“Disgusting” Fat Bodies & Young Lebanese-Canadian Women’s Discursive Constructions of Health

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Using feminist poststructuralist and postcolonial lenses, we investigate how young Lebanese-Canadian women discursively construct health in the current context of a dominant obesity discourse. Participant-centered conversations on the topic of health were conducted with 20 young Lebanese-Canadian women. Results attest that the participants construct health as a matter of physical appearance and more specifically on the basis of being “not fat.” While doing so, they generally show disgust for overweight and obese bodies although some participants express compassion as they see obesity as a deterrent to health and a serious “disease.” Our results address the language used by participants to construct their multiple and shifting subjectivities as they speak about health. We reflect on such language and the impact of diasporic spaces on young women’s changing and complex subject positions.

In Canada and Western countries in general, obesity studies have exploded in the public sphere. The World Health Organization (WHO) has declared obesity a “disease” and developed an action plan to reduce and prevent the spread of the so-called “global obesity epidemic” (WHO, 2006a, 2006b). In spite of the ongoing debates on the conclusions and claims of biomedical and epidemiological obesity studies, young women in Canada are being exposed to a gendered and racialized discourse on obesity that is usually intertwined with popular discourses on femininity.

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and ideal body weight and shape that generally portray the ideal female as thin, white, heterosexual, and bourgeois. Given such situation, it seems crucial to critically investigate the “effects” (Foucault, 1973, 1979) of the dominant obesity discourse on young women’s constructions of health, especially those of cultural minorities as we expect that such women’s social, cultural, and economic conditions put them at more risk vis-à-vis the effects of the mainstream obesity discourse. While a large body of feminist and critical literature exists on the emergence of dominant discourses of health and the body, on the social construction of beauty ideals and fatness (i.e., Braziel & Lebesco, 2001; Garland-Thomson, 2005), and on the cultural ideals that women from different cultural backgrounds have in relation to the body (Bartky, 1990; Bordo, 1993; Orbach, 1988), there has been very little empirical research on how young women construct their understandings of health within the context of a very present obesity discourse. Furthermore, studies that examine such constructions among women who are from ethnic minorities are even more limited. Current research on health and the body is largely structured by positivist, racist, and heterosexist perspectives and the large majority of studies are quantitative and epidemiological in nature.

This paper aims to contribute to fill the gaps in the literature on young women from cultural minorities and their constructions of health. Its purpose is also to provide empirical knowledge to assist health professionals in their socio-culturally contextualized interventions to improve young women’s health. Using a qualitative methodology that is informed by feminist poststructuralist and postcolonial theories, our overall aim is to report on the discursive constructions of health among one group of young women coming from an ethnic minority: Lebanese-Canadian women. The specific objectives of this paper are: (a) to obtain an empirically-grounded account of how young Lebanese-Canadian women discursively construct health; (b) to examine the relationship between these constructions and the prevailing obesity discourse; (c) to understand how young women position and construct themselves within dominant and/or alternative bodily discourses; and (e) to develop a better understanding of how young women’s cultural identities inform their constructions of health.

HEALTH STUDIES & LEBANESE-CANADIAN WOMEN

A vast literature exists on the health status of women from ethnic minorities in the United States (e.g., Guyll, Matthews & Bromberger, 2001; Troxel, Matthews, Bromberger & Sutton-Tyrrell, 2003; Pavalko, Mossakowski & Hamilton, 2003; Schulz, Israel, Williams, Parker, Becker & James, 2000). These studies show a clear association between minority
women’s perceived racism and discrimination and poorer physical and mental health. Relatively fewer studies have examined the health status of immigrant women in Canada and those that have focused on women from ethnic minorities are even more limited. While some of these studies show that male and female immigrants report better health than native Canadians (i.e., Ali, McDermott & Gravel, 2004), others argue that immigrants are more likely to report poorer health than Canadians (i.e., Newbold, 2005; Newbold & Danforth, 2003). Still others note that immigrants are in better health than Canadians upon their arrival in Canada but that after several years of residence in Canada, their perceived health declines to the level experienced by native Canadians (Dunn & Dyck, 2000). Similarly, other researchers have documented lower levels of overweight and obesity (McDonald & Kennedy, 2005) as well as chronic diseases such as heart disease and diabetes (Perez, 2002) among recent immigrants; however, these researchers have found that the odds of overweight, obesity and chronic diseases increase with years spent in Canada.

Studies focusing on female immigrants’ perceptions of their health have also reported inconsistent findings. In their investigation of the effects of women’s migration experiences and residence in Canada on self-perceived health and self-reported chronic conditions, Vissandjée and colleagues (2004) have found that female immigrants report poorer health and more chronic diseases than Canadian-born women after both 2 years and 10 years of Canadian residence. In a qualitative study conducted by Meadows, Thurston and Melton (2001), 42 female immigrants were interviewed in order to better understand the complexity of their immigration experiences. The majority of the women considered themselves to be in good or better health than native Canadians. Various responses were noted in relation to the effects of migration on their health status. While many women did not experience change, others said that their health had worsened, and a minority found that their health had improved. Issues such as stress and abuse were common among women when discussing their families, immigration experiences, and utilization of medical resources. Most women reported focusing on the importance of social support as well as spiritual and religious practices in coping with such health problems.

A few studies have particularly focused on children’s (Wright & Burrows, 2004) and students’ discursive constructions of health in New Zealand and Australia (Burns & Gavey, 2008; Wright, O’Flynn & Macdonald, 2006), and one focused on such constructions among adolescents in Canada (Rail, 2009). The common themes that emerge from these studies are the children and adolescents’ sense of personal responsibility for the maintenance of health and a healthy body, their constructions of health in bodily terms as opposed to mental or
psychological ones, their belief in a direct relationship between body size and health, and their belief in the monitoring of eating habits and physical activity to bring about health. Using Foucault’s notion of discourse, Wright and colleagues (2006) have discussed how young Australian women and men take up dominant health discourses and how the latter shape their constructions of health and fitness and, consequently, their bodily practices. It is noteworthy that women and men read health discourses in different ways. Unlike young men, the majority of the young women in Wright and colleagues’ study equated a healthy body with a thin one. Young women also emphasized their responsibility with regards to the monitoring of eating habits and physical activity in their quest to obtain an “appropriate” body shape (Wright et al., 2006) and to stay “healthy.” While many participants recognized the presence of gendered discourses of health that emphasize a relationship between health, body weight and appearance, these authors have argued that young people are still not empowered to resist such problematic discourses. Similarly, based on accounts of young bulimic women, Burns and Gavey (2008) have discussed how these women associate a healthy body to a slender one and how they view the manipulation of energy intake and expenditure as a form of healthy body management. The young women in Burns and Gavey’s study as well as those taking part in Rail’s study perceived the ideal (thin) body to be a sign of success and control. Ironically, for the participants in these studies, the desire for a slender body was expressed in terms of achieving health. In the end, in order to be “healthy,” many participants focused on their appearance and engaged in calorie reduction and physical activity. In addition, a number of Canadian and Australian participants adopted not so healthy practices such as the consumption of diet pills, fasting, and liposuction. Authors have explained these findings in light of the strongly intertwined gendered discourse of femininity and the popular discourse of health since both tend to normalize a number of unhealthy and risky behaviours in the name of health.

Only a small number of studies have specifically examined the constructions of health among women from various cultural communities in Canada (Choudhry, 1998; Elliot & Gillie, 1998; Farrales & Chapman, 1999; George & Rail, 2006; Kim & Rail, 2007; Rail, 2009; Rail, Beausoleil, Dallaire, Laberge & Voyer, 2006). In these studies, women consistently mention the importance of a balanced diet, physical activity, and having an appropriate weight. For instance, the young (i.e., 18-25 years old) South-Asian Canadian women in George and Rail’s (2006) study constructed health using many elements but mostly equated health with “looking good” and being “not fat.” Consequently, many of them reported their involvement in a range of questionable bodily practices (e.g., diets, fasting, use of pills and cosmetics, electrolysis, skin
bleaching in the case of women of colour) in order to “look good.” Similarly, the young (i.e., 19-30 years old) Filipino women in Farrales and Chapman’s (1999) study distinguished Canadian norms that emphasize thinness from Filipino ones that value fatness to maximize disease resistance. However, a majority of these Filipino-Canadian women desired a thinner body. Such findings suggest that some young women from ethnic minorities in Canada may have “traditional” beliefs about the body and health, but may yet adopt more “modern” Canadian norms.

While women in the latter studies (Farrales & Chapman, 1999; George & Rail, 2006) were relatively young, other researchers have examined the constructions of health of older women. For instance, the South-Asian-Fijian women in Canada who were aged between 21 and 84 years mainly conceptualized health as a balance of physical, emotional, and spiritual well-being (Elliot & Gillie, 1998). In the same line, 40-80 years-old Indo-Canadian women considered a balanced diet to be the most important component of being healthy but insisted on strong relationships with their families, spiritual engagement, and being happy (Choudhry, 1998). Similarly, in the 2006 Canadian study by Rail and her colleagues, 65-75 years-old immigrant women discursively constructed health as a personal responsibility but did not associate health with thinness, physical appearance or beauty. Most of these older women rather focused on autonomy and functionality, as well as the importance of spirituality and prayer for health.

In brief, although there is a burgeoning literature on immigrant women’s health, the majority of studies remain biomedical and epidemiological in nature, and they do not take into account the intersectional issues of ethnicity, gender, sexuality, social class and religion nor the impact of the latter on women’s experiences and discursive constructions of health. We contend that the above approaches disregard the richness and depth of minority women’s stories and perspectives. In addition to the limitations of studies on immigrant and ethnic women’s health, the territory of young women’s discursive constructions of health has not been well investigated yet. With this paper, we aim to contribute filling this gap.

**FEMINIST POSTSTRUCTURALIST & POSTCOLONIAL FRAMEWORK**

Our study is informed by feminist poststructuralist and postcolonial theories. Feminist poststructuralism presupposes a number of key concepts, notably discourse, subjectivity, power, and knowledge. Discourses are systems of thoughts or collections of statements that are composed of ideas, attitudes, actions, beliefs and practices. These
discourses construct and govern speaking subjects as well as their worlds. Foucault (1972) situates discourses in the wider context of social power to show how “truths” are constructed and maintained and how they reproduce power relations. Another central concept to feminist poststructuralism is that of subjectivity. According to Weedon (1997[1987]), subjectivity is “the conscious and unconscious thoughts and emotions of the individual, her sense of herself, and her way of understanding her relation to the world” (p. 32). Foucault (1980) views subjectivity to be formed within structural power relations that are sustained by discourses. In other terms, individuals’ understandings of themselves are socially constructed within different contexts in which discursive ideas and practices are perpetuated (Weedon, 1997[1987]). While Foucault (1978) may appear deterministic when he considers subjectivity as an “effect” of dominant discourses and power relations, he does underline the agency of subjects—their capacity to choose from or to resist subject positions available to them. In this regard, Weedon (1997) notes the existence of alternative and marginalized discourses that offer sites for challenging hegemonic practices: “As individuals, we are not the mere objects of language but the sites of discursive struggle, a struggle which takes place in the consciousness of the individual” (p. 102). Although individuals are subjected to power, there is always room for resistance by those who refuse the subject positions that are available to them on the basis of their race, gender, class, and culture (Weedon, 1997[1987]).

Complimentary to feminist poststructuralist theory, we use feminist postcolonial theory (Bhabha, 1994; Spivak, 1995[1988]; Minh-ha, 1988) to interpret the narratives of the participating Lebanese-Canadian women. The key concepts we borrow from postcolonial theory are colonial discourse, cultural identity and hybridity. Postcolonial theory is concerned with revisiting the colonial past and analyzing how it continues to shape colonized subjects’ lives at the social, cultural, ideological, and political levels (Gandhi, 1998). We particularly adopt Mohanty’s (1988) conceptualisation of colonialism as a discursive notion that not only involves obvious economic and political domination but also the production of a discourse about the third world, especially about third world women. Mohanty (1988) argues that feminist texts discursively produce a singular image of the “third-world woman.” In comparison to Western women who are represented as independent, liberated and possessing control over their lives, the third-world woman is discursively portrayed as inferior and financially dependent on men. With regard to cultural identity, we contend that it is an effect of discursive processes; our identities are constructed within the cultural discourses available to us. Brah (1996) argues that identity is social and is “constituted in and through culture” (p. 21); hence, notions of culture
and identity are inseparable. But identity is not fixed; rather, it is in constant change. Identity is continuously negotiated and contested within the social relations that produce it (Rutherford, 1990). It is always in the process of construction and re-construction within discourses of history and culture (Hall, 1990). In that regard, it is crucial to consider the positioning of women in diasporic space. Brah (1996) defines such space as “the point at which boundaries of inclusion and exclusion, of belonging and otherness, of ‘us’ and ‘them’ are contested” (p. 181). Diasporic space, therefore, refers to the experiences of insertion into the social relations of class, gender, sexuality and other determinants of differentiation in the host country. Spivak (1996) discusses how women’s identities are formed in complex ways as a result of their interactions with both their homelands and their new surroundings. Further, she argues that women’s diasporic identities and space are strongly shaped by their class, gender, and ethnicity as they inform their negotiation of the multiple discourses to which they are exposed. Hall (1992) argues that in today’s world of open frontiers and borders, immigration is associated with identities that are “poised, in transition, between different positions.” Therefore, diasporic identities can be viewed as discursive constructions of diverse and concurrent forms of attachments to the homeland and the host society. Finally, we use Bhabha’s (1994, 1996) notion of hybridity, which is a central concept in postcolonial theory. Bhabha contends that a hybrid identity emerges from the mingling of elements of the coloniser and colonised, thus challenging the purity of any essentialist cultural identity. According to Hoogvelt (1997), hybridity is “celebrated and privileged as a kind of superior cultural intelligence owing to the advantage of in-betweeness, the straddling of two cultures and the consequent ability to negotiate the difference” (p. 158). Therefore, we see the world of immigrants as a third space of in-betweeness in which immigrants face a multitude of (often conflicting) realities and transform themselves and their identities.

**Participant-Centered Conversations & Feminist Poststructuralist Discourse Analysis**

Our poststructuralist and postcolonial framework has led us to choose a qualitative approach in order to capture the complexity of the “stories” of the young Lebanese-Canadian women in this study. Many researchers have advocated participatory methods and ethical symmetry to increase opportunities for inclusive democratic citizenship (Christensen & Prout, 2002; Valentine, 2000). We have taken up this challenge by conducting participant-centered conversations with 20 Lebanese-Canadian women who are between 18 and 25 years old. Nineteen of the participants are Christians and one is Druze. We have purposely chosen not to include Muslim women in the present study, as
issues of the veil and its intersection with ethnicity and other structural factors deserve separate studies (Jiwani & Rail, 2010; Tlili & Rail, 2010, 2011). Particular efforts were made to have young women who are from diverse socioeconomic backgrounds. Eleven out of 20 participants are either full-time or part-time students, 4 of the women have full-time white collar jobs, and the other 5 work in full-time or part-time jobs in the food and retail industries. The first few participants were recruited through purposive sampling through the personal social network of the first author, Lebanese restaurants and cafés as well as religious communities in the Ottawa and Montreal regions. A snowball sampling method was used to complete the sample with attention to increasing its diversity with regard to age and socioeconomic status. The conversations lasted between 1 and 2 hours. Participants were encouraged to engage in an open-ended and relaxed conversation rather than an interview where they would simply answer a list of questions; however the first author used a conversation guide in order to make sure certain topics related to health would be addressed.

All conversations were audio-digitally recorded and transcribed verbatim. The conversational texts were then analyzed according to two consecutive methods of analysis. First, a thematic analysis was conducted and second, a poststructuralist discourse analysis method (Rail, 2009; Weedon, 1997[1987]; Wright, 1995) was used to explore further the conversational texts and to investigate the ways in which the participants negotiate shifting power relations that circulate through competing discourses. Our second analysis focused on how participants, as subjects (Butler 1990, 1997), constantly position and re-position themselves within dominant and/or alternative discourses related to health and the body. We also questioned how conversational texts work to actively reflect and shape power relations in society (Mills, 2004; Peräkylä, 2005) and attempted to locate the “truths” that impact on our participants’ constructions of their social realm. Overall, we explored how the young Lebanese-Canadian women construct health and how their meanings about the body and health are constructed in specific sociocultural circumstances.

A number of scholars have suggested alternative ways to represent research findings. Richardson (2000a), for example, has argued that the majority of qualitative researchers often adopt a static writing mode in which the self of the researcher is diminished, if not completely suppressed. Richardson (2000b) encourages creative genres of writing and notably the use of “evocative representations” that “re-create lived experience and evoke emotional responses” (p. 931). Such representational texts move away from a positivist paradigm that privileges science as a discourse providing one objective “truth” (Guba, 1990) to a postmodern one that suggests that there are multiple, socially-
constructed and context-dependent realities and that the researcher cannot be separated from the research product (Denzin & Lincoln, 2005).

Given that our research is situated within a feminist poststructuralist and postcolonial framework, we have taken Richardson’s plea to heart and unapologetically incorporated our subjective selves into the research reporting process and product. We, therefore, present the findings of this study in the form of two literary pieces: A Healthy Conversation, which is a short story about the young Lebanese-Canadian women’s discursive constructions of health, and Health and Dancing Identities, which is a poem about the young women’s cultural identities and the ways in which they inform their constructions of health. We have sent these two pieces to the participants of our study and asked them to return their reactions, feedback, and any required changes. The young women who responded to the request agreed with the content of both the short story and the poem and felt they generally represented their positions and views about health and cultural identities. We do not claim that the poem and short story are illustrative of the experiences of all 20 young Lebanese-Canadian women in our study or of all Lebanese-Canadian women. Instead, we intend for the two pieces to depict bits and pieces of the young women’s reality in a trustworthy fashion.

**Young Lebanese-Canadian Women’s Discursive Constructions of Health**

**A Healthy Conversation**

Our first evocative representation is a short story that consists of a dialogue between two young hypothetical Lebanese-Canadian women, Salma and Jessica. The dialogue reflects the various themes emerging from our thematic analysis and relates to the young Lebanese-Canadian women’s discursive constructions of health. The italicized parts of the dialogue represent the actual words of the participants and the other parts are paraphrases from the recorded narratives. Overall, the dialogue serves as an accessible way to illustrate both the Lebanese-Canadian women’s dominant and marginal ways of constructing health. On the one hand, Jessica’s articulations of health are typical of those of the majority of the participants who construct themselves as “Lebanese-Canadian” or “Canadianized” subjects and mostly take up dominant neoliberal discourses related to health and the body to construct health even if at times they show moments of awareness, negotiation, and micro-resistance to these discourses. On the other hand, Salma’s constructions of health are representative of those of a small number of participants who construct themselves as mostly “Lebanese” and locate themselves as subjects within contemporary “Lebanese” cultural discourses related to health and the body. 
A Healthy Conversation

Salma and Jessica spend most of their spare time together comparing boyfriends, hairstyles, and dreams. They are both in their mid-twenties and were born in Ottawa to Lebanon-born parents. From time to time, they visit their larger family in Lebanon and it is the case this summer. On a typically sunny July afternoon in Beirut, the two young women are reunited at the beach and engage in a lively debate as they bask in the warm Mediterranean sun.

“I can’t believe how thin that girl is; she must be very unhealthy,” Jessica says. She curls her upper lip in disapproval as she stares at the young woman. “And why is she wearing heels? Look at her! She put on all the makeup she can find on her shelf. Does she think she’s in a fashion show? She’s so Lebanese!”

Salma rolls over lazily on her blanket. Her startled eyes take in the scene. Her voice rises with emotion as she replies, “What are you talking about, Jessica? She looks great! Look at those abs! I’d die to have her body and willpower. Would you rather be fat, then? Ewww! Not me, I don’t need my gossipy aunt sissying on me: ‘Ya habibti (my love), you’ve gained a pound, why are you eating that?’”

“Fat?” snorts Jessica, a frown wrinkling her forehead. “I guess I’m fat compared to all these skinny women.”

“You? Fat? Oh, come on, you know what I mean. Fat—like that woman over there at three o’clock. Haraaaam, she’s obese,” says Salma, pity flooding her voice. Then, lowering her voice to a serious, determined pitch, Salma affirms, “I would never ever let myself get to that point. You can tell if people are healthy just by looking at them. She probably has diabetes and high cholesterol among other health problems. And she knows she’s fat, so why is she wearing such a revealing swimsuit?”

Jessica’s on the defensive now. Her shoulders stiffen and her expression turns cold. “Well, what if she’s completely happy? I don’t see how a certain shape or size determines a healthy body. It’s more about the balance of the body, mind, and soul. Maybe she has a job that she enjoys and is content with her life—who knows? Just because she has a big stomach and dimpled thighs
doesn’t mean she’s less healthy than a skinny woman who probably doesn’t eat enough.”

“Look at my mom,” Jessica continues proudly, her shoulders relaxing a little. “She’s not obese or overweight or anything like that. She might be heavier than she should be, but she eats fine and walks around the block sometimes. She’s the happiest person you’ll ever find.”

Jessica stops and contemplates the chaotic sea for a moment, then looks directly into Salma’s eyes. “Life is unfair you know; it’s way easier for men to be healthy. They build muscle and lose weight in the blink of an eye. We, women, have so much junk in the trunk.” Jessica laughs out loud at this thought, her face softening. “To make things worse, we have to give birth, take care of the kids, and clean the house—oh, and deal with periods and menopause. No wonder it’s easier for men to be healthy,” she adds, a small edge to her words again.

Silent for a moment, Salma considers the opinion Jessica has just offered. “You have a point,” she finally says, “but I still think that you have to take care of your body regardless of your gender. Body weight is a simple equation. It’s all about calories in and calories out. There’s a place in Hull that has sandwiches that are this big!” “It has delicious turkey, crispy lettuce and juicy tomatoes.” Salma stretches her hand out as far as it will go, as if she had a gigantic sandwich that her hand could barely contain. “And it only costs three dollars. If you’re really motivated to lose weight, you can find a place to get healthy, delicious food in your own neighbourhood. But big people are just lazy,” says Salma, shaking her head in disgust.

Jessica is starting to lose her patience. She takes a slow, deep breath, and then says, “No offense, Salma, but sometimes I wonder if you’ll ever Canadianize. Why are you so judgmental of people’s looks?”

“Oh, please! We’re Lebanese, after all. We care about our looks—it’s in all of us,” insists Salma, smoothing her long hair back with her slender fingers. “And don’t start lecturing me about your Canadian values of acceptance and kindness.”

Jessica shrugs her shoulders and concedes with a smile, “I can’t deny that I took a lot from Lebanese values, but I also learned a
lot from Canadians. I think I am a big mix of both. I’m not Lebanese and I’m not Canadian – I’m Lebanese-Canadian! That affects how I see health. Now let’s go have some low-fat ice cream and then swim a few laps to burn it off. Let’s put our talk about health into practice!”

As highlighted in A Healthy Conversation, the young Lebanese-Canadian women construct health using a number of elements. In particular, five main themes emerge from the narratives of the participants. To them, health is (in order of frequency of mentions in the narratives): (a) being physically active, (b) eating well, (c) not being fat, (d) feeling good and happy, and (e) having a balance of the body and mind. In the following, we focus our discussion on the main themes and the sub-categories they entail.

With regards to the first two themes, the participants’ narratives most often imply that being healthy is equated with everyday lifestyle behaviours like “being physically active” and “eating well.” According to the young women, “being physically active” is mostly about involvement in non-organized activities, like “going to the gym,” “walking/jogging outside,” and “strength training at home.” Often in tandem with physical activity, “eating well” means “eating fruits and vegetables,” “avoiding junk food” or “having a balanced diet with all categories of the Food Pyramid.”

In addition to the prominent “healthy eating and regular physical activity” couple, a few participants speak of the importance of “taking care of the body” through other means such as “keeping stress at a low level,” “getting enough sleep,” and “staying clean.” Only two participants discuss health in connection to public health messages concerning abuse of harmful substances such as drugs, alcohol, and cigarettes and none of them mention the importance of safe sex or driving practices. With regard to external influences on health, only one participant alluded to environmental pollution.

These findings are not surprising as the young women repeat “typical” and ubiquitous messages related to good nutrition and physical activity that are bombarded on young women by various Canadian media and educational outlets. The overwhelming presence of nutrition and physical activity in the narratives of the participants clearly indicates that they are interpellated by “healthist” (Crawford, 1980) and “individualist” discourses (Rail, Holmes & Murray, 2010) that throw the primary responsibility of “being healthy” on individuals and that link “health” to practices that are performed on the body. In that regard, the young Lebanese-Canadian women’s constructions of health clearly point to their appropriation and reproduction of a dominant obesity discourse (Rail, 2012) that links weight to health and that over-emphasizes the
need to maintain a balance of energy intake and expenditure through good nutrition and rigorous physical activity in order to remain or become “thin” and “healthy.” The body is thus conceptualized in purely mechanistic ways and health is constructed in a manner that discounts social, environmental, and political factors. Our findings coincide with studies that have focused on children’s (Wright & Burrows, 2004) and young women’s and men’s discursive constructions of health (Burns & Gavey, 2008; Wright et al., 2006) in Australia as well as those of adolescents in Canada (Rail, 2009). Like the young Lebanese-Canadian women, participants in these studies emphasize the importance of personal responsibility for the maintenance of health as well as the monitoring of eating habits and physical activity as a primary route to health.

With respect to the third theme, all the young Lebanese-Canadian women in our study construct health as a matter of physical appearance of the body and specifically on the basis of “not being overweight” or “not being obese.” The participants draw close links between weight and health; they portray obesity as a morbid “disease” that causes other diseases, notably high cholesterol, diabetes, and heart problems. However, while most of the participants equate a healthy body with being “not fat,” some of the young women also point to the dangerous side effects of extreme thinness, and thus construct health as having a “normal” weight or a “normal” body that is neither too fat nor “too thin.” Furthermore, a few participants refuse to associate health with a specific body size and argue that health is rather related to feelings such as contentment with one’s body, self, and life. Unfortunately, such marginal subject positions are only temporary; the participants who adopt them at times soon thereafter locate themselves in compliant positions within the dominant obesity discourse, where they not only condemn “big bodies” but also judge themselves (who are not “obese”) for not being disciplined enough in their quest for the “ideal” and “healthy” (i.e., “not fat”) body. The young Lebanese-Canadian women’s discursive constructions of health are close to those found in the handful of studies on this topic as other young women also equate a healthy body with being “not fat” and the monitoring of eating habits and physical activity (George & Rail, 2006; Wright et al., 2006). Like their South-Asian Canadian counterparts (George & Rail, 2006), the young women in our study tend to reproduce a dominant obesity discourse that perpetuates discriminatory messages about fat bodies. While the participants assuredly position overweight and obese bodies as “disgusting,” “abnormal” and “unhealthy,” they simultaneously criticize mainstream Western cultural beauty ideals, notably the extremely slender ideal promoted by contemporary media outlets. Nevertheless, despite the disapproval of many young Lebanese-Canadian women of
“too thin” bodies, they still seem to yearn for weight loss. Most of the participants’ subjectivities are conflicted in relation to their health and bodies. Indeed, contradictions are often present in their narratives: what they construct as “health” in general (and for others) is not necessarily in line with the ways in which they construct their own health. Moreover, the practices they associate to health (e.g., diet and regular physical activity) are not often those they report for themselves.

It is relevant to note that the participants’ ideas of health shift between gendered and un-gendered images of physical appearance. At first glance, the majority of the young women insist that there are no differences between their constructions of a “healthy woman” and those of a “healthy man.” Nevertheless, the participants show their awareness of cultural beauty expectations and media ideals, notably the thin and slightly toned body for women and the muscled and strong one for men (cf. Bordo, 1993). The young women refuse to equate such gendered images with health yet they later go on to contend that women are less healthy than men for reasons that seem to conflate health with weight loss (“it is easier for men to be healthy because they lose weight and build muscle fast”). Such fragmented subject positions are evident throughout the narratives of most of the young Lebanese-Canadian women, whose subjectivities are changing yet never too far from the dominant obesity discourse and the dominant gender discourses.

In the fourth and fifth themes, the young women construct health in relation to a mental, psychological, and/or social state of well-being. They particularly associate health with: (a) positive attributes (i.e., “being happy,” “being optimistic,” and “being friendly”); (b) a sense of balance (i.e., “being all-rounded,” “feeling healthy from the inside and the outside,” and “having a balance of the body, mind, and soul,”); (c) a healthy mind (i.e., “not having depression or anxiety,” “being able to perform every-day activities,” “having a purpose in life”); (d) positive bodily feelings (i.e., “feeling good about your body”); and (e) having social capital (i.e., “having lots of friends”). Such constructions of health go hand in hand with the findings of Elliot and Gillie (1998), Choudry (1998) and Rail et al. (2006) who have reported that women of various ethnic minorities underline the importance of psychological well-being and spirituality for health. The construction of health in terms of such non-bodily factors among these women may highlight the importance of social networks and cohesion in ethnic communities and the ways in which such factors may overshadow prevailing discursive elements of dominant discourses such as the one purporting the centrality of the weight and shape of the body for health.

That being said, while most of the young women in our study construct health in mental and psychological terms at various points in their narratives, they locate themselves as “un/healthy” largely on the
basis of bodily and lifestyle factors like body size, levels of physical activity, and nutritional habits. Furthermore, although most of the participants construct themselves as “healthy,” they do express feelings of guilt for not being “healthier” or “thinner” because they perceive as insufficient their level of involvement in the main activities they cite as essential for health. The young women further speak of their struggles to overcome daily obstacles such as “laziness,” “lack of time,” “lack of willpower,” “love of food,” and “stress,” in their attempts to “perform” health. The young Lebanese-Canadian women, thus, shift between “healthy” and “unhealthy” subject positions because they construct themselves at times as healthy, and at other times as guilty subjects who are not doing enough for their health. These findings show the young women’s recuperation of dominant health and obesity discourses that have generated new forms of normalizing practices that focus on the regulation of bodies to reduce health risks. While we recognize that participants recite many elements of such discourses (e.g., the importance of personal discipline; individual responsibility for health and weight), they are far from being naïve subjects who blindly repeat dominant notions about health and obesity. Indeed, the participants are aware of, and interpellated by, the alternative discourse of “health at any size” as well as discourses that construct health on the basis of psychological and mental well-being. Overall, the complex and fluid subjectivities of the young Lebanese-Canadian women highlight the “effects” (Foucault, 1970) of the power circulating through the interwoven discourses of health, obesity, and gender.

Health & Dancing Identities

Our second evocative representation, “Health and Dancing Identities,” is a poem about the “cultural identities” (Hall, 2003; Tsolidis, 2003) constructed by the young Lebanese-Canadian women in their health narratives. Poetic representation is a relatively novel endeavour in the social sciences, albeit a very promising one. Richardson (2000b) contends that “writing up interviews as poems, honouring the speaker’s pauses, repetitions, alliterations, narrative strategies, rhythms, and so on may actually better represent the speaker than the practice of quoting prose snippets” (p. 933). We, therefore, chose to write a poem that depicts not only what the young women told us, but also what they left untold. We follow Denzin and Lincoln’s (2005) view of research as value-laden; research in which each researcher’s class, ethnic, and cultural characteristics affect her preconceptions and assumptions toward the social world. Although the participants have evaluated the poem as a very good depiction of their issues as immigrant and/or minority women, it is important to mention that we have clearly manipulated the
content of this piece, which stands as a co-construction of the results: our words and those of the participants. Consider the poem below.

Health & Dancing Identities

I look into the mirror and wonder
Who am I? Where do my borders lie?
Lebanese
Canadian
Does either describe me?
Lost in perplexity

What land is home?
Within which arms do I belong?
Lebanon
Canada
Maybe it’s me
Who doesn’t fit, who’s wrong

Some times I’m Canadian
Others, Lebanese
I’ve grown tired
of having to choose between

I want that thin, tight magazine body
To be pampered with mom’s hummus
Calorie laden and fattening
Creamy, tasty, healthy for my soul

Jogging on the beautiful canal
I dream of finishing a marathon one day
Of living like the big jolly women of my village
Relaxing under my house’s ancient trees
Exchanging gossip with cousins
Breathing the gentle Mediterranean breeze

This, I call health. Or not.
I feel healthy when my diet and I don’t compete
Perhaps my Grandma Anisi was right from the start
I have more energy when I eat more
Am I healthier when chubbier?
No, no. We live a world apart

Eat little, move a lot
Lose weight, be healthy
A happy balance is key
And don’t forget fat is the enemy

I peer in the mirror again and try to decide
Lebanese? Canadian?
No need to choose, to insist on pride
Lebanese-Canadian is my identity
My health is my identity
Being happy, being me

As illustrated in the above poem, the young Lebanese-Canadian women construct health in relation to their shifting cultural identities; the participants perform both their Lebanese and Canadian identities when they construct health. Following Butler’s (1988) conceptualization of gender performativity—in which she argues that what we commonly associate with femininity and masculinity is a “performance,” one that is imposed upon us by heterosexist discourses—we see cultural identity as performative as well. Cultural identity is far from being a fixed and essentialist concept; it is real to the degree that it is performed by a subject. Cultural identity is constantly (re)constructed within dominant and/or alternative cultural discourses that constitute subjects in certain times and places. Therefore, we do not refer to the Lebanese-Canadian women as possessing stable “Lebanese” or “Canadian” identities but rather as performing certain acts that are expressive of their multiple and fluid cultural identities.

Interestingly, while most of the participants construct themselves as hybrid Lebanese-Canadians, they portray other Lebanese-Canadian women differently. Many participants use certain terms such as “so Lebanese” and “Canadianize” in their narratives to construct other Lebanese-Canadian women on the basis of two fixed categories, either “Lebanese” or “Canadian.” This is not surprising since cultural identity is portrayed by white colonial discourses as complying either with truth or falsity, thus erasing the fluid nature of cultural “performativity” and serving as a form of social control and regulation. The young Lebanese-Canadian women in our study reproduce stereotypes of “true” “Canadian” and “Lebanese” cultural identities as they discursively construct health. According to the participants, the performance of a “Lebanese” identity entails the construction of health within contemporary “Lebanese” discourses of femininity and beauty, therefore, on the sole basis of the physical appearance of the body along with an extreme disgust of overweight and obesity. In contrast, the performance of a “Canadian” identity is associated to constructions of
health with a focus on the balance of bodily and non-bodily aspects of being healthy as well as an open-mindedness toward fat.

As the participants construct health, they are constantly involved in processes of association with and dissociation from both their “Lebanese-ness” and “Canadian-ness.” Handa (2003) explains that immigrants face many challenges as they struggle between assimilation to Western society and maintenance of their original cultural identity; this phenomenon is replicated in our young Lebanese-Canadian women’s narratives. For example, many participants dissociate themselves from today’s women in Lebanon and show their disagreement with the latter’s conflation of health with thinness and beauty. In doing so, they affirm their “Canadian-ness” and perform their “Canadian” subjectivity. Paradoxically, the participants not only dissociate themselves from today’s Lebanese women, whom they describe as extremely self-consumed and absorbed with fashion and beauty; they also dissociate themselves from older and more “traditional” Lebanese women who equate health with a small excess of weight or plumpness but who, at the same time, construct very big bodies as being severely diseased and deserving pity. For example, while speaking of their parents’ reactions to the sight of a so-called “obese” woman, some participants explained that their parents construct obesity as equivalent to a morbid disease such as cancer and use expressions such as Sakhneh (she is sick) along with Haram (poor thing) to express their feeling of extreme disgust or pity. The participants disagree with their parents’ extreme positions and rather construct overweight and obese bodies using less extreme terms. Some of the young Lebanese-Canadian women even have non-judgemental attitudes toward fat persons, at times reproducing a subversive discourse of fat acceptance.

Overall, by distancing themselves from their parents’ intermingled constructions of health and obesity, the participants clearly attempt to locate themselves as “Canadians” or at least as more “Canadianized” than their parents.

Some of the participants praised Canadian women for engaging in physical activity to improve their general sense of well-being. By contrast, the participants depicted Lebanese and Lebanese-Canadian women as being inescapably focused on thinness with regard to health and as engaging in physical activity for the sole purposes of weight loss and beauty. But in further processes of association and dissociation, the young Lebanese-Canadian women also dissociate themselves from Canadian women, whom they construct as more interested in improving their health than in changing the (bad) appearance of their bodies. In doing so, the young women in our study affirm what they see as their “Lebanese-ness” and perform their “Lebanese” subjectivities by dissociating themselves from their Canadian counterparts. These
alternations between the performance of “Lebanese” and “Canadian” subjectivities are operated through the recuperation of competing cultural discourses that surround health, obesity, and the body. The participants can be seen as hybrid subjects who construct their multiple identities in diasporic space as they constantly borrow from Lebanese, Canadian, and Lebanese-Canadian stereotypes and discourses to construct health and themselves. Our findings coincide with those of Abdelhady (2006, 2008) who concludes that Lebanese immigrants in Montreal, Paris and New York are in a constant struggle to reshape their identities within the ongoing inter-exchange between the norms and values perpetuated by the dominant discourses of both their “home” and host countries.

It is worthwhile to mention that, although the participants alternate between distancing themselves from Lebanese and Canadian women in their narratives, they seem to envy their Canadian counterparts and predominantly aspire to fully become “Canadianized” in relation to their constructions and performances of health. This situation is also reflected in the participants’ basic choice of language; for example, three of the participants chose Arabic pseudonyms—Dalia, Samia, and Nora—unlike all the rest, who chose Western names such as Jessica, Jennifer, and Laurie. Such distinctions may indicate the desire of the small first group to associate with an Arab culture and of the second larger group to dissociate from it. Our findings echo those of Eid (2008) on Arab-Canadian students’ positionings in diasporic space, and those of George and Rail (2006) on South-Asian women in Canada. For instance, second-generation Arab-Canadian youth in Montreal did not reproduce their parents’ cultural values in a direct manner but drew upon them to (re)build their identities in ways that downplay their “Arabness.” Similarly, young South-Asian-Canadian women felt that they were less “South-Asian” than their parents. In our study, it is quite clear that the young Lebanese-Canadian women actively negotiate their positioning and (re)create their cultural identities within the Lebanese-Canadian diaspora despite their families’ attempts to convey collective norms and values about health and fat bodies. On the one hand, the participants resist and overtly criticize the demanding “Lebanese” standards of femininity as well as the “Lebanese” women who take up such standards and become overly preoccupied with weight loss for aesthetic reasons. On the other hand, the participants speak of the pressures to be thin and the additional body monitoring they undergo before a trip to Lebanon; in doing so, they reproduce what they see as the “Lebanese” discourse of beauty to which they simultaneously object. As the participants explain, the wrongful performance of one’s perceived cultural identity (i.e., the performance of a “Canadianized” identity while visiting Lebanon) engenders a set of direct and indirect punishments such as judgemental
and marginalizing gazes from relatives and friends. The young Lebanese-Canadian women confess of engaging in a range of disciplinary practices before going to Lebanon; such practices allowing them to “appropriately” perform a cultural identity closely interconnected to “Lebanese” discourses of beauty and health. Although thinness is a Western construct (Becker, Burwell, Gilman, Herzog & Hamburg, 2002; Bordo, 1993), the young Lebanese-Canadian women link their lust for thinness to a “Lebanese” discourse of beauty rather than a “Western” or “Canadian” one. They subsequently condemn Lebanese and Lebanese-Canadian cultures (which are represented as homogeneous blocks of patterns and values) for the perpetuation of “superficial” notions.

In addition to their negotiation of a “Lebanese” discourse of beauty that idealises thinness and severely condemns fatness, some participants express their refusal of sexist roles within traditional Lebanese families while partially subscribing to them. For instance, many of the participants object to their mothers’ submissive position and reluctance to take care of their own health for the benefit of their children’s and husbands’ well-being. The participants’ resistance to the traditional “Lebanese” discourse of heterosexuality and motherhood is not complete however as they occupy ambivalent subject positions within such discourse. Although they appropriate several of its elements (e.g., they mention that they will get married, they will perform motherly roles), they also contest others. For example, the participants compare the “Lebanese mother” and the “Canadian mother” to emphasize how the former always put her family above her own health needs, while the latter has a balanced life as she simultaneously takes care of her personal health and that of her family. While the young Lebanese-Canadian women appreciate their mothers’ “sacrifices,” they aspire to perform “Canadian mother” roles in the future. The narratives point to the participants’ appropriation of white colonial discourses that discursively produce a singular image of the “third-world woman” as traditional, inferior and financially dependent on men in comparison to Western women who are represented as modern, independent, liberated, and possessing control over their lives (Mohanty, 1988). Again, the participants unwittingly paint fixed and uniform images of the “Lebanese” and “Canadian” women; these depictions go hand in hand with their discursive portrayals of Canadian women as superiorly broad-minded with regard to physical appearance and health. Such ideas suggest that the participants’ constructions of health, Canadian women, and themselves are highly rooted in White colonialism and racism.

Paradoxically, the young Lebanese-Canadian women perform resistance to white colonial discourses by refusing to choose between the performance of a “Lebanese” cultural identity and a “Canadian” one.
when they construct health. They affirm both their Lebanese and Canadian subjectivities as they negotiate traditional as well as modern “Lebanese” and “Canadian” discourses surrounding health, obesity, and the body. The participants thus emerge as hybrid Lebanese-Canadian subjects located in a “third space” characterized by ambivalence and resistance (Bhabha, 1990). We explain such third space subject positions as born out of tensions between competing discourses of “Canadian-ness” and “Lebanese-ness” that speak to health and the body. It is possible that the young Lebanese-Canadian women construct their identities as hybrid to counteract a monolithic representation of “Lebanese” women in Canada. They negotiate a subjectivity that is partly Canadian and partly Lebanese to affirm their “Canadian-ness” and partial belonging to the dominant (i.e., Canadian) society. In other words, this strategy may be an attempt to strengthen their position and weaken the hegemonic discourses of racism and whiteness that inform constructions of health and of minority women in Canada.

CONCLUDING THOUGHTS

In this paper, we have explored young Lebanese-Canadian women’s discursive constructions of health. We have also shed light on how the cultural identities of these women inform their constructions of health. The results of our thematic analysis show that the young Lebanese-Canadian women primarily construct health on the basis of individual factors that are related to lifestyle (i.e., physical activity and healthy eating) and to a “normal” appearance of the body (i.e., being “not fat”). Notably, the majority of the young women show disgust for overweight and obese bodies when constructing health. However, they also view obesity as a serious deterrent to health and a “disease” whose bearer deserves compassion. The participants clearly distinguish between “Lebanese” and “Canadian” ways of constructing health. They represent the “Lebanese” way as backward, overly focused on thinness, and extremely judgemental toward “fat” bodies. In contrast, the “Canadian” way is seen as progressive, more holistic (i.e., taking into consideration the physical, psychological, and mental well-being of the individual), and open-minded with regard to overweight/obese individuals. While the participants locate themselves in-between a Canadian space and a Lebanese one, they speak of being more “Canadian” when constructing and “performing” health.

Our poststructuralist stance allowed us to look at how the young Lebanese-Canadian women speak about health while taking up, negotiating, and/or resisting a number of discourses. The participants most often occupy neoliberal subject positions and construct themselves as self-authored subjects (i.e., in control of their lifestyle choices, weight,
and health) within the dominant obesity discourse that links weight to health and the discourse of personal responsibility for one’s health and lifestyle. However, these compliant subject positions are not absolute as the young women also construct themselves as timid “poststructuralist” subjects (Davies et al., 2006; Weedon, 1997[1987]) showing moments of awareness of, and slight resistance to, such mainstream neoliberal discourses. Overall, subjects have complex and at times conflicted positions, for instance when they link health to feelings of happiness and contentment with one’s life, but at the same time construct themselves as un/healthy on the basis of factors such as level of involvement in physical activity, eating habits, and the weight and shape of their bodies. While the participants’ construction of themselves as subjects within both dominant and resistant discourses may appear incongruous, we believe that it is merely a depiction of the non-unified nature of subjectivities (Hall, 2001). We also believe that the positions that the young women adopt are temporary, since they are bound to re-construct their subjectivities in different social and temporal contexts. Subjectivities are also constructed in the context of our recorded conversations. No doubt that the interviewer’s identity (a university-educated Christian Lebanese-Canadian woman) as well as her preconceptions in relation to issues of health and the body had an influence on the conversations with the participants. Had the second author (an atheist, white, queer Québécoise) engaged in conversations with the participants, they might have performed their subjectivities in different ways.

Complimentary to our feminist poststructuralist stance, our feminist postcolonial lenses allowed us to better our understanding of the ways in which notions of culture and cultural identity impact the young Lebanese-Canadian women’s constructions of health. At first glance, these women seem to perform both (what they and many others understand as) “Lebanese” and “Canadian” cultural identities. However, a further look at the narratives unveils their desire to become more like Canadian women, whom they portray as superior to Lebanese or Lebanese-Canadian women because of their capacity to live balanced lives and to detach themselves from the superficiality of physical appearance with regard to health. The use of the term “Canadianize” by some of the participants reflects their desire for “cultural hybridization” (Bhabha, 1994). Although the participants often subscribe to a white colonial discourse that homogeneously portrays young minority women as inferior “Others” who should “Canadianize,” the young Lebanese-Canadian women’s constructions of themselves as hybrid can be seen as a form of opposition to Western neo-colonial discourses that represent Arab and/or Middle Eastern women as resistant to modernity (Said,
Abou-Rizk & Rail: FAT BODIES, LEBANESE-CANADIAN WOMEN

1987) as well as a form of appropriation of “modern” Western standards when discursively constructing health.

The way in which the hybrid cultural identities of the young Lebanese-Canadian women inform their constructions of health is complex and in no way uniform and clear-cut. To further understand the issue, it would be crucial to analyse further how the ethnicity, cultural identity and gender of the young Lebanese-Canadian women intersect with structural factors such as religion, socioeconomic status and sexuality to inform constructions of health. For example, the small number of participants in the present study prevents us from drawing any conclusions, but we suggest that participants with relatively lower socioeconomic backgrounds seem to occupy more complying subject positions in comparison to their privileged counterparts. The women from disadvantaged backgrounds explicitly appropriate elements of dominant discourses of obesity, personal responsibility for health and lifestyle, and traditional femininity in their narratives, in addition to so-called “Lebanese” discourses of beauty when they speak of health and their extreme preoccupation with weight loss and thinness. In contrast, while most of the participants of privileged milieus also occupy neoliber al positions and engage in questionable “health” practices, they simultaneously express more awareness of alternative discourses. This is not to say that women coming from disadvantaged backgrounds are naïve subjects vis-à-vis mainstream discourses, but to propose that they may be exposed to a limited array of subversive discourses surrounding health, obesity, and the body, and that they may not be sufficiently empowered to resist dominant corporeal discourses. We argue, therefore, that Lebanese-Canadian women of lower socioeconomic status are at an increased disadvantage in face of the heterosexist, classist, and gendered discourses related to health and the body, and that these women warrant the most attention, given the detrimental “effects” that such discourses may have on them.

Finally, it is our hope that this paper will serve as a starting point to assist health researchers, interventionists, and officials in their socio-culturally contextualized interventions to better understand—and ultimately improve—minority women’s health beyond the weight and shape of the body. Based on the results of our study, we offer a few suggestions here. First, additional resources should be allocated to train public health practitioners in the development of culturally-mindful interventions that take into account certain cultural specificities, such as those described by the young Lebanese-Canadian women in our study. However, it seems crucial to also focus on training health practitioners in better understanding the complexity and fluidity of ethnic minorities’ cultural identities and avoiding the reproduction of stable, fixed images/stereotypes of diverse groups of ethnic minority women.
Notably, given these women’s conflation of weight and health and their over-emphasis on physical appearance, it seems crucial to provide them (and other minority women) with counter discourses and more appropriate health-related messages. Second, although it is well documented that the most important determinant of health is socio-economic status—a factor that is often outside an individual’s locus of control—the young Lebanese-Canadian women’s narratives strongly emphasize individual responsibility for health. Despite Canada’s reputation as a leader in the field of Population Health, health professionals and policymakers emphasize “downstream” behavioral strategies rather than “upstream” ones that address the broader structural determinants of health (Raphael, 2003). It thus seems necessary for health interventionists to make serious and pragmatic efforts to integrate alternative discourses that do not blame individuals who fail to “perform” health and to rather consider the social determinants of health (WHO Commission on SDH, 2005) for the design of health interventions that should be tailored for minority women. Third, perhaps due to the power of “health” industries and systems, obesity and the controversial rhetoric of a “global epidemic of obesity” have continued to appear on public agendas. Given the harms associated to this rhetoric as well as the problematic shift in health priorities it has engendered (see Gard, 2010; Rail, 2012; Wright & Harwood, 2009), health professionals and public health officials are urged to seriously acknowledge the greater impact of social, economic, cultural, and environmental factors on young women’s health (i.e., work on upstream strategies) as well as to pay more attention to the language they use in their (downstream) interventions. More specifically, it is preferable that health professionals avoid health interventions that emphasizes weight and physical appearance and rather to adopt an empathetic approach that does not put the onus of being healthy solely on the individual. We contend that the creation and reproduction of alternative discourses, such as that of the social determinants of health, could potentially impact women in general—and Lebanese-Canadian women in particular—and bring them to construct health and health promotion not solely as a personal responsibility but as a social responsibility. Fourth, we see that there is an urgent need to debunk cultural stereotypes and generalizations about Lebanese-Canadian women. Despite our relatively small sample of participants, it is quite clear that it is impossible to homogenize these young women, since their constructions of health and their subject-positions vary to a large extent according to the intersection of their gender, ethnicity, socio-economic status, and religion. Health interventions should be mindful of the effects of Orientalist stereotypes about Arab women (Said, 1987). Homogeneous constructions of Arab women that are perpetuated through Western media outlets and
institutions should be actively deconstructed not only to decipher the ideological misrepresentations they perpetuate, but also to understand the “regime of truth” (Foucault, 1980) that sustains neo-colonial discourses (Bhabha, 1994). Fifth and last, the constant links that the young Lebanese-Canadian women make between health and individual behaviors (e.g., physical activity) or attributes (e.g., weight) should act as a wake-up call for health officials who should reconsider current policies and health programs. While nutrition and physical activity are undoubtedly elements that impact on health, they seem to be closely intertwined with an ultimate desire for thinness and beauty among the young Lebanese-Canadian women in our study. Such particularities ought to be taken into consideration in the design of health interventions and programs in order to deconstruct the stubborn and dangerous connections between health and weight, and eventually to deliver more appropriate and effective health messages.

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