we eat. (OW, Urban)

You have to have a variety of nutritional foods, which we all know is all the fresh stuff. And I very seldom buy the packaged fish and chips and stuff like that. I find, I think they're probably pretty unhealthy, so it's a little more work to do everything from start to finish, but around our house, that's what we do." (OW, Rural)

However, they were also fully aware that it takes time and energy to make healthy meals from scratch. They sympathized with those women that didn't have the time to make wholesome meals because of work commitments or other priorities:

We don't eat processed foods if at all possible because of the salt... Variety is important and taste, and good wholesome homemade cooking! And I have time for that. It's harder when you're working. (OW, Urban)

I make them from scratch, but I also have the luxury of not having a job outside the home. I just feel so, not sorry - that's not the word – but I

understand my kids, as they go to their job and they come home and their kids are hungry and they have to put food on the table, so of course you're gonna take out some battered french fries and you're gonna take out some fish and you're gonna take out something out of a package that's easy and quick to cook. (BB, Urban)

1d. Eating the Good & Limiting the Bad

Among women who were actively trying to eat healthier, many different strategies were used. These included eating the largest meal of the day at lunch time, focusing on smaller portion sizes, making more of an effort to eat breakfast, eating more vegetables, using a smaller dinner plate, and avoiding certain types of foods. In fact, many women said that they avoid certain foods in their effort to eat healthier and/or lose weight. The most commonly avoided foods were bread, potatoes, sweets/dessert, red meat, fatty foods, ice cream, processed foods, high-sugar foods, and artificially sweetened products. This avoidance of certain foods that were deemed to be 'bad' for health was common among all of the groups. When talking about avoiding certain foods for health reasons, bread was the most common, with 27 mentions. Bread was seen to be counterproductive to health and weight goals, as these comments demonstrate:

I still sneak the sweets, but I gave up a lot of bread. I read one time that it's a lot of bread is what puts it on to your stomach, and I thought, oh yes, I have a stomach and I'd sure like to get rid of it! (OW, Rural)

We saw that if we ate less bread and less potatoes that we felt a lot better because it does bloat you, and a lot of times they say you're not even supposed to have potatoes with your meat and vegetables. You're supposed to have just meat and vegetables. My mom doesn't eat bread anymore either. She just makes herself some cookies with ground-up grains and that is her bread. (BB, Rural)

It is interesting to note that for many women, the foods they were limiting or cutting out of their diet were often the ones they loved the most:

I like my carbs, I really do. Bread and potatoes and perogies and all that. But in the last few years, I really have tried to, you know, be more conscious of how much of that I eat every day, and the fats too. (BB, Rural)

Other women were concentrating more on adding healthful foods into their diets, as opposed to focusing on restriction. The foods that were seen to have the greatest health benefits included vegetables and salads, fruits, flaxseed, fish, lean proteins (chicken, pulses), yogurt, oats, blueberries, and high-fibre foods.

I think we eat pretty healthy all in all. Personally, in the house, I try and eat a lot of yogurt, fruit. We always eat lots and lots of vegetables and maybe I try to cut back a little bit on the red meats. (BB, Urban)

We have gone over to eating more elk and bison instead of beef, hopefully it is better than beef. I'd like to say it is. And you know, fresh fruits and vegetables. Blueberries have been high on the radar for a while now. (OW, Urban)

When I found out that sweet potatoes, for example, have more vitamin C, that makes it more attractive for sure. So it's something that we deliberately choose just because it's better in vitamin C. (BB, Rural)

1e. Nutrients of Concern

The women in this study were generally very knowledgeable about nutrition and were cognizant of certain nutrients and their role in health. Most women were aware that certain nutrients should be avoided and others should be emphasized in the diet. The nutrients that women were trying to increase in their diet were vitamin B₁₂, calcium, vitamin D, fibre, and 'good' fats (e.g., omega-3 fatty acids). The benefits of fibre were well known and many women were looking at fibre content when checking nutrition labels at the grocery store:

We're supposed to get lots of fibre, so I'm checking a lot of the cereals, and it's amazing the difference. Special K breakfast [cereal], well, there's no fibre in Special K! You know, you have to read the fibre and it's

supposed to be at least four grams, so I try to get four [grams] or more.
(OW, Urban)

Given that our sample was composed of women ages 46 to 84 years, many of whom had reached peri-menopause or menopause, it is not surprising that calcium and vitamin D were nutrients of priority. Calcium was mentioned a total of 30 times throughout the focus groups, and vitamin D was mentioned 26 times. Throughout their lives, these women had received lots of messaging surrounding the importance of calcium for bone health and were concerned about the risk of developing osteoporosis. While vitamin D was also seen to be important, there was much more confusion surrounding the role and requirements of this nutrient:

I find it's confusing with the vitamin D. I always took the vitamin D, I take calcium, you know, aging of the bones. Last week at the Farm Women's conference, they said, well if you're taking your Vitamin D with your Calcium, it's not doing you any good. And I always take it at night, I heard one time you're supposed to take your calcium at night. I drink milk during the day, so I take my calcium pill at night, and took my Vitamin D at night before I went to bed. They said it's not doing you any good. You should be taking it with oil. Well, my goodness! So anyway, I stuck the Vitamin D on the cupboard and when I'm making bread, I put some oil in the bread, so I throw the Vitamin D on that oil spoon and take that. But otherwise I just take it and I don't know, I mean, it's confusing. One tells you one thing when you should be taking these things, and then somebody else comes along and they tell you another thing. And you hate to ask the doctor because then they want to give you another prescription! (OW, Rural)

When talking about nutrients of concern, a common theme that arose was confusion surrounding nutrient supplementation. The women felt lost and overwhelmed with the amount of conflicting information they were receiving and didn't know what they should be doing. They were eager for answers about supplementation and wanted to know exactly what they should be taking, how much, with what, and on what schedule.

For this reason, they were generally skeptical of taking on new supplements, out of concern that they would later find out it was bad for their health:

I take the vitamin B₁₂ on the doctor's suggestion, and vitamin D, that's the current vitamin of choice. I get very confused about all the different studies. A few years ago, vitamin E was the cure-all for absolutely everything, including diabetes, so I started to take vitamin E religiously. Well then, it was proved that it really made very little difference, so I thought, well I don't need that expense! So no, I think that I don't want any more or less than what I'm taking now, and the confusion that exists by the different studies really upsets me. (OW, Rural)

The problem with vitamins is, if you take a multi-vitamin, everything is in there, and then the doctor says you're supposed to take 1500 milligrams of calcium a day, that's 3,500 a day, with the Vitamin D tablet. So like, how do you... And then you start taking so much calcium that all of a sudden you're starting to get constipated. You're going, hey, just hang on a minute. What am I supposed to drop here? Am I supposed to drop my multivitamins? Should I stop my calcium? What is, you know? So yeah, you're totally baffled after a while. (BB, Rural)

There were also several nutrients that women recognized as harmful for health, and therefore, were trying to consume less of. These nutrients included sodium/salt, sugar, the 'bad' fats (i.e., saturated fat, trans fat), and 'carbohydrates' (as a general category). Fat was mentioned in a negative light at least 35 times. Baby boomer and older women were all very aware of the negative health effects of certain types of 'bad' fats, namely saturated fat and trans fats. Specifically, women were very knowledgeable about the relationship between dietary fat and blood cholesterol, and because of this, they were looking for products that contained lower amounts of fat, not only for themselves, but for their family members.

Many women also had negative feelings towards sodium/salt and were aware of the relationship between sodium and health (i.e., blood pressure). In fact, sodium and salt were mentioned a combined total of 45 times throughout the focus groups. Many women

were aware of the dangers of high sodium intake and were doing everything in their power to cut back. Like fibre, sodium was one of the nutrients that they were paying attention to when reading labels at the store:

Sodium, that's the first thing I look at. And I also look at the list of ingredients and if it's a huge long list of things you don't even recognize, I won't buy it. So I try to, as much as possible, avoid pre-packaged and processed things. (BB, Rural)

Well, in the last two years, I've lowered the salt content of all our food. I watch how much salt is in the stuff that I buy. (OW, Rural)

They recognized that sodium is a primary ingredient of processed foods and that a large proportion of the food supply is high in salt. They lamented the fact that it was becoming increasingly difficult to buy foods that are lower in sodium:

I do read how much sodium is in everything. In some of them, it's horrific, isn't it, the amount of sodium! (BB, Rural)

I very seldom buy any ready-to-eat foods because I have to stay away from salt and that is a major thing that is hard to find a lot of ready-to-eat foods that are low in salt or low salt. Thank heaven for no salt in salmon, so that makes it easier to choose that can, but, you know, any ready meals usually have too much salt. It's something that I think probably the processed food manufacturers should address, because I think there's a lot of people that would buy those kinds of meals if they had something with less salt. I realize it's probably also a preservative for the processed [items], but if it's frozen, that shouldn't be such a big problem. (OW, Rural)

Sugar was also seen as harmful to health and was mentioned a total of 34 times.

In fact, several women had especially harsh feelings towards sugar, believing that it was the cause of many modern ills. These women used very strong language to express their feelings about sugar, referring to it as 'the enemy' or 'white death':

I try to watch labels for lower fat and lower sugar. Although sugar is probably my nemesis. I like it, but I try to watch it. (BB, Rural)

It's really important on labels, especially with cereal. They all have sugar, and all you really need is the grain with fibre, and just, just don't even buy any of that sugar stuff! Sugar is really white death, in my opinion. (BB, Urban)

I've always been interested in this topic, so I just catch on to everything that I hear about this discussion. And one comment I heard not long ago was that, you know, with the low fat craze, we were blaming everything on the high fats, and our industries were asked to change their stand on that and what they put in. And so they put in low fat but it won't sell that way, so they upped the sugar! And now, I have started viewing sugar as the enemy, visualizing it as the enemy, and what it does inside my body, and white flour and so on, and that has been enormously helping me not to get into baking, baked goods and all those kinds of things. (OW, Urban)

2. Barriers to Healthy Eating

As baby boomer and older women discussed their thoughts surrounding healthy eating, it became very clear that they experience numerous barriers when it comes to eating healthfully. The most commonly reported barriers were: cooking for one (living alone), family preferences/influences, availability of/access to nutritious foods, time/busy lifestyle, dislike of cooking, personal preferences/habits, social situations, and emotional eating issues.

2a. Cooking for One

Nearly 30% of the women in this study reported that they live alone. For these women, many of whom were in the older women category, living alone posed numerous barriers to healthy eating. Many women in this situation felt that it was not worth the effort to make a balanced, nutritious meal for just one person:

To me, I can't make sense of going and making one potato and a piece of whatever, just for me. (OW, Rural)

I find it hard because I'm one now, and it's hard to cook for just one. To put a roast in the oven or do a chicken, it's a lot leftover, so of course, yes, I eat the leftovers. So I'm just finding it hard to cook for one person. (BB, Rural)

I find, because I'm by myself, it's harder to say, okay, tonight I'm going to have, you know, meat, potatoes, and salad and vegetables. You know? Oh, maybe I'll just have a bowl of soup or a sandwich or something like that. Whereas, if you had somebody that you were cooking for, you [would do] more planning. (OW, Urban)

Even when they did have the time and energy to make larger, more nutritious meals for themselves, this would result in large amounts of leftovers. A big problem with living alone was having to eat the same thing, day in and day out:

It's just monotonous, and it's, you know, if you're making a casserole, either somebody's coming over to finish it, or you're giving it away, or you're gonna be eating it for three or four days! (BB, Rural)

I think part of my problem is, since I'm alone, lots of times, I'm just too lazy, or I make a big meal and I eat it for three days. (OW, Urban)

A couple of women spoke about how they would invite family or friends over, just to help them finish the meals they had prepared the day before:

Well, if I make something for myself, like soup or whatever, I don't want to eat it for a week, so thank god the kids come every day and away it goes! (OW, Rural)

More often, though, food would go to waste because they couldn't eat it fast enough. In fact, food spoilage was a major issue among women who lived alone, especially for fresh produce:

I'm alone now, so I have to make myself get the fruit. And the salad mixes are fine, but I find that they spoil. I can't seem to eat, you know, everything without spoiling. So yeah, that's a factor right now, buying in smaller quantities. (BB, Urban)

I try to eat healthier, more fruits and veggies, and things that are good for me, but I also find it very difficult to buy what you should have or need for one person, and that's a big complaint I have with grocery stores. Like,

for example, one grocery store has buy 10 items for a lot less dollars. Well, I mean, 10 items would do me most of the year... Or buy one and get the other half price. Well, I just want half of one, I don't want two whole ones! (OW, Urban)

Because they saw cooking as requiring a lot of effort that wasn't justified for just one person, they would often rely on quick meals and snacks that they thought were lacking in nutritional adequacy. These quick and easy meals were often higher in refined carbohydrates, which as previously mentioned, was something many of them were trying to avoid:

Cooking for one is not fun, and what do you cook that you want to eat for the next four days, you know? And is it a healthy thing you cook? So I really do find myself cooking far too much pasta and quick things that one shouldn't have so much of. (BB, Rural)

You're gonna cook a potato, and it's gonna last you all week. So you might as well have toast, or you eat maybe porridge for supper. (OW, Rural)

The challenge for me is being on my own sometimes, being alone and making these meals that include all the food groups. But more so, just being in a hurry, you know, and grabbing. I mean, you tend to just grab things, and they're not always the healthiest things. (BB, Urban)

Several women talked about how it's easy to fall into certain bad habits when you live alone and there's no one else to keep you accountable:

I live by myself. I don't feel like making a meal for myself, so I'll just heat something up in the microwave, quick, you know. Or on the way home, if it's payday, oh, what the heck, I'll just stop in and get a hamburger and some onion rings. And I'm thinking afterwards, why did I do that? But you know, it's just, I'm alone. (BB, Urban)

In contrast, a small subset of women found that living on their own actually made healthy eating easier because they no longer had to worry about accommodating someone else's preferences or schedule. One woman said:

I eat the way I think I should. I try to eat the vegetables and the fruit. I have those things in my diet and it's easier feeding myself because nobody else is complaining, so I don't find that there are barriers to the way I want to eat. (BB, Rural)

2b. Family Preferences/Influences

As the previous quote subtly suggests, having to feed other people in the household was a major barrier in these women's lives. Among women who lived with their partner or family, accommodating everyone's preferences was a major consideration when it came to putting food on the table every day. Accommodating kids' preferences was especially difficult, as this woman explains:

Between my husband and I, we have six kids... That's a lot of mouths to feed and a lot of people who don't like green flecks in the food. So it's really hard to cook and eat healthy when you're cooking. It's kind of the opposite of cooking for one. It's like, oh my god, what do I make for 10 people?! (BB, Urban)

Accommodating likes and dislikes was even an issue among women with adult children:

There's certain vegetables my kids will eat, so those are the ones you're gonna cook more than the other ones. There's certain ones that you try to get them to eat, and they just pick at their food, even though they're more than 20-some years old! (BB, Rural)

Several women talked about how they feel the need to sacrifice their own preferences (which were usually for healthier meals) because of the preferences of others. As this quote demonstrates, it was not uncommon for women to cater to others' preferences over their own:

When you have a spouse or you're cooking for others, you're more conscious of what they might like, and not so much what's good for YOU, but what seems to be good for all. (BB, Rural)

They also spoke about the various ways in which feeding a family interfered with their weight loss goals:

I think if I could cut down on my portions, then it would help a lot... If it was just me, I could probably do it. But it's hard when you're making meals for others in the family too. (OW, Urban)

I was single till my mid-30s, I had no problem with my weight... I know it's a combination of things, probably time, cause when you're single you can focus on yourself. But when you have a family, I would have to say yes, family probably affected what I ate. (BB, Urban)

In addition to children, husbands were another major barrier to healthy eating.

Women struggled with wanting to eat healthfully, but also wanting to satisfy and please their husbands. Even when they, themselves, would be happier (or would prefer to) eat lighter, healthier meals, the women felt a responsibility to accommodate their husband's needs. These women felt conflicted about family meals; they wanted to eat healthy and make better choices, but at the same time, worried that this would leave their partner feeling unsatisfied:

I often blame it on my husband. Because, I think, if I didn't have to cook for him, I could make the stuff I'm supposed to... Because he won't eat, he doesn't need to lose weight, so if I fed him what I'm supposed to eat, he wouldn't be satisfied with that. I know it's excuses, but that's the way I feel. (OW, Urban)

My husband can have everything because he has no cholesterol problem, no weight problem, nothing. And you know, the doctor one time told me, 'You should lose weight'. And I said, 'Yes, I know I should, but you know, my husband can eat everything, and I don't believe in making him suffer because I'm not supposed to have these things'. (OW, Rural)

This sense of responsibility posed difficulties because the husband's preferences often didn't align with her personal desires to eat healthy. As a result, his preferences would often take precedence over her own:

I can't eat some of the things [I want to]. Well, I can eat them, I just never get a chance because some of the things I would like to eat, my husband can't or doesn't want to eat. (OW, Urban)

He loves perogies and holupsi [cabbage rolls] and homemade soups, and he loves his meat and he just loves to eat. Whereas I would like raw vegetables and a salad and a small piece of meat or chicken, you know. But I don't want my chicken to be smothered in cream, you know. I don't like that kind of food, but that's what he likes, so sometimes I have to cook it. (OW, Rural)

Some women had become accustomed to cooking several different entrees in order to satisfy everyone's needs and preferences:

I'm married for 50 years and I've cooked for this man for 50 years, and I don't always get to eat... Like, I'd love to eat more fish, but he doesn't like it. He wants to eat more beef and I really don't care for it. So sometimes I cook two meals, like two pieces of meat. I might have chicken and he might have steak, or I might have shrimp and he might have steak. (OW, Urban)

I eat chicken and fish and salads, but my husband doesn't like chicken and fish and salads, so I give him other things. And he has salad and he has sugar and he has lots of butter, and that's what he wants and that's what he wants me to make him. (BB, Urban)

A few women had taken more of a hard stance on the issue, and refused to cook separate meals for their husbands:

I have learned, you know, what he's gonna do, he's gonna do. But I don't cook for him anymore. I did when we were younger, but I don't anymore. I just cook what I cook, and if you're not happy, you can eat toast! (BB, Urban)

I hate making separate meals! I did that when I was in Weight Watchers. I would eat something different and have to make meals for the rest of the family. (OW, Urban)

Another common feeling among the women in this study was that husbands have a tendency to sabotage healthy eating and dieting efforts, albeit unconsciously. The women who were struggling to lose weight felt like their husbands simply didn't understand what they were going through, and wished that they could be a bit more supportive. One woman explained:

I also have a husband who has a sweet tooth and doesn't need to lose weight and likes to eat and offers me things. He's getting better. I don't want anymore, you know, but I think he's finally catching on. It's hard. It's like smoking, I guess. If someone you're living with smokes... it just reminds me of the same sort of thing. You're being very determined to try and lose weight and the person you're living with doesn't need to. (OW, Rural)

It was especially difficult when their husbands didn't have a weight problem. Some of the women felt it was unfair that their husbands didn't have to worry at all about what they ate, while they were constantly in a state of restriction:

Barriers? There's no doubt that it is cooking for somebody that's got a metabolism that is opposite you. 'Why don't you put whipped cream on it?' he asks. 'Cause I can't have that!' Yeah, I mean, so, that's just sort of what happens in our house. (BB, Rural)

This is a man who says, 'You know, I think I'm getting a little fat', doesn't eat after supper for three days, loses 12 pounds! I just want to kill him! Meanwhile, I'm struggling and watching everything I'm eating, and he's like, 'You must be on a diet, cause I'm gonna make toast now'. Do you know how good toast smells at 8:00 at night?! Oh god, it's so good!... Because he loses weight so well, it's just not fair. (BB, Urban)

One woman spoke openly about the diet sabotage that took place in her home:

All my life being big, my husband was very skinny. I always thought, boy it would be nice if he had a weight problem because then he could understand, then we could diet together and it wouldn't be just me. But I was always very, no, I'm eating this. I would still make other things for the rest of them, whatever. It was just, this is how life has got to be. Well then he, you know, gets 40 and a pot [belly] and he started needing to lose weight. And so we try to go on a diet together, and we can't do it! We sabotage each other! We deserve this chocolate bar, and instead of me saying no, we sin together! Like, it's stupid! You'd think that the two should help and it's only gotten worse. (BB, Urban)

Another difficulty when it came to healthy eating and/or dieting was feeling 'tempted' by the foods their husbands had the 'freedom' to eat. That is, they found it hard to maintain control over their cravings when their husband was eating something tasty

and delicious. For example, dessert following dinner was often the source of much temptation and conflict:

We do have a healthy meal twice a day, but my drawback is my husband likes a pie every once in a while. So when I bake a pie, then I have the odd piece too! (OW, Urban)

He always gets up from the supper table and says, 'Well what are we having for dessert?' So that makes it okay, I've got a reason. I can blame him for my eating! And then he goes and buys these foot-long chocolate bars at Superstore and then he takes it out after supper and sticks it under my nose! (OW, Urban)

The women also found it difficult when their husbands would take on some of the food-related responsibilities, such as shopping or cooking. They wanted their husbands to help out in the kitchen, but then when they did, they weren't particularly pleased with the types of foods being purchased and prepared:

Well, the thing is, he's the one that wants to do the cooking. Like, he was a chef so he is the one that cooks in our house on a daily basis... But you know, he doesn't have a weight problem and never has, and he still cooks the way he did when he was cooking in the restaurants or in the army. And you know, like he doesn't fry things, but there is always lots of butter, you know, sauces, gravies, things like that that I personally could do without, weight-wise... I could probably be more forceful with him and say, you know what? We should have... Like, he would never make a vegetable unless I said, 'What's the vegetable tonight?' (BB, Rural)

A great big lovely meal to him is perogies and sausage rolls, you know, things like that. I have broken him of quite a bit of that, but he still likes to cook part of the meals and he tends to... I don't know whether he thinks a famine is coming, but he likes to have lots of food! (OW, Urban)

2c. Dislike of Cooking

Some women simply did not enjoy cooking, which made it difficult to find motivation to prepare healthy and enjoyable meals, as was the case with this woman:

I really and truly hate cooking and I hate baking. You can ask anybody that. If I have to go and take a dainty somewhere, it's usually bought. But I

do like to eat the stuff, and I would rather eat out than eat my own cooking. (BB, Rural)

Some women explained that they were just too lazy to cook meals at home:

I find [cooking] is a real chore sometimes. Like, getting up and saying, what do I want to take out of the freezer today? You know? (OW, Rural)

For others, it was a matter of cooking fatigue. After doing it every day for so many years, they were simply tired of food preparation:

I can't believe you still like to cook like that! I'm just done! I said, I've been doing this too long. I'm fed up with cooking! (OW, Urban)

I would like to have a bit more variety as well. Like, I used to do more of that when we had kids, but after a while, you get tired of cooking. (BB, Rural)

This dislike of cooking or fatigue of cooking often resulted in monotonous meals and boredom with eating. Several women complained that they wished their meals had more variety:

I'm bored. I don't know what to cook. Like, everything seems to be the same thing you're cooking all the time. You need something different, and I don't know what to cook. (BB, Rural)

2d. Time/Busy Lifestyle

For baby boomer women especially, busy lifestyle and lack of time were major barriers to healthy eating. Many of the baby boomer women in this study were still working and/or still had families and children at home, so this placed a lot of demands on their time. Many of them lamented the fact that their lives were so busy. With everything else on their plates, it was hard to make healthy eating a priority:

No, I don't eat the way I would like to eat. I try very, very hard, but it's, I'm very rarely successful. And for me, it's a question of time. When you're running from one job to another or whatever, you don't have time

to even think about what you're eating, never mind, how to cook it and where to get the ingredients. (BB, Urban)

These women often commented on how much time and effort it truly takes to prepare healthy meals from scratch. They were too busy to do all of the planning, shopping, preparing, chopping, cooking, and clean-up that is involved with serving homemade meals. This frustrated them, as they truly wanted to make healthy homemade meals for their families, but simply didn't have the time to do so:

A friend of mine makes a salad every night, and I think, man, that's amazing! Really! Time, time to cut up, that's a barrier. Time to prepare all those veggies all the time, that's the barrier for me. (BB, Urban)

The other thing I find about eating a little healthier is the time that it takes. And when I'm in a hurry, which is quite frequently, I make poor choices both for myself and for my spouse, if I happen to be cooking, cause it might be quicker. So finding a way to reduce that prep time to have good healthy food would be, for me, something that would be really beneficial. (BB, Rural)

For these busy baby boomer women, it was clear that there were other things they would rather be doing than spending their precious limited time in the kitchen:

Well, I don't always stop and make a meat and potato, vegetable or pasta, you know. Cause I've got other things I'd rather do than that! (BB, Rural)

Many of them had come to rely on convenience foods in order to feed themselves and their families on particularly busy days. However, this resulted in feelings of guilt and personal failure. They wanted to feed their families healthy homemade meals, but found themselves turning to on-the-go meals, which tended to be less healthy:

I find our days are busy from morning till night and, you know, you're working away from the home, and so you're not there to prep the meals on a daily basis. And so you're doing maybe bulk prep, and you know, some are in the door and some are out the door, and yeah, it's just busy I find. You're working through the week and the boys are busy in hockey on the weekend, so you're away from home and you're grabbing stuff, you know, out of the canteen as opposed to having that stuff ready at home. You try,

at least two or three times a week to do a slow cooker thing and have your square meal, but yeah, just the busy-ness of everybody's day. (BB, Rural)

Yeah, sometimes, it's much easier to go out, cause it's like, oh, it's quarter to five, I'm home, and I have to be somewhere at 6:30. 'Honey, let's go to A&W'. We'll just go there for supper. And really, if I made it myself, it would be so much better, but it's a time thing. (BB, Urban)

2e. Availability/Access to Nutritious Foods

Among the rural focus groups, availability of and access to healthy foods emerged as a recurring barrier. Women who lived in rural areas of Manitoba repeatedly commented on the poor availability of fruits and vegetables in rural areas. Many of them wished they could have greater variety of produce options in their smaller local stores:

One thing I wish we could have maybe a little bit more in our local stores is fresh vegetables. That's something that's just tough to find. (BB, Rural)

Well, the availability in the store. Whether or not it's there. I might have to choose something that wouldn't have been my first pick. (OW, Rural)

The quality (appearance, freshness) of produce was also an issue in rural areas, as demonstrated by these comments:

Sometimes I get annoyed when I go uptown to the grocery store and find that the fresh produce on the shelf, I won't bring it home, it's old, it's dried out, you know. They've got a pile of asparagus there, but it's so wilted already that you can't bring it home. That's what annoys me, because when you go to the larger centres and you walk into those stores, the lettuce is beautiful, the radishes are crisp. You know, everything looks good. (OW, Rural)

I would love to eat avocados, but I can never buy one that's not going bad. I find that we're limited somewhat by where we live, you know? (BB, Rural)

Price was also a barrier for some women, both in urban and rural areas. They felt that healthy food (particularly fresh produce) was simply more expensive than eating less healthy processed foods:

I also find that it's very, very, very expensive to eat healthy. Wow, you know? And I mean, between my husband and I, we have six kids... and that's a lot of mouths to feed... You try to throw the vegetables and the salads and things like that, but it's expensive and it's hard. So for me, a lot of it is expense. (BB, Urban)

I love blueberries, strawberries, and all that. The expense can drive you to bankruptcy! It's horrible, and like, during the winter, it's almost impossible! Like, I'm on a fixed income and there's just no way I can eat that... I do avoid because I can't pay for it. I buy frozen, but for some reason or other, it doesn't have the same taste as the fresh. I mean a little container, a clam shell, of raspberries is almost four dollars! How does anyone afford it? I don't care how much money you have, it still cuts into the budget! (OW, Urban)

The women in rural areas were aware that they paid more for healthy foods than people in urban areas. For example, some women in the rural municipality of Hamiota were frustrated with the price difference between their local stores and the larger stores in Brandon (a bit over an hour away):

When you go and you look at the price of bananas in our store today or yesterday, they were 99 cents a pound. Now, if I was in Brandon, I would be getting them for 69 or 79 cents a pound. People who just can't get to Brandon can't take advantage of the cost of that kind of food, and so therefore, you don't eat a banana every day. At 99 cents a pound, that's expensive. (OW, Rural)

The women recognized that the cost of healthy foods was especially prohibitive for certain segments of the population, such as older adults, young families, and single-income households:

I think cost is starting to come in as a factor with an awful lot of elderly people who are now on one income... living on a pension. And the way the cost of food is going up, it is impossible for people to eat healthy, especially if you want to go and buy, you know, organic strawberries or organic raspberries. (OW, Rural)

One woman was quite concerned about the increasing food prices, and worried that the increase in food prices would outpace her retirement income:

I'm zeroing in money issues because when I look at prices of groceries in the store now, and yogurt is five dollars for a litre sometimes, and I'm thinking, if I live another 20 years, with the inflation the way it's going, maybe all this food is going to be way [over] priced! Like, snap peas for instance, if you don't grow it in the garden. And some of the foods is going way out of line, and our grocery store is the only one and so they can charge you two dollars for a cucumber. Or maybe I'm going to outlive my money, and our pension is not going up at the rate food, at the rate of inflation. Everything is going up pretty even. So that's another factor I think. And on the TV the other day, they were talking about the price of milk and they were saying that New Zealand was the highest price, it was \$5.69. And then I've got my bill and a 4-litre of milk is \$5.89 here. So \$5.89 for a 4-litre of milk, and not too long ago, it was three dollars. Now is that going to go to 10 dollars pretty soon or what? (OW, Rural)

One woman who was on social assistance and received disability benefits commented on how it was difficult for her to eat healthy when she had to rely on a food bank for some of her food:

For me, because I'm on disability, I'm not working, and I am a food bank user. And I know, with the groceries, you know, like you get a lot of pasta and potatoes and flour. It's like you don't really get a lot of healthy stuff, in my opinion anyways. So I find it really hard. (BB, Urban)

2f. Personal Preferences and Habits

Many of the women in this study struggled to eat healthy because of personal preferences or habits that would 'get in the way'. For instance, some women simply loved food and loved eating, and while they got a lot of pleasure out of cooking and enjoying food, they also were aware that this was likely the cause of their weight problems:

I like cooking, and maybe that's one of our biggest problems. And we love dessert too, which is another big problem. And sometimes we do seem to crave the dessert part after [dinner], and maybe it's just a silly habit we've gotten into. (BB, Rural)

I love to cook, and that's my problem! I would like to make all kinds of things and I haven't taught myself totally that you don't just eat everything

you make! So I'm really trying to educate myself, but when you love food and you love to make things... Yes, I can make salads, but it's much more fun to make desserts and rich sauces! (OW, Urban)

Portion control was also seen as a personal barrier to healthy eating. Many women stated that they don't have trouble choosing the healthier foods, but that they do have trouble with controlling their portion sizes:

I think I eat too much. I like food and I enjoy eating and then sometimes I'm uncomfortable after because I've had a little bit too much. Somebody said one time, you should stop eating when you still want a little more. But you know, that takes a lot of self-discipline to do that. (OW, Urban)

My sort of control is to stop going to seconds. You know, we got cooking for kids and now that the kids have left home, we're still cooking the same amount! So it's to convince my husband, and also, don't go back for seconds. If we don't, then there's enough for another meal, and you know, we can stop eating. You've had enough. It's just comfort, comfort eating is the killer. (BB, Rural)

Some women struggled more with choosing healthy foods, because their taste preferences were geared towards unhealthy items. They had trouble eating healthy because they viewed healthy foods as less tasty. These women struggled to eat enough fruits and vegetables, simply because they didn't enjoy them. As one woman stated:

It is good for my body, but it isn't good for my taste buds! Like, it isn't scrumptious, you know?! (BB, Urban)

Women also commented on the power of habitual behaviour. They realized that unhealthy habits were easily formed, but difficult to break:

I have to say that desserts are downfall in our family and we have them every time we eat together, at supper time. It's just not complete without sweets. And I can't manage to change that. I try to choose some healthier desserts but that's tricky. (BB, Rural)

I decided last January that I was going to quit eating bread and potatoes. Next to steak, they're my favourite foods. And man, it is hard to give up, and especially when you live alone. It's so easy to make a sandwich, put a

piece of bread in the toaster. It is so easy to fall into that habit. (OW, Rural)

A few women realized the influence of the home environment in encouraging unhealthy habits and we're trying to change their surrounding environment to help facilitate more healthy choices:

Now, it's just to get out of eating dessert every day, twice a day or three times a day. You know, a slice, a cookie, or whatever. [My husband] made me throw a cookie jar out the other day, cause I had it on the counter and it was always full of cookies, and every time I'd walk by, I'd dip my hand in the cookie jar. So, it's gone. And now I just keep my cookies in the cupboard. Out of sight, out of mind, they say. I don't know if it's gonna help or not, but... (BB, Rural)

2g. Social Situations

Social situations were also perceived as a barrier to healthy eating. The women were keenly aware that social gatherings tend to revolve around food, and that the food options available at these social events are usually not very healthy. Thus, making consistently healthy food choices was much more difficult outside the home and with others, as compared to eating alone at home. They found that in order to maintain a social life, they had to put themselves in situations that involved food. These situations were especially common around holidays, such as Christmas, and during times of celebration (e.g., family gatherings). These few comments describe what many women were feeling:

I love socializing, and I haven't, nobody has, invented a way to socialize with older people without food! You've always got food, food, food! There's food everywhere, so what do you do? (OW, Urban)

Social life, as well, dictates very often, factors into what you eat. You'll go to a funeral, I'll just use that as an example, and of course, there's always the dainties and sandwiches and whatever. And because I like sweets, I end up eating more sweets than I should, whereas if I was just at home that day, I wouldn't be eating them. So I think social lifestyle has a good part in deciding what we're going to eat, at least for me. (OW, Rural)

2h. Emotional Eating Issues

A final barrier that some women spoke at length about was their ongoing issues with emotional eating:

I eat if I'm stressed. Well, actually, I eat when I'm happy, I eat when I'm bored, I eat when I'm sad. I don't eat when I'm really angry. When I'm really, really angry, I don't eat, but every other time, I eat. (BB, Urban)

Probably my frustration is I made great headway for the last year, and then it slipped. And so, sometimes I think it's more stress. And so my way of handling things is rather than get out, get out and walk and do something about my stress, I have a tendency to get my hand movement going and bring it to my mouth! And I think like everybody said, it's frustrating. (BB, Rural)

Women also commented on experiencing cravings on a regular basis. These cravings were often for their favourite comfort foods:

Yeah, bread is a killer, isn't it? It's so nice to have a piece of bread and put butter on it. Even though you might have eaten a complete meal, I find myself sneaking back and having a piece of bread and butter... It's just comfort. Comfort eating is the killer. (BB, Rural)

I think some of the barriers are that carbs are just so much easier and they satisfy you a lot more readily. I think that is totally a barrier for me, because it's not necessarily quantity for me, but I know it's the carbs for sure. It's a comfort thing. (BB, Urban)

Late-night was seen as a particularly troublesome time for many women, where their healthy eating efforts would fall to the wayside. Often, these women ate very healthy during the day time, but as soon as evening rolled around, they struggled to control their eating. Many women felt that their tendency to eat late at night was the main cause of their weight problem.

My worst [time] is evenings. I can eat non-stop, from dinner on till I go to bed, you know. And that has to be my worst, and I can't seem to break it. I don't know whether it's boredom or because I'm alone now... (OW, Urban)

It makes me mad at myself because, for the most part, I'm really good. And usually good all day, till I get home at night... I'd give anything, because that's my worst time. (BB, Urban)

The combination of television and late-night snacking was particularly problematic for some women:

Yeah, food can be an issue. You just have to sit and watch TV and look at all those food commercials, and then, what am I doing?! (BB, Rural)

I went to a dietitian and I do tend to overeat the wrong things, especially in the evening. If I'm sitting watching television and all those commercials come on – it's just bad! (BB, Urban)

It became clear that many women struggle to maintain a sense of control over their eating. Moral struggles surrounding food were very common, with women labeling themselves as 'good' or 'bad' depending on what they ate and their ability to resist tempting or desirable foods. Many of them were struggling with ongoing weight issues and were caught up in the dieting mentality of all-or-nothing thinking and negative self-talk. When they were largely unsuccessful in their attempts to monitor or control their eating, they experienced overwhelming guilt and blamed themselves for their failures. Many of them believed that it was just a matter of willpower, and if only they could have more self-discipline, they would be able to succeed:

I believe that, ultimately, it does come down on you, yourself, to try and control, but it's also very difficult. Every day, the consumer world is flashing things at you constantly and you have to have very strong willpower to say no to whatever they might be flashing at you. And I don't have that willpower, basically. But again, that comes down to me then. I need to improve my willpower. (OW, Rural)

I think women are good at that. We're good at really coming down on ourselves really hard, saying, no no, we screwed up, we're bad people. Just go and have the cake now. That's what we do, right? We eat our feelings away and we don't tell anybody. (BB, Urban)

Clearly, many women were struggling with eating and had developed dysfunctional relationships with food as a result.

3. Food Choice Influences

There were many different factors that influenced the women's food choices. The most commonly cited factors were cost, convenience, quality (taste/appearance), brand loyalty, family influences, desire for wholesome, unprocessed products, health issues, nutritional value, and various media/information sources.

3a. Cost

Cost was a major factor in food-related decisions, for both baby boomer and older women, and those in urban and rural areas. When discussing food choice influences, price (or cost) was mentioned a total of 23 times. Women are looking for the value in their food purchases – they want to get the ‘best bang for their buck’. While grocery shopping, they often keep their eyes out for items that are on-sale. A few women commented that paying attention to price was a habit or an ingrained behaviour that was almost automatic or sub-conscious:

Our whole lives, it has always been, there was never a lot of money. I never had a job, I was home, making everything from scratch. We always bought the cheapest and that's a hard pattern to change. So for me, it's always price first... It's become a learned behaviour (BB, Urban)

For one woman with a lower income, paying attention to price was an absolutely necessary part of her food purchasing experience:

I just watch the prices and see, you know, what I can afford at the time. I like to do comparison shopping and look at the prices and stuff like that, cause I like to make my money last as long as I can. So if the week comes

and I can't afford it, well I'll wait till the next time that it comes on sale.
(BB, Urban)

3b. Convenience

Given that busy lifestyle and a lack of time were notable barriers for these women, many of them were looking for food products that provided some degree of convenience. Even though women didn't like using processed or convenience products on a regular basis, they admitted that on particularly busy days, using these products helped them get dinner on the table in a shorter amount of time. In this way, these convenience foods were viewed as a sort of 'necessary evil'. Many women reluctantly admitted that they keep easy-to-prepare convenience foods on hand for those busy days where time was limited:

Okay, we've got a pizza in the freezer for those moments when you just don't have the time to do something. Like, there's always something in the freezer that can be just sort of popped in and cooked quickly. (BB, Urban)

Even though most women admitted that they do rely on convenience foods in a pinch, most were doing their best to make the healthiest choices. They recognized that even when they are pressed for time, they have the opportunity to make the healthiest choice possible:

If you're going to buy package for convenience, I'm just saying that you can buy a salad. You don't have to buy the fish sticks or the chicken fingers. You can buy healthy products that are pre-packaged. (BB, Urban)

A few women were specifically looking for quick and easy food items to eat on-the-go, either for themselves or their children:

I still have kids who are in high school that need to take something to eat at high school, so I have to buy stuff that they will take, because they won't make anything in the morning because they don't get up early enough to make it. It has to be something they can throw in their

backpack, so granola bars, fruit, that kind of thing. But yet, I don't want it to be to the point where they're taking unhealthy things with them. So you kinda have to read a lot of labels and think about what you're buying. So for me, it's more the health factor... but convenience is also very big. (BB, Urban)

A few women commented that they are usually pressed for time at the grocery store. They have a limited amount of time to complete their shopping and as a result, they are making quick point-of-purchase decisions:

Sometimes, it's what's available and what seems to be close at my eye level. I'm quite frequently in a hurry. I have to be honest, I would rarely look at the label to determine some of the calorie content and such, but it's usually the factors of what might be available and looks good in the store to me, and really, what just catches my appeal. Even though I have a list, I would just, because I can't go that frequently because of time, I might buy, you know, some poor choices. But it's about time. (BB, Rural)

3c. Quality

Another factor that is important to women is the quality of the food, including its taste, freshness and appearance. Several women stated that they choose whatever looks appealing at the store:

It's usually the factors of what might be available and looks good in the store to me, and really what just catches my appeal. (BB, Rural)

I'm a visual grocery shopper. I go [to the store] and, oh yes, that looks good, that looks good. I'll buy that way, you know. (OW, Urban)

Others were more focused on the taste of the food. A common concern was being able to balance healthfulness with good taste. A few women believed that taste was the most important factor to consider when purchasing food:

First thing, taste. It's the most important to me. I mean, otherwise, why would you bother?! (BB, Rural)

It depends on the taste. If it doesn't taste good, I don't care if it's got one calorie and I don't care if it's super good for me. If it tastes yucky, I'm not gonna eat it. Everything in moderation... Except wine! (BB, Urban)

3d. Brand Loyalty

Some women chose foods based on their positive experiences with a particular brand. These women valued the taste of particular products and said they would always buy that brand, even if the price was slightly higher than the generic version:

I look at brand names, probably cause I've looked at the ingredients and therefore, have found a certain brand that I think is the best. So I look at brand names when I'm purchasing. (OW, Rural)

I think brands are also part of my buying habits. You get used to something that you like and you avoid other brands. You know, you always look for a particular brand. (BB, Rural)

3e. Family Influences

The women commented that family upbringing (and what they grew up eating) played a role in their current day food choices. For example, some older women had grown up with the mentality that a 'proper' meal consists of a meat, potato and vegetable. One woman commented on how her upbringing had fostered a 'depression-era mindset' with respect to food and eating:

My parents both came through the dirty 30s where food was very scarce and my father ate porridge two or three times a day, cause that's all his mother could give him. And the line, every meal in our house as children, was 'clean up your plate'. You left nothing on your plate. (BB, Rural)

The preferences of other family members (partners, children) were also taken into consideration when planning and preparing meals:

"I still have three teenagers at home, so a factor has to be what they like. I like to make one thing for supper, so I choose something that number one, they all like and number two, is somewhat nutritious." (BB, Urban)

3f. Nutritional Value

Women were very concerned with making nutritious meals. In fact, when talking about food choice influences, nutrition was mentioned a total of 181 times. Clearly, healthy eating was very important to these women. They valued nutritional balance and were looking for products that they considered to be healthier or more nutritious:

I don't know if it was Home Ec or my mom saying, you know, something green and something yellow on your plate, or green and orange, and then you've got a balance of vitamins. (BB, Urban)

I think health consciousness is kind of in the back of my mind, because I think broccoli is great and whole wheat bread is great, and so I do think of the health benefit of the food, I guess. And lettuce, romaine lettuce is supposed to be the best kind of lettuce; it's on a lot of health food diets, so I think of that. (OW, Rural)

Nutrition labels were seen as very important in helping them make healthy choices at the grocery store. Many women reported reading food labels on a regular basis. As these comments demonstrate, food labels definitely play an important part in the food purchasing decisions of baby boomer and older women:

I do look at the labels and I'm always looking for the fat content and any other little hidden things there that, you know, like the sugar content. Definitely whether it's a natural sugar or whether it's an additive. I'm always looking at whether it's a salad dressing or whatever, and it says low-calorie, low-fat, that kind of thing. I'm always trying to find out. (BB, Urban)

I certainly read labels and I like to cook from scratch. But it's so important to read your labels and compare because it's amazing, anything you're looking for in the grocery store, if you read your labels, the differences in the salt, the difference in sugar, the difference of fat, can just be absolutely amazing from one brand to another. So it's very, very important to read the labels. (OW, Urban)

Many women were reading ingredient list on the label in their effort to avoid overly-processed foods with artificial ingredients:

I also look at the list of ingredients and if it's a huge long list of things you don't even recognize, I won't buy it. So I try to, as much as possible, avoid pre-packaged and processed things. I mean, you can't always do that from a convenience standpoint, but as much as possible I try to do that. (BB, Rural)

However, label reading did have its downsides. In fact, as much as label reading was seen to be important for making healthy choices, there were a lot of barriers that interfered with their ability to use the information on the label. For instance, label reading takes time, and many baby boomer women did not want to spend more time at the grocery store than absolutely necessary. Others in the older groups complained that they have a hard time reading the labels because the print size is so small. Many women found the information on the label to be confusing; others were frustrated with mis-leading labelling and package claims. A few women commented on the difficulty of comparing products when the serving sizes on each label are different:

Please be aware that up at the top it says the amount, the serving portion. Cause you could read through the label and think, well this can of soup has, say, 80 calories. But then you look at the portion serving, and it's only for half a can! So that's important. (BB, Urban)

I do check [labels] too when I buy, and I wish, sometimes you know, you come to the realization... You check them and then you check the next kind and they'll say for $\frac{3}{4}$ of a cup, these are the percentages. And then the next one, you just assume it's the same, but that'll say a cup! It's so misleading because you're trying to compare apples and oranges! (OW, Rural)

3g. Health Issues

Part of the reason that women placed so much importance on nutrition and label reading was because they were trying to prevent or manage certain health conditions. When talking about food choices, cholesterol issues and/or heart health was mentioned 23 times, diabetes was mentioned 18 times, blood pressure received 17 mentions, and

allergies/intolerances came up 15 times, with digestive issues and osteoporosis mentioned less frequently. As one woman commented:

I think that our age group is moving into the level where it's whatever your health symptoms are that will dictate what you have to eat and what you can and you can't. (OW, Rural)

Several women were struggling with recently diagnosed health issues and were trying to figure out what they can/should eat to help manage the condition:

The doctor told me that I had high cholesterol and it's purely genetic, cause it's always been that way. And I thought, oh great, you know, here I can eat whatever I want, but no, I can't now because I've got this cholesterol issue. That was really hard because it's like, I don't even know how to deal with that because I've always eaten what I wanted to eat and it just seemed so weird to restrict an area. And I didn't really know, frankly, how to do that very well. So then I quit doing that because it didn't make much of a difference anyway. (BB, Urban)

Others were very aware of what they should be doing to take control of their health issues and were doing their best to make healthy and informed decisions about their diet:

Well, because of the diabetes, we have to watch carbohydrates, of course. And I find that baked potatoes might be quite a bit smaller than they used to be, and we might have brown rice instead of something... Those kinds of choices. (OW, Urban)

I have chronic eye problems, so I'm very aware of the vitamin supplements and dietary items that are good for eye health. (OW, Urban)

Many women had altered their eating to focus more on healthy choices not because of their own health issues, but because of the health problems of other family members:

A lot of my eating is driven by the fact that my husband had a heart attack six years ago and so he's got to watch what he eats and watch his cholesterol and that, which maybe in some ways is good because it does kind of force us to eat less red meat, eat more fish and chicken and salads and that sort of thing. (BB, Rural)

Food is a big issue in our family because my mom has to control a lot of her diet because she's got, you know, digestive problems. And my husband now has high blood pressure, so we don't use salt. So it seems that, when I

think about it, I seem to change to accommodate other people more than myself. Like, it's not myself that motivates; I'll change for other people around me. (BB, Rural)

3h. Media and Information Sources

The final factor that influenced women's food choices was the information they received from media and other sources. Television advertisements, talk shows, radio programs, websites, magazines, books, newspaper articles, and other publications were all mentioned as sources of nutrition information. However, this information was not always deemed to be correct or credible. Furthermore, the mere amount of nutrition information was often overwhelming. Many women were confused about which sources they should or shouldn't listen to and were unsure how to judge whether something was propaganda or mis-information. As these comments suggest, many women were frustrated with the amount of conflicting information they received on a daily basis:

One day broccoli is good for you and the next day, it's not. So you know. You hear that on the radio all the time. (BB, Urban)

I think people get so confused. I get so confused! One minute, it was Becel margarine, and we just have stuck to it. I've never bought anything else. But you hear so much controversy, it's this, and it's that, and you know, I worry. Younger people, how do they know what to eat?! Cause I don't know what to eat anymore! They confuse us so much with what's right and what's wrong. And the egg thing. My grandparents lived till they were 90 something and they ate eggs every day, and you know, it's just, it's confusing! That's what bothers me most about food, is the confusion. (OW, Rural)

I think that's a big issue. One day, they're pushing calcium, and down the road a little bit, oh you shouldn't be taking such high quantities. Like, how do you know? And to say you should be getting all the nutrients out of your diet, but then you're being told, well you need the extra vitamins. You need this, you need that. Lower your cholesterol with flaxseed. You don't know what is right and what is wrong! (BB, Rural)

Repeatedly, women mentioned that they wished nutrition could be less confusing and overwhelming. Over and over again, in every focus group, they stressed the need for clear, reputable and understandable nutrition information that is easy to follow:

I do think it's nice to have a solid example of what the good stuff is, to balance out all the junk that comes at us. That is, if we can constantly have information on what's good and what you can eat, then you can pick and choose according to your health problems. (OW, Rural)

We sure need a lot more real information... I'm a grandparent and a parent, and you know, you want to give good habits, good eating habits to your kids and your grandchildren, and you need that knowledge to be able to justify all these choices and we've never learned the real facts that much. Like I mean, yeah, you know that fruits and vegetables, and you know, the Food Guide and stuff, but there's so much more. And I think it's time that we get that right information, you know. People want it now. (BB, Rural)

Focus Group Results: Attitudes towards Specific Food Products

During the focus groups, attitudes related to specific food products were also explored. Table 5.5 provides a summary of the qualitative themes and sub-themes that will be discussed in detail below.

Table 5.5: Qualitative Themes –Food Product Attitudes

Major Theme	Sub-Themes
1. Local food products	1a. Supporting local community and economy 1b. Seasonal barrier 1c. Distrust of foreign products
2. Organic food products	2a. Eat certain foods in organic form 2b. Cost barrier 2c. Skepticism of farming/labeling practices
3. Functional food products	3a. Occasionally eat, but not seeking them out 3b. Uncertainty of health claims
4. Diet food products	4a. Trying to cut back on fat and calories 4b. Trial and error approach 4c. Lack of taste and texture 4d. Aware of nutrient substitutions

1. Local Food Products

Overall, women valued local eating and made an effort to consume local products as often as possible. The types of local products that women were purchasing varied from person to person, but the most commonly sourced local food products included vegetables (potatoes, corn, tomatoes, carrots), fish, meat (beef, pork), poultry, eggs, flax, honey, and flour. These local foods were obtained from a variety of different sources, including farmer's markets, nearby farms, family and friends, certain grocery stores, and home gardens. In fact, gardening was seen as a very important source of local and organic food. Many women, particularly those in rural areas, gardened every year and preserved the fruits of their labour through freezing, canning and other preservation methods. Many of these women really valued and took pride in their gardens. They took great pleasure in eating the fresh, homegrown produce that was the result of their own efforts. One woman stated:

I made it my mission in life to never buy a vegetable. I want to grow all my own and so far this year, I've had to [buy] potatoes because I didn't have any potatoes. They drowned out, but that's one thing I never bought. I've always eaten my own vegetables. (BB, Rural)

1a. Supporting Local Community and Economy

Local eating was seen as highly important for a number of reasons, including environmental sustainability, economic growth, and individual/population health. Women in both rural and urban areas wanted to support local growers and contribute to the local economy:

I would say most of what we eat is local – the meat and the vegetables, potatoes, things like that. I suppose I buy fruit and canned foods that come from far away, but yeah, I would like to support the local people as much as possible. (BB, Rural)

I love to go to Tall Grass Prairie [a local bakery] because of the quality of their food and I love their philosophy. Their philosophy is that when you have hands on, it makes a difference in giving it to the community. So I love that mindset and I also love to buy locally. I love to buy, I buy eggs from a farmer and I think more and more I like that I can buy local products. I'm becoming a bit more fanatical about buying locally and supporting our own community. I think it's important. I absolutely will not buy vegetables that are coming from China, pea pods and things like that. I read the labels as well for those things. So I feel strongly. And restaurants too; it's awesome to go to support local restaurants. (BB, Urban)

In addition to fostering community development and economic growth, local foods were viewed as fresher, tastier, and generally better quality than the items in the grocery store that had travelled long distances:

When all the gardens start coming out, the market gardens and things like that, I tend to go to a market gardener on Henderson highway, because I know everything that he's got in there has been grown locally and I know those potatoes that I'm going to be eating have been picked within the last couple of days and they're gonna taste fantastic. (OW, Rural)

I do try to buy, like if I've got a choice between Peak of the Market vegetables and something that's made in California, I'll choose Manitoba or Canadian grown. But I too believe that our food supply is very safe and whatever. I do support the farmer's market here, but more for support rather than, feeling that I'm getting more nutritional food. It might taste fresher. (BB, Rural)

1b. Seasonal Barrier

A barrier to local eating was that certain foods are simply not available locally due to the regional climate, growing conditions and geography. Several women wished they could eat exclusively local, but explained that it would be too restrictive because of where they live:

I do like to buy local, although I have to admit that when it comes to variety, it's hard to get from somewhere else. Like in winter months – there's a time you can't get all the vegetables locally cause, like, lettuce

and things like that just aren't grown here for the most part. And same with fruits. How many fruits do we really grow right here in Manitoba? Not a lot! So you're still forced to, well if you want variety, you still have to buy them imported from another country. I have to say I get quite upset when there are no Manitoba carrots available in the spring, cause there's not a carrot that tastes as good as Manitoba carrots! (OW, Rural)

A common frustration was that they could only obtain local foods in the summer and fall months. They wished that they could get local produce in the winter months, but knew that it just wasn't feasible with the harsh and cold northern climate of Manitoba:

I totally agree with buying locally produced food, but it depends on the season. Like, in the summer, you can get far more locally grown products than you can in the winter. But I certainly think it's a good idea when you can, and I try to. (OW, Urban)

1c. Distrust of Foreign Products

In addition to growing gardens and visiting farmers markets, women were making more of an effort to read the labels in the grocery store and chose products that were made or produced in Canada. There was a lot of worry and distrust about packaged products that came from countries outside of North America. They were particularly weary of products that came from China, and many women stated that they outright avoid these products to the best of their ability:

I check cans because I don't like food that comes from far away, cause I'd rather buy fresh than buy mushrooms that came from China or India, or wherever they come from. You're not sure what's in those tin cans. (BB, Rural)

When I buy canned fruit, I look to see where it's being processed, and if it's, if I can possibly avoid something that's [made] in China, I will. I will choose the USA over that, or Canada. And the reason for that is that we've had different things come out of China, you know, scares with, well, they had a milk scare and things like that. (BB, Rural)

Overall, they wished there was more availability/options for local products in the grocery stores:

When I think locally, I think Manitoba grown, and we can't get a lot of that in the store. Maybe in the city when you go, there's a section, but in our little stores, we don't have a section. And we go to the market garden if I don't have it in my own garden, but that's summer time. (OW, Rural)

2. Organic Food Products

2a. Eat Certain Foods in Organic Form

In most of the focus groups, organic eating was somewhat controversial. Discussions around organic food products usually prompted conflicting responses among the group. There were a few women in each group that made an effort to buy organic foods. These women liked the idea of organic foods for their environmental and health benefits, but didn't purchase them consistently or habitually. Of these women, no one ate exclusively organic, but rather, they were looking for certain products they believed to be better or safer in organic form. The most common organic items that women were seeking out included apples, strawberries, soy-based products (e.g., soy beans, soy milk), flours, potatoes, and celery.

Not all food is necessary to have it organic, because some foods absorb the pesticides and some reject it and don't absorb it... It's probably good if you can find out which foods have the least pesticide residue as well, if you're looking to eat more healthy. (OW, Rural)

Among the women who did make an effort to consume organic produce, the reasons were varied, but mainly focused on wanting to eat healthy (better nutritional value) and/or wanting to avoid pesticides and chemicals (environmentalism).

We grow some organic crops, we're just starting to. And I agree, it's not that the product is healthier, it's the way you're producing it that's different. And I guess some people really want to encourage less use of

pesticides, and so it's basically the way you grow it that is more environmentally friendly. So if people want to pay for that, that's another alternative. But to me, I agree, it's not whether a crop or milk or produce is any healthier, it's the way it's produced. (BB, Rural)

I believe organic, in general, is better for you, although I don't think that we can all afford everything organic, and not everything is available organic. So you really have to sort of decide, you know, what you really want to get organic that's important to you, and what you're willing to put up with that's not organic in other foods. (OW, Rural)

2b. Cost Barrier

A primary reason for *not* buying organic items was their increased cost. For the majority of women, the higher price was a major deterrent to eating organic:

Ask a person who is starving whether they're gonna eat organic food or non-organic food. When you're hungry, does that make a difference?... Nine times out of ten, people cannot afford to buy organic because the price is just, just so exorbitant, simply because of the practices you have to do to produce organic and the restrictions you're put upon. You don't get the same volume of crop from an organic processing place, so to me, that's big. (BB, Rural)

I know I've often wanted to try the organic, you know. But like I say, price wise, I've really got to watch my pennies, you know. So yeah, as much as I'd like to try, I just stay away from that aisle. (BB, Urban)

2c. Skepticism of Farming and Labeling Practices

The other main reason for not buying organic foods was because of skepticism surrounding organic farming practices and labelling laws. There was great confusion surrounding the definition of 'organic' and much suspicion about the regulation of organic food products:

The thing is, how do we really know? I've seen organic, that's just like having a peeing section in the pool! You know? They're here and you're here, and it's the spray, and please! Let's face it! (BB, Urban)

I don't buy it either. And my husband informs me that, how do you know that the flax that we're paying twice as much for in the organic food store,

hasn't just been taken out of the bin and put in the bag! There's no proof.
(OW, Rural)

Several women chose not to buy organic because they believed that the Canadian agricultural system was perfectly safe. Those living in rural areas, in particular, had a sense of trust in the non-organic Canadian farming system. Many of these women lived close to farmers, knew someone in the agriculture industry, or farmed themselves. This insider knowledge made them more confident in the quality and safety of the broader food system, and therefore, they refrained from buying organic:

As far as buying organic, no, that's not a big thing to me. My daughter's in agriculture, and I know all about the fertilizers and how they are controlled, or chemicals that are used on the foods that we eat, and how they're regulated. (BB, Urban)

I avoid organic foods because I believe in this country, all our food is safe. And having lived and worked on farms, we didn't grow organic, and I think we grew as good a food as anybody else. And so when I look at organic, I walk by. (OW, Rural)

I feel that there isn't enough difference, and that was just confirmed yesterday or this morning by a news item that said it's not actually true. It's not totally, truly organic. So I feel okay with, you know, washing the pesticide off, if there is some. I am pretty confident, as long as I'm buying Canadian. (OW, Urban)

3. Functional Food Products

3a. Occasionally Eat, But Not Seeking Them Out

Like organic foods, discussions around functional foods (FF) contained a lot of confusion and a fair amount of skepticism. However, in general, women said they were willing to try these products and would buy them if they looked good or were on sale. When asked about FF products, the majority of women said they were 'occasional' eaters. They were aware of them and not necessarily opposed to them, but weren't

specifically searching them out. They would buy FF on occasion; for example, if they were on sale or if a product label caught their eye. In general, they were willing to try these products, but didn't feel overly attached to them:

I am aware of things that are labeled omega-3. And when you buy it, you sort of mentally think, oh this should be good, but I mean, I don't go looking for that product. (BB, Rural)

If it's there beside the one I normally buy and I'm looking straight at it, and it's on sale, okay maybe. But I will not go looking for it. (BB, Urban)

I probably just go, what is the most cost effective thing that's on sale? And I mean, the calcium-fortified orange juice was what was there and I decided that's what I'm gonna buy, but I wouldn't consciously go and buy it. Same with plant sterol margarine and things like that. They're good for you, but I wouldn't just necessarily make sure that that was right on my shopping list. (BB, Rural)

The most commonly purchased FF products were: omega-3 eggs, plant sterol or omega-3 margarines, calcium-fortified orange juice, probiotic yogurts, and fibre-enhanced cereals. Among women who were actively seeking out these products, the main reason was for their proposed health benefits:

I do consciously look for stuff like that because I think, if it's added in, it's going to be a benefit to me. So I'm trusting that their labeling is correct and what they're saying is beneficial for me. So I will consciously make an effort to buy if I've got the choice. (OW, Rural)

Yes I do [buy FF]. I heard that omega-3 is just very, very healthy for a person... Like, I've never been much into yogurt and milk and that sort of thing, but now that they have the omega-3 in eggs and milk and yogurt, yeah, I really enjoy it. I make that extra effort. To me, I just feel, well, I just feel like my body's worth it. (BB, Urban)

3b. Uncertainty about Health Claims

The main reasons for not purchasing or consuming FF products were their expense and skepticism surrounding their proposed health claims. In general, women

were confused about how these types of products were produced and there was a lot of uncertainty around their ingredients. There was also a lot of skepticism surrounding the marketing of these products; most women didn't believe that consuming FF would make a substantial difference to their health.

I think that they probably put a wee little bit of something in there and say that it contains that. And so I guess I'm skeptical that they are really, really that beneficial. And they are more expensive. (OW, Rural)

I'm not convinced... I'm a little more critical of what it's trying to sell me, you know? It contains how much in there? And what exactly is that supposed to do? You know? So I'm a little more critical. (BB, Urban)

These women preferred to get their nutrients from 'natural foods' and stated that they would rather focus on eating a healthy diet consisting of whole nutritious foods rather than use FF products to compensate for lacking nutrients:

No, I don't make an effort to consume them. My philosophy is that, if I pick a healthy diet that I get a good bulk of my nutrition from fruits and vegetables and whole grains, I'm probably covering most of those bases. I don't need to buy something specifically like an orange juice that has calcium added. I'd rather drink a glass of milk! (BB, Urban)

I don't pay too much attention to the additives. The orange juice with calcium added is appealing to me, but someone told me that they feed the chickens fish to get omega-3 eggs. Well, I figure, I might as well eat the fish myself! (OW, Urban)

Some women explained that they prefer to enhance the nutritional value of their meals by adding their own special ingredients at home, such as flaxseed to baking or whey powder to smoothies. As one woman stated:

I have trouble believing some of that stuff. I don't think I'm really a skeptical person, but I don't know. There's just some of those that I don't tend to buy. You know, if I want more fibre, I'll throw in some All Bran myself or something. (BB, Rural)

4. “Diet” Food Products

4a. Trying to Cut Back on Fat or Calories

Some women made an effort to choose low-fat, low-calorie, or ‘light’ products as often as possible. These women, many of whom were trying to lose weight or were struggling with a specific health condition (e.g., high cholesterol) were trying to cut back on fat or calories and saw these products as being potentially helpful in that pursuit. The most common products that they wanted in lighter versions included salad dressings, sour cream, mayonnaise, yogurt, bread, cheese, breakfast cereals, and snack foods (e.g., 100-calorie snack packs).

A few women were choosing diet products to help them meet their nutritional requirements in light of a busy lifestyle that lacked time for proper meals:

The only thing I ever bought that was specifically for a diet was Slim Fast, and that’s when you’re going from one job to the next and you’ve got half an hour to get there and no time to eat, and the only reason I bought that was because I can drink a Slim Fast shake, and there’s all the nutrients I need for a meal, so at least I know I’m getting some kind of stuff that’s good for me. (BB, Urban)

Several women commented that they do look for lighter products for themselves, but would never serve them to guests:

I do that on occasion. I guess if I’m having company in, then I want the best sour cream or whatever, then I will purchase it and of course, then we end up eating the rest of it. It’s sort of on an occasional basis that I do purchase the not-so low fat. (OW, Rural)

In some cases, the women would buy the diet/reduced products for themselves, but would also have alternate (e.g., higher fat) versions on hand for others in the household who wouldn’t accept the lower-fat substitutions:

I mean, for myself, I would probably go with the light, but my son has mayonnaise in his sandwiches and he says he's got to have proper mayonnaise. It just doesn't have the flavor otherwise. (OW, Rural)

4b. Trial and Error Approach

A common sentiment was that it is worth trying out a particular product, because if you can save a few calories or a few grams of fat here or there, it helps in the long run. The general consensus among women was that they were willing to try the 'lighter' product, but they wouldn't buy it again if the taste was poor.

I do buy some of the low-fat products like Cheese Whiz, salad dressings. But if I try something and I don't like it, I go back to regular. But I do quite like the low-fat salad dressings and Cheeze Whiz. I don't notice anything different. Again, a matter of choice. You give it a try and if you don't like them, you exclude them. (OW, Urban)

I agree with these ladies that I would buy the low-calorie or low-fat salad dressings, so I would look at them and decide. There's some products that are better than others for flavor, and so you just, yeah, trial and error. (OW, Urban)

4c. Lack of Taste and Texture

Among women who refused to buy diet products, lack of taste or poor texture was cited as the main reason for avoiding them:

Every time I try a low-fat product, it could be sour cream or whatever, I just don't like it. I just go back to my regular sour cream and I cannot eat that low-fat cottage cheese, no way. To me, all they've done to it is add water, the taste isn't there. It doesn't have a big dollup when you want it! (OW, Rural)

I agree, fat-reduced products, I've tried the cheese and the guys were just furious! It has no taste. If you have fat-reduced cheese, it's rubbery. (BB, Rural)

Because of the poor taste of diet products, some women felt it was better to have the real thing, but just eat less of it. Because they used products like cheese and sour cream on an occasional basis, they felt it was worth it to get the real thing and truly enjoy the taste:

As far as Miracle Whip goes, I cannot tolerate the taste of the low-fat, and I don't use very much. I don't use much sour cream, regular cream, or any of those things, so I think for the few times that I use it, I'm not gonna worry about it. If I use it every day, I would probably consider the more low-fat [version]. (OW, Rural)

We tried the low-fat sour cream and it's almost gelatinous. It doesn't look like sour cream and it didn't have any taste to it or appeal. And for the amount we use, we try to eat healthy on other things, so this will make up for watching other things. And if you deprive yourself, then you're causing trouble. You know, you've got to have something in life that's good. (OW, Rural)

Diet products were seen to be less filling, and therefore, often left them feeling 'cheated'. They explained that because diet products were less satisfying, you can actually end up eating more:

I actually try to avoid those things because I think if you see something that says, oh this is half the calories, then you eat two or three of them, right? Like, you just feel that, oh it's a lower calorie, so it's alright to have a couple. So yeah, I avoid those. (BB, Rural)

I talk to people, when they know it's light, they eat a lot more of it. So you know, what's the point? Might as well eat a little bit of the stuff that you really like that tastes good [rather] than eating too much of something. Cause really, people do that a lot of times. (BB, Urban)

Some women believed a lot of the diet products on the market were just pushing false promises of weight loss. They recognized the influence of food advertising and product packaging, and didn't trust or believe the claims that were being made:

I often look at those TV [advertisements], oh if you buy this, you know, it'll help you lose weight! And I'm thinking, if it were only that easy! Then we'd all be skinny, right?! (BB, Rural)

All those diet things, I think could be dangerous. Sometimes they are. No, I think you'd just got to eat the right basic food and never mind all that stuff, in my opinion. (OW, Rural)

One woman who had purchased diet products in the past had the following to say:

Yes, I do buy the products that say diet, mainly because I'm looking at the carb content and unfortunately, they're still sitting in my cupboard because I will buy them in the hopes that they will satisfy my need for sweets, but they rarely do. Usually they taste like cardboard, although I don't eat much cardboard. But I think, you know, there's so much advertising on TV promoting these products that we're brainwashed into thinking that this is really going to do the trick for us. And we're hoping, yes, it's going to do the trick, but unfortunately like I said, I do buy them and then I'm disappointed. (BB, Rural)

4d. Aware of Nutrient Substitutions

Another common complaint related to diet products was the tendency of food producers to make nutrient substitutions. They were fully aware that when manufacturers remove one nutrient (e.g., fat) from a product, they usually compensate by adding more of another nutrient (e.g., sodium or sugar), and this frustrated them to no end:

I used to really watch the calorie versus fat on products and stuff like that, but I sort of shifted away from that... Like, they say if it's lower in fat, then it's higher in sugar usually, and especially when they say 'fat-free', then you really have to watch cause the sugar content can be just exploded in there! (BB, Rural)

It seems like if it's low calorie, then it's high in fat. Like, you can't have both, so you're damned if you do and damned if you don't! (OW, Rural)

When a box has been labeled on the front as 'no fat added', they tell you to look out, because there will be too much sodium. Or you think you're buying a safe item, but you're getting an overdose of sodium or sugar. So I find that's tricky to find out which is best. (OW, Urban)

Lastly, several women chose not to purchase diet products because they believed these products contained more chemicals or additives and they wanted to avoid ingredients that they considered to be potentially harmful:

I'm totally against buying Weight Watchers food. They quite often want you to buy the packages in powder, you know, with all this chemical stuff, and I don't like it at all. (OW, Urban)

I'm very, very afraid of all those fad diets, and those, is it Jenny Craig that gives you the food and stuff? I'm always afraid of what they put in their food. I'd rather make my own. (BB, Urban)

DISCUSSION

General Discussion

In this paper, we have explored the food and eating-related perceptions, attitudes and behaviours of baby boomer and older women living in urban and rural areas of Manitoba. More specifically, we explored their attitudes towards and barriers of healthy eating, factors that influence food choices, and their attitudes towards certain types of food products (namely, local, organic, functional foods, and diet products). To date, little attention has been given to the food and eating attitudes and behaviours of baby boomers. This paper adds to the existing literature by exploring how baby boomer women (and their older counterparts) make sense of eating and food choices in today's complex sociocultural environment.

Healthy Eating & Food Choices

It was discovered that healthy eating is very important to baby boomer and older women, not only for their own health, but also for the health of their families. Many women had maintained their role as nutrition gatekeeper of the family and felt responsible for making healthy food decisions for their families. Women recognized the relationship between diet and health and often commented that when they eat well, they feel better. They also spoke of food as a means to control weight. Some were also

focused on improving their diet in order to prevent or manage certain disease states such as hypercholesterolemia or diabetes. To this end, the women in this study were very aware of the nutritional value of foods and were reading labels on a regular basis to help them make good food decisions. This was not surprising, as previous literature suggests that female gender and older age are associated with an interest in health and nutrition (e.g., Glanz, Basil, Maibach, Goldberg & Snyder, 1998), and that women tend to be more concerned with healthy diets than men (Berrigan, Dodd, Troiano, Krebs-Smith & Barbash, 2003).

In discussing what it means to eat healthy, a few key themes emerged. For these women, healthy eating consisted of variety, balance, and moderation. Many had a history of unsuccessful dieting and had learned that restriction was not the key to success. Thus, they were striving for balance and flexibility by including most foods in moderation. It is worth pointing out that this ‘all-foods-fit’ mentality (also referred to as the ‘total diet approach’) has been promoted by health and nutrition professionals for many years (Freeland-Graves & Nitzke, 2013). Despite their desire to get away from the overly restrictive dieting mentality, many women did make reference to ‘bad’ versus ‘good’ foods. There were definitely certain foods (e.g., bread, potatoes) that they considered to be ‘bad’ (detrimental to health), and they were making every effort to avoid or limit these foods. Other foods, such as vegetables, fruit, fish, and flaxseed, were seen as ‘good’ in that they contribute to health and well-being. Past research has commented on the tendency of women to judge and classify foods as good or bad based on their health-promoting status and relationship to body weight (Hayes, D’Anci & Kanarek, 2011). For a long time, nutrition researchers have been cautioning individuals about the danger of

this mindset that promotes all-or-none thinking, quick-fix diets, and disordered eating behaviours (e.g., binge eating to compensate for previous restriction) (Freeland-Graves & Nitzke, 2002).

Another theme that emerged was the importance of home-cooked meals prepared with natural, whole and unprocessed ingredients. Many women avoided processed foods as much as possible, and they made every effort to make homemade meals as often as they could. This aligns with the current consumer trends of looking for more ‘natural’ food products, free of chemical additives, which are considered to be healthier (Dickson-Spillman, Siegrist & Keller, 2011; Sloan, 2009). Among the older women there was a notable sense of nostalgia around home cooking, with many speaking fondly of the ‘ways of the past’ and expressing worry about the loss of cooking skills among the younger generation of women.

In general, the women were very aware of, interested in, and knowledgeable about nutrition and healthy eating. They had the knowledge and skills to eat healthy – they were fully aware of how to eat healthy and knew what foods they should be consuming. However, when asked if they are eating the way they want to eat, many said they were finding it difficult to eat as healthfully as they would like to. This reinforces the belief that knowledge does not always equal behaviour. That is, having a high level of nutrition *knowledge* does not automatically equate to a healthier diet. There were many barriers that interfered with their ability to eat healthfully, including living alone (cooking for one), availability/access to food, cost, family preferences, dislike of cooking, emotional/comfort eating, lack of time, and preferences/behaviours of their husbands. These reported barriers are consistent with those previously reported in the literature

(Gustafsson & Sidenvall, 2002; Whiting et al., 2010; Welsh et al., 2012; Kearney & McElhone, 1999). Many women struggled to keep up with the busy and fast-paced nature of today's society, and found that they did not have the time or energy to do all of the work involved in food preparation. Baby boomer women, many of whom were still working and had children living at home, were having a particularly hard time balancing their priorities of work and having a home-cooked, healthy dinner on the table every night. The habits, behaviours and preferences of their husbands made things even more difficult. Many women found it difficult to eat the way they wanted while living with another person who didn't share the same goals or priorities. On the other hand, older women who were living alone missed the social aspect of shared meals and were finding it difficult to eat healthfully while cooking for one. Similar results were found in a qualitative study with older women, where women who were living alone lacked the motivation to cook, whereas women who lived with a partner struggled to resist the tempting treats their husbands desired (Gustafsson & Sidenvall, 2002).

Aside from health and nutrition, there were many different factors that influenced women's food choices. Taste, cost and nutrition emerged as the top priorities when shopping for foods; however, convenience (ease of preparation), brand loyalty, and media/advertising also played a role in food decisions. Similar to the findings of Slater et al. (2011) and Hammond & Chapman (2008), family preferences were also a major consideration when choosing what foods to buy and prepare, almost to the extent where women were willing to sacrifice their own preferences to make everyone else happy. Other researchers have also commented on the complex and multi-factorial nature of women's food choices (Williams et al., 2012; Hammond & Chapman, 2008; O'Mahoney

& Hall, 2007; Glanz et al., 1998). In general, the women in this study were looking for healthy, uncomplicated foods that taste delicious and provide good value for their money. Most were trying to stay away from processed and packaged foods and were reading food labels to help them make informed decisions.

A major theme that emerged when discussing their food choice influences was the confusion surrounding food and nutrition information. They felt overwhelmed by the sheer amount of nutrition information they received on a daily basis, felt confused about which foods and supplements they should or shouldn't be eating, and didn't know which sources to trust for reputable information. They desperately wanted clear, concise, and easily understandable information that would enable them to make the best choices for themselves and their families.

Food Product Attitudes

After talking more generally about eating and health, the women were asked to share their thoughts and opinions about certain categories of food items. Local foods were seen as very important for health, community growth, and economic sustainability, and many women were making a substantial effort to purchase local food products. Particularly for women in rural areas, local foods from farmers markets, nearby farms, personal gardens, and local produce suppliers (e.g., Peak of the Market) were a very important component of their diet. Eating locally was somewhat difficult in the winter because of the seasonal climate, but during the summer and fall months, the women took pride in supporting local food producers. This widespread support of local eating was

reflected in their questionnaire responses, in which 80% of women reported consuming local products at least once per week.

Organic foods were not consumed as often as local foods. There was a fair amount of skepticism and confusion surrounding organic farming practices, as well as organic food labeling and regulation. For these reasons, as well as the increased price, many women were choosing not to make organic foods a part of their daily diet.

Like organic foods, the topic of functional foods (FF) was met with a lot of confusion and a fair amount of skepticism. In general, women said they were willing to try these products, but did not feel overly attached to them. They admitted they would buy FF on occasion, for example, if they were on sale or if a product label caught their eye, but they weren't actively seeking them out. The general consensus was that FF products probably won't do any harm to health, but that they probably won't have much benefit either. In general, most women would prefer to get their nutrition through eating a healthy diet consisting of whole foods and 'natural' ingredients. Several women said that they already boost the nutritional value of their foods by adding certain ingredients at home (e.g., flaxseed, Bran Buds, whey powder). The attitudes towards FF expressed in this study are similar to those reported in past European studies, where consumers are somewhat skeptical of health claims and would prefer to get added nutrition from natural and less-processed foods (Niva, 2007; Urala & Lähteenmäki, 2004; Landström, Hursti & Magnusson, 2009).

A fairly large proportion of women in this study were engaged in some sort of dieting behaviour in their effort to lose weight. Many others were simply 'trying to limit' or 'cutting back' their intake in order to maintain a healthy weight. Beyond their weight

loss goals, many women were also trying to manage existing health conditions, such as high cholesterol, high blood pressure, or type II diabetes. It is not surprising, then, that a fair number of women were choosing so-called ‘diet’ food products that might help them with their health and weight loss goals. These women said that they personally use these products to help cut back on fat or calories, but would never force them upon guests or other family members. The general consensus was that they’re worth a try, but that they would not continue to buy them if the taste or texture was lacking. In fact, the poor taste and texture was the main reason that some women refused to use these products. Many women said they would prefer to eat the ‘real’ (i.e., full-fat) thing and just use less as opposed to eating a less-than-satisfactory product that leaves you wanting more. There was also a lot of frustration surrounding nutrient replacements, in which a particular product would be lower in one nutrient (e.g., fat), only to be discovered to be higher in another (e.g., sugar). Throughout all of the discussions pertaining to organic, functional and diet foods, it became pretty clear that women were fed up with misleading labelling and sensationalized marketing, and would prefer to make things from scratch, whenever possible.

Implications

The findings of this study have several important implications for dietetic practice and the local food industry.

Dietetic Practice

Registered Dietitians are the go-to health professionals for information about food, nutrition and diet. Dietitians should be aware that most baby boomer and older women do not have a lack of food and nutrition knowledge. In fact, many are very attentive to and knowledgeable about healthy eating. In fact, the larger problem may be information overload. Many women in this study felt overwhelmed with the amount of nutrition information they receive, were frustrated with the amount of conflicting information, and were confused about what or who they should be listening to. Dietitians have a key role in providing nutrition information to their clients and to the public, and should make every effort to disseminate clear, evidence-based and easily understandable information. In today's context of mass media and information-overload, dietitians need to figure out ways to position themselves as easily-accessible and credible experts in nutrition. Dietitians also need to become more familiar with new and emerging food categories, such as organic and functional foods so that they are able to address misconceptions and provide clients with appropriate, understandable, and evidence-based recommendations. As these new product categories continue to grow in popularity and market share, dietitians will need to be equipped to educate and inform the public regarding their use and value for individual and population health.

At the basic level, these women knew how to eat healthfully; clearly, lack of knowledge is not the issue when it comes to their diets. Rather, this study demonstrates that these women experience many other barriers when it comes to healthy eating. Thus, instead of just disseminating nutrition education, dietitians need to adopt more client-centered counselling approaches that recognize the unique situation and circumstances of

each client. Dietitians need to acknowledge the difficulty of making lifestyle changes, and provide individualized and empathetic counselling and support. Nutrition counselling should focus on client-centered goal setting and the identification of strategies to help overcome personal barriers. Given that many women seem to struggle with food and eating, dietitians should be aware of the dieting mentality and be prepared to discuss effective ways of handling negative emotions, so that food does not become an emotional crutch or coping mechanism. Nutrition professionals can also discourage dichotomous thinking (i.e. ‘good’ vs. ‘bad’ foods, all-or-nothing diet plans), and promote healthful diets with an emphasis on enjoyment and variety, not restriction.

Finally, there is a clear need for more nutrition services and programs in rural areas of Manitoba. Women in rural areas wanted access to reputable nutrition information and services, but felt that there was nowhere they could go. This often resulted in them turning to the internet or popular diet programs for answers to their food and eating issues. They also expressed interest in community-based food and nutrition programming (e.g., cooking classes, heart health classes, etc.). The development of rural programs that target the specific nutritional needs, concerns and barriers of baby boomer and older women would be hugely beneficial for improving the overall health and well-being of this demographic group.

Local Food Industry

Baby Boomers are a lucrative consumer group that holds great economic power (Pak & Kambil, 2006). Baby boomer and older women, in particular, have substantial influence over the food industry because they remain the primary food providers of

households (Heslop et al., 2006; Beagan et al., 2008; Polegato & Zaichkowsky, 1999). Thus, in order to stay competitive, food producers, product developers, and marketing agencies need to understand what baby boomer and older women want from food products and ultimately, re-evaluate their product development and marketing strategies in order to meet the needs of this distinctive cohort of women.

As demonstrated by this study, food and nutrition-related attitudes play an important role in food purchasing and consumption habits of baby boomer and older women. Food producers should take note of the fact that these women are looking for healthy and tasty items that provide good value for their money. These women are very attentive to nutritional content, read food labels, and are trying to avoid overly processed foods, in favour of ‘wholesome’ and natural ingredients. They also value local foods and ingredients and seek these products out on a regular basis. A subset of baby boomer women are also looking for healthy convenience products that help them achieve their healthy eating goals, while also limiting the amount of time spent on food preparation. Older women who live alone are looking for smaller packaging and easy-to-cook meals that are tasty, but appropriately sized for one person.

In short, local food producers and developers could utilize these findings to acquire a more accurate consumer profile of baby boomer women, and then develop products that receive greater consumer acceptance. This will, in turn, benefit baby boomer women who are seeking food products that meet their specific needs and preferences. Food producers also need to be aware that many consumers are looking for health-promoting foods, but at the same time, have great skepticism towards and distrust of product claims. As such, food producers should continually strive to improve the

clarity and truthfulness of product packaging and should avoid the use of sensationalized and false nutrition claims in the marketing of their products.

Limitations

This study is somewhat limited by its sampling techniques and sample composition. First of all, the sample was not random, and therefore, is not representative of the general population. There is also the possibility of sampling bias, in that women who expressed interest in participating in this study may have been those with a preexisting interest in or experience with eating issues. Given that the eligibility criteria excluded male participants, this study only represents the female perspective.

Furthermore, the majority of participants in this study were Caucasian and from middle-class households. Thus, the experiences and voices of ethnic minorities and individuals across the socioeconomic spectrum were not well represented in this study.

The presence of the researcher, who is a Registered Dietitian, could have limited the types and depth of responses obtained through the focus groups. Past research suggests that the presence of a health professional can make some people embarrassed and cause them to withhold, disguise, or exaggerate certain attitudes, opinions or experiences. Social desirability bias (wanting to avoid criticism) and social approval bias (seeking praise) are two additional problems involved with obtaining data related to food and eating, especially among women (Hebert et al., 1997).

CONCLUSION

In conclusion, healthy eating is very important to baby boomer and older women, both for themselves and for their families. Many of them have the basic knowledge to make healthy choices, but they experience numerous barriers and challenges that interfere with their ability to eat the way they would like to. Baby boomer and older women also tend to have very specific food habits, preferences and attitudes that influence how they interact with food on a daily basis. They value 'natural', wholesome, homemade, and unprocessed local foods, and are looking for healthy, uncomplicated foods that taste delicious and provide good value for their money. At the same time, they feel overwhelmed by the amount of nutrition information they received on a daily basis and have much skepticism and distrust of product claims and marketing strategies. They want clear, concise, and easily understandable information that would help them make the best choices for themselves and their families. The results of this study have important implications for dietitians as well as local food producers.

CHAPTER 6

General Discussion

DISCUSSION

The overarching objectives of this study were to (1) explore perceptions and experiences related to body dissatisfaction, aging, and the use of body work practices, and (2) explore healthy eating attitudes and barriers, food choice influences, dieting behaviours, and food product usage/attitudes among baby boomer and older women. A mixed-methods approach, with a slightly greater emphasis on the qualitative component, was used to explore these topics with 137 women ages 46 to 84 years from across urban and rural areas of Manitoba.

The results of this study have been presented as two stand-alone research papers. The first paper (Chapter 4) addresses the first objective by focusing on the results pertaining to body dissatisfaction, concerns about and experiences with aging, and the use of body work practices (including dieting and anti-aging products). This paper explored the connections between aging and the body, examined the meanings that women construct and ascribe to their aging bodies, and identified the various behaviours that they adopt in an effort to manage their bodies. It was discovered that perceptions of and attitudes towards the body are extremely varied, unique, personal, and complex – a result of individual circumstances, decisions, values, and experiences.

In general, body dissatisfaction is an issue among baby boomer and older women in Manitoba, especially when framed in terms of weight or specific body parts. When it comes to overall appearance, however, most women seem to be fairly satisfied and ‘make

do' with what they have. There were no significant differences in BD based on demographic factors, such as income, education level, relationship status, age category, or location of residence. Not surprisingly, it was found that women with a higher BMI tend to be more dissatisfied with their bodies.

It was also discovered that the experience of aging is intricately connected to body image. Age-related changes in appearance and functioning can be overwhelming and can cause a fair amount of stress in women's lives. In general, women are very concerned about aging, not only because of their changing appearance (e.g., wrinkles, greying hair, weight gain), but also due to changes in functioning, mobility, health, and independence. Overall, appearance is very important to baby boomer and older women, especially outside of the home. Women recognize the value of maintaining an 'acceptable' outward appearance and do their best to look 'neat and tidy' in the presence of others. In order to maintain their appearance and minimize the signs of aging, baby boomer and older women engage in a variety of body work practices, including dieting, exercise, supplements, skin care regimes, hair dye, make-up, and specific clothing choices. When choosing their body work practices, women strive to look as 'natural' as possible. In addition to the appearance benefits, these products and practices can also increase a woman's inner confidence and sense of control.

Dieting was found to be a common response to body dissatisfaction, with over half of the sample engaging in some sort of dieting behaviour over the past year. Baby boomer women and those in urban areas were significantly more likely to have used a formal diet plan/program (e.g., Weight Watchers) within the past five years than older women and women in rural areas. Some women cycle on and off formal diet plans and

programs, whereas others are constantly exercising self-control and restraint over their intake. Some women are caught up in a negative dieting mentality that promotes restriction, deprivation, and feelings of guilt. It was fairly clear that most women who diet do not achieve long-term success, and many end up feeling frustrated and discouraged. A fair number of women have struggled with weight issues throughout their entire lives and are caught up in repetitive yo-yo dieting and weight cycling. It was found that women who had dieted within the past year had a higher BMI, on average, than those that did not diet – a finding that is congruent with previous studies on the effects of dieting.

The second paper (Chapter 5) addresses the second research objective by focusing on the results pertaining to healthy eating, food choices, and food product attitudes. This paper examined attitudes towards food and nutrition and explored how baby boomer women and their older counterparts make sense of eating in today's complex sociocultural environment. Overall, healthy eating is very important to baby boomer and older women, both for themselves and their families. Healthy eating is considered to be important for disease prevention, weight management, successful aging, and overall well-being. Women feel responsible for the health and well-being of their families and want to be healthy role models for their children and grandchildren.

When it comes to their diets, women strive for balance and moderation. Women consider homemade meals to be at the root of healthy eating and do their best to cook from scratch as often as possible. They value wholesomeness, real foods, and natural ingredients and try to avoid processed foods to the best of their ability. In general, baby boomer and older women are very knowledgeable about nutrition and as a result, they

pay close attention to the nutritional value of foods. They refer to foods as ‘good’ or ‘bad’ and do their best to consume more of the ‘good’ ones (e.g., vegetables, fruit, lean proteins, flax) while limiting the ‘bad’ (e.g., bread, potatoes, red meats). Many of them read nutrition labels in their effort to avoid certain nutrients of concern (e.g., sodium, sugar, saturated/trans fats, carbohydrates) and get more of others (e.g., fibre, calcium, vitamin D). In addition to nutrition, baby boomer and older women take many other factors into consideration when making food-related decisions, such as food cost, level of convenience, brand preferences/familiarity, quality (taste), family influences/preferences, and ongoing health issues (e.g., high cholesterol). Accommodating the preferences of other family members is a major consideration, and at times, the source of much stress and frustration. Overall, women are looking for healthy, simple, unprocessed, easy-to-prepare foods that taste delicious and provide good value for their money.

The majority of baby boomer and older women in this study have the knowledge and skills to eat healthfully. However, they also experience numerous barriers and challenges that interfere with their ability to eat the way they would like to. Some of the more common barriers include lack of time (particularly for working women), cooking for one (an issue for women who live alone), accommodating family preferences, the food habits and behaviours of husbands, the availability of healthy foods, a dislike of cooking, social situations that revolve around food, personal preferences/habits, and emotional eating issues. The women also feel overwhelmed by the amount of nutrition information they receive on a daily basis and often feel confused about certain nutrition recommendations. They want clear, concise and easily understandable information that will help them make the best choices for themselves and their families.

Baby boomer and older women have very specific preferences and attitudes when it comes to certain categories of foods. Local foods were seen as very important for health, community growth, and economic sustainability, and many women were making a substantial effort to consume local foods on a regular basis. In contrast, organic eating was not a main priority, partly because they cost more than non-organic foods. There was also a fair amount of skepticism and confusion surrounding the farming and labeling of organic foods. Rural women consumed local and organic foods more often than urban women. Attitudes towards FF and diet products were mixed. Baby boomer and older women do purchase FF on occasion, but do not feel overly attached to them. Women are generally not opposed to these products, but do not go seeking them out on a regular basis. Urban women were significantly more likely than rural women to consume FF products on a regular basis. In general, the women from rural areas stated that they would prefer to get their nutrition through whole foods and ‘natural’ ingredients. Diet products were seen as potentially useful for reducing fat/calorie intake, but many women were disappointed in their lack of taste/texture and frustrated by the tendency of food producers to substitute one ‘bad’ nutrient for another. There were no differences in frequency of consumption of diet products between baby boomer and older women and those living in urban versus rural areas.

Together, these two papers provide an in-depth examination of the body image perceptions, aging experiences, eating behaviours, and food attitudes of baby boomer and older women living in urban and rural Manitoba. Ultimately, it was discovered that body image, aging, and food are intricately linked in women’s lives. Body image is intimately connected to the experience of aging, and age-related changes in appearance and

functioning can influence body image perceptions and evaluations. Food is also related to women's body image. Women are keenly aware of the relationship between eating and body weight and many are engaged in some sort of dieting or dietary restraint in an effort to lose weight and improve their body image.

Overall, body dissatisfaction, concerns about aging, weight issues, and dieting failures seem to be a common experience among baby boomer and older women. In general, these women experience many different pressures when it comes to their health and their bodies. As a result, their relationships with their aging bodies and with food are often fraught with a considerable amount of stress and anxiety. Many struggle to eat healthfully, age successfully and maintain a positive body image in the context of today's sociocultural environment. And yet, despite these ongoing challenges, many women show undercurrents of strength, resilience, and self-acceptance. As a group, they are very knowledgeable, skilled, resourceful, and self-aware of their daily challenges and ongoing barriers. These women are truly doing their best to be healthier, happier, and more self-accepting, and they want to be positive role models for future generations of women.

This research has made an important contribution to the growing body of literature on body image and aging by including baby boomer women as the population of interest. This thesis adds value and insight to the conversation by exploring the connections between aging, food, and the body, from the perspectives of baby boomer women and their older counterparts.

LIMITATIONS OF STUDY

This study is somewhat limited by its sampling techniques and sample composition. As is usually the case with qualitative and mixed-methods research, a combination of convenience and snowball sampling techniques were used to recruit participants. Thus, the sample was not randomly selected, and therefore, may not be representative of the general population. There is also the possibility of sampling bias, in that women who volunteered to participate in this study may have been those with a pre-existing experience with body image issues and/or a strong interest in food and nutrition. Given that the eligibility criteria excluded male participants, this study only represents the female perspective. Furthermore, the majority of participants in this study were Caucasian and from middle-class households. Thus, the experiences and voices of visible minorities and low-socioeconomic groups may not be well represented.

One of the inherent limitations of focus groups is that not all participants are equally articulate and perceptive, and therefore, there is the risk of missing out on certain individuals' equally important contributions. In some groups, there were one or two individuals that liked to monopolize the discussion. The moderator did their best to manage these group dynamics, but in some cases where the rest of the group members were quiet, one or two voices dominated. Each focus group had seven to twelve participants. Given the complexity of the topic, the moderator had to be more careful with the time in the larger groups. As a result, not everyone was able to elaborate as much as they may have liked. Given that each session could only last for a predetermined amount of time, the desire to solicit responses from everyone in the group may have resulted in a lack of depth in some responses. In future work, it will be important to limit the size of

the group to no more than eight to ten people so that the researchers are better able to elicit in-depth responses on the topic at hand.

Another factor that could have limited the types and depth of responses received was the presence of the researcher, who is a Registered Dietitian. While every effort was made to create a warm, welcoming, and non-judgmental atmosphere, there is always the possibility that some participants will feel slightly intimidated by the presence of a health professional. Past research suggests that the presence of a health professional can make some people embarrassed and cause them to withhold, disguise, or exaggerate certain attitudes, opinions or experiences. Social desirability bias (wanting to avoid criticism) and social approval bias (seeking praise) are two additional problems involved with obtaining data related to food and eating, especially among women (Hebert et al., 1997).

IMPLICATIONS OF STUDY

The findings of this study have several important implications for health care, dietetic practice, community programs, as well as the local food industry.

Health Care

All health care professionals must be aware of body dissatisfaction, aging concerns, and dieting among baby boomer and older women, and should be trained to deal with these issues appropriately. In all areas of practice, health care professionals should be sensitive and empathetic to women's needs, concerns, and circumstances as they age. Health care professionals who work with middle-aged and older adults must consider the effects of aging, illness, and chronic conditions on self-image and body

satisfaction. Professionals must also be aware that life transitions, such as menopause, loss of spouse, and disability can greatly affect a woman's body image and eating behaviours. If health care professionals are made aware of the body image and aging issues experienced by women, they will be more equipped to recognize potentially dangerous attitudes/behaviour and provide effective counseling (both preventative and treatment-based) in an empathetic and appropriate manner.

Health professionals must also be sensitive when counseling clients about their weight. Clearly, weight gain affects many Canadian adults and obesity is a significant public health concern that should not be ignored. As evidenced by this study, many women have had life-long struggles with weight and dieting, and thus, health professionals must approach this topic with sensitivity. When providing any sort of weight loss education or counseling to baby boomer and older women it is important for health professionals to maintain a positive, non-judgmental practice environment that respects the uniqueness, diversity, and body sensitivities of each and every client. Whenever possible, health professionals should focus on promoting healthy lifestyle behaviours instead of achieving an 'ideal' weight through unsustainable quick-fix solutions. By taking the focus off of weight, body dissatisfaction, self-objectification, weight preoccupation, and habitual body monitoring can all be reduced. There is a fine balance between promoting healthy weights and perpetuating weight preoccupation and disordered eating among women. Brandsma (2007) emphasizes that "professionals need to be sensitive to the data on the pernicious effects of dietary restraint, yet be cautious about undermining efforts at appropriate weight control" (p. 166).

Lastly, health professionals should be trained to assess the presence of BD and disordered eating among middle-aged and older female clients, as recognition is the first step to appropriate treatment. Currently, many eating disorders go un-noticed among older individuals (Lapid et al., 2010). This is most likely due to the fact that the physical signs of eating disorders are non-specific, and may be overlooked in the presence of other illnesses and health concerns. Early identification of body image disturbances and dieting behaviour has the potential to prevent the development of dangerous eating disordered behaviours.

Dietetic Practice

Dietitians are the go-to health professionals for information about food, nutrition and diet. Thus, the results of this study have implications for dietitians that provide nutrition counseling to baby boomer and older women. It is important to recognize that most women in this age group do not have a lack of food/nutrition knowledge. Many are very attentive to and knowledgeable about healthy eating. In fact, the larger problem may be information overload. Many women in this study felt overwhelmed with the amount of nutrition information they receive, were frustrated with the amount of conflicting information, and were confused about what or who they should be listening to. Dietitians have a key role to play in providing nutrition information to their clients and to the public, and should make every effort to disseminate clear, evidence-based and easily understandable information. In today's context of mass media and information-overload, dietitians need to figure out ways to position themselves as easily-accessible experts in nutrition. Dietitians also need to become more familiar with new and emerging food

categories, such as organic and functional foods so that they are able to address misconceptions and provide clients with appropriate, understandable, and evidence-based recommendations. As these new product categories continue to grow in popularity and market share, dietitians will need to be equipped to educate and inform the public regarding their use and value for individual and population health. Dietitians also have a role to play in terms of advocating for healthier food environments and systems for all Canadians.

In general, baby boomer and older women know the basics of healthy eating. They are aware of what foods they *should* be eating, appropriate portion sizes, and the basics of healthy shopping and cooking. They also know how to read food labels and are aware of what nutrients they should pay attention to. Thus, when discussing ways to target issues of overweight and obesity among middle-aged and older women, clearly, a lack of knowledge about healthy eating is not the primary issue. There is a clear distinction between having nutrition knowledge and being able to make long-term behavioural changes. As evidenced by this study, baby boomer and older women experience many other barriers that interfere with their ability to make healthy behaviour changes. Thus, instead of just disseminating nutrition information, dietitians need to adopt more client-centered counselling approaches that recognize the unique situation and circumstances of each client. Dietitians need to acknowledge the difficulty of making lifestyle changes, and provide individualized and empathetic counselling and support. Nutrition counselling should focus on client-centered goal setting and the identification of strategies to help overcome personal barriers.

Lastly, when providing nutrition counseling to baby boomer and older women, it is important for dietitians to maintain a positive, non-judgmental practice environment that respects the uniqueness and diversity of each client. It is important for dietitians to recognize that many clients have struggled with weight their entire lives, have tried repeatedly to lose weight without success, are caught up in self-defeating cycles of yo-yo dieting, and have developed dysfunctional relationships with food. Given that many women seem to struggle with food and eating, dietitians should be aware of the dieting mentality and be prepared to discuss effective ways of handling negative emotions, so that food does not become an emotional crutch or coping mechanism. Nutrition professionals can also discourage dichotomous thinking (i.e. ‘good’ vs. ‘bad’ foods), and promote healthful diets with an emphasis on enjoyment and variety, not restriction.

Community Health Promotion

Community-based organizations (such as seniors centres) could utilize the results of this study to help develop resources, workshops, and programs that address healthy aging, provide appropriate and meaningful nutrition education, and ultimately, promote healthy lifestyles and body attitudes among baby boomer and older women. All women need to be educated regarding healthy body weights, ‘normal’ aging, the dangers of quick-fix diets, and the negative health outcomes of chronic dieting and weight cycling. These programs should promote all aspects of health (spiritual, emotional, social, and physical), as well as functional ability, skill development, and personal growth. Community programs may be the perfect place to provide this type of education, since

health professionals often have very limited time to discuss these sorts of deeper issues in the clinic setting.

Group workshops and activities that allow participants to share personal stories, experiences and opinions among a group of women who are at similar life stages may be very ‘therapeutic’ for those involved. By discussing commonly experienced issues in a social environment, women may realize that they are not alone in their thoughts about body image, concerns about appearance, and fears of aging. This sense of community could serve as a valuable social support network for vulnerable women who are struggling with BD. Community programs that adopt a holistic, health-centered approach can help women to develop a sense of self-esteem and self-worth that is based on more than their outward appearance. These sorts of community initiatives can have major positive impacts on the body image and quality of life of baby boomer and older women.

Finally, there is a clear need for more nutrition services and programs in rural areas of Manitoba. In this study, women in rural areas desperately wanted access to reputable nutrition information and services, but felt that there was nowhere they could go. This often resulted in them turning to the internet or popular diet programs for answers to their food and eating issues. They also expressed interest in community-based food and nutrition programming (e.g., cooking classes, heart health classes, etc.). Group programs that center around cooking and social interaction promote eating in a positive and pleasant environment, while providing a sense of social support and community. The development of rural programs that target the specific nutritional needs, concerns and barriers of baby boomer and older women would be hugely beneficial for improving the overall health and well-being of this demographic group.

Local Food Industry

Baby Boomers are a lucrative consumer group that holds great economic power (Pak & Kambil, 2006). As such, the aging of baby boomers is expected to have a substantial effect on Canadian society, including food systems and consumption trends (Agriculture and Agri-Food Canada, 2005; Agriculture and Agri-Food Canada, 2009). Baby boomer and older women, in particular, have substantial influence over the food industry because they remain the primary food providers of households (Heslop et al., 2006; Beagan et al., 2008; Polegato & Zaichkowsky, 1999). Thus, in order to stay competitive in the current market, food producers, product developers, and marketing agencies need to understand what baby boomer and older women want from food products and ultimately, re-evaluate their product development and marketing strategies in order to meet the needs of this distinctive cohort of women.

As demonstrated by this study, food and nutrition-related attitudes play an important role in food purchasing and consumption habits of baby boomer and older women. Food producers should take note of the fact that these women (who are doing the majority of household food shopping) are looking for healthy and tasty items that provide good value for their money. These women are very attentive to nutritional content – they read food labels and are trying to avoid overly processed foods in favour of ‘wholesome’ and natural ingredients. They also value local foods and ingredients and seek these products out on a regular basis. A subset of baby boomer women are also looking for healthy convenience products that help them achieve their healthy eating goals, while also limiting the amount of time spent on food preparation. Older women who live alone

are looking for smaller packaging and easy-to-cook meals that are tasty, but appropriately sized for one person.

In short, local food producers and developers could utilize these findings to acquire a more accurate consumer profile of baby boomer women, and then develop products that receive greater consumer acceptance. This will, in turn, benefit baby boomer women who are seeking food products that meet their specific needs and preferences. Food producers also need to be aware that many consumers are looking for health-promoting foods, but at the same time, have great skepticism towards and distrust of product claims. As such, food producers should continually strive to improve the clarity and truthfulness of product packaging and should avoid the use of sensationalized and false nutrition claims in the marketing of their products.

FUTURE WORK

As a result of this study, there are several different avenues for future research on this topic. This study has been one of the first to explore the body image, aging and food attitudes and experiences of baby boomer women. Given the relative size and influence of the baby boomer cohort, more research with this unique population group is needed.

As was identified in the limitations section, more work is needed to explore the body image, aging and food issues of other population groups, for example, men and individuals of differing sexual orientations. While an increasing amount of work is being done to explore the body image/aging issues of men, more work in this area is needed to elicit older men's experiences. Future work in this area should strive to include a greater diversity of ethnic and cultural groups, as well as individuals from across the

socioeconomic spectrum. There is also a need for more aging and nutrition-based research in rural and remote areas of Canada.

In continuing research on this topic, it will also be important to move beyond an assessment of the problem to potential solutions. Future research should explore how and why certain people are able to maintain a positive body image throughout life and into old age. Future research could also focus on identifying the facilitators of healthy eating among baby boomer and older women. Another avenue for future work is the development and testing of an educational/training module for Registered Dietitians (or dietetic students) that focuses on the increasing awareness of body image and eating issues of clients and providing training for appropriately addressing these issues in a counseling setting. The goal of this sort of work might be to educate and enable current and future dietitians to provide nutrition counselling to middle-aged and older women in a way that minimizes body dissatisfaction, increases self-esteem and self-efficacy, prevents disordered eating, and promotes successful aging.

There is also a need for intervention research in this area; that is, studies that develop and evaluate the effects and benefits of health and social programs/services targeted towards middle-aged and older women. The ultimate goal of future investigations should be to identify best practices for improving the nutritional health, overall well-being and quality of life of middle-aged and older women who are struggling with body image, aging, weight, and nutrition issues.

TAKE AWAY POINTS

1. Baby boomer and older women experience many competing pressures and challenges when it comes to their aging bodies, their diets, and their overall well-being. Many women experience body dissatisfaction, concerns about aging, and weight issues into later life. These women struggle to eat healthfully, age successfully and maintain a positive body image in the context of today's complex sociocultural environment.
2. Body image, aging and food are intricately connected in women's lives. That is, (a) feelings about the body are closely connected to the experience of aging; (b) age-related changes in appearance influence body image; (c) dieting is used as a means of altering the body; and (d) food attitudes/choices are intertwined with beliefs about weight and health.
3. Baby boomer and older women engage in a variety of body work practices, including dieting, in an effort to alter their appearance, minimize signs of aging, control their weight, increase their inner confidence, and ultimately, maintain their social value.
4. Healthy eating is very important for baby boomer and older women, both for themselves and their families. Women feel a responsibility to provide homemade, nutritious and satisfying meals for their families. They value natural, wholesome and unprocessed foods and are looking for healthy, simple foods that taste delicious and provide good value for their money.
5. Local foods are seen as important, not only for individual health, but also for economic development and community support. Organic foods and functional

foods are not consumed as often as local products, partly due to their increased price and skepticism surrounding their claims. Some women use diet products to help cut back on fat and calories, but lack of taste and poor texture are seen as major issues with this product category.

6. Many baby boomer and older women have the knowledge and skills to eat healthfully, but they experience numerous barriers and challenges that interfere with their ability to eat the way they would like to. In addition to the common barriers of family preferences, cost, cooking for one, and lack of time, nutrition information overload is also a notable problem.
7. Food and eating issues, coupled with concerns about health and aging, cause a fair amount of tension, stress and anxiety in the lives of women. Many women have had life-long struggles with their weight, which has resulted in a potentially harmful pattern of yo-yo dieting, weight cycling, and emotional eating.
8. Despite ongoing stress related to aging, food and health, many women show signs of strength, resilience, and self-awareness. They are doing their best to be healthier, happier and more self-accepting, and they strive to be positive role models for future generations of women.

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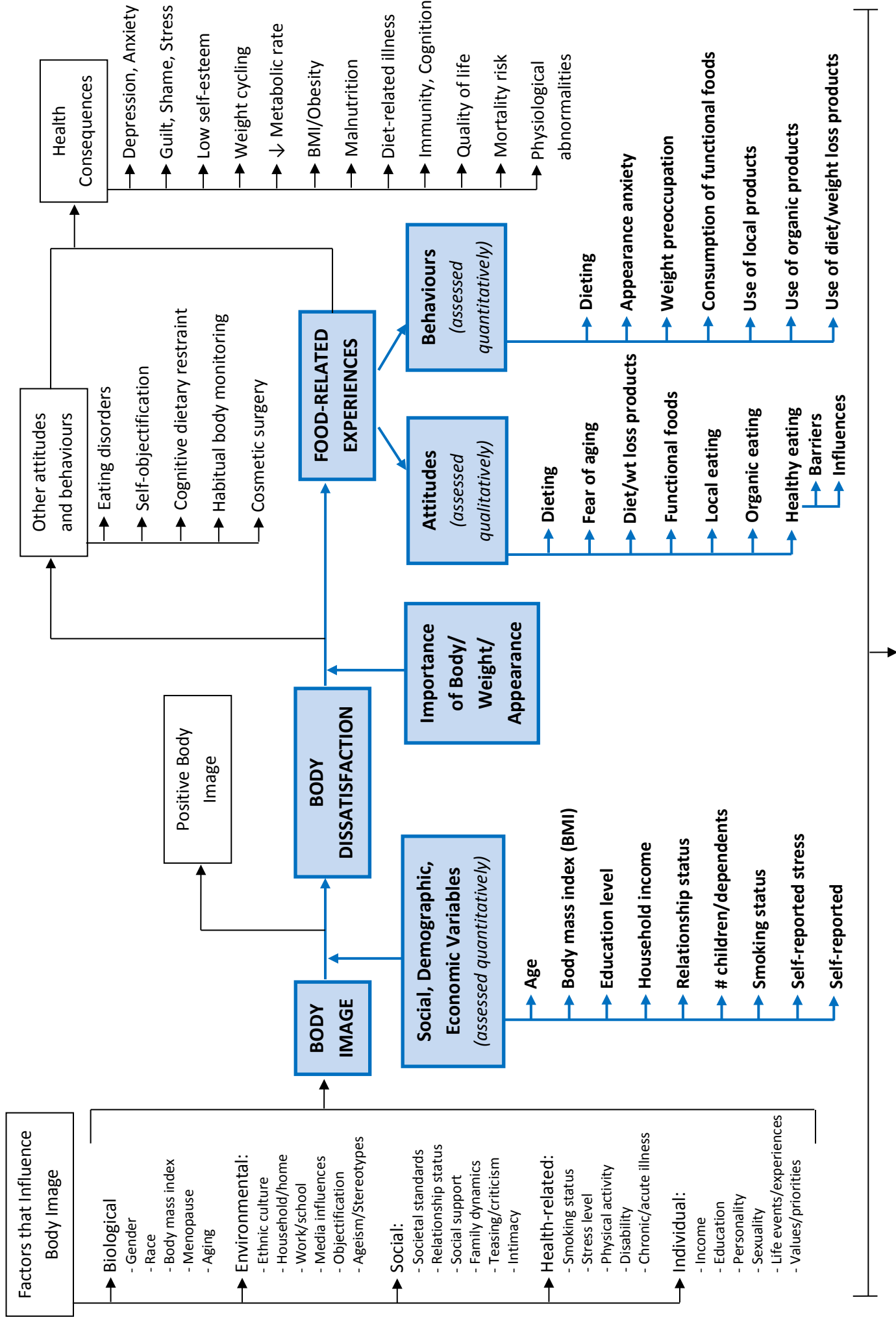
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APPENDIX A

Guiding Framework

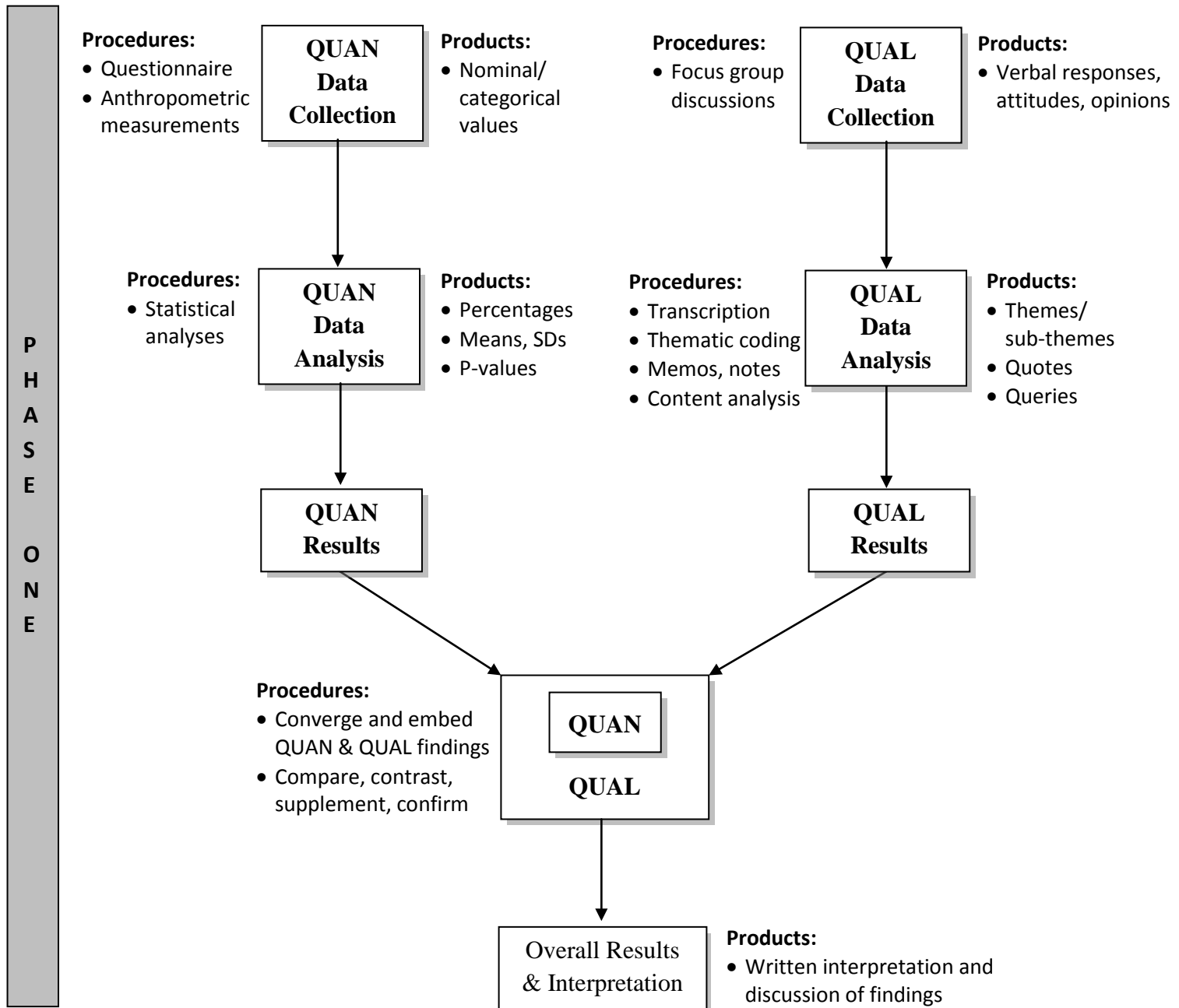


Implications for Health Care, Dietetic Practice, Public Policy & Food Industry

APPENDIX B

Mixed-Methods Study Design

**Visual Diagram of the Quantitative & Qualitative Procedures Used in Proposed Study
Using a Mixed-Methods Concurrent Research Approach: Single Phase Embedded Design**



QUAN = Quantitative

QUAL = Qualitative

* Adapted from Creswell & Clarke (2007)

APPENDIX C
Recruitment Poster

Participants Needed for A University of Manitoba Research Study!



We are seeking opinions about body image, body weight, dieting and nutrition. We also want to explore eating patterns, food choices, and concerns about aging.

You are eligible to participate if you meet the following criteria:

- Born before the year 1966
- Live in Manitoba and speak English fluently
- Can attend a 1 ½ – 2 hour focus group session
- Can fill out a brief survey with questions about body satisfaction, dieting, aging concerns and food choices
- Only one participant per household

After completion of the questionnaire and focus group, participants will receive an honorarium of \$25 in the form of a gift certificate to a local grocery store, as a token of appreciation.

**For more information, contact: Catherine Marshall
at (204) 474-6051 or body_image@ymail.com**



UNIVERSITY
OF MANITOBA

APPENDIX D

Letter to Manitoba Women's Institute Representatives



UNIVERSITY
OF MANITOBA

Faculty of Human Ecology
Human Nutritional Sciences

418 Human Ecology Bldg.
University of Manitoba
Winnipeg, MB, R3E 3N4
Phone: (204) 474-6051
Fax: (204) 474-7592

Dear NAME,

My name is Catherine Marshall – I am the primary investigator on the research study titled “Influence of Body Image on Food Choices of Baby Boomer and Older Women”. My advisor is Dr. Christina Lengyel at the University of Manitoba. I will now be the primary contact person, should you have any questions about the study or your responsibilities.

First of all, I would like to thank you for your interest in and willingness to help out with this study. Not only will your help assist me in completing my graduate thesis, but it will also help to shed light on an issue that, up until this point, has not been well researched.

The purpose of this letter is to explain the project, your role, and participant recruitment procedures. I apologize in advance for the length of this letter, but please take the time to read the following information carefully, as it contains important details about the study procedures.

Information about Study:

The purpose of this study is to (a) explore body image perceptions, body/weight satisfaction, concerns about aging, and attitudes towards nutrition and dieting and (b) examine how these factors influence food choices and eating behaviours. The study involves three components:

1. *Questionnaire:* Each participant will receive a questionnaire by mail. They will be asked to complete the questionnaire at home and bring it to the focus group session. The questionnaire will gather information pertaining to: demographics, body image perceptions, body/weight satisfaction, concerns about aging/appearance, dieting behaviours, eating behaviours, food choices, and preferences for local, organic, functional, and diet products.
2. *Focus Groups:* We will be holding two focus groups in each region, one with baby boomer women (ages 46 to 65) and one with older women (ages 66+). Each focus group will be approximately 1½ to 2 hours in length, and will involve 8 to 10 women. The focus group questions and discussion will be used to explore body image perceptions, body/weight satisfaction, concerns about aging, attitudes towards nutrition and dieting,

and food choice behaviours. The session will be recorded on audio tape to facilitate data collection and analysis. Participants will be provided with beverages and snacks. There will be a total of 12 focus groups (6 regions, 2 groups per region).

3. *Body Measurements:* The height and weight of each participant will be measured at the start of the focus group session.

Your Role:

As the MWI Representative for the **INSERT REGION**, you will be helping us to:

- Recruit participants in your region (8-10 in each age group; total of 16-20 women)
- Schedule the focus group date, time and location
- Communicate the focus group date, time and location to participants
- Purchase beverages and snacks for the session (\$5.00 per participant). Invoices will be sent to Christina Lengyel and you will be promptly reimbursed.
- Purchase \$25 gift certificates (one for each participant) from a local grocery store. Invoices will be sent to Christina Lengyel and you will be promptly reimbursed.

We will be holding two focus groups in your region, one with baby boomer women* (born 1946 to 1965) and one with older women (born before 1946). Each age group must have at least 8 to 10 women.** (Thus, you will need to recruit a total of 16 to 20 women). Our hope is that we can have both focus groups on the same day, one in the morning, and the other in the afternoon. If a daytime session is not possible for the baby boomer group (e.g., for women who work during the day), we might be able to schedule that group in the evening. Focus groups will be scheduled in November and December of 2011. **We will contact you around the beginning of October to schedule a day for the focus groups.**

*Baby Boomer women (born 1946 to 1965) must be between the ages of 46 to 65 years as of December 31, 2011.

**Older women (born before 1946) must be 66 years of age (or older) as of December 31, 2011.

Participant Recruitment:

Please use the attached poster to recruit women in your region. This poster can be put up at community centres, libraries, stores, or other public places where women will see them. The poster highlights the topic of the study, the honorarium, and your contact information. You can also recruit participants by word-of-mouth (i.e., telling women you come into contact with). If someone has more questions about the study or wants to know what is involved, you can give them the attached information letter. At the bottom of the letter, I have included your contact

information (for them to sign-up) as well as mine (in case they have more specific questions about the study).

Please keep a list of potential/interested participants (including their name, birth date, mailing address, and phone number). Once a date has been scheduled for the focus group, you will need to contact each person to confirm that they are able to attend on that day. Once this is done, and you have a final list of participants (8-10 in each group), you can pass along the list to us. We will then be mailing each participant an information package, which includes a letter, consent form and a hard copy of the questionnaire.

Other Important Information:

It has come to my attention that you may have already been sent documents about this study (i.e., questionnaire, moderators guide, etc). These documents are for your information only, and should not be shared or distributed to the participants. This is extremely important, as we do not want participants to know the focus group questions in advance.

The findings from this study will be shared with the MWI in the form of a report and a research presentation at your annual convention.

Thank you again for your hard work and assistance with this project. We couldn't do it without you! If you have any questions about the study or information presented in this letter, please feel free to contact me at...

Phone: 204-474-6051

Email: body_image@ymail.com

With kindest regards,

Catherine Marshall

APPENDIX E

Recruitment Letter

October, 2011

Dear Participant,

Thank you for your interest in our study titled “Influence of Body Image on Food Choices of Baby Boomer and Older Women”. The purpose of this study is to (a) explore body image perceptions, body/weight satisfaction, concerns about aging, and attitudes towards nutrition and dieting and (b) examine how these factors influence food choices and eating behaviours. To participate in this study, you must be born before the year 1966 (i.e., will be 46 years or older by December 31, 2011). The study will involve the following:

- 1) *Focus Group*: You will attend a single focus groups session with 8 to 10 other female participants. The session will be no longer than 1½ to 2 hours. During the session, we will be exploring body image perceptions, body/weight satisfaction, concerns about aging, attitudes towards nutrition and dieting, and food choice behaviours. The session will be recorded on audio tape to facilitate data analysis.
- 2) *Questionnaire*: An anonymous questionnaire will be sent to you by mail and will gather quantitative information pertaining to: demographics, body image perceptions, body/weight satisfaction, concerns about aging/appearance, dieting behaviours, eating behaviours, food choices, and preferences for local, organic, functional, and diet products. You will be asked to complete the questionnaire at home and bring it with you to the focus group session.
- 3) *Anthropometric Measures*: Height and body weight will be measured at the start of the focus group session. This will be done off to the side or in a separate room so that participants cannot see or comment on each other’s measurements.

After completion of the entire study (focus group, questionnaire, and anthropometric measurements), you will receive an honorarium of \$25 in the form of a gift certificate for a local grocery store. Snacks and beverages will also be provided at the focus group session.

Results will not be reported by individuals' names nor will any names be associated with the results. Participants will be identified by number only. All data will be kept strictly confidential.

To enroll in this study, please contact **NAME** (Manitoba Women’s Institute Representative) at **PHONE #** or **EMAIL**. Any questions about the study procedures can be directed to Catherine Marshall (204-474-6051 or body_image@ymail.com) or Dr. Christina Lengyel (204-474-9554).

Thank you for your interest in this project.

Sincerely,

Catherine Marshall, BSc.(HNS)
Masters Student

Dr. Christina Lengyel, PhD., RD.
Advisor & Assistant Professor

APPENDIX F

Participant Letter



UNIVERSITY
OF MANITOBA

Faculty of Human Ecology
Human Nutritional Sciences

418 Human Ecology Bldg.
University of Manitoba
Winnipeg, MB, R3E 3N4
Phone: (204) 474-6051
Fax: (204) 474-7592
Email:body_image@ymail.com

Dear Participant,

October, 2011

Thank you for agreeing to participate in our study titled “Influence of Body Image on Food Choices of Baby Boomer and Older Women”. The purpose of this study is to (a) explore body image perceptions, body/weight satisfaction, concerns about aging, and attitudes towards nutrition and dieting of Baby Boomer and older women and (b) examine how these factors influence food choices and eating behaviours. To participate in this study, you must be born before the year 1966 (i.e., will be 46 years or older by December 31, 2011).

We are providing you with this information package, which consists of this information letter and a consent form. **Please read and sign the consent form at home and bring it with you to the focus group on DATE.** The study will involve the following components:

- 1) *Focus Groups*: You will attend a single focus groups session with 8 to 10 other female participants. The session will be no longer than 1½ to 2 hours. During the session, we will explore body image perceptions, body/weight satisfaction, concerns about aging, attitudes towards nutrition and dieting, and food choice behaviours. The session will be recorded on audio tape to facilitate data collection and analysis. Participants will be provided with beverages and snacks. A summary of the focus group results will be provided to you upon request.
- 2) *Questionnaire*: An anonymous questionnaire will be completed to quantify aspects of the discussion. The questionnaire will gather quantitative information pertaining to: demographics (age, income, education, etc.), body image perceptions, body/weight satisfaction, concerns about aging/appearance, dieting history, food choices, and preferences for local, organic, functional, diet, and anti-aging products. The questionnaire will be given to you at the beginning of the focus group session to fill out before the discussion starts. The questionnaire is anonymous (i.e., you will not be asked to put your name on it).
- 3) *Anthropometric Measures*: Height and body weight will be measured at the start of the focus group session. This will be done off to the side or in a separate room so that participants cannot see or comment on each other’s measurements.

Your focus group session will be held on **DATE** at **TIME** at **LOCATION** in **TOWN/CITY**. Snacks and beverages will be provided. After completion of the entire study (focus group, questionnaire, and anthropometric measurements), you will receive an honorarium of \$25 in the form of a grocery store gift certificate as a token of appreciation.

Results will not be reported by individuals' names nor will any names be associated with the results. Participants will be identified by a number only. All data will be kept strictly confidential by the researcher and under lock and key until published or for five years whichever is shorter. During the focus groups sessions, participants' will be asked to keep the information confidential; however, the researcher cannot guarantee that all participants will abide by this guideline.

If you are unable to attend your session, please contact **NAME** (Manitoba Women's Institute Representative) at **PHONE #** or **EMAIL**. Any questions about the study procedures can be directed to Catherine Marshall (204-474-6051 or body_image@ymail.com) or Dr. Christina Lengyel (204-474-9554).

Thank you for your time and assistance with this project.

Sincerely,

Catherine Marshall, BSc.(HNS)
MSc. Candidate

Dr. Christina Lengyel, PhD., RD.
Advisor & Assistant Professor

APPENDIX G

Consent Form



UNIVERSITY
OF MANITOBA

Faculty of Human Ecology
Human Nutritional Sciences

418 Human Ecology Bldg.
University of Manitoba
Winnipeg, MB, R3E 3N4
Phone: (204) 474-6051
Fax: (204) 474-7592
Email: body_image@ymail.com

CONSENT FORM

Project Title: “Influence of Body Image on Food Choices of Baby Boomer and Older Women”

Researchers: Catherine Marshall, BSc. (MSc. Student) & Dr. Christina Lengyel, PhD., RD.

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. Please take the time to read this consent form carefully and understand any accompanying information provided. If you would like more detail about something mentioned here, or would like additional information, please contact Catherine Marshall by phone (204-474-6051) or by email (body_image@ymail.com).

The purpose of this study is to (a) explore body image perceptions, body/weight satisfaction, concerns about aging, and attitudes towards nutrition and dieting of Baby Boomer and older women and (b) examine how these factors influence food choices and eating behaviours. This research project is being conducted in partial fulfillment of the requirements for a Master’s degree in Human Nutritional Sciences from the University of Manitoba. Funding for this project has been provided by the University of Manitoba SSHRC Research Grants Program.

The study involves the following:

- 1) *Focus Groups:* The single session you will be attending with approximately 8 to 10 other female participants will be no longer than 1½ to 2 hours. It will be used to explore body image perceptions, body/weight satisfaction, concerns about aging, attitudes towards nutrition and dieting, and food choice behaviours. The session will be recorded on audio tape to facilitate data collection and analysis. Participants will be provided with beverages and snacks.
- 2) *Questionnaire:* An anonymous questionnaire will be completed to quantify aspects of the discussion. The questionnaire will gather quantitative information pertaining to: demographics (age, income, education, etc.), body image perceptions, body/weight satisfaction, concerns about aging/appearance, dieting history, food choices, and preferences for local, organic, functional, diet, and anti-aging products. The questionnaire will be given to you at the beginning of the focus group session to fill out before the discussion starts. The questionnaire is anonymous (i.e., you will not be asked to put your name on it).
- 3) *Anthropometric Measures:* Height and body weight will be measured at the start of the focus group session. This will be done off to the side or in a separate room so that participants cannot see or comment on each other’s measurements.

After completion of the study (focus group, questionnaire and anthropometric measurements), you will receive an honorarium of \$25 in the form of a gift certificate for a local grocery store as a token of appreciation. To receive a summary of the results from the focus groups, complete the section at the end of this consent form (page 3).

No names will be associated with collected data and reporting will be done on a total group basis only. Data related to personal information and results obtained including audio tapes will be kept in a locked cabinet in a locked room for 5 years or until data are published, whichever comes first. All data and information of a personal nature will be shredded after the time has expired. During the focus group sessions, participants' will be asked to keep the information confidential; however, the researcher cannot guarantee that all participants will abide by this guideline.

Your signature on this form indicates that you have understood the information regarding participation in the research project and agree to serve as a participant. This does not waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and/or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so feel free to ask for clarification or new information throughout your participation. This study is being conducted by Catherine Marshall (204-474-6051 or body_image@ymail.com), under the supervision of Dr. Christina Lengyel (204-474-9554).

This research study has been approved by the Joint-Faculty Research Board of Ethical Review at the University of Manitoba. If you have any concerns or complaints about this project, you may contact the above-named persons or the Human Ethics Secretariat at 474-7122 or e-mail margaret_bowman@umanitoba.ca.

Please bring this consent form with you to the focus group session. A copy of this consent form will be given to you to keep for your records and reference.

Participant's Signature

Date

Researcher and/or Delegate's Signature

Date

FOR A COPY OF THE STUDY RESULTS, PLEASE COMPLETE THE FOLLOWING:

Name (Please Print)

Preferred Mailing Address (check one of the following):

☐ E-mail

☐ Regular Post

E-mail Address

Street Address

City/Town

Postal Code

APPENDIX H

Focus Group Moderator's Guide

Moderators Guide & Focus Group Questions

1) Introduction of Moderator “and Group”

Hello everyone. Thank you for coming today and participating in this session. My name is Catherine Marshall and I will be leading the focus group session today. The note taker today is _____.

2) Overview of Study

The purpose of this study is to explore the body image perceptions, body/weight satisfaction, attitudes towards nutrition and dieting, and concerns about aging, and then examine how these factors might influence food choices. In order to promote positive body images for women and develop healthy food products that meet your needs, we need to better understand the factors that influence the eating behaviors and food choices of middle-aged women. As was indicated on the consent form, this session will take no longer than 1 ½ to 2 hours to complete. This session will include a general discussion of the following: body image perceptions, satisfaction with weight/appearance, concerns and expectations about aging, thoughts and experiences with dieting, use of anti-aging products and diet products, factors that influence food choices, barriers to healthy eating, and your attitudes towards and use of local foods, organic products, and functional foods.

The session will be recorded on audio tape to facilitate data collection. Please feel free to share your opinions and thoughts about the questions with us. Results will not be reported by individuals' names nor will any names be associated with the results. Participants will be identified by a randomly assigned number only during the transcription of the audio tapes. All data will be kept strictly confidential by the researcher. You are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice, judgment or consequence.

3) Ground Rules

A few things to remember:

- a) There are no right or wrong answers to any of the questions I will ask you. Please feel free to share your opinions and thoughts.
- b) Since this is a group session, it is important that we listen to and respect each other's comments.
- c) If any participant expresses comments that are perceived as judgmental or disrespectful, they will be reminded of these ground rules and the discussion will promptly return to the topic at hand.
- d) Since this session is being audio taped, it is important that everyone speaks in their turn and as loudly as possible. Try not to interrupt when others are talking and when you have the floor, try to speak clearly and loudly.
- e) Please state your name before speaking to help in record keeping and note taking.

- f) If you have a thought while someone is speaking, feel free to use the pen and paper provided to write it down and present your idea(s) during the session.
- g) Participation is restricted to the invited focus group participants, moderator and note taker whom are seated around this table.

4) Ice Breaker

To begin, I would like to go around the table for introductions. Please state your first name and either your favourite food or your favourite activity that makes you feel good about yourself.

5) General Discussion

We will now begin with the questions. There are three broad categories that I hope we can talk about as a group. First, we will talk about body image, next we will talk about the experience of aging, and finally, we will talk about eating and food choices.

1. Body Image/Body Satisfaction Questions:

- a. How satisfied or dissatisfied are you with your body weight, size, and shape. What are your feelings about your current body?
 - *Prompt:* How would you describe your body? How does it make you feel?
 - *Prompt:* Does your current weight and shape affect you in any way?
- b. How important is your appearance or body weight to you?
 - *Prompt:* How much time do you spend thinking about your appearance or weight?
- c. What strategies have/are you using to control your weight?
 - *Prompt:* Have you ever dieted or controlled your food intake to lose or maintain your weight?

2. Aging Questions:

- a. Are you worried about the effects of aging on your body appearance?
 - *Prompt:* Describe one thing that concerns you most about your body and/or aging.
- b. Are there foods or cosmetic products that you use or regimens you follow to prevent or minimize the effects of aging?
 - *Prompt:* What are they? *or* Please describe.

3. Food Choice/Eating Questions:

- a. Do you eat the way you would ideally like to eat?
 - *Prompt:* How would you define healthy eating? Do you eat this way?
 - *Prompt:* Give one word that would describe your current eating pattern.
- b. Are there any barriers that interfere with your ability to eat the way you would ideally like to eat?
- c. What factors influence your food choices?
 - *Prompt:* Do you choose foods based on their nutrient value, taste, appearance, convenience, brand name? Or do you take other factors into account?
- d. Are there any specific nutrients or food components that you are concerned about or would like to consume more of in your diet?

4. Attitudes and opinions toward certain types of food products:

- a. What do you think about Local eating? Do you make an effort to consume locally-produced foods (i.e., foods produced/grown in Manitoba)?
 - *Note: Local foods are ingredients or products that are grown or produced in Manitoba.*
- b. What do you think about Organic eating? Do you make an effort to consume products labeled as organic?
 - *Note: Organic foods are produced without the use of chemicals, pesticides, chemical fertilizers, or irradiation.*
- c. What do you think about Functional foods? Do you make an effort to consume these products?
 - *Note: Functional foods claim to offer unique health benefits and/or reduce the risk of chronic disease. (e.g., granola bars/cereal with added fibre, calcium-fortified orange juice, pro-biotic yogurt, omega-3 eggs, etc.).*
- d. What do you think about diet or weight loss products Do you make an effort to purchase/consume these products?
 - *Note: Includes foods labeled as diet, weight loss, Weight Watchers, low-calorie, low-fat, etc.*

6) Opportunity for additional comments, clarification and/or requests to delete previous comments

Does anyone have any additional comments or opinions regarding any of the topics we have discussed or would anyone like to clarify their previous comments?

7) Thank Participants

I would like to thank all of you for attending this session and sharing your opinions with us. We greatly appreciate it. A special thank you to MAFRI Business Development Specialists (STATE NAME(s)) for helping to organize this session. Finally, we would like to acknowledge funding from _____.

8) Closing Statement

On a final note, I would just like to say that each one of us is unique and beautiful in our own way. There is no point in comparing yourself to other people, because we are all so different. I would like to encourage all of you, in your everyday lives, to accept and respect the natural diversity of body sizes and shapes that exists all around us, and that includes appreciating your own body. Remind yourselves daily just how wonderful and beautiful you truly are. Be grateful for the many things your body can do, and take pleasure in simply being alive. Instead of trying to look like someone else or achieve a certain number on the bathroom scale, focus on living a healthy, balanced and fulfilling life.

9) Distribution of Resource List

If anyone would like more information on body image or healthy eating for yourself or someone you know, I have compiled a list of websites, resources, and organizations that you can consult. (*Give one copy to every person*). Under the heading, “Nutrition & Healthy Eating”, there is a 1-800 number for the free service, Dial-A-Dietitian. If you have specific concerns regarding nutrition, body image, or eating disorders, you can contact that number and they can refer you to counseling services in your area. You can also use the “Find a Dietitian” service (through the Dietitians of Canada website) to locate a registered dietitian in your particular area of residence. The Provincial Eating Disorder Prevention & Recovery Program offers group workshops for adults who are experiencing disordered eating, weight preoccupation and body image concerns. The Women’s Health Clinic in Winnipeg also provides counseling services on a variety of topics (sexual health, eating disorders, nutrition counseling, smoking cessation, etc.). The contact information for the Women’s Health Clinic and the Provincial Eating Disorder Prevention & Recovery Program are given on the resource list I have distributed.

Thank you all again for coming. I greatly appreciate your participation!

APPENDIX I

Questionnaire

Questionnaire

Instructions:

- Please respond to the following questions (on front and back side of page).
- Circle your answer, use a check mark (✓), or fill in the blank, where appropriate.
- Ask the moderator if you have questions or concerns about any of the items on this survey.
- ***Your answers are very important and will be kept strictly anonymous and confidential.***

1. Age: _____
2. Current relationship status
 - a. Single (never married)
 - b. Dating
 - c. Engaged
 - d. Married
 - e. Common Law
 - f. Divorced
 - g. Separated
 - h. Widowed
 - i. Other: _____
3. Including yourself, how many people live in your household: _____
4. Annual household income (before taxes):
 - a. Less than \$20,000 _____
 - b. \$20,000 to \$39,999 _____
 - c. \$40,000 to \$59,999 _____
 - d. \$60,000 to \$79,999 _____
 - e. \$80,000 to \$99,999 _____
 - f. More than \$100,000 _____
5. Highest level of education achieved:
 - a. Less than high school _____
 - b. High school diploma _____
 - c. Vocational/Trade _____
 - d. College (diploma/certificate) _____
 - e. University (bachelor degree) _____
 - f. Graduate degree (Masters or PhD) _____
 - g. Other (specify): _____
6. Cigarette Smoking:
 - a. I currently smoke cigarettes
 - b. I quit smoking cigarettes
 - c. I have never smoked cigarettes
 - d. Other: _____
7. How would you describe your health compared to others your age?
 - a. Excellent
 - b. Very Good
 - c. Good
 - d. Fair
 - e. Poor

8. Without using a scale, estimate what you weigh today: _____ (circle: pounds or kilograms)
9. How much would you ideally *like* to weigh? _____ (circle: pounds or kilograms)
10. How satisfied are you with your *current body weight*?
- Very satisfied
 - Moderately satisfied
 - Neutral
 - Moderately dissatisfied
 - Very dissatisfied
11. How satisfied are you with your *overall appearance*?
- Very satisfied
 - Moderately satisfied
 - Neutral
 - Moderately dissatisfied
 - Very dissatisfied
12. I am worried about the effect of aging upon my overall appearance.
- Strongly agree
 - Agree
 - Neutral
 - Disagree
 - Strongly disagree
13. During a typical day, how often do you think about your appearance?
- Always
 - Often
 - Sometimes
 - Rarely
 - Never
14. Do you feel self-conscious about your body size/shape when in the company of other people (Examples: at the beach, in public change rooms, at the gym, etc.)?
- Always
 - Often
 - Sometimes
 - Rarely
 - Never
15. Do your feelings about your body size/shape prevent you from participating in activities you enjoy?
- Yes (Specify: _____)
 - No

16. Within the past year, have you ever controlled, restricted or reduced your food intake *in an effort to lose weight?*
- Yes (Specify how often within the past year: _____)
 - No
17. Have you participated in a formal weight loss program or diet plan within the past 5 years?
(Examples: Weight Watchers[®], Atkins[®], South Beach Diet[®], Jenny Craig[®], Herbal Magic[®], etc.)
- Yes
 - No
18. How often do you use local food products?
- Daily (6 – 7 times a week)
 - 3 – 5 times a week
 - 1 – 2 times a week
 - 2 – 3 times a month
 - Once a month or less
 - Never
 - Not sure
- Local foods are ingredients or products that are grown or produced in Manitoba.*
19. How often do you use organic foods?
- Daily (6 – 7 times a week)
 - 3 – 5 times a week
 - 1 – 2 times a week
 - 2 – 3 times a month
 - Once a month or less
 - Never
 - Not sure
- Organic foods are produced without the use of chemicals, pesticides, chemical fertilizers, or irradiation.*
20. How often do you use functional foods or products with added nutrients? (Examples: granola bars with flax, calcium-fortified orange juice, pro-biotic yogurt, omega-3 eggs, margarine with plant sterols, etc.)
- Daily (6 – 7 times a week)
 - 3 – 5 times a week
 - 1 – 2 times a week
 - 2 – 3 times a month
 - Once a month or less
 - Never
 - Not sure
- Functional foods claim to offer unique health benefits and/or reduce the risk of chronic disease.*
21. How often do you use foods or supplements that claim to aid in weight loss? (Examples: products with ‘diet’, ‘weight loss’, ‘Weight Watchers[®]’, ‘low-calorie’, ‘low-fat’ on the label).
- Daily (6 – 7 times a week)
 - 3 – 5 times a week
 - 1 – 2 times a week
 - 2 – 3 times a month
 - Once a month or less
 - Never
 - Not sure

22. How often do you use products that claim to minimize the signs of aging? (Examples: anti-aging skin creams, pills, cosmetic products, etc.)
- a. Daily (6 – 7 times a week)
 - b. 3 – 5 times a week
 - c. 1 – 2 times a week
 - d. 2 – 3 times a month
 - e. Once a month or less
 - f. Never
 - g. Not sure

For questions 23 and 24, draw a tick mark to indicate your response as shown in the example below.

EXAMPLE:

Are you experiencing any pain today?

If you felt some mild discomfort but no real pain, you may respond by making a mark on the line as shown below:

No Pain |————— ✓ —————| Extreme Pain

Please answer the last two questions below by placing a tick mark on the line:

23. Within the last year, how stressed do you feel, on an average day?

Not at all Stressed |—————| Extremely Stressed

24. How important is your overall appearance to you?

Not at all Important |—————| Very Important

APPENDIX J

Forms for Expert Review



UNIVERSITY
OF MANITOBA

Faculty of Human Ecology
Human Nutritional Sciences

418 Human Ecology Bldg.
University of Manitoba
Winnipeg, MB, R3E 3N4
Phone: (204) 474-6051
Fax: (204) 474-7592
Email: body_image@ymail.com

Research Project Title: “Influence of Body Image on Food Choices of Baby Boomer & Older Women”
Researchers: Catherine Marshall, BSc. (MSc. Student) & Dr. Christina Lengyel, PhD., RD.

This consent form will give you a basic idea of what the research study is about and what your role as an expert reviewer will involve. Please take the time to read this consent form carefully and sign at bottom.

The purpose of this study is to explore body image perceptions, body/weight satisfaction, concerns about aging, and attitudes towards nutrition and dieting among Baby Boomer and older women and examine how these factors influence their food choices and eating behaviours. Eligible participants are women who reside in Manitoba and were born before the year 1966. All participants will complete a questionnaire and attend a focus group session. This research project is being conducted as part of the requirements for a Master’s degree in Human Nutritional Sciences from the University of Manitoba.

Review by an expert panel will make us aware of any problems with certain questions so that we can make improvements. This process will also help to improve the content validity of the questionnaire. After reading all of the information on this form, please sign at the bottom. If you agree to act as a reviewer, please read through the study objectives and research questions on the following page. This will familiarize you with the intent of the study and will help you assess the relevancy of each question. You will then proceed to the questionnaire on the following pages and rate each item on its relevancy and clarity. There is also space to provide additional feedback and/or suggestions for improvement at the end. Your input and suggestions are incredibly valuable.

Based on the results of your review, as well as pilot testing with a sample group of women from the target population, we may make modifications to the questionnaire before use with the study participants. Your feedback as a reviewer will not be shared with anyone other than the primary investigator and will be used only to improve the content/wording of the questionnaire. All forms will be kept in a locked cabinet in a locked room for 5 years or until data are published, whichever comes first. All data will be shredded after the time has expired.

Your signature on this form indicates that you have understood the information regarding the research project and agree to serve as a reviewer. This does not waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw at any time, and/or refrain from answering any questions you prefer to omit, without prejudice or consequence. This study is being conducted by Catherine Marshall (204-474-6051 or body_image@ymail.com), under the supervision of Dr. Christina Lengyel (204-474-9554).

This research study has been approved by the Joint-Faculty Research Board of Ethical Review at the University of Manitoba. If you have any concerns or complaints about this project, you may contact the above-named persons or the Human Ethics Secretariat at margaret_bowman@umanitoba.ca or 474-7122.

Reviewer’s Signature

Date

Study Information

Please note: This page is for your information only and is being provided to help you more easily assess the relevancy of questionnaire items (on the following pages).

Please do not review/assess the information on this page.

Research Objectives:

The objectives of this research project are to:

1. Explore the attitudes, perceptions, and experiences of body/weight satisfaction among Baby Boomer and older women; and
2. Examine how body satisfaction (or dissatisfaction) influences their food choices and attitudes.

Research Questions:

Questions that will be answered through quantitative analysis (questionnaire data):

1. What is the prevalence of body dissatisfaction among Baby Boomer women and how important is body weight/appearance to these women?
2. Among Baby Boomer women, are there relationships between level of body dissatisfaction and any of the following factors: age, relationship status, household income, education level, location of residence, number of children, body mass index, smoking status, self-reported stress level or self-reported health status?
3. Among Baby Boomer women, is body dissatisfaction related to weight preoccupation, appearance anxiety, fear of aging or dieting behaviour?
 - a. Does level of importance attributed to body weight/appearance moderate the relationship between body dissatisfaction and weight preoccupation, appearance anxiety, fear of aging or dieting behaviour?
4. Do women with greater body dissatisfaction report consuming functional, local, organic, diet/weight loss, anti-aging products more often?

Questions that will be answered through qualitative analysis (focus group responses):

5. How do Baby Boomer women describe their body and its importance in their lives?
6. Do Baby Boomer women experience concerns about aging and its effect on their appearance?
7. What strategies do Baby Boomer women use to control their weight and/or prevent aging?
8. How do Baby Boomer women describe their current eating patterns?
 - a. What barriers interfere with Baby Boomer women's ability to eat the way they would ideally like to?
 - b. What factors influence the food choices of Baby Boomer women? (e.g., do women choose foods based on nutritional value, taste, appearance, convenience, brand name, or personal health issues, etc.?)
 - c. What nutrients and food components/characteristics are Baby Boomer women concerned about?
9. What are the attitudes and opinions of Baby Boomer women with respect to functional, local, organic, and diet/weight loss products?

Questionnaire

Please rate each item on its relevancy and clarity, using the corresponding scale on the right hand side of the page. A score of '1' suggests that the question is completely irrelevant or extremely unclear/confusing. A score of '5' suggests that the question is very relevant or very clear and understandable. If you are working with an electronic document, please place an 'X' in place of the number you wish to select. Please note that the formatting of each question has been modified slightly to allow space for the rating scales on the right side.

1. Age: _____
Relevancy: 1 2 3 4 5
Clarity: 1 2 3 4 5

2. Relationship status
a. Single (never married)
b. Dating or engaged
c. Married
d. Divorced, separated or widowed
Relevancy: 1 2 3 4 5
Clarity: 1 2 3 4 5

3. Annual household income (before taxes):
a. Less than \$20,000 _____
b. \$20,000 to \$39,999 _____
c. \$40,000 to \$59,999 _____
d. \$60,000 to \$79,999 _____
e. \$80,000 to \$99,999 _____
f. More than \$100,000 _____
Relevancy: 1 2 3 4 5
Clarity: 1 2 3 4 5

4. How many children (or other dependent persons) are currently living in your household?
a. None
b. One
c. Two
d. Three
e. Four or more
Relevancy: 1 2 3 4 5
Clarity: 1 2 3 4 5

5. Smoking status:
a. I currently smoke
b. I used to smoke, but have quit
c. I have never smoked
Relevancy: 1 2 3 4 5
Clarity: 1 2 3 4 5

6. Highest level of education achieved:
a. Less than high school _____
b. High school diploma _____
c. Vocational/Trade (<1 year program) _____
d. College (2 or 3 year diploma/certificate) _____
e. University bachelor's degree _____
f. Graduate degree (Masters or PhD) _____
Relevancy: 1 2 3 4 5
Clarity: 1 2 3 4 5

7. How would you describe your health compared to others your age?

- a. Excellent
- b. Very Good
- c. Good
- d. Fair
- e. Poor

Relevancy: 1 2 3 4 5

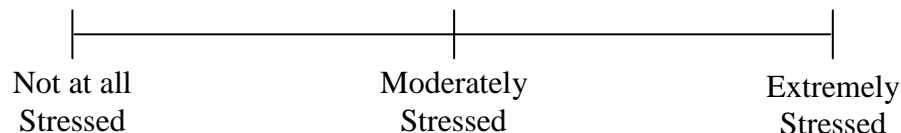
Clarity: 1 2 3 4 5

8. Within the last year, how stressed are you, on an average day?

(Place a tick mark on the line below).

Relevancy: 1 2 3 4 5

Clarity: 1 2 3 4 5



9. What is your current weight (give lbs or kg units)? _____

Relevancy: 1 2 3 4 5

Clarity: 1 2 3 4 5

10. What is your ideal weight (i.e., how much would you *like* to weigh)? _____

Relevancy: 1 2 3 4 5

Clarity: 1 2 3 4 5

11. How satisfied are you with your current body weight/shape?

- a. Very satisfied
- b. Moderately satisfied
- c. Neutral/Don't care
- d. Moderately dissatisfied
- e. Very dissatisfied

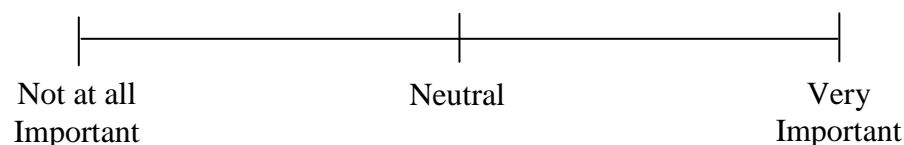
Relevancy: 1 2 3 4 5

Clarity: 1 2 3 4 5

12. How important is your appearance (body shape, size, weight, facial features) to you? (Place a tick mark on the line below).

Relevancy: 1 2 3 4 5

Clarity: 1 2 3 4 5



13. I am worried about the effect of aging upon my body and appearance.

- a. Strongly agree
- b. Agree
- c. Neutral/Don't care
- d. Disagree
- e. Strongly disagree

Relevancy: 1 2 3 4 5

Clarity: 1 2 3 4 5

14. During a typical day, how often do you think about your body weight/appearance? Relevancy: 1 2 3 4 5
Clarity: 1 2 3 4 5
- Always (I am preoccupied with how I look and spend a lot of time thinking about it)
 - Often (I think about my weight/appearance once or twice a day)
 - Sometimes/Occasionally (Once or twice a week)
 - Rarely (When I'm having a "bad" day/It is not usually a concern)
 - Never (I don't think about it at all/my appearance does not concern me)
15. Do you feel self-conscious about your body size/shape when in the company of other people (e.g., at the beach, in public change rooms, at the gym, when eating out, etc.)? Relevancy: 1 2 3 4 5
Clarity: 1 2 3 4 5
- Always
 - Often
 - Sometimes/Occasionally
 - Rarely
 - Never
16. Have you dieted within the past 5 years? Relevancy: 1 2 3 4 5
Clarity: 1 2 3 4 5
- Note: Dieting refers to joining a formal weight loss program (e.g., Weight Watchers®), going on a self-monitored "diet" plan (e.g., Atkins®), or simply restricting the amount you eat in an effort to lose weight.*
- Yes
 - No
17. How often do you purchase/consume local food products (i.e., foods produced/grown in Manitoba)? Relevancy: 1 2 3 4 5
Clarity: 1 2 3 4 5
- Almost always (or as often as possible)
 - Often
 - Sometimes/Occasionally
 - Rarely
 - Never
18. How often do you purchase/consume organic foods? (*Note: Organic refers to farming methods that avoid the use of chemicals, synthetic pesticides, irradiation, and foods that are not derived through genetic engineering. Organic farming uses methods that protect the soil, water, and environment.*) Relevancy: 1 2 3 4 5
Clarity: 1 2 3 4 5
- Almost always (or as often as possible)
 - Often
 - Sometimes/Occasionally
 - Rarely
 - Never

19. How often do you purchase/consume functional foods or products with added nutrients? *(Note: Functional foods offer unique health benefits that go beyond simply meeting basic nutrient needs. Many also help to reduce the risk of chronic disease. Functional foods contain ‘bioactive compounds’ that offer health and wellness benefits).* Examples: granola bars with flax, calcium-fortified orange juice, pro-biotic yogurt, omega-3 eggs, etc. *Relevancy: 1 2 3 4 5*
Clarity: 1 2 3 4 5
- Almost always (or as often as possible)
 - Often
 - Sometimes/Occasionally
 - Rarely
 - Never
20. How often do you purchase/consume diet products (i.e., foods or supplements that claim to aid in weight loss)? For example, products with ‘diet’, ‘weight loss’, ‘Weight Watchers®’, ‘low-calorie’, ‘low-fat’ on the label. *Relevancy: 1 2 3 4 5*
Clarity: 1 2 3 4 5
- Almost always (or as often as possible)
 - Often
 - Sometimes/Occasionally
 - Rarely
 - Never
21. How often do you purchase/use anti-aging products (i.e., skin creams, pills, cosmetics, or other products that claim to minimize the signs of aging)? *Relevancy: 1 2 3 4 5*
Clarity: 1 2 3 4 5
- Almost always (or as often as possible)
 - Often
 - Sometimes/Occasionally
 - Rarely
 - Never

Feedback

Please use the space below to provide additional feedback regarding specific items on this questionnaire. Feel free to elaborate upon your above ratings or make specific suggestions for improvement.

APPENDIX K

Forms for Pilot Testing



UNIVERSITY
OF MANITOBA

Faculty of Human Ecology
Human Nutritional Sciences

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Researchers: Catherine Marshall, BSc. (MSc. Student) & Dr. Christina Lengyel, PhD., RD.

This consent form will give you a basic idea of what the research study is about and what your participation as a reviewer will involve. Please take the time to read this consent form carefully and understand any accompanying information provided.

The purpose of this study is to (a) explore body image perceptions, body/weight satisfaction, concerns about aging, and attitudes towards nutrition and dieting among Baby Boomer and older women and (b) examine how these factors influence food choices and eating behaviours. Eligible participants are women born before 1966 who reside in Manitoba. All participants will complete a pen-and-paper questionnaire and attend a focus group session. This research project is being conducted as part of the requirements for a Master’s degree in Human Nutritional Sciences from the University of Manitoba.

Your role as a reviewer is to test out the questionnaire and provide comments and suggestions for improvement. This will ensure that our questionnaire is understandable by and appropriate for the study participants. After reading all of the information on this form, please sign at the bottom. If you agree to act as a reviewer, you will then fill out the questionnaire on the following pages (pages 2-4), as if you were a participant. Once you are finished, please complete the Feedback Form (page 5-6), which asks you to review the questionnaire. Your input and suggestions are incredibly valuable.

You are not required to provide your name or other identifying information anywhere on the questionnaire or feedback form. Page 1 (this form) will be separated from your questionnaire so that your responses remain anonymous. Your feedback as a reviewer will not be shared with anyone other than the primary investigator and will be used only to improve the content/wording of the questionnaire. Your responses to the questions will not be included as part of the results of this study. All materials will be kept in a locked cabinet in a locked room for 5 years or until data are published, whichever comes first. All data will be shredded after the time has expired.

Your signature on this form indicates that you have understood the information regarding the research project and agree to serve as a reviewer. This does not waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw at any time, and/or refrain from answering any questions you prefer to omit, without prejudice or consequence. This study is being conducted by Catherine Marshall (204-474-6051 or body_image@ymail.com), under the supervision of Dr. Christina Lengyel (204-474-9554).

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Reviewer’s Signature

Date

Questionnaire

Please respond to the following questions (on front and back side of page). Circle your answer, use a check mark (✓), or fill in the blank, where appropriate. Feel free to ask the moderator if you have questions or concerns about any of the items on this survey.

1. Age: _____

2. Relationship status

- a. Single (never married)
- b. Dating or engaged
- c. Married
- d. Divorced, separated or widowed

3. Annual household income (before taxes):

Less than \$20,000 _____

\$20,000 to \$39,999 _____

\$40,000 to \$59,999 _____

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\$80,000 to \$99,999 _____

More than \$100,000 _____

4. How many children (or other dependent persons) are currently living in your household?

- a. None
- b. One
- c. Two
- d. Three
- e. Four or more

5. Smoking status:

- a. I currently smoke
- b. I used to smoke, but have quit
- c. I have never smoked

6. Highest level of education achieved:

Less than high school _____

High school diploma _____

Vocational/Trade (<1 year program) _____

College (2 or 3 year diploma/certificate) _____

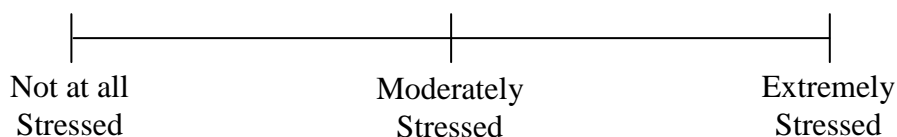
University bachelor's degree _____

Graduate degree (Masters or PhD) _____

7. How would you describe your health compared to others your age?

- a. Excellent
- b. Very Good
- c. Good
- d. Fair
- e. Poor

8. Within the last year, how stressed are you, on an average day? (Place a tick mark on the line below).



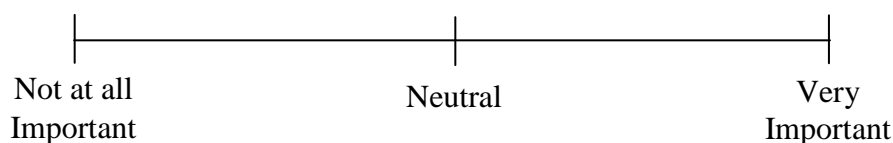
9. What is your current weight (give lbs or kg units)? _____

10. What is your ideal weight (i.e., how much would you *like* to weigh)? _____

11. How satisfied are you with your current body weight/shape?

- a. Very satisfied
- b. Moderately satisfied
- c. Neutral/Don't care
- d. Moderately dissatisfied
- e. Very dissatisfied

12. How important is your appearance (body shape, size, weight, facial features) to you? (Place a tick mark on the line below).



13. I am worried about the effect of aging upon my body and appearance.

- a. Strongly agree
- b. Agree
- c. Neutral/Don't care
- d. Disagree
- e. Strongly disagree

14. During a typical day, how often do you think about your body weight/appearance?

- a. Always (I am preoccupied with how I look and spend a lot of time thinking about it)
- b. Often (I think about my weight/appearance about once or twice a day)
- c. Sometimes/Occasionally (Once or twice a week)
- d. Rarely (When I'm having a "bad" day/It is not usually a concern)
- e. Never (I don't think about it at all/my appearance does not concern me)

15. Do you feel self-conscious about your body size/shape when in the company of other people (e.g., at the beach, in public change rooms, at the gym, when eating out, etc.)?

- a. Always
- b. Often
- c. Sometimes/Occasionally
- d. Rarely
- e. Never

16. Have you dieted within the past 5 years?

Note: Dieting refers to joining a formal weight loss program (e.g., Weight Watchers®), going on a self-monitored "diet" plan (e.g., Atkins®), or simply restricting the amount you eat in an effort to lose weight.

- a. Yes
- b. No

17. How often do you purchase/consume local food products (i.e., foods produced/grown in Manitoba)?
- Almost always (or as often as possible)
 - Often
 - Sometimes/Occasionally
 - Rarely
 - Never
18. How often do you purchase/consume organic foods?
- Note: Organic refers to farming methods that avoid the use of chemicals, synthetic pesticides, irradiation, and foods that are not derived through genetic engineering. Organic farming uses methods that protect the soil, water, and environment.*
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 - Often
 - Sometimes/Occasionally
 - Rarely
 - Never
19. How often do you purchase/consume functional foods or products with added nutrients?
- Note: Functional foods offer unique health benefits that go beyond simply meeting basic nutrient needs. Many also help to reduce the risk of chronic disease. Functional foods contain 'bioactive compounds' that offer health and wellness benefits. Examples: granola bars with flax, calcium-fortified orange juice, pro-biotic yogurt, omega-3 eggs, etc.*
- Almost always (or as often as possible)
 - Often
 - Sometimes/Occasionally
 - Rarely
 - Never
20. How often do you purchase/consume diet products (i.e., foods or supplements that claim to aid in weight loss)? For example, products with 'diet', 'weight loss', 'Weight Watchers[®]', 'low-calorie', 'low-fat' on the label.
- Almost always (or as often as possible)
 - Often
 - Sometimes/Occasionally
 - Rarely
 - Never
21. How often do you purchase/use anti-aging products (i.e., skin creams, pills, cosmetics, or other products that claim to minimize the signs of aging)?
- Almost always (or as often as possible)
 - Often
 - Sometimes/Occasionally
 - Rarely
 - Never

Feedback Form

Please answer the following questions and take the time to provide additional comments/suggestions at the bottom. Your feedback is very valuable and will be used to improve the content and/or structure of the questionnaire.

1. How many minutes did it take you to complete the 3 page questionnaire? _____
2. What did you think about the questionnaire's length?
 - a. It was too long (too many questions)
 - b. It was just the right length (right amount of questions)
 - c. It was too short (too few questions)
3. Was the font type and size easy to read?
 - a. Yes
 - b. No

If you answered B. (No) to the above question, please elaborate: _____

4. Overall, were the questions clear and easy to understand?
 - a. Yes, the questions were clear and easy to understand
 - b. There were a few questions that were hard to understand
 - c. No, most questions were hard to understand

If you answered B. or C. to the above question, please elaborate: _____

5. Were there any words in the questionnaire that you didn't understand? If so, list them below:

6. Was the definition of "functional foods" (#19) clear to you? _____

7. Did you have any trouble understanding how to answer the scale-type questions (items #8 and #12)?
 - a. No
 - b. Yes

If you answered B. (Yes) to the above question, please elaborate: _____

8. Were there any questions that made you uncomfortable?
 - a. No
 - b. Yes

If you answered B. (Yes) to the above question, please explain: _____

9. Please provide any additional feedback or suggestions for improvement below:

APPENDIX L

Code List

Final Code List

1. Body Image

- a. **Body perceptions**
 - i. Body dissatisfaction
 - Specific body parts
 - ii. Body satisfaction
 - General acceptance
- b. **Temporal and situational nature**
- c. **Factors that influence body image**
 - i. Clothing and fashion
- d. **Importance of appearance/body/weight**
 - i. Important
 - Outside the home
 - ii. Not important or don't care
- e. **Self-consciousness**
- f. **General body image comments**

2. Aging

- a. **Aging attitudes**
 - i. Positive experiences/attitudes
 - ii. Negative experiences/attitudes
 - iii. General acceptance of aging
 - iv. Feel young / subjective age
 - v. Use of humour
 - vi. Double standard of aging
- b. **Concerns about aging**
 - i. Appearance
 - ii. Functioning
 - iii. Health status

- iv. Not concerned
- c. **Anti-aging strategies**
 - i. Yes – Use (all)
 - Skin care
 - ii. No – Do not use
 - iii. Attitudes towards anti-aging products
 - iv. Barriers to use

3. **Weight Loss & Dieting**

- a. **Body weight attitudes**
 - i. Negative attitudes
 - ii. Positive attitudes
 - iii. Life-long struggles
 - iv. Weight surveillance
- b. **Weight loss and dieting**
 - i. Desire to lose weight
 - Want to lose, but no effort
 - ii. Motivation for losing weight
 - Appearance
 - Health and fitness
 - Illness or health issue
 - iii. Strategies for losing weight
 - Dieting
 - General experiences of dieting
 - Successful dieting
 - Unsuccessful (incl. chronic or yo-yo dieting)
 - Opposed to dieting
 - Diet plans and programs
 - Dietary restraint
 - Physical activity / exercise
 - Feelings and attitudes towards exercise
 - Barriers to exercise
 - Other strategies

4. Healthy Eating & Food Choices

a. Healthy/ideal eating

- i. Motivations for healthy eating
- ii. Foods avoiding
- iii. Foods consuming

b. Barriers to healthy eating

- i. Living alone / cooking for one
- ii. Availability / access
- iii. Boredom (monotony)
- iv. Busy / time
- v. Cost (price of healthy foods)
- vi. Dislike cooking
- vii. Family
 - Husbands
- viii. Like to eat / portion sizes
- ix. Personal taste preferences and habits
- x. Emotional eating (incl. temptations, cravings, late-night eating)
- xi. Other barriers

c. Food choice influences

- i. Availability
- ii. Body – weight, appearance, dieting
- iii. Family and upbringing
- iv. Health issues, conditions, intolerances
- v. Nutrition
- vi. Preferences / habits
- vii. Price
- viii. Taste / quality
- ix. Time / convenience
- x. Other factors

d. Nutrients of concern

- i. B vitamins
- ii. Calcium
- iii. Calories
- iv. Carbohydrate
- v. Fats – bad
- vi. Fats – food

- vii. Fibre
 - viii. Iron
 - ix. Multivitamins
 - x. Protein
 - xi. Sodium / salt
 - xii. Sugar
 - xiii. Vitamin D
 - xiv. Other nutrients
- e. **Other food/eating attitudes and comments**
- i. Confusion about food and nutrition information
 - ii. Reading food labels
 - iii. Importance of variety, balance and moderation
 - iv. Nostalgia for home-cooked meals/ways of the past

5. **Food Products**

- a. **Local eating**
- i. Yes – Eat local
 - ii. No – Do not eat local
 - iii. Attitudes towards local foods
 - iv. Barriers to local eating
 - v. Gardening
- b. **Organic eating**
- i. Yes – Eat organic
 - ii. No – Do not eat organic
 - iii. Attitudes towards organic foods
 - iv. Barriers to eating organic
 - Price
 - Skepticism
- c. **Functional foods (FF)**
- i. Yes – Eat FF
 - ii. No – Do not eat FF
 - iii. Attitudes towards FF
 - iv. Barriers to eating FF

d. **Diet products**

- i. Yes – Eat diet products
- ii. No – Do not eat diet products
- iii. Attitudes towards diet products

6. **Other (Free Nodes)**

- a. Health issues/conditions
- b. Health professionals / health care system
- c. Sources of nutrition information
- d. Media/societal influences

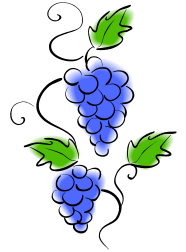
APPENDIX M

Resource List



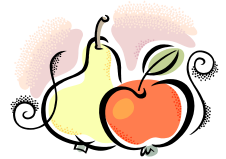
RESOURCE LIST

For more information on...



BODY IMAGE:

- Women's Health Clinic: <http://www.womenshealthclinic.org/> (1-866-947-1517)
- Canadian Women's Health Network: <http://www.cwhn.ca/node/40776>
- Body Image Works Inc.: <http://www.bodyimageworks.com/>
- Body Positive: <http://www.bodypositive.com/>
- Health Canada: http://www.hc-sc.gc.ca/fn-an/nutrition/weights-poids/leaders_image-chefs_image-eng.php
- Dove's Campaign for Real Beauty: <http://www.dove.ca/en/default.aspx#/cfrb/>
- Media Awareness Network: <http://www.media-awareness.ca/>
- Womenshealth.gov: <http://www.womenshealth.gov/bodyimage/>



NUTRITION & HEALTHY EATING:

- Dial-A-Dietitian: 1-877-830-2892 or 788-8248 in Winnipeg
- Dietitians of Canada (Eat Well, Live Well & "Find a Dietitian" Service): http://www.dietitians.ca/public/content/eat_well_live_well/english/index.asp
- Health Links: 1-888-315-9257 or 788-8200 in Winnipeg
- Health Canada: <http://www.hc-sc.gc.ca/fn-an/nutrition/index-eng.php>
- Dairy Farmers of Canada: <http://www.dairygoodness.ca/>
- Heart and Stroke Foundation of Canada: <http://www.heartandstroke.mb.ca/>
- Nutrition Labeling Education Centre: <http://www.healthyeatingisinstore.ca/>
- American Dietetic Association: <http://www.eatright.org/public/>



EATING DISORDERS:

- Women's Health Clinic: <http://www.womenshealthclinic.org/> (1-866-947-1517)
- MB Provincial Eating Disorder Prevention & Recovery Program:
Phone: 1-866-947-1517 or Email: deprogram@womenshealthclinic.org
- Canadian Mental Health Association:
http://www.cmha.ca/BINS/content_page.asp?cid=3-98
- National Eating Disorder Association: <http://www.nationaleatingdisorders.org/>
- National Eating Disorder Information Centre: <http://nedic.ca/>
- Eating Disorder Education Organization: <http://www.edeo.org/info/index.htm>
- Eating Disorder.org: <http://www.eating-disorder.org/>
- National Institute of Mental Health: <http://www.nimh.nih.gov/health/publications/eating-disorders/complete-index.shtml>
- Sheena's Place: http://www.sheenasplace.org/index.php?page=body_image
- Something Fishy: <http://www.something-fishy.org/>