Understanding the relationship between body image and menopause in South Asian Canadian women

Taranjot Kaur Dhillon, Bachelor of Kinesiology (Honours)

Applied Health Sciences (Kinesiology)

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Faculty of Applied Health Sciences, Brock University St. Catharines, Ontario

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ABSTRACT

Research regarding women’s body image during menopause is limited; few studies reflect the experiences of ethnic women, especially South Asian women living in Canada. Cultural differences play an important role in both body image and menopause experiences and may be particularly important to South Asian women, who often fear stigmatization and struggle with openly discussing health concerns. This study used interpretive phenomenological analysis, which focuses on understanding and interpreting the experiences of the participants, to explore the relationship between body image and the transition of menopause in South Asian Canadian women. Nine first generation South Asian immigrant Canadian women (aged 49-59 years), in perimenopause or postmenopause were recruited for semi-structured individual interviews. Overall, three themes were constructed: 1) Complexity and intertwining of body image and menopause experiences, which showed that although women understood body image as a multidimensional construct, their own body image focused on weight and appearance that was impacted by menopause and aging; 2) “It's just something we go through silently”: The challenges of body image and menopause experiences, which highlighted the lack of personal support from family and South Asian community and the disconnected feeling from their bodies through the menopause transition; and 3) The push and pull of South Asian and Western cultures, which focused on conflicts between the two cultures and influence of the South Asian culture on beauty, body image, and aging. Results showed that participants often upheld Western body image ideals by equating positive body image practices and attitudes with these ideals, and this was often worsened by South Asian cultural norms. Additionally, women’s understanding of body image and
menopause showed a gap between their personal understanding and research. Participants emphasized a lack of ethnically appropriate education for body image and menopause, suggesting there is a need for the implementation of culturally-appropriate and community-based interventions, and resources (e.g., workshops, seminars, support groups). Moreover, an underlying narrative of cultural conflict (Western vs South Asian cultures) and impact of the South Asian culture was evident. Therefore, further examination of the complexity and influence of the South Asian culture on body image and menopause experiences is required.

Keywords: body image, menopause, South Asian women, Canada, culture, ethnicity
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CHAPTER 1: LITERATURE REVIEW

Body Image

Body image is a multidimensional construct that encompasses perceptions and attitudes of the body’s appearance and functionality (Cash & Pruzinsky, 1990; Cash & Smolak, 2011). Cash (2012) developed a cognitive-behavioural model to describe the relationship between the self and body image. Body image is comprised of two dimensions: 1) perceptual body image, and 2) attitudinal body image. Perceptions refer to an individual’s subjective views of their body’s appearance, including weight, size, and shape. Attitudes consist of cognitive, emotional and behavioural dimensions and consists of two elements: body image evaluation and investment (Cash & Smolak, 2011). Body image evaluation refers to satisfaction or dissatisfaction with the body, whereas investment refers to the cognitive, behavioural, and emotional importance of (usually) appearance to the self. The ability to cope with body image as outlined in this model includes three strategies: 1) avoidance (avoiding situations, thoughts or feelings that threaten body image); 2) appearance checking and fixing (constantly checking one’s appearance, and fixing or altering themselves, as it is perceived flawed, in order to meet the ideal); and 3) positive rational acceptance (self-care and acceptance of one’s appearance and body’s functionality; Cash, Santos, & Williams, 2005; Cash & Smolak, 2011; Cash 2012).

Though a heuristic lens, the sociocultural model attempts to conceptualize negative body image, a construct that is highly prevalent in North America. In this model, societal ideals of beauty exist within a culture, and these ideals are promoted through various sociocultural avenues (e.g., friends, family, media, social media; Cash & Smolak,
The ideal appearance differs between men and women. The ideal for men is a muscular and lean body, while for women the ideal focuses on thinness with some muscle tone (Cash & Smolak, 2011; Grogan, 2017). More specifically, the female ideal is depicted as a “young, tall, long-legged, large-eyes, moderately large breasted, [slightly] tanned”, perfect skin (no acne or scarring) and extremely thin with some muscle tone (Cash & Smolak, 2011, p. 13). Although implicit in this ideal is White and able-bodied, body weight and shape (i.e., thinness with some muscle tone) are the most critical aspects, which many women attempt to achieve via engaging in both healthy (e.g., intuitive eating, exercise) and unhealthy (e.g., restrictive eating, smoking) behaviours. The ideal for both men and women is unrealistic to achieve for most people, yet, because these ideals are so pervasive, they are internalized by many individuals. As a result, many people strive for the ideal appearance, believing it will lead to positive wellbeing, happiness, success, and satisfaction (Cash & Smolak, 2011). However, because most often people are unable to meet this ideal, they remain constantly dissatisfied with their appearance.

**Negative Body Image**

Body image consists of two distinct constructs, negative and positive body image, although the majority of research has focused on negative body image, and most often body dissatisfaction (Cash & Smolak, 2011). Negative body image consists of discontented attitudes about the body, most often of one’s appearance but also related to functional aspects of the body (Cash & Smolak, 2011; Fredrickson & Roberts, 1997; Fredrickson, Hendler, Nilsen, O’Barr, & Roberts, 2011). Body dissatisfaction is often
conceptualized as the discrepancy between perceptions of one’s own physical characteristics and the characteristics one wishes to possess (i.e., the ideal; Grogan, 2017; Sahay & Piran, 1997). Body dissatisfaction can lead to unhealthy behaviours (e.g., disordered eating or weight-control practices such as restrictive eating and binge-eating, cosmetic surgeries; Cash & Smolak, 2011; Slevec & Tiggemann, 2011) and negative psychological outcomes (e.g., depression, anxiety, low self-esteem, shame; Slevec & Tiggemann, 2011).

While the majority of body image research has examined negative body image, the emergence of positive body image research has begun to examine constructs such as body acceptanc e, body satisfaction, and body appreciation.

**Positive Body Image**

Positive body image is defined as an overarching love and respect for the body (Tylka & Wood-Barcalow, 2015). It is characterized by body acceptance (being comfortable with one’s body and focusing on its assets), body appreciation (valuing the body for what it can achieve), and overall satisfaction with the body’s appearance and function regardless of whether it meets societal ideals (Tylka & Wood-Barcalow, 2015). Tylka and Wood-Barcalow (2015) argued that positive and negative body image are not simply opposite ends of the same continuum; instead, they are distinct constructs that operate separately. As a result, individuals can experience both positive and negative body image simultaneously. It is important to note that as distinct constructs, the absence of one does not imply the presence of the other (e.g., reducing negative body image does not lead automatically to positive body image). Instead, reducing negative body image can lead to a neutral body image – neither positive nor negative.
Positive body image has been linked to engaging in health promoting behaviours (e.g., physical activity, intuitive eating) and positive psychological outcomes (e.g., higher self-worth and self-esteem, confidence, optimism; Tylka & Wood-Barcalow, 2015). Tylka and Wood-Barcalow (2015) highlighted that well-being, self-care and eating behaviours are uniquely linked with positive body image. For example, Avalos, Tylka, and Wood-Barcalow (2005) assessed positive body image (specifically body appreciation) in four independent samples of US college women and reported a strong link to well-being (self-esteem, optimism, proactive coping).

Just as negative body image differs across gender, there is some evidence positive body image may also differ. Tiggemann (2015) reviewed literature on positive body image across social identities, including gender, and concluded these gender differences are generally smaller and less consistent in positive body image than those in negative body image. Studies which directly compared men and women from a variety of nations (i.e., French, Brazilian, Indonesian, US, UK, participant samples) generally showed higher body appreciation in men than women (Kertechian & Swami, 2017; Swami et al., 2011; Swami & Jaafar, 2012; Todd & Swami, 2020; Tylka, 2013). However, one study showed that Malaysian women had higher body appreciation than Malaysian men. A few studies have shown no gender differences in body appreciation in samples from Britain, Spain, and Poland (Razmus & Razmus, 2017; Swami, Hadji-Michael, and Furnham, 2008; Swami, García, and Barron, 2017). Moreover, evidence shows that both men and women report in engaging in similar self-care behaviours (e.g., intuitive eating; Tylka, 2013). These inconsistent findings hint at cultural differences that may exist in positive body image, and thus examining social identities such as age and ethnicity is warranted.
Ethnicity and Body Image

Within Western cultures, implicit within the ideal of beauty is an assumption of lighter skin (Cash & Smolak, 2011). The Western ideal oppresses and confines women of colour from expressing their own interpretation of beauty, as they often internally judge themselves on how closely they meet the Western ideal (i.e., White). As such, visible minorities may struggle even more than White women to reach this body image ideal.

Grabe and Hyde (2006) conducted a meta-analysis reviewing body dissatisfaction in three groups of minority American women (Asian, Black and Hispanic-American) and White women. Body dissatisfaction was present across all the groups; however, the degree and sources varied. The majority of the studies found White women reported higher levels of body dissatisfaction compared to Black women. Studies comparing Asian-American and Hispanic women to White women found little to no evidence of body dissatisfaction differences between these groups (Grabe & Hyde, 2006).

Further, Swami, Henry, Peacock, Robert-Dunn, and Porter (2013) noted ethnic identity is a factor often neglected in body image research. Ethnic identity includes both affective (ethnic identity attachment – belonging, committing to one’s ethnic group) and developmental (search for one’s ethnic identity) factors (Swami et al., 2013). Those who are high in ethnic identity attachment report struggling with their body image, and often feel pressured to conform to Western societal standards of body image, which can lead to negative body image (e.g., skin tone dissatisfaction; Swami et al., 2013).

It is possible the sources of dissatisfaction differ between White women and ethnic women. Grogan (2017) and Swami et al. (2009) argue that cultural pressures and the degree of acculturation, which is a multi-dimensional process that describes one’s
acquisition of a new or dominant culture, play important roles in influencing body image attitudes in women. From a Western cultural standpoint, ethnic individuals who are immersed in a predominately White environment face greater body dissatisfaction, disordered eating and overall discontent with their bodies than the White population (Cash & Smolak, 2011; Grogan, 2017). Swami et al. (2009) argued that acculturation to Western ideals that cause negative body image (i.e., body dissatisfaction) may be mediated by culture-specific ideals (e.g., acceptance of a variety of body shapes) of ethnic populations. For example, compared to White women, Black women tend to be more satisfied with their bodies, as cultural ideals tend to promote less thin body-shape ideals (Grogan, 2017).

Tiggemann (2015) reviewed research on positive body image across various social identities including ethnicity/culture. Overall, research shows the existence of positive body image constructs (i.e., body appreciation) across various cultures and ethnicities in women (i.e., German, Hispanic, Caribbean, and South Asian women). However, Tiggemann (2015) highlighted concerns when measuring body appreciation via the Body Appreciation Scale (BAS; Avalos et al., 2005). Some evidence suggests that although the BAS has a unidimensional structure in Western populations (i.e., US, UK, Australian, and German populations), in other cultures (i.e., Malaysian, Indonesian, and Brazilian populations) a two-factor structure has been reported as a better fit, in which body appreciation is distinct from investment (Swami & Chamorro-Premuzic, 2008; Swami & Jaafar, 2012; Swami et al., 2011). These studies indicate that the language translation of the BAS and each distinct population’s understanding of the BAS items (e.g., the meaning of bodily acceptance and respect; Swami & Jaafar, 2012) may strongly
influence how body appreciation is operationalized and call into question the invariance of the scale’s factor structure.

Cross-cultural factors (i.e., cultural attitudes of body image) may influence body image and need to be further investigated. For instance, Swami et al. (2009) argued ethnic minority women may not internalize the Western thin body ideal, as their cultural-specific ideals may differ in perceptions of physical attractiveness and may emphasize interpersonal factors (i.e., self-worth) over appearance, which could lead to higher body appreciation and positive body image. In a North American context, Swami et al. (2009) noted that research shows that ethnicity may protect women from negative body image attitudes and dissatisfaction in at least two ways: 1) their cultural ideals are different from the thin Western ideal, or 2) their values are not only related to their external appearance, but to internal characteristics such as self-esteem and confidence, which are associated with more positive body image (Swami et al., 2009).

Although in general there is limited research on body image in ethnic groups, researchers have particularly noted the scarcity of research with Asian-American women, including South Asian women, which is directly related to the limited knowledge of body image amongst this population (Grabe & Hyde, 2006). Given the influence of cultural factors on body image, to understand body image in South Asian women in particular, cultural ideals and practices must be examined.

South Asian culture. South Asian ethnicity is defined as descending from the nations of India, Pakistan, Afghanistan, Bangladesh, Nepal, Bhutan, Maldives, and Sri Lanka. According to Census Canada 2016 (ethnic origin population), in Canada, the South Asian population represents 5.7% of the total population (8.9% in Ontario, 8.0% in
British Columbia, 5.8% in Alberta), while South Asian women represent 5.5% of the total population (8.7% in Ontario, 7.8% in British Columbia; 5.7% in Alberta; Statistics Canada, 2017a-c). The South Asian culture is a symbiotic interaction between the self, the family, and the community. There is an overall notion that personal goals, social behaviours (duties, obligations, mannerisms), and the orientation of relationships are based on communal ideals (Ahmad, Mahmood, Pietkiewicz, McDonald, & Ginsburg, 2012). It is expected that South Asian individuals, especially women, must place their family and community above all in order to create and uphold a good reputation within their community. Furthermore, questions and thoughts that may deviate from cultural norms are not acceptable or encouraged. As such, in order to maintain order and harmony, personal goals and beliefs are both suppressed and sacrificed. In contrast, the Western culture is “independent, personal goals have priority over group goals, social behaviour is guided by attitudes, personal needs, rights and contracts, and relationship maintenance is critically analyzed for advantages and disadvantages” (Ahmad et al., 2012, p. 248).

The South Asian community is built on the notions of closeness, strong familial and friendship bonds, and an overall support system. However, this community can become a confining factor for many South Asian women. Compared to men, family dynamics for women show higher levels of parental conflict and over-protection (Swami et al., 2009). As such, this cultural and familial influence often suppresses South Asian women’s desire for independence. For South Asian women in Canada, it can be difficult to balance both the South Asian and Western cultures.
As the South Asian community has immigrated to the West, cultural conflicts occur as South Asian women struggle between conforming to the Western culture while also maintaining their traditional (desi) norms. A phenomenon described as the ‘two-world hypothesis’ by Katzman and Lee (1997) occurs when there is an affiliation to more than one culture, which occurs for many South Asian women living in Western societies, including Canada. To preserve their traditional norms, South Asian women quite often integrate desi ways and practices into their daily (Western) routines, such as wearing traditional clothes over North American fashion trends. Additional desi practices include dietary regimens, home remedies, prayers, rituals, and consultations with homeopaths (Hilton et al., 2001). To ensure the preservation of the South Asian culture, familial influence is heavily present (i.e., in a child’s upbringing, household responsibilities and health care needs), especially when cultural practices are not followed. For instance, women often feel pressured to use homeopathic medicines that were sent from family in India (Hilton et al., 2001). For young girls, their childhood experience involves “observing, hearing, and reading about [desi] practices” (Hilton et al., 2001 p. 559). Culturally, it is the responsibility of the mothers to ensure these practices are taught to daughters; women who lack such skills and knowledge are viewed as culturally inept. Therefore, for many women these desi practices help maintain their cultural traditions and identity as South Asian women.

While experiencing pressures from families and the South Asian community more broadly to maintain cultural traditions, South Asian women in Canada of all ages also feel pressure from the media, friends/peers and industry to embrace Western cultural traditions and to conform to Western norms. As such, conflict between traditional and
Western practices occurs (Hilton et al., 2001). This conflict holds true for health-related behaviours in South Asian women. Influenced by their culture, South Asian women tend to concern themselves with the needs of others and sacrifice their personal needs (Ahmad et al., 2012). As such, their health concerns are often neglected unless familial interference occurs.

**Body image in South Asian women.** Overall, studies investigating body image in South Asian women in Canada are few, but in general, research with samples from Western countries show that South Asian women tend to have more negative body image (e.g., body dissatisfaction) than Caucasian and other ethnic (i.e., African Caribbean and Hispanic) women (Furnham & Husain, 1999; Råberg, Kumar, Holmboe-Ottesen, & Wandel, 2010; Sahay & Piran, 1997; Swami et al., 2009; Swami et al., 2013). Råberg et al. (2010) investigated overweight and weight dissatisfaction-related indicators (i.e., socio-economic status, integration, and dietary habits) in Pakistani and Sri Lankan immigrants (aged 30-60 years) in Oslo, Norway. The results showed approximately 30% of the normal weight, about half of the overweight, and most of the obese men and women were dissatisfied with their weight. In addition, 80% of the women with normal weight desired to weigh less. Weight dissatisfaction increased with increasing body mass index (BMI) for both men and women. Further, those classified as overweight or obese were less inclined to reduce their weight compared to those in the normal weight group. The authors also reported that South Asian women who had attempted to lose weight (i.e., made attempts to eat less frequently throughout the day) in the past year tended to be more dissatisfied with their bodies and were more likely to engage in weight-loss behaviours than women who were satisfied with their body weight.
Swami et al. (2009) examined differences in positive body image among Caucasian, South Asian, African Caribbean, and Hispanic female undergraduates in Britain. Participants completed measures of body appreciation, societal influences on body image, and self-esteem. The results showed that South Asian women had the lowest body appreciation of all groups, consistent with the notion that they are at a greater risk for developing negative body image and eating disorders (Swami et al., 2009). In addition, self-esteem was the strongest predictor of body appreciation across all groups (Swami et al., 2009). The authors suggested that high self-esteem may act as a protective measure against negative sociocultural and/or family influences, contributing to more positive feelings about one’s appearance and body size (Swami et al., 2009).

One factor that may be particularly related to body dissatisfaction in South Asian women is skin colour. Sahay and Piran (1997) investigated skin colour preferences and body satisfaction in South Asian-Canadian (n = 100) and European-Canadian (n = 100) female university undergraduate students, 18 to 24 years of age. Participants’ parents were either of European/North American or South Asian (i.e., Indian, Pakistani, Sri Lankan, or Bangladeshi) descent and the participants were either born in Canada or immigrated before the age of nine. Participants completed measures of skin colour preferences and satisfaction with the body, including overall appearance and skin colour. Results showed that South Asian-Canadian women preferred lighter skin, while European-Canadian women preferred to be darker in skin colour, aligning with the popularity of the tan ideal in Western societies. In terms of body satisfaction, South Asian-Canadian women had lower body satisfaction than European-Canadian women. Within the South Asian-Canadian group itself, medium-skinned women had lower body
satisfaction than those with dark-skin. This finding was interesting, as it was inconsistent with the hypothesis. Sahay and Piran (1997) argued that in instances where the Western White skin ideal was far from attainable, there was little negative impact on body dissatisfaction; this was especially true for South Asian women with the darkest skin tone. This finding suggests that skin tone affected body dissatisfaction for women who felt pressured to meet the Western ideal; by contrast, those who recognized that the ideal was not suitable for them, may have been more content with their body appearance.

Swami et al. (2013) examined skin tone dissatisfaction, using a skin tone chart, among at least second-generation British-Caucasian, British-South Asian, and British African-Caribbean men \((n = 476)\) and women \((n = 724)\). In addition to the skin tone dissatisfaction measure, body appreciation, ethnic identity attachment and self-esteem were assessed. Results showed women had higher skin tone dissatisfaction and higher ethnic identity attachment than men. South Asian participants had a significantly lighter skin tone ideal than both Caucasian and African-Caribbean participants. In addition, results showed that skin tone dissatisfaction predicted body appreciation over ethnicity, gender, ethnic identity attachment, and self-esteem, and was a stronger predictor of body appreciation than gender. Overall, the findings showed that the ethnic minority groups (British-South Asian and African-Caribbean participants) experienced skin tone dissatisfaction which may have been driven by societal ideals, along with historical connotations (i.e., stemming from European colonialism and racism), which suggests a negative narrative and disadvantages for darker skin tones.
Although limited, research does show some differences in body image based on ethnicity. In addition to gender and ethnicity, other social identity factors may also be related to body image, including age.

**Aging and Body Image**

As individuals age, the body undergoes physical appearance and functional changes that can impact body image. During middle-age, between the ages of 45-65 years, the body undergoes changes that become noticeable to the self and others. These changes include hair loss, grey hair, wrinkles, weight gain, loss of muscularity or muscle tone, reduced joint mobility, and poorer posture and balance (Bailey, Cline, & Gammage, 2016; Cameron, Ward, Mandville-Anstey, & Coombs, 2019; Jankowski, Diedrichs, Williamson, Christopher, & Harcourt, 2016). In general, these changes move women further away from the ideal. As noted above, the Western ideal is impossible to achieve for most women, but this may be especially true after age-related body changes have occurred. For women in particular, there is exceptional pressure to “age gracefully” (maintain their youthful appearance while also trying to be age appropriate; Jankowski et al., 2016), as aging is seen as a period of decline and is often associated with negative societal stereotypes, such as loss of function/ability and loss of femininity (Cameron et al., 2019; Ferraro et al., 2008; Hofmeier et al., 2017). There is pressure for maturing women to maintain their body and conform to societal ideals (Hurd, 2000; Liechty, 2012).

A number of reviews have examined body image in older populations. Tiggemann (2004) conducted a review of body image research throughout the lifespan, with a focus on aging adults. She concluded that even though the aging body moves further away from
the ideal, body dissatisfaction remains relatively stable across the lifespan for women. Dissatisfaction likely does not increase, because the importance of body appearance (i.e., body shape and weight) decreases with increasing age, as relatively greater importance is placed on functional ability and health (Tiggemann, 2004). In addition, Tiggemann (2004) noted that, especially in women, the correlation between body dissatisfaction and self-esteem weakens with age as appearance and weight become less important sources of self-esteem, resulting in improved global self-esteem in women.

More recently, Roy and Payette (2012) conducted a review of quantitative and qualitative body image research in Western seniors. Studies differed in their definitions of seniors, with most studies examining those 60 years and older, and some studies including individuals 50 years or older. Overall, older women, were dissatisfied with their bodies, with rates ranging from 31-71% across studies. This finding was further supported by qualitative studies, which highlighted that body dissatisfaction (particularly related to appearance, weight, and shape) was commonly experienced in older women. In addition, older women were generally more likely to overestimate their body size. This was consistent with conclusions that the ideal weight was lower than current weight, and consistent with the ideal weight of younger women. However, qualitative studies generally found that women were more likely to make comparisons with women their own age, or younger women from their youth.

Further, evidence suggested that body image, especially body appearance, remains important for aging adults, although it proportionally decreases in importance as body function and competence become more important. Qualitative studies have highlighted this latter point that body appearance and function are both important for
older populations. Consistent with this concern for both appearance (especially weight) and function of the body, older adults, particularly women, may engage in dieting and exercise to reach weight goals (Bedford & Johnson, 2006; Hetherington & Burnett, 1994; Roy & Payette, 2012). Several tensions related to body image in older women were noted; women reported a double standard of aging compared to men. For example, importance placed on health was appropriate, while importance placed on appearance was vain. Similarly, natural aging (unaltered by culture, such as cosmetics or cosmetic surgery) was viewed positively by women who rejected the use of appearance altering approaches compared to unnatural aging (altered through body modification interventions, such as anti-wrinkle creams, hair dyes, makeup, cosmetic surgery). By contrast, women who engaged in these practices felt natural aging was undesirable and unattractive. A third tension related to the inner body (or mind) and outer body; the aging body was often believed to be mismatched to their true identities. Thus, although there are changes to body image associated with aging, there are also many similarities in body image between younger and older populations. The narrative to retain one’s beauty and resist changes to physical appearance that move the body away from the ideal still exists throughout the aging process.

More recent research has shown similar results in middle-aged women. Medeiros de Morais et al. (2017) investigated body image perceptions of middle-aged Brazilian women 40 to 65 years old, and found that regardless of body size, 86.4% of women reported being dissatisfied due to their low or overweightness. Of this 86.4%, 82% were dissatisfied with being overweight, and consequently reported low quality of life scores. This study suggests that in middle-aged women, dissatisfaction with body size and shape
is an important aspect of body image, consistent with earlier studies (Ferraro et al., 2008; Tiggemann & Lynch, 2001).

Tiggemann and Lynch (2001) investigated women’s body image across the lifespan framed within self-objectification theory (Fredrickson & Roberts, 1997). Australian women, aged 20 to 84, completed questionnaires that measured body dissatisfaction, self-objectification, habitual body monitoring, body shame, appearance anxiety, disordered eating, dietary restraint, and self-esteem. As predicted, across the entire sample, the ideal figure was significantly smaller than their current figure. No significant correlations between age and body dissatisfaction, body-esteem body shame, or self-esteem were found. However, with increasing age, self-objectification, habitual body monitoring, and appearance anxiety decreased. In addition, a small but significant negative relationship was found between dietary restraint and disordered eating symptoms with age. These results indicated that while body dissatisfaction and other aspects of body evaluation remained stable across the lifespan, some aspects of body image (i.e., self-objectification, habitual appearance monitoring, appearance anxiety, dietary restraint, and disordered eating) declined with age.

Reboussin et al. (2000) explored correlates of satisfaction with body function and body appearance in sedentary US middle-aged and older adults (35 to 75 years of age; N = 854). As most of the research tends to overlook the middle-aged population, it is important to note this study’s inclusion of this population, especially due to its relevance to this present study. Participants were classified as White (n = 593), African American (n = 201) or unspecified (n = 53) ethnicity. Results showed women were less satisfied with both their body function and body appearance than men. Additionally, a positive
relationship between age and satisfaction with body function and body appearance was found. This evidence supports a decrease in body image concerns between the 50-54-year-old group and 60-64-year-old group, suggesting attitudes towards body image may improve with increasing age. Furthermore, the researchers suggested that body satisfaction was closely related to quality of life, affect, and depression in both men and women. Findings also showed age and race (African American participants were more satisfied with their bodies than the Caucasian participants) as consistent predictors of satisfaction with both body function and body appearance. In addition, findings showed that among middle-aged and older adults, perceived well-being was more related to satisfaction with body function than body appearance and therefore, a more valued factor in the aging process (Reboussin et al., 2000). This evidence suggests that although society places a strong emphasis on appearance, specifically a youthful thin ideal, health and function of the body become more important as women start to reach middle-age.

Hofmeier et al. (2017) conducted a qualitative study exploring the thoughts, feelings and attitudes women 50 years of age and older experience about their bodies and aging. Four primary themes emerged: 1) physical and psychological experiences of aging; 2) challenges of aging (e.g., societal pressure) 3) importance of self-care (i.e., intuitive eating, physical activity, health goals); and 4) role of aging women in society. Women reported experiencing a wide range of body image emotions (e.g., shame, anxiety, confidence, pride) about their aging bodies. Women hinted at feeling insecure about their bodies due to societal pressures; however, they recognized that self-care through intuitive eating and physical activity ensured their bodies remained functioning, and this was of more value than appearance as they aged. Further, women mentioned
feeling invisible and a lack of recognition as they aged. Some women indicated that compared to younger populations and men, they felt irrelevant, while others mentioned feeling they were no longer attractive due to the natural changes occurring to their bodies. Similar to previous findings in the literature, Hofmeier et al. (2017) noted that while value was placed more on beauty and appearance when younger, general dissatisfaction exists throughout the lifespan; there is a shift towards function over appearance, especially when the process of aging is accepted and embraced.

The emergence of positive body image and its relationship with aging is also important. In Tiggemann’s (2015) review of positive body image, studies generally showed a positive relationship between age and body appreciation, as there is a shift from appearance towards health and functionality, which may promote self-care and self-worth. In addition, studies found that age affected the relationship between body appreciation and body satisfaction. Body appreciation was also significantly positively correlated with body dissatisfaction-satisfaction, suggesting that body appreciation and satisfaction are not interchangeable. This relationship was mediated by age; the correlation between body dissatisfaction-satisfaction and body appreciation weakened as age increased (Tiggemann, 2015). This finding also supports the notion that both positive body image (i.e., body appreciation and respect for the body) and negative body image (i.e., body dissatisfaction) can be experienced at the same time at different levels (Tylka and Wood-Barcalow, 2015).

While age is clearly related to body image, there are several critical time points across the lifespan that are also relevant for body image – for example, puberty in
younger populations and menopause for middle-aged and older women. It is important to distinguish the effects of aging from changes resulting from these critical times.

**Menopause and Body Image**

Menopause is a critical time period for women. It is considered to occur after 12 consecutive months with no menstrual cycle and marks the end of the reproductive phase of life (Nelson, 2008; Sherman, 2005). The menopause phase itself consists of several stages. The Stages of Reproductive Aging Workshop (STRAW) developed the seven-stage model, which outlines the reproductive stages for a healthy woman (Illustrated in Figure 1.1 below; -5 to +2; Nelson, 2008; Sherman, 2005). The menopause transition consists of three general stages. The first stage is perimenopause (-2 to -1) and is considered the transitional menopause phase that generally begins when women are in their mid-to-late 40s (Nelson, 2008). It is marked by menopause symptoms (e.g., hot flashes) and an irregular menstrual cycle. Stage 2, menopause, is the stage where the final menstrual cycle occurs. The final menstrual period generally occurs between the ages of 40 and 58 years (Nelson, 2008). Stage 3 is postmenopause (+1 to +2), which is defined as occurring 1 year after the final menstrual period (FMP) and a woman reaches the one-year mark without her menstrual period.

Vasomotor symptoms manifest in the latter part of the perimenopause period and extend to the postmenopause period, lasting up to 5 years after the final menstrual period and approximately 15 years overall (Dutton & Rymer, 2015). Common menopause symptoms include hot flashes, moodiness, insomnia, headaches, dizziness, fatigue, and weight gain. Although the symptoms experienced vary depending on the individual, Hall, Callister, Berry, and Matsumura (2007) found that women struggled to recognize and
manage many menopause symptoms. Understanding the experiences of menopause and the symptoms that arise throughout the transitions may provide more knowledge and understanding about the symptoms experienced (Hall et al., 2007; Lindh-Astrand, Hoffmann, Hammer, & Kjellgren, 2007).

Figure 1.1

*Stages of Normal Reproductive Aging (STRAW)*

<table>
<thead>
<tr>
<th>Stages</th>
<th>-5</th>
<th>-4</th>
<th>-3</th>
<th>-2</th>
<th>-1</th>
<th>+1</th>
<th>+2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Terminology</td>
<td>Reproductive</td>
<td>Menopause Transition</td>
<td>Postmenopause</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early</td>
<td>Peak</td>
<td>Late</td>
<td>Early</td>
<td>Late</td>
<td>Early</td>
<td>Late</td>
<td></td>
</tr>
<tr>
<td>Variable cycle length (&gt;7 days different from normal)</td>
<td>≥2 skipped cycles and an interval of Amenorrhoea (≥60 days)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duration of Stage</td>
<td>Variable</td>
<td>Variable</td>
<td>1 yr</td>
<td>4 years</td>
<td>Until Demise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Menstrual Cycle</td>
<td>Variable to Regular</td>
<td>Regular</td>
<td>Amenorrhoea for 12 months</td>
<td>None</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note:* Adapted from Nelson (2008).

Overall, research on menopause generally focuses on physical changes. Relatively little work has attempted to identify and understand the body image experiences of women during menopause (Deeks & McCabe, 2001; Erbil, 2018; Pearce, Thøgersen-Ntoumani, & Duda, 2014), despite the fact that researchers have noted menopause is an important influence on body image (e.g., Hofmeier et al., 2017; Tiggemann, 2004).

Menopause tends to indicate a change to a women’s role or purpose in life; as such, psychosocial aspects of their lives change (Deeks & McCabe, 2004). Menopause can also create a feeling of identity loss for women. They can no longer bear children and there
can be reduced feelings of sexuality and femininity (Pearce et al., 2014). Koch and Mansfield (2004) argue that most women are uncertain about how to navigate through the menopause transition due to the lack of education on menopause.

Deeks and McCabe (2001) investigated the association between menopause stages (premenopause, perimenopause and postmenopause) and age (from 35 to 65 years of age) on Australian women’s perceptions of their body image. Participants were asked to complete measures of appearance, fitness, and health evaluation (i.e., dissatisfaction), overweight preoccupation, and satisfaction with specific body parts as well as measures of current and ideal body size to indicate overall body dissatisfaction. Results showed premenopausal women had higher ratings of appearance evaluation and feelings of fitness than the menopausal women. Premenopausal women were also more positive about their appearance compared to menopausal women. Furthermore, the premenopausal women chose smaller figures for their current, ideal and societal ideal body sizes than the menopausal women. In addition, the younger age group (aged 35-44 years) chose smaller figures as their ideal compared to the middle age group (aged 45-54 years), who chose smaller figures compared to the oldest group (aged 55-65 years). However, once age was considered, differences due to menopause were no longer significant. Thus, the authors were unable to separate out aging versus menopause effects on body image. This may be in part because many age-related changes to the body can also be a result of menopause; for instance, weight gain and changes to fat distribution occur as a result of both aging and menopause (Deeks & McCabe, 2001). Furthermore, Deeks and McCabe (2001) argued that understanding the body image experiences during the menopause transition
may provide better knowledge into how these women can be supported throughout these transitions and as they grow older.

More recently, in a scoping review, Pearce et al. (2014) examined women’s body image during the menopause transition. A total of 15 studies were reviewed. Two major themes were identified. Firstly, the relationship between body image and menopause is complex. Women often interpreted their menopause and body image experiences as both positive and negative. For example, menopause could be viewed as liberating (e.g., end of menstrual cycle, freedom from responsibilities) but also as loss (e.g., of social role of childbearing, reduced sex drive). Similarly, women who accepted that their bodies were undergoing changes associated with menopause (e.g., weight gain) reported feeling positive, experiencing few menopause symptoms, and having better body image (e.g., higher body satisfaction, appearance evaluation and self-esteem). By contrast, those concerned with changes to their appearance, such as weight gain, experienced menopause and body image more negatively (e.g., mood, health, quality of life).

Secondly, there was confusion over the changes to the body during menopause and how they may impact body image. Body changes (e.g., weight gain, end of menstruation) during menopause are often viewed with negative connotations of being unwell, loss of control of one’s body, and deviance from the societal ideal, which in turn could affect body image negatively and reduce body satisfaction and feelings of attractiveness. Western society, especially as it emphasizes a biomedical approach to health, views the menopause transition negatively and as a disease that requires treatment; however, feminist researchers argue that these misconceptions around menopause require a change (Ballard, Elston, & Gabe, 2009; Dillaway, 2005; Pearce et
al., 2014). The menopause transition should be viewed as positive time point in a woman’s life that marks a transition into a new period of her life. This positive perception could encourage acceptance of body changes, which as a result, may improve body image and promote concepts of well-being and self-care.

This ‘positive perception’ notion is supported by a study by Erbil (2018), who explored attitudes towards menopause, body image and depression levels of menopausal Turkish women (38-75 years of age). Fifty-four percent of these women had negative attitudes towards menopause. Further, women with negative attitudes towards menopause reported poorer body image and higher depression scores than women who had positive attitudes towards menopause. In addition, women who had entered menopause naturally (versus surgically) reported more positive attitudes to menopause and better body image.

Some more recent studies have examined dissatisfaction with the body associated with menopause. Szymona-Palkowska et al. (2019) explored whether Polish women’s (25-60 years of age) body image (investment and dissatisfaction with appearance) varied depending on their reproductive status (i.e., premenopausal, menopausal or postmenopausal). Compared to those in the premenopause and menopause groups, postmenopausal women had greater body satisfaction and attributed less importance to appearance. Findings showed fewer appearance concerns about the face (nose, mouth), limbs (hands, nails, feet), and body parts associated with femininity (breasts, stomach, waist, butt, thighs) for postmenopausal women compared to premenopausal and menopausal women. The study showed premenopausal women were more critical of their appearance than the other two groups, while women in the postmenopause period were more likely to adapt and accept the changes that occur to their appearance by menopause.
Hofmeier et al.’s (2017) qualitative study explored thoughts, feelings and attitudes of women over the age of 50 years about their bodies and their experience of aging, including the described influence of menopause. Findings showed that women associated menopause with physical changes, including appearance changes such as dry skin, drooping breasts, and increased spread of cellulite, as well as an increase in weight gain and metabolism changes after menopause, which often negatively affected exercise and eating habits. These changes worsened their dissatisfaction with their bodies. Some women felt blindsided by the physical changes that occurred after menopause; they struggled between experiencing a loss of their younger body and accepting their older body.

Ginsberg et al. (2016) analyzed data from a longitudinal study to explore the prevalence and correlates of body image dissatisfaction in over 75,000 postmenopausal women aged 50-79 years. Overall, most of the women (83%) were dissatisfied with their bodies, most often because they did not meet their weight ideal. In addition, women who reported high depressive scores at baseline reported more dissatisfaction. BMI and change in BMI were the strongest predictors of body dissatisfaction, accounting for almost 18% of the variance. Demographic (e.g., age, ethnicity) and physical and mental well-being (e.g., quality of life mental health score) variables together accounted for less than 3% of the variance.

Although the research shows consistencies around body image during menopause (Ferraro et al., 2008; Ginsberg et al., 2016; Szymona-Palkowska et al., 2019), there is an overall consensus that women are uncertain about menopause (e.g., menopause experiences), its symptoms, and its effects on their bodies (Koch & Mansfield, 2004;
Pearce et al., 2014), in part because the menopause experience varies between women. Researchers have noted that the lack of menopause education and information (e.g., symptoms, bodily changes) available for women leave them surprised and vulnerable to facing menopause without any support, which can lead to a negative experience that consequently leads to poorer health outcomes (e.g., depression) and negative body image (e.g., body dissatisfaction, weight concerns, low self-esteem; Hofmeier et al., 2017; Pearce et al., 2014). In addition, menopause symptoms and their effect on their bodies is undetermined. It should be noted that much of the research is still unable to differentiate between the bodily changes related to aging versus menopause (Deeks & McCabe, 2001; Pearce et al., 2014). In addition, ethnic differences may also influence how menopause is experienced by women.

**Menopause in South Asian women.** Research on menopause is limited and tends to focus on Western populations; as a result, there is a lack of research on the experiences of menopause of ethnic communities. Melby, Lock, and Kaufert (2005) conducted a review examining the relationship between culture (Caucasian, African-, Chinese- and Japanese-American, Italian, Iranian, Greek, Lebanese, Korean, Moroccan, Turkish) and menopause symptoms. The researchers found that cultural differences influence the experience of menopause; therefore, insight into the transition of menopause in different ethnic populations may be revealed by exploring biological and cultural interactions. Similar to body image, the experiences and attitudes towards menopause are defined by cultural differences.

Hunter, Gupta, Papitsch-Clark, and Sturdee (2009) conducted a quantitative and qualitative study looking at the experiences of menopause symptoms in 153 peri- and
postmenopausal women aged 45-55 years. The sample was split into three groups: migrated South Asian women living in the UK (UKA), UK Caucasian women (UKC) and South Asian women living in Delhi, India (DEL). Quantitatively, the study used questionnaires that collected lifestyle information (i.e., smoking status, alcohol use, dietary habits, and exercise behaviour), perceptions of general health, health behaviours in relation to menopause and general health in women (depressed mood, anxiety, and vasomotor symptoms). Findings showed that vasomotor symptoms were related to the country of residence, not ethnicity or religion. The UKC sample reported no significant predictors of vasomotor symptoms; the DEL sample showed depressed mood as a significant predictor of vasomotor symptoms. The UKA sample, however, showed anxiety, depressed mood, overall poor health, and extent of acculturation as significant factors of vasomotor symptoms. Qualitatively, experiences and meanings of menopause were explored. Data showed that menopause experiences in the UKA and UKC groups aligned more closely to each other than did UKA and DEL groups. For instance, hot flashes, hot sweats, and cold flashes were experienced and interpreted as menopause symptoms in both UK groups while the DEL group did not report experiencing many of these symptoms, and when they did, they were attributed to high blood pressure (Hunter et al., 2009). In contrast, in terms of “knowledge” of menopause, both the UKA and DEL groups mentioned not talking to anyone about it or seeing a doctor. This was surprising for the UKA group, as they had access to medical services. Hunter et al. (2009) concluded that the migrated UKA group reported more anxiety and depression and vasomotor symptoms compared to the DEL group, which challenged their view that
migrated women would take on broad Western beliefs and gain a more medicalized perspective of menopause.

Hunter et al. (2009) also found cultural differences in beliefs/meanings about menopause. For instance, ‘menopause with aging’ was viewed as inevitable, but in a negative context; UKA women noted it as sign of getting older, slowing down, and the end of life, while UKC and DEL women were more accepting of the aging process. The study highlighted three consistent sub-themes across all three groups: vasomotor symptoms, other physical symptoms and emotional symptoms; however, the interpretation of menopause experiences differed between groups. For instance, hot flashes were a consistent symptom; the UKA women described them intense and severe, the UKC women as a common feeling, while DEL women suggested they may have experienced hot flashes, however, the symptoms were often attributed to high blood pressure (Hunter et al., 2009).

**Body image and menopause in South Asian women.** Although research regarding women’s body image and menopause exists, studies do not reflect the experiences of minority women, most notably of the South Asian population (Hall et al., 2007; Pearce et al., 2014), leaving them unrepresented in the literature. Despite the size of the South Asian population in Canada, the disconnect in research between menopause and body image experiences of South Asian women leads to a limited understanding of these issues in this group. Given the links of these issues to important health-related outcomes (e.g., eating habits, exercise behaviours, anxiety, depression, self-esteem; Cash & Smolak, 2011; Fredickson et al., 1998; Slevec & Tiggemann, 2011; Tylka & Wood-Barcalow, 2015), exploring and addressing issues of menopause and body image in South Asian
women is important. Concepts of open communication and discussions surrounding health can be difficult for South Asian women; as such, understanding the relationship between body image and menopause in this population is difficult. It is often hard for older South Asian women to talk about their health as many grew up in a traditional society where concepts of puberty, menstruation, sex, and menopause were considered taboo (Bottorff et al., 2001). Providing women in this group with the opportunity to discuss these issues openly and freely will not only enhance the knowledge of researchers and practitioners working with these individuals but will also provide them the opportunity to have their voices heard on this important topic.
CHAPTER 2: RATIONALE AND PURPOSE

Rationale

Body image research has predominately examined young Caucasian women and is rooted in the Western ideal of beauty; for women the most critical aspect of the ideal is thinness with some muscle tone. However, the ideal is also implicitly young, White and able-bodied (Cash & Smolak, 2011). Although social identities based on characteristics such as age and ethnicity can impact body image (Swami et al., 2009; Swami et al., 2013; Tiggemann, 2004; Tiggemann, 2015), research investigating experiences of middle-aged women and minority populations is very limited. The Western ideal oppresses and confines women of colour and older women from expressing their own interpretation of beauty, as many internally evaluate how closely they meet the Western ideal. However, for women from other cultures living in Western societies, both sets of societal and cultural norms influence body image (Slade, 1994).

Culture plays an integral role in body image in all groups (Cash, 2012), including in South Asian girls and women. In one of the few studies to examine body image in South Asian women, Swami at al. (2009) found that young South Asian women had lower body appreciation compared to Caucasian, African Caribbean and Hispanic female groups, which is consistent with the notion that they are at a greater risk for developing negative body image and eating disorders. Body image research on aging South Asian women focuses primarily on body dissatisfaction and weight concerns, especially since they can be linked to physical health outcomes (e.g., obesity, heart disease; Kumar, Meyer, Wandel, Dalen, & Holmboe-Ottesen, 2005; Råberg et al., 2010) or skin colour (Sahay & Piran, 1997; Swami et al., 2013). However, most studies do not consider the cultural experiences of South Asian women; thus, it is difficult to determine how their
body image may be linked to important health-related outcomes (e.g., dietary habits, exercise behaviours, mental health). In addition, ignoring their voices and concerns will continue to exclude them from society.

As noted above, age also impacts body image (Reboussin et al., 2000; Roy & Payette, 2012; Tiggemann, 2004). In general, as women age, physical changes to the body (e.g., weight gain, gray hair, wrinkles, loss of strength) tend to move them further away from the ideal and changes to social roles also occur. In general, while dissatisfaction with appearance remains relatively stable throughout the lifespan, as women age, they tend to place greater importance on the function of the body relative to its appearance; further, some aspects of body image such as self-objectification and body shame may improve as women age (Reboussin et al., 2000; Tiggemann, 2004; Tiggemann & Lynch, 2001). In addition, there are some critical time points in the aging process that may be particularly relevant to body image, such as menopause.

Similar to body image, the experiences and attitudes towards menopause are influenced by cultural differences. For South Asian women, these cultural influences include their upbringing, relationships, goals, decisions and health concerns. Again, the experiences of menopause of South Asian women, particularly those living in Western nations, have been virtually ignored. There is one study, however, which explored menopause in South Asian women in a Western context. Hunter et al. (2009) quantitatively and qualitatively explored experiences of menopause symptoms in three groups of women: UKA, UKC, and DEL. Results showed that menopause symptoms were related to country of residence, not ethnicity. UKA women were more likely to experience significant factors (i.e., anxiety, depressed mood, overall poor health, and
degree of acculturation) that predicted vasomotor symptoms of menopause, than the UKC and DEL women. In addition, qualitative data showed that UKA and UKC women had more similar menopause experiences (e.g., hot flashes, hot sweats, cold flushes) than the UKA and DEL women. Ultimately, results showed that acculturation, a multi-dimensional process that describes one’s acquisition of a new or dominant culture (Grogan, 2017; Swami et al., 2009), was a significant factor for vasomotor symptoms and experiences and interpretations of menopause for the UKA women (Hunter et al., 2009).

Hilton et al. (2001) argued that the Western culture and healthcare practices are rooted in the biomedical model. By contrast, in South Asian cultures, health is viewed as a holistic construct that requires a balance between physical, psychological and social well-being; these concepts are reflected in the biopsychosocial model (Hunter & Randell, 2007). Therefore, research investigating body image and menopause in primarily Caucasian women from Western cultures does not reflect the cultural health practices and beliefs of the South Asian population in Western countries. In North America, the South Asian community often incorporates desi health practices to remedy health issues; however, they are often integrated with Western medicine (Hilton et al., 2001). Traditional health practices vary, and consist of home remedies, dietary regimens, prayers, rituals, and consultation with hakims (Arabic for ‘physician who utilizes traditional practices’), babajis and pundits (priest or spiritual teacher), granthis, homeopaths, and jyotshis (Sanskrit for astrology; Hilton et al., 2001). The decision to choose traditional versus Western health practices is often influenced by several lifestyle, social and cultural factors, such as childhood upbringing, exercise and dietary behaviors,
traditional use of herbal medicine, family members, the severity of the health concern, and previous experiences.

This study provides insight into the relationship between body image and menopause in first generation South Asian immigrant women living in Canada. Bottorff et al. (2001) suggested that understanding the body-related experiences in South Asian women will shed light on how to support this group as they grow older and begin the menopause transition. Given that body image has been linked to numerous health behaviours (Furnham & Husain, 1999; Råberg et al., 2010; Swami et al., 2013), it is an important issue to examine in populations other than young White women. Hall et al. (2007) further argued that becoming familiar with cultural influences of menopause and empowering women about menopause management will assist healthcare professionals in improving their care for menopause women.

**Purpose**

This study explored South Asian Canadian women’s body image throughout the transition of menopause. More specifically, the objectives of this study were to examine:

a) Body image experiences in South Asian women who were in the menopause transition.

b) Menopause experiences in South Asian women.

c) The interaction between body image and the menopause transition in South Asian women.
CHAPTER 3: METHODOLOGY

Interpretive Phenomenological Analysis (IPA)

This study followed the qualitative methodology of interpretive phenomenological analysis (IPA), which focuses on understanding and interpreting the experiences of participants. IPA places attention on thoughts, feelings, and beliefs that affect the individual’s experience (Murray & Holmes, 2014). As such, it is difficult to separate the body (individual) and subject (topic of interest) as the experience directly affects the individual. This study focused on how body image (subject) and menopause (subject) affect South Asian women (body). In this case, the body-subject relationship was interconnected; to understand the relationship between body image and menopause, the experiences of South Asian women were explored. In IPA, researchers attempt to examine how individuals make sense of important life events and therefore, use other qualitative methodologies to capture these lived experiences. IPA is derived from the principles of phenomenology, hermeneutics, and idiography (Pietkiewicz & Smith, 2012).

Phenomenology focuses on how people perceive objects and experience events. It involves “bracketing” one’s preconceptions and allowing the phenomena itself to offer insight to the study (Pietkiewicz & Smith, 2012). This notion of “limited literature” was considered because the literature is Western-driven, but it is possible South Asian women may already understand their bodies, but the supportive research is lacking. It is important to remember that regardless of previous knowledge, phenomenology focuses on how the individual is affected by a phenomenon. As such, IPA researchers look to interpret and make meaning of the “body-subject” relationship and how it connects to the world. The lived experience of the individual affects the researcher’s interpretation of the phenomena through a hermeneutics lens.
The second principle of IPA, *hermeneutics*, is considered both a theory and methodology. It is the theory of interpretation. Unlike phenomenology, which is the study of experiences of individuals from the perspective of the researcher, hermeneutics focuses on understanding and interpreting what participants experience from their own perspective. This is achieved through a holistic analysis of the experience, which consists of first understanding the experience from the participants’ perspectives, followed by understanding their interpretation of it. Finally, the researcher creates meaningful and interpretive data. In order to understand the context of an experience, the perspective of the individual needs to be considered (Smith, Flowers, & Larkin, 2012).

To understand how body image changes throughout the transition of menopause in South Asian women, their understanding of both body image and menopause and their connections to these concepts was defined first. Once the individual’s perspective was understood, the interpretation of their experiences was holistically (the participant’s experience and interpretation of it) analyzed and deduced from the individual’s perspective. The participant was the “experiential expert”; therefore, the process of interpretation is dependent on the researcher and participants (Peat, Rodriguez, & Smith, 2019). For example, participants were asked about their own understanding and experiences of body image, and this was interpreted in terms of the broader body image literature. In IPA research, this is known as double hermeneutic or dual interpretation process (Pietkiewicz & Smith, 2012). In terms of hermeneutics analysis, the theory is best understood when interpreted as the ‘hermeneutic circle’, a dynamic relationship between the whole and individual parts of a phenomenon (Smith et al., 2012). Essentially, each individual component of a concept connects to the whole phenomenon. Within this study,
the individual perspectives of body image and menopause connected to a greater phenomenon of how these two concepts affect South Asian women throughout their transition of menopause.

*Idiography* refers to applying the research to the individual and focusing on understanding the individual as a unique and complex entity. Each participant’s case was explored independently before producing any general statements about the sample (Pietkiewicz & Smith, 2012). Idiography emphasizes individual narratives, followed by cross-case comparisons and contrasts. For instance, every participant had their own unique, individual menopause experience, however, collectively, similar patterns were noticed, such as emotional distress, confusion, and lack of understanding of their menopause symptoms/experience. Themes and patterns were generated through the convergence and divergence of perceptions and experiences of the individual cases (Miller, Chan, & Farmer, 2018). This theory places value on individuality, and as such, the experiences of body image and menopause in South Asian women varied. Therefore, it was important to focus on each case independently before connecting and comparing themes and ideas with all the cases.

Based on IPA methodology, the study consisted of both interpretive and phenomenological research theories. Interpretive research focuses on understanding human behaviour and the meaning of phenomena (Green & Thorogood, 2004). Rather than focusing on reality and the structures of the world, interpretivism attempts to answer questions surrounding individuals’ perceptions of phenomena. For instance, in this study, the emphasis was towards interpreting South Asian women’s experiences with body image during menopause. IPA is particularly useful for under-researched phenomena, as
it allows for constructive and insightful interpretative accounts of individual experiences (Peat et al., 2019). Smith and Osborn (2015, p. 41), who studied pain, highlighted that IPA is also useful for “complex, ambiguous and emotionally laden” topics, which aligned well with exploring body image and menopause in South Asian women. On the other hand, phenomenological research, in this context, attempts to make sense of experiences and transform them into consciousness as individual and shared meanings (Patton, 2015). These two theories were incorporated into the methods of the study, through the interview guide. The guide focused on gaining knowledge of the experiences of body image and menopause individually (one-on-one interviews; single-case analysis) and as a collective group (cross-case analyses). As the researcher, I attempted to understand and interpret the experiences of South Asian women in terms of their relationship with body image during their transition of menopause.

**Participants and Sampling Strategy**

*Participants.* Sample sizes for IPA methodology vary and are dependent on the extent of the research. Smith et al. (2012) emphasize that IPA is based on the quality of the content and heavily relies on the richness of the individual cases. Similarly, Peitkiewicz and Smith (2012) highlighted that there is no general rule for the number of participants required; the sample size is again dependent on individual cases, the depth of the analysis process, and the discretion of the researcher. In this study, the number was dependent on when saturation was reached. Saturation entails the continuation of recruitment and interviewing until redundancy or no new data emerges (Liamputtong, 2013; Patton, 2015).
This study recruited nine first generation South Asian immigrant women (seven self-identified as Punjabi-Sikh participants, two as Indian participants), between 49-59 years of age, living across Canada (Ontario, Alberta, and British Columbia). Participants’ BMI ranged from 20.3 to 29.4. The frequency of additional demographic characteristics (location, menopause status, highest level of education and preference/use of healthcare) are reported in Table 3.1. Of the nine participants, six had immigrated in their youth (under the age of 18), and three had immigrated in their adulthood. All nine participants were from India – 8 from Northwestern India, and one from Western India. Seven identified as practicing Sikhs, while two mentioned no religious followings.
Table 3.1

*Demographic Characteristics*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td></td>
</tr>
<tr>
<td>Ontario</td>
<td>5 (55.6)</td>
</tr>
<tr>
<td>Alberta</td>
<td>2 (22.2)</td>
</tr>
<tr>
<td>British Columbia</td>
<td>2 (22.2)</td>
</tr>
<tr>
<td>Menopause Status</td>
<td></td>
</tr>
<tr>
<td>Perimenopause</td>
<td>1 (11.1)</td>
</tr>
<tr>
<td>Menopause</td>
<td>0</td>
</tr>
<tr>
<td>Postmenopause</td>
<td>8 (88.9)</td>
</tr>
<tr>
<td>Highest Education Level</td>
<td></td>
</tr>
<tr>
<td>High School Diploma</td>
<td>3 (33.3)</td>
</tr>
<tr>
<td>College Degree</td>
<td>3 (33.3)</td>
</tr>
<tr>
<td>Bachelor’s Degree</td>
<td>1 (11.1)</td>
</tr>
<tr>
<td>Master’s Degree</td>
<td>2 (22.2)</td>
</tr>
<tr>
<td>Preference/Use of Healthcare</td>
<td></td>
</tr>
<tr>
<td>Family Doctor/Walk-in Clinic</td>
<td>9 (100)</td>
</tr>
<tr>
<td>Naturopath (i.e., homeopathic medicines)</td>
<td>5 (55.6)</td>
</tr>
<tr>
<td>Home/Herbal Remedies</td>
<td>8 (88.9)</td>
</tr>
<tr>
<td>Other (i.e., gynecologist, nutritionist, dietician, woman’s hospital)</td>
<td>4 (44.4)</td>
</tr>
</tbody>
</table>

To participate in the study, participants needed to meet the following inclusion criteria: (a) a woman of the South Asian community (defined as descending from the nations of India, Pakistan, Afghanistan, Bangladesh, Nepal, Bhutan, Maldives, and Sri Lanka); (b) currently in one of the stages of menopause (perimenopause, menopause, or postmenopause); (c) reached the menopause phase “naturally”; and (d) English and/or
Punjabi-speaking. As the researcher, I am fluent in both English and Punjabi. In an attempt to derive more meaningful responses, participants who preferred to complete the individual interview in their preferred speaking language were welcomed to participate in the study. All interviews were conducted in English; however, majority of the participants mentioned a few words and phrases in Punjabi/Hindi (e.g., home remedies, such as ‘haldi’, which is turmeric). The exclusion criteria were women who had undergone hysterectomy, mastectomy, or hormone replacement therapy since surgeries and hormone replacement therapy can lead to “artificial menopause”, which is a different experience than women with “natural menopause” (Włodarczyk & Dolińska-Zygmunt, 2018).

**Sampling Strategy.** IPA suggests using a homogeneous sample that will offer meaningful data (Smith et al., 2012). For this study, participants were recruited through purposive sampling, which focuses on deliberate selection of participants specific to the study. This study required South Asian women undergoing the menopause transition. For the purpose of this study, intensive sampling, which focuses less on extreme cases and more on cases that enrich the phenomenon of interest, was implemented to recruit participants (Patton, 2015). This type of intensive sampling allows these information-rich cases to provide insight into the relationship between body image and menopause in the South Asian population. Participants were recruited through: (1) social media (i.e., personal Facebook, Twitter and Instagram); (2) social services organizations (i.e., PCHS – Punjabi Community Health Services, SACHSS – South Asian Canadians Health & Social Services); and (3) referrals, also known as snowballing, which asks participants to suggest or invite other cases; this was useful due to the sensitive nature of the study (3 of
the 9 participants were ‘referrals’; Green & Thorogood, 2004). Due to COVID-19 restrictions (meaning online interviews were conducted) and participant availability, participants were recruited across all of Canada. It is important to note that although these participants can be considered a homogenous sample, they only represent one South Asian country – India. The South Asian countries listed in the first chapter are comprised of various cultures, languages, and religions, that are not represented in this present study’s sample.

**Epistemological Framework and the Researcher**

As a researcher, I hold an interpretivist and constructivist worldview, which includes multiple constructed realities and subjectivities (Reeves, Albert, Kuper, & Hodges, 2008). Interpretivism consists of a hermeneutical approach, where the meaning is hidden and must interpreted by the researcher (Ponterotto, 2005). Constructivism questions the positivist assumption of one stable, pre-existing reality (Green & Thorogood, 2004). As a constructivist, I believe that the world is socially constructed, and look to further question these social constructs and their structures in the world. This worldview challenges paradigms, looks to facilitate reconstruction and offers empowerment and liberation (Denzin & Lincoln, 2011). This study focused on an ethnic population, South Asian women, and their body image throughout the transition of menopause. Current body image and menopause literature is limited and particularly lacks inclusivity of this population; therefore, my interpretivist and constructivist worldview fit well with this study’s objectives. Through these lenses, I added a meaningful perspective or “reality” to the existing body image and menopause literatures.
This constructivism-interpretivism epistemology considers the interaction between the researcher and participant as dynamic and a “lived experience” (Reeves et al., 2008). The paradigm of this worldview cannot separate the researcher’s values and lived experiences from the research process. Therefore, as a South Asian Sikh woman, I acknowledged my values and biases in this study. Since my background gave me an insider perspective into the culture and the population, I acknowledged my preconceptions of the community in order to approach the study through an outsider perspective to ensure the data was collected with no biases. These preconceptions included the influence of culture and interference of family in women’s health, and women’s tendency to internalize their concerns, including their health issues. Qualitative research generally relies on the researcher’s perspective, and this is particularly important in the interpretative component of IPA research.

However, to mediate these concerns, I included reflective notes on these biases when journaling and writing field notes prior to and during the data collection process (these interpretations are integrated in the results and discussion sections); this further reinforced the transparency of this study. My insider perspective with the community, however, gave me easier access to and the ability to build rapport with the participants. Since I understood many issues present within the South Asian community, I was able to ask appropriate questions that encouraged the women to speak more about these preconceptions or other issues they faced (i.e., cultural factors, and community and family influences). At the same time, my rapport with the participants was further built through the language criteria of this study. This study welcomed any participants who preferred to speak or use terms in Punjabi, as some individuals felt that their explanations
were better interpreted from their native language. In the results section, readers will notice phrases written in Punjabi with English translations to supplement the participant’s thoughts on a particular topic of discussion. Since I am fluent in Punjabi, this allowed me to build more rapport and trust with my participants and gain more information-rich data.

In addition, it is important to note that my supervisor operates under a primarily post-positivist perspective, and although our worldviews tend to sit on opposite sides of the spectrum, our distinct perspectives work well together. As a qualitative researcher, it is easy to become engulfed in the qualitative natural of my work, so I find it helpful having a quantitative mind looking over the data and my interpretations. As such, the different perspectives brought to this study further enriched the writing of this thesis.

**Procedures**

Once ethics clearance was obtained (see Appendix A for Certificate of Ethics Clearance), interested participants were welcomed to contact me via email. Participants were sent electronic copies of the consent form, individual interview guide, and the demographic questionnaire form (see Appendix B, C, D). Eligible participants took part in a one-on-one in-depth interview session.

*Individual interviews.* Although in-person interviews were initially planned for and preferred, with social distancing COVID-19 restrictions that were in place at the time of data collection, interviews were conducted virtually for safety and due to guidelines for research by the university. Furthermore, as the use of technology increases, online platforms in research methodology, also known as online research methodology (ORM), for data collection are more becoming common and accepted (Oates, 2015).
In addition to being useful for situations in which in-person contact is not allowed, the use of ORM allows researchers to expand their geographical reach for their research and participant sample. Further, the use of online platforms offers a sense of accessibility for the participants and the researchers, as well as flexibility of time and location of the interview, more interview time, and minimal travel cost and time (Mirick & Wladkowski, 2019; Oates, 2015). It is also important to acknowledge a few challenges that may arise with technology (specific to this study, fortunately, these challenges did not arise for the individual interview sessions). Technology issues (i.e., compatibility concerns between the device and online platform) and connectivity concerns (i.e., lagging video or audio, distorted video) may act as barriers for the interview process and may lead to missed data (Mirick & Wladkowski, 2019). Although online interviews cannot completely replace the face-to-face interaction of in-person interviews (Lo Iacano, Symonds, & Brown, 2016), online interviews create a unique opportunity for meaningful data collection.

Interviews were semi-structured and one-on-one. Semi-structured interviews allow for better dialogue and flexibility towards the topics that were discussed in this study than questionnaires and structured interviews. Semi-structured interviews are defined by the interaction between the researcher and participant; they focus on what the participant says about their experiences (Smith et al., 2012). Interviews were 45-90 minutes in length, which allowed for an in-depth interview with participants (Miller et al., 2018; Smith et al., 2012). These interviews were audio-recorded on a password protected recording device. Field-notes were taken by the researcher during and after the interview,
which recorded facial expressions and observations of the participant as well as any additional thoughts (e.g., surprising/interesting responses).

Platforms such as Lifesize, Skype, Facetime, and Zoom were utilized for the interviews; the type of online platform was dependant on the participant’s preference. Access to the online interview room was restricted and shared only between myself and the participant via email. Once the participant joined the online videoconferencing platform, I verbally summarized the informed consent forms and asked the participant to verbally consent prior to the start of the interview. This statement of verbal consent was asked again once the audio-recording began to ensure the participant’s consent was recorded for the transcripts. Following the interview session, participants were asked to verbally complete the demographic information form (see Appendix D for Demographics Questionnaire).

*Interview guide.* The interview consisted of three parts (see Appendix C for Interview Guide). Part 1 focused on body image experiences, such as what they consider the ideal female body to be. Part 2 investigated the experiences of menopause, including their roles in society, and their interpretation of menopause. Part 3 addressed the interaction of body image and menopause, including how both appearance and function of the body have changed during their menopause experience. The questions were open and expansive, allowing for a deeper discussion between the participant and myself (Braun & Clarke, 2012).

The guide was tested in three phases prior to any individual interviews to ensure its appropriateness and rigour: (1) internally through academic experts (i.e., my supervisor and committee); (2) expert testing with other academic experts outside the
research to (i.e., fellow graduate students); and (3) externally piloted by an individual who met the participant criteria. The pilot interview was included as major adjustments to the guide were not needed.

Post-interview. Summaries of individual interviews were electronically sent through email to participants, who agreed to receive and review their interview for member checking or participant validation (Liamputtong, 2013) within 3 weeks. Every participant agreed to member check and were sent their individual interview summary to review. This provided the participants with an opportunity to clarify any data that did not make sense or required additional explanation. One participant asked for further clarification about how her interview responses would be utilized, and confirmation they would remain anonymous, and I assured the participant a pseudonym name would be used and identifying characteristics from any direct quotes would be removed (e.g., children’s names, name of workplace).

Debriefing. Feminist research emphasizes the use of debriefing with marginalized groups and sensitive topics (Leavy & Harris, 2019). As discussed in the literature review, the South Asian community refrains from openly discussing health concerns and experiences, and as such, this study provides these women a new avenue to discuss, without judgment, their experiences of body image and menopause. Debriefing was completed via email for all the participants who took part in the study. Participants were sent a summary of the study’s results via a hardcopy by mail or electronically emailed (as requested) and posted online on the lab’s website.
Data Analysis Strategy

The semi-structured interviews were audio-recorded and transcribed verbatim. IPA’s overall purpose is to understand and interpret the content participants provide into meaning. IPA analysis guidelines are flexible and can draw from other data analysis strategies due to the complexity of the data. As such, this study’s data analysis strategy was derived from IPA and reflexive thematic analysis strategies. Reflexive thematic analysis guidelines can be complex and multi-directional depending on the data collection process but provide an additional perspective of the data (Braun & Clarke, 2012, 2019).

The data analysis strategy was split into two stages; the first stage focused on single case analyses, and the stage on cross-case analyses. Overall, the analysis proceeded through seven steps (see Figure 3.1), and closely followed IPA strategies used in current literature (Braun & Clarke, 2012, 2019; Pietkiewicz & Smith, 2012; Smith et al., 2012).
1) **Multiple readings and making notes.** As a novice researcher, multiple reads of the transcripts were important prior to making notes. This step allowed me, as the researcher, to immerse myself in the data and reflect on the transcripts. The written transcripts and audio assisted in highlighting the type of language used.
such as the repetition of phrases, pauses, and context of phrases. Exploratory comments were generated here, along with noting distinctive phrases and emotional responses (Pietkiewicz & Smith, 2012). For better organization, these exploratory comments were divided into descriptive (context of what was said), linguistic (language use) and conceptual (exploring how content connects to research question) comments (Smith et al., 2012). In addition, interpretative notes, such as my own ideas and thoughts on how ideas or quotes connected, were included. In terms of a coding strategy, open coding is best suited for IPA, as it focuses on line-by-line analyses of the transcript. This coding strategy was appropriate for this study, as it broke down and pinpointed specific phrases that connected to the relationship between body image and menopause in South Asian women. Open coding consists of highlighting a phrase or quote and adding labels, definitions, and my own interpretative notes to it. For instance, when a participant said, “it’s just something we go through silently”, the context of this quote related to experiencing menopause and health issues alone (with no support). This quote was labelled as ‘silent suffering’ and ‘lack/need of support’, and my interpretative notes saw this quote as a ‘need for intervention’ and ‘lack of South Asian cultural/community awareness’.

2) **Deductive and inductive analysis (thematic analysis;** Green & Thorogood, 2004). This step reflected on the use of thematic analysis to interpret the data. In deductive or “top down” analysis (framework analysis), themes and explanations were derived from existing concepts, such as the interview guide and current literature, while inductive or “bottom up” analysis (thematic content analysis)
derived its themes and explanations from the data without regard to existing literature and theory (Braun & Clarke, 2006). Braun and Clarke (2012) argued that coding and analysis of data requires the use of both approaches. Therefore, for the purpose of this study, both analysis strategies were used to determine if the data fit with existing body image and menopause literature, or if the data created new knowledge.

3) **Highlighting generated themes (thematic analysis; Braun & Clarke, 2019).**

The interpretative notes generated in steps 1 and 2 made it easier to generate themes in the data. This step reduced the amount of content analyzed, as interrelationships, connections and patterns began to emerge (Smith et al., 2012). The question here, as a novice researcher, was how do you define what a theme is from the data? Braun and Clarke (2006) argue that there is no fixed guideline for defining a theme; as long as it captures and connects the data to the research question, the theme is considered significant. I analyzed the data through an essentialist and constructionist lens. Essentialism dictates how the data is theorized into meaning as a unidirectional relationship between meaning, experience and language exists (Braun & Clarke, 2006, 2012, 2020). In a sense, semantic (explicit) thematic analysis aligns with essentialism, where the data is broadly theorized into meaning (Braun & Clarke, 2006). In contrast, meaning and experience are socially produced in the constructionist lens. This lens tends to closely follow latent (interpretive) thematic analysis, which identifies and examines the underlying ideas and assumptions, and attempts to derive more from the concepts and ideas that exist in the data (Braun & Clarke, 2006; 2012). For
instance, through semantic analysis, one can conclude that the lack of understanding of body image and menopause concepts is due to the lack of education. However, through latent analysis, one can identify underlying factors to that statement, such as lack of culturally appropriate resources and hesitancy and stigmatization by South Asian community of these concepts. Together, these two analyses suggest that body image and menopause could be better understood and interpreted if culturally appropriate interventions (e.g., workshops) and resources to destigmatize these concepts are implemented in South Asian community.

4) **Connecting relationships and themes.** At this step, I focused on the transcript as a whole and highlighted similarities and common phrases that generated as themes. From these phrases and themes, I looked for connections and phrases that could be clustered together. The processes by which relationships and themes can be organized is dependent on the nature of the themes. Smith et al. (2012) highlighted six popular methods: *abstraction, subsumption, polarization, contextualization, numeration, and function* (see Table 3.2) for descriptions of each), however, the process of analysis does not cease until the data is exhausted of all other potential outcomes.
Table 3.2

Theme Generating Strategies

<table>
<thead>
<tr>
<th>Theme Strategy</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstraction</td>
<td>Sub-themes/patterns forming within existing theme.</td>
</tr>
<tr>
<td>Subsumption</td>
<td>Sub-themes/patterns can be merged into a general/overall theme.</td>
</tr>
<tr>
<td>Polarization</td>
<td>Themes with oppositional relationships.</td>
</tr>
<tr>
<td>Contextualization</td>
<td>Highlighting themes that hold narrative, cultural, temporal contexts.</td>
</tr>
<tr>
<td>Numeration</td>
<td>Accounting for the frequency of theme in the data.</td>
</tr>
<tr>
<td>Function</td>
<td>Examining how a theme fits into the transcript and connects to research questions – Themes can be presented as positively supporting existing literature, or negatively contradicting existing literature, and therefore, creating new knowledge.</td>
</tr>
</tbody>
</table>

*Note:* Adapted from Smith et al. (2012).

5) **Next case analysis** (Smith et al., 2012). In an attempt to commit to the ideas of idiography, each case was analyzed individually without the previous one factoring in on the analysis process. Steps 1-4 were repeated for all the cases.

6-7) **Cross-case analysis** and **themes across cases** (Smith et al., 2012). At this step, all existing patterns and themes across all cases were compiled into a master list. This process required re-examining the existing content and realigning and relabelling relationships to reduce the volume of the material. Common themes and patterns, along with idiosyncratic ideas were noted. Similar to the single case analysis, theme strategies (Table 3.2) were used to redefine themes and patterns. In the cross-case analysis process, certain strategies were seen more effective than others. For instance, the *function* strategy seemed to constrict the multidimensionality of the data; the description of the patterns and themes went beyond the objectives of this study, they overlapped with one another, and created
this narrative (contextualization strategy) across all the cases. The themes that were produced tell this complex and intertwined story of the participants’ body image and menopause experiences, along with an underlying narrative of cultural conflict (South Asian vs Western cultures).

As noted in Smith and Osborn (2015; p. 31), conducting research via IPA for “complex, ambiguous and emotionally laden” topics is particularly useful. As such, exploring body image and menopause experiences in South Asian women through IPA was an appropriate choice for this study’s methodology and data analysis. Every interview, using participants’ pseudonym names, was transcribed verbatim and stored electronically on a password-protected device to ensure confidentiality. Each transcript was analyzed via the data analysis process outlined in Figure 3.1. After the initial transcribing, fieldnotes and journal comments were added to the transcripts, which included verbal or visual cues I noticed from the participants during interviews, or overall reflective thoughts (e.g., responses that surprised me) that came to mind during and after the interview. Each participant’s transcript was read individually and thoroughly multiple times; with each read I added my own notes and interpretations to the data and began to highlight and label key phrases and sentences. After this step, the data was viewed through a deductive lens using the interview guide and current literature to identify potential patterns. After this point, I stepped away from the data for a few days and returned to look over it with an inductive lens; here I looked for codes and patterns without any regard to existing theory and literature. After these steps, patterns and themes were generated via semantic and latent thematic analysis, followed by connecting phrases and patterns to cluster together to create themes to represent the data.
The final step was to compile a master list of the existing patterns and themes across all the cases; this process was completed several times as I realized the themes I had initially generated was not a full representation of the data. After consulting with my supervisor, and receiving feedback on my interpretation of the findings, it was apparent I needed to reorganize the themes. The initial organization of the themes was confined to the interview guide and lacked the multidimensional representation of the data. The new configuration of the themes was completed through inductive and latent lenses, which fit well with my interpretivist and constructivist worldview.

**Quality and Rigour**

*Transparency* relates to the explicitness of how the study is conducted. Since I am a novice researcher, this study closely followed methods and data analysis strategies previously used in IPA research. Concerns of particular procedures were addressed to ensure transparency. For instance, participants had the right to remove themselves from the study at any time point.

*Reliability* relates to the ‘repeatability’ of interpretation. Essentially, if the study were to be replicated, would similar themes arise, or would the data be coded the same way by other researchers. This is important if multiple coders are used to analyze the data (Green & Thorogood, 2004). To ensure this type reliability, the process of data collection and analysis was detailed, which can also be considered as transparency of the research method. This ‘audit trail’ allows readers to examine the study’s research process (Liampittong, 2013).

In addition, respondent/participant validation or member checking was used. The purpose of member checking was to assure the participants that I, as a researcher, would
complete the analysis and write-up process using their words, but with my interpretations. Feminist research argues that the researcher must become an ‘ally’ of the community and attempt to balance interpreting the data without bias and prioritizing the perspective of the participants of the study (Leavy & Harris, 2019). This process involved taking the transcribed data back to the participant to validate the content the individual provided during the interviews. For this study, participants were sent a summary of their interview to review, and they were given the opportunity to change, correct, or add to any of the interpretations that were made.

Credibility of the research process was additionally validated through peer review. An external individual familiar with the study and qualitative research conducted the peer review and examined the reliability of the methods and analysis process, and the analyzed data (i.e., themes and subthemes; Liamputtong, 2013).

Validity refers to the credibility of the data and justifying the use of a particular analysis method. The purpose of this study’s data analysis strategy was to emphasize the experience and its interpretation through the perspective of the participant. Therefore, the use of verbatim extracts provided further justification for arguments made by the researcher. Smith et al. (2012) argued that this data analysis process gives “participants a voice in the project and [allows] the reader to check the interpretations being made” (p. 180-181).

Reflexivity, which refers to reflecting on the data generated, was completed through journaling in this study. In addition, this study also incorporated the use of four reflexive awareness strategies (Green & Thorogood, 2004). Methodological openness speaks to explicitly mentioning the steps taken in the data’s production and analysis,
which was outlined in the methods and data analysis strategy sections. *Theoretical openness* relates to addressing theoretical starting points and assumptions made, which were highlighted in the introduction. *Awareness of the social setting of the research itself* focuses on the interactions between the researcher and participants. This was explicitly outlined in the verbatim transcription of the interview. *Awareness of the wider social context* refers to how the research is possible and constrained in the social environment. Smith et al. (2012) noted that the extent of ‘harm’ to a particular group of participants can vary and be caused by talking about a sensitive topic. Since this study’s topic of interest was highly sensitive, reflexivity was extremely important to ensure the participants were not pressured or restricted from providing valid data.

*Triangulation*, which refers to the use of multiple sources, further validated the data. In qualitative research, triangulation is viewed as a strategy for validity of the data using multiple sources. Triangulation was implemented through *data triangulation*, the use of multiple data sources (i.e., one-on-one interviews, journaling) and *methodological triangulation*, which involved using multiple methods to gather data (Patton, 2015). For example, interviews were transcribed using the audio-recording, field notes, member-checking, and journaling.

**Ethics**

*Informed consent*. Due to the sensitive nature of the topics, all participants were provided with informed consent forms prior to and at the individual interview session to ensure the participants had time to read them thoroughly and understand what their agreement to the study entailed, that they willingly give consent, and they understand they were free to withdraw from the study at any time. It also allowed the participants to
decide whether they would like to participate in the study. At the beginning of each session, I provided full information on the study and its procedures. For the online interviews, participants were asked to verbally consent twice. Oates (2015) mentions that some participants after joining the online session may no longer feel comfortable to conduct the interview, and therefore may consent under duress. To mediate this concern, participants were given a verbal summary of the consent forms and asked to consent prior to audio-recording; they were asked to consent again with the audio-recording on to ensure it was recorded in the transcripts.

Risk and harm. As the researcher, it was my responsibility to ensure participants are safe from any risks or harm. The sensitivity of the topics discussed could have caused emotional and psychological harm to the participants. In that case, as outlined in the consent form, participants were allowed to withdraw from the study or choose not to answer any questions. However, to ensure the mental health of participants, additional resources, such as contact information for local mental health services (i.e., counsellors or psychologists) were provided regardless of whether participants completed the entire study.

In addition, the location of the interviews needed to be considered. Conducting interviews remotely via an online platform must consider the privacy of the participants in two ways: 1) the location in which I conducted the interview session; and 2) the location in which the participant chose to complete the interview. As the researcher, I ensured I conducted the interview in a private room where no disruptions could occur, and no other individual was present. In addition, I ensured the participant was also able to complete the interview in a private room; the presence of their husband, children or other
family members could have caused discomfort and prevented them from openly
discussing the topics.

Anonymity ensures information provided by the participants does not hold
distinctive features that could be matched to certain participants. The use of audio
recording and transcripts was completed using identification numbers and pseudonyms in
the writing process; however, this method of data collection cannot be considered
completely anonymous. In order to complete the transcribing component, the audio
recording and field notes were matched to each participant. Although during the
transcription and analysis phase participants was not completely anonymous, the write-up
eliminated any distinctive information in the writing to protect the identity of the
participants. Once transcription and data analysis were completed, the audio-recordings
were deleted.

Confidentiality refers to the expectation that the information participants provide
will be kept private and not shared with anyone else (Green & Thorogood, 2004). This
statement holds true with this study, as the data remained with the researcher and shared
with only individuals involved in the study, such as the supervisor, which participants
were aware of beforehand. All data, including audio recordings and transcripts, were kept
in a secure, password or lock-protected location, to which only I had access. In addition,
audio recordings were deleted after the transcription and analysis processes were
completed.
CHAPTER 4: RESULTS AND DISCUSSION

As I analyzed the data, I realized that attempting to present it in a uniform and single dimensional piece would take away from the multidimensional and interwoven concepts that were identified. As the reader, you will notice an overlap of themes as well as the shared and individual experiences of the South Asian Canadian women, which add a dynamic dimension to the themes. Each participant provided meaningful data on their own body image and menopause experiences, topics which are often considered taboo and rarely discussed in the South Asian community (Bottorff et al., 2001). It is important to note that all the names included are pseudonym names for the participants and interviewer. The interviewer (first author) is referred to as ‘Tirath (I)’ throughout this section.

Through the analysis process, it became apparent that the data was intricate and complex, and this is reflected through the themes. Overall, three themes were constructed from the analysis: 1) Complexity and intertwining of body image and menopause experiences; 2) “It's just something we go through silently”: The challenges of body image and menopause experiences; and 3) The push and pull of South Asian and Western cultures. A thematic map summarizing the themes and subthemes is presented in Figure 4.1.

Figure 4.1 illustrates the interconnection and complexity of the themes. The darker coloured circles represent the themes, while the lighter circles represent the subthemes. The dotted lines that connect each theme shows how closely connected the themes are to one another. The space that forms in the middle of the enclosed triangle-shape between the themes represents a blank canvas for infinite research ideas, thoughts,
and patterns. This study was the first to explore body image and menopause in Canadian South Asian women; greater representation, focus, and research conducted within this population is critical to understanding these factors in this population, leading to the formation of newer and more inclusive theories, concepts, and literature for that ever-evolving canvas.
Figure 4.1

*Thematic Map of Themes and Subthemes*

- **Complexity & intertwining of body image & menopause experiences**
- **The impact of menopause & aging on body image**
- **Menopause: ‘Sense of the unknown’**
- **Conflicts between South Asian & Western cultures**
- **Contradictions in body image**
- **Positive & negative body image can co-exist**
- **“It's just something we go through silently”**: The challenges of body image & menopause experiences
- **Betrayal of one’s body**
- **Lack of support from family & South Asian community**
- **Cultural standards on beauty, body image, & aging**
- **The push & pull of the South Asian & Western cultures**
- **The impact of menopause & aging on body image**
Complexity and intertwining of body image and menopause experiences

This theme highlights the complexity of body image and menopause experiences in first generation South Asian immigrant women in Canada. The theme starts off with the participants’ interpretations and understanding of body image and menopause, followed by the interconnection between the two constructs. Quite often, participants spoke of the overlap of body image and menopause experiences, which often led to feelings of confusion and being ‘let down by their bodies’. In this theme, four subthemes were generated: 1) contradictions in body image; 2) positive and negative body image can co-exist; 3) menopause: sense of the ‘unknown’; and 4) the impact of menopause and aging on body image.

Contradictions in body image. Overall, when defining the term ‘body image’ in general, participants had a multidimensional idea of the construct. However, in terms of their own body image, the women’s understanding was much narrower and lacked dimensionality. When it came to describing the ideal female, all participants described an ideal that went beyond physical appearance. Participants spoke of positive characteristics and attitudes, such as confidence, being strong and healthy, and, as Davinder explained, “loving yourself no matter what”, consistent with conceptualizations of positive body image (Tylka & Wood-Barcalow, 2015). Harinder explicitly noted, “Size doesn't matter. There could be anything. It could be any size, right? You would want most females to be able to voice their opinion and be strong and be able to respect it for that”.

However, at the same time, participants still upheld the Western appearance ideal; they emphasized weight, and particularly thinness, and youth. For instance, Tejinder explained the idea young female as someone with, “nice good hair, nice face, no
Participants described their personal ideal to be slim, pretty, with nice hair and skin, and no wrinkles (consistent with the Western ideal – see Cash & Smolak, 2011). Every participant made implicit and explicit comments on thinness and/or body size. For example, participants mentioned women needed to be healthy and that was achieved through being slim/very slim; another commented on feeling more confident when they were younger and skinnier. Another participant noted that being slim and her ability to maintain her weight occurred through engaging in health behaviours (i.e., exercising – running/working out). Davinder explained, “When I was younger, I was so skinny. But there was always that I didn't want to go past a certain point of you know, my weight. But it was always forefront of my mind, you know, (right). Don't get, don't eat too much. And don't eat the junk food and stuff”. Based on these comments, it seemed that the participants often equated positive body image practices (i.e., intuitive eating, exercising) and attitudes (e.g., confidence, body satisfaction; Tylka & Wood-Barcalow, 2015) with Western body image ideals (i.e., weight control, restrictive eating; Cash & Smolak, 2011; Grogan, 2017; Slevec & Tiggemann, 2011).

This limited idea of body image was even more obvious with respect to their own body image, with most participants focused on their appearance, providing commentary on their appearance, weight, and body shape in particular. For example, Harinder (who described an ideal in which size was not important as noted above), described her own body image very differently, as she mentioned, “My appearance, okay, petite. I’m five feet. And let's say I have gained weight after 35 in wrong places, which is very difficult to shed away. Just due to stress, and I guess diet”. Harinder’s comments reflected the
common tendency of the participants to focus on appearance with respect to their own body image, without even recognizing the contradiction with their definitions of the ideal. This fluctuation between a unidimensional and multidimensional definition of body image was similarly found in Bailey, Gammage, and van Ingen (2017), who explored how members of an exercise facility for special populations (i.e., seniors, individuals with chronic disease, those with spinal cord injury) and student trainees defined body image prior to participating in a positive body image intervention. In Bailey et al. (2017), weight concerns were commonly described. Participants also talked about body image multidimensionally, describing components of both perceptual (subjective views of one’s body) and attitudinal (thoughts, feelings, behaviours) body image. By contrast, in the present study, participants focused on their own body image attitudes centred primarily around their appearance and weight.

Heena reflected a common trend of associating positive body image with an appearance that was close to the ideal. When discussing her body image, she explained,

So basically, I had really, really good figure good, you know, body image and all that. But I think in last couple of years, or maybe I would say this year, I feel like body's like little bit losing its tone and appearance is becoming, which I used to be like, I don't know, but I was very compulsive in exercise or like, you know, in all throughout my life, and because my mother was state level athlete and all that so they also started saying, which I don't like, but oh my god, you're only 45 and look at you your upper arms looks a little bit big and all that so I don't know why but like certain areas of body (*pointed/grabbed parts of her body, i.e., upper arms, back, tummy*) is started and I'm a busty woman. So it started like started
becoming bigger... And yeah, so I feel like the body tone is gone down a little bit... on the tummy, which I always hated and but inside my I know but still like, means like, I'm sure that I won't look like 18 or 20 years old for sure. But I can still make myself a little bit more tighter or bite size not by doing any those cosmetic things in the outside. No I don't believe that because no the thing is I have to accept that okay, this is the body and I'm no more 20 or 30...

In the beginning of the quote, Heena conflates the idea that having a good figure or slim body size is equivalent to having a positive body image; however, this is not consistent with the positive body image literature. Positive body image is characterized by body acceptance (being comfortable with one’s body and focusing on its assets), body appreciation (valuing the body for what it can achieve), and overall satisfaction with the body’s appearance and function regardless of whether it meets societal ideals (Tylka & Wood-Barcalow, 2015). Yet, in the context of Heena’s quote, it seems like she misunderstood or misinterpreted positive body image compared to researchers’ definition of this construct. Bailey and Gammage (2020) explored the effects of a positive body image program in older adults and individuals with physical disability and chronic illness, found that prior to the intervention, many participants viewed body image in a unidimensional sense and often equated body image to an ideal appearance and body weight (i.e., weight loss would improve their body image), similar to the women in this study; following the intervention, for most participants, they described a more multidimensional definition of body image. However, one participant was disappointed in the positive body image program, because she did not get the weight loss tips she was expecting. Thus, they noted a conceptual gap in researchers’ understanding of body
image and the public’s understanding. The present study shows that this gap exists in another population (i.e., South Asian women going through menopause) and highlighting the lack of appropriate knowledge translation of positive body image research to the public.

Furthermore, Heena continued to emphasize the importance of appearance, specifically weight concerns and thinness, and when changes (i.e., weight gain) occurred with age, they were often seen negatively. Throughout this interview, I noticed several internal conflicts experienced by Heena. She seemed content and accepting of some of the changes to her body (e.g., wrinkles, gray hair), yet, at times, she struggled with specific changes, such as weight gain, which had occurred over time. She was less accepting towards weight gain because she had been slimmer when she was younger, so the shift in her body weight had been difficult for her to deal with, reinforcing the importance of a slimmer body size and lower weight in this population. The findings from Råberg et al. (2010), which included Pakistani and Sri Lankan immigrants (aged 30-60 years), were consistent with this belief; they found that most of the participants were dissatisfied with their weight. Even in women classified as normal weight, 80% of them desired to weigh less and were dissatisfied with their bodies.

An interesting pattern I noticed throughout each interview was the hesitancy and long pauses following the body image-related questions. There was often an initial struggle to articulate an answer, followed by an external/appearance-specific answer; a few participants even asked or looked for validation from me on whether their response was correct or appropriate to my question. Similarly, in Bailey et al. (2017), participants admitted to searching for the definition of body image online prior to taking part in
interviews as they were unable to define body image on their own. Thus, this struggle to understand body image is apparent in diverse populations. In the current study, participants held many roles; they balanced being daughters, sisters, mothers, partners, friends, homemakers, and breadwinners. Body image is multidimensional, and goes beyond appearances, yet the easiest responses for the participants to make were superficial ones about their appearance rather than their abilities and roles as dynamic women in the community.

Tiggemann (2015), in a review of positive body image across various social identities (i.e., age, culture, gender, and special population), provided interesting insight into how gender roles and feminism may influence one’s body image. She noted that women ingrained in traditional femininity ideology (endorsement and practice of traditional beliefs, such as dependency on their male partner, purity and passiveness, role of caretaker and mother; which is a fair description of the South Asian community’s expectation of women; Swami & Abbasnejad, 2010) experience lower body appreciation. To contrast, it is possible that the development of modern feminism, which promotes multidimensionality of women’s roles may lead to resisting cultural ideals (body image and gender roles), and potentially more positive body image (e.g., body-size acceptance; Tiggemann, 2015).

Furthermore, participants who engaged in heathy behaviours (e.g., exercising, intuitive eating) were often motivated with the idea of meeting some sort of ideal (usually based on body size/shape) or losing weight, but often lost interest when there were few to no results. For instance, Davinder, who struggled with her weight, explained,
“I am probably 50 pounds heavier than when I was before this, so it's really… (*sighs*) slowed me down. I yeah, I actually don't even feel like exercising because the extra weight…. (*sighs*) You know, it's definitely I feel sluggish. I feel kind of gross… grossed by my body… (*long pause*) Yeah, and I just didn't go to the gym because yeah, I just felt kind of it wasn't helping. (*long pause and sighs*) Like I did for many years and then I still gained weight. And I just stopped, I gave up I think. (*long sigh*)”

As they aged, the emphasis on thinness and appearance for these women remained important, and the importance of appearance is interwoven throughout this theme. Throughout Davinder’s interview, specifically, I noticed her struggle with body image and her weight. This was a tough conversation for her; she took several pauses and long deep breaths as she spoke about her body image experiences. It seemed like this was the first time she was truly speaking out about her experiences and was willing to do so with someone (myself) who did not know her and would ultimately understand and refrain from judging her. Since the interviews were conducted online, I always took a few minutes prior to beginning the interview to build rapport with my participants, such as asking them their current day-to-day routine, and how they were coping with COVID-19. Oates (2015) acknowledged the important of context questions and self-disclosure by the interviewer; I found it led to the establishment of credibility and building rapport with participants to allow for detailed and meaningful responses. This was particularly important because these interviews were not conducted in-person, and I wanted to create a safe and welcoming atmosphere for the women, and personally I felt that this led to more meaningful conversations, regardless of how difficult they were.
Positive and negative body image can co-exist. Participants experienced both positive and negative body image at the same time, a finding which has been consistent in previous research (Bailey et al., 2016; Gattario & Frisén, 2019; Rodgers, Paxton, McLean, & Damiano, 2016). A study by Bailey et al. (2016), explored the representation of body image in middle-aged and older adult (predominantly White) women. Findings showed that the women experienced both negative and positive body image. This finding has been similarly seen in other diverse populations. Gattario and Frisén (2019) examined individuals who had overcome negative body image in early adolescence and developed positive body image as they moved into adulthood. Findings showed that participants experienced both positive and negative body image before stabilizing into positive body image with age. Rodgers et al. (2016), via a Facebook thread, examined attitudes and reactions to physical changes in midlife Australian women. Results showed a coexistence of positive and negative feelings (i.e., both content and dissatisfaction with aspects of their bodies) towards their bodies. An interesting theme that emerged was women’s positive and negative feelings towards lack of attention; participants mentioned no longer getting the ‘second look’ and “missed being visible” (Rodgers et al., 2016, p. 399).

An interesting pattern that emerged in this subtheme was the importance of body function. The emphasis on body function was not surprising, given that middle age and older women begin to place greater relative importance on health and function compared to appearance (Roy & Payette, 2012; Tiggemann, 2004). However, even when participants had positive attitudes towards their bodies, most struggled with their health or functional abilities, which resulted in negative body image. For example, Kiran noted:
**Kiran:** Yeah, I think, again, it's not as active as, once upon a time. Yeah. And I think that's, that is the factor that you you have to sort of consider like you, you're not able to function as much as, like, sort of hardy work that I used to be able to.

**Tirath (I):** Yeah. How has it made you feel over time just kind of losing that function?

**Kiran:** Yeah, at first, I was really depressed because I… (*pauses to think of response*) a prime example would be, I was able to do a lot of outdoor activities like gardening, and so on. And then, two years ago, my… my knee kind of got somehow, I don't know what happened to my knee, maybe I the way I sat. So I kind of suffered for that sort of injury to my knee for about two years…

For Kiran, at age 59, her functionality had been extremely important to her. She worked fulltime and took care of the household, so when she noticed changes to her function that impacted her day-to-day living (e.g., unable to garden, no longer able to wear heels at work), it affected her body image and mental health negatively (i.e., depression). This focus on negative aspects of function is generally inconsistent with the positive body image literature, as focusing on and appreciating the function of the body tends to be associated with positive body image (Alleva et al., 2018; Tylka & Wood-Barcalow, 2015).

However, as recently noted by Alleva, Holmqvist Gattario, Martijn, and Lunde (2019) in their qualitative study exploring themes generated from participants’ descriptions of their body functionality and physical appearance, emphasis on function alone does not necessarily result in positive body image, although it is an influential
factor. Rather, the researchers noted that when encouraging individuals to focus on function, it should be accepted regardless of limitations and changes to their functionality. Kiran had not accepted that fact – she was still stuck on a functional ideal or at least wanting to return to a previous functional capacity she had at a younger age. Interestingly, to mediate the changes occurring to her body, Kiran engaged in positive behaviours, such as participating in yoga. Although engaging in positive behaviours can lead to positive body image, Kiran’s experience was more complex. Initially, she refused to accept the functional changes occurring to her body; it was not until function had improved before she was accepting of her body’s functional abilities.

In another instance, Davinder, who since COVID-19 had engaged in positive health behaviours, explained:

Well, you know, since COVID, I think I’ve been more aware, just because I think we have more time now. And so I’ve been more aware of what I eat. We’ve been eating at home. None of these late late night parties on the weekends. (Yeah) So it's been more consistency. Me and my sons, we work out together now. We started that, like three months ago.

Since COVID, it seemed that Davinder did attempt to change the way she felt about her body, aiming towards a more positive outlook on herself and her body image by engaging in healthy behaviours (consistent with positive body image; see Tylka & Wood-Barcalow, 2015). It is important to note that, initially, prior to COVID, her motivation for engaging in intuitive eating and exercise behaviours was to lose weight, but she often struggled to consistently maintain these behaviours. As such, with her history of health-related (e.g., eating behaviours) and weight concerns, Davinder still struggled with her
body image. She mentioned, “I hate my body. Like it's a... it's doing something that honestly, I don't want it to do. (Right). And I... I just don't know what to do right now. Like, I'm so confused” (*Lots of head shaking and distress on Davinder’s face*).

Throughout her interview, Davinder provided insight to her constant struggle with body image. Although most of her experiences were negative, due to a change in circumstance (COVID-19), her outlook on her body had shifted towards engaging in positive behaviours that made her feel good about her body, and as stated in her quote, this change was the result of familial support and motivation from her sons. Research (Bailey et al., 2016; Thorpe et al., 2015; Tiggemann, 2015; Tylka, 2013) shows that body acceptance by others helps women be less critical of their bodies and appreciate them more. For instance, Thorpe et al. (2015), who explored older Australian women’s accounts of their bodies and embodied intimate relationship experiences, found women attached importance to their partners’ perceptions of their appearance. Even when dissatisfied with their own appearance, women were still able to embody positive experiences as they felt their partners were loving and affectionate regardless of appearance. Overall, these quotes demonstrated that constant battle between positive and negative body image, and how both constructs can be experienced by an individual.

**Menopause: Sense of the ‘unknown’.** At the time of the interviews, the majority of the participants were in postmenopause. When reflecting on their menopause experiences, most spoke of a prolonged, negative experience. Kiran (5 years postmenopause) explained,

“... most ladies experience like for five, six years or even down the road 10 years. I think even more like mine was more than 10 years, that I was experiencing a lot
of disturbance in hormones like I would be will be all over mood swings, and, you know, you kind of like go through anxiety, depression and I found for no reason, like, you know, you can like, feel sad. And then you also felt that, you know, like, have that negativity towards like, okay, you know, I can't do things that I wanted to do, like, so yeah, it was just very bizarre experience. And then I would have some sweat. But not like, you know how people say hot flashes? (Yeah), I would have it at odd time, even during the day, and some people will wake up with a, you know, sweaty shirt but in my case, it was like all over it. Could be a day could be a night? I don't know, it just was all over. It's very crazy.”

Kiran’s menopause experience here is quite interesting because the physical symptoms endured through the menopause transition led to disruptions to her routine and life. She felt like she was unable to do things she normally could, she was no longer in control of her body, and she had an overall sense of constant discomfort. Similarly, Lakhwinder mentioned constant mood swings and feeling weak/sick, “I see my mood change, I get angry too fast. And then when I do my work, I feel kind of low energy. I feel tired as well too”.

In addition, there was a strong negative emotional aspect related to the menopause experience; participants mentioned feelings of confusion, anger, sadness, depression, and anxiety. Manvinder explain feeling lonely, stressed, and anxious, “Like if something is like hurts me, I make a big deal of it. I don’t know”. Simran explained even after going through the menopause transition, “Still, I don't know what's going on with my body. You know? (Right). All the time sometime, very weak, I get tired. No, I don't know what's going on with my body”. Aside from the common physical symptoms, such as
headaches, weight gain, weakness, and fatigue, the emotional symptoms took a toll on Simran, as she explained, “I was nervous. I was like... felt sadness. And I felt emotional. I even stopped driving”. Even in postmenopause, Simran felt her functionality had been greatly affected, which, in turn, affected her emotional wellbeing.

For Simran, the experience of menopause was a “very, very bad thing”; and the majority of the participants echoed similar sentiments, especially when it came to emotional wellbeing. In the present study, all participants, including two who had been diagnosed with depression at a younger age, spoke of facing depression and/or emotional distress throughout their menopause experience, and as such, mentioned negative menopause experiences. Harinder, who experienced a “painful” 10-year transition, explained, “emotionally you, you will feel like crying [and] not know why. So your emotions are pretty much all over”. The majority of the participants experienced menopause for a prolonged period of time, and despite time passing, they still remembered and felt the impact of their experiences. Hunter et al. (2009) quantitatively and qualitatively explored menopause experiences in peri- and post-menopausal UKA, UKC, and DEL women. Researchers found similar findings in the emigrated UKA group to women in this study, as they too described their experiences as “intense and severe” (Hunter et al., 2009, p. 30). In this study, when recounting their experiences, many participants could not believe what they went through; many of them paused during our conversation and were almost taken aback by how much they had endured.

**The impact of menopause and aging on body image.** The concepts of menopause and aging and how they impacted body image were often confused. This reflects the conflicting research, with some studies showing body image related to
menopause status (e.g., McLaren, Hardy, & Kuh, 2003), while other studies have found no relationship between menopausal status and body image when controlling for age (e.g., Deeks & McCabe, 2001). In this study, participants admitted that as they noticed changes to their body, they were unsure whether they were due to menopause, aging, or both. When Kiran suffered a knee injury, which affected her functionality, she struggled with determining the factor(s) that caused the injury. She explained,

After two years, I was at the point I've had maybe… maybe this age, maybe it is, you know, maybe this is the way life's gonna be. For two years it was very depressing. Because I used to do yoga and was sitting down with my cross legs, and no, and I was very depressing that I couldn't do it. And it was more to do with my injury than anything else. I think it was, could be related to my postmenopause as well, the age factor and all that, but I think I feel good about that, able to do that now.

For Kiran, she began to lose her function as she aged, however, at the same time she was undergoing the menopause transition, which led to poorer mental health (i.e., depression), and this affected her negatively. This experience was consistent with findings in previous research (e.g., Erbil, 2018), showing that women with greater wellbeing (i.e., lower depressive symptom severity) and positive attitudes towards menopause reported higher positive body image than women with poorer wellbeing (i.e., higher depressive symptom scores). Moreover, Kiran reflected the idea that these changes to body image could be impacted by both menopause and aging, and it was difficult to distinguish, consistent with previous research (see Pearce et al., 2014). In a scoping review (of studies with predominately White female participants) that examined women’s body image during the
menopause transition, Pearce et al. (2014) found two themes that parallel my own: (1) the relationship between body image and menopause is complex; and (2) there was confusion about the changes that occurred to the body during menopause and how it may impact body image. Although the studies in the review did not explicitly mention South Asian women participants, the inclusion of other ethnic populations (i.e., Middle Eastern, African American participants; Dillaway, 2005; Jafary, Farahbakhshk, Shafiabadi, & Delavar, 2011) and consistent findings with this present study, suggest that these relationships can be shared across other diverse groups of women.

Several participants did highlight that although they experienced an ongoing battle with aging and the menopause transition, they needed to embrace change and accept both as a part of life. When speaking about their menopause experiences, and how body image was affected, many participants spoke about aging. As Gagan explained,

I'm one of those people that are experiencing that. And so therefore, my mind has to catch up with everything that's kind of going on with my body. But I'm hoping to get that resolved. Over the next little while. I'm aware of it. I just, I need to come to peace with it. Yeah, your body does change. And it changes because it's supposed to change. It's not supposed to. It's not supposed to look like the way that it looked before and that's okay. And I think we all have to be okay with that. Instead of trying. Even just like you see what a 50-year-old woman looks like now or a 60-year-old woman instead of trying to I mean be healthy, but you don't have to look like a 20-year-old.

Gagan’s perspective here is interesting because despite the confusion and little to no understanding of the changes occurring to the body from menopause and as she continues
to age, she believed these changes need to be accepted. Aging is a natural process, and although it causes an onset of declines in function, sensory systems, and changes in body appearance, women suggested it should be accepted. Deeks and McCabe (2001) investigated the association between menopause stage, age, and body image. Although, across the three groups, women expressed negative feelings about their bodies, premenopausal women were more positive about their body image than menopausal women. Moreover, as women went through the menopause stages and aged, their rating in body image measures changed such that postmenopausal women were more accepting of their current larger figure than the other participant groups. This suggests that, as independent variables, age and menopause stage may influence how women feel and perceive their bodies (e.g., positive, negative, or neutral attitudes).

Many participants echoed similar sentiments; their body image and understanding of their body’s changes very much overlapped with menopause and aging, and they felt that when they were able to or attempted to accept their bodies as they were, they felt more content with themselves. Several researchers (Ballard, Elston, & Gabe, 2009; Dillaway, 2005; Pearce et al., 2014) have argued a need for a perceptual change around menopause. The menopause transition marks a new period in a women’s life and encouraging women to accept and embrace it as a positive event that represents change and a new beginning may lead to more positive outcomes, such as body image experiences and positive health behaviours (e.g., self-care). For example, McKinley and Lyon (2008) found that more positive attitudes towards menopause were associated with higher body esteem and lower body surveillance, an indicator of self-objectification. Additionally, Tiggemann and McCourt (2013) noted that although the positive
relationship between age and body appreciation was small to moderate, older women (over 50 years of age) had greater body appreciation than the other two younger groups. This finding suggests that at this older age, women are reaching a significant period of their life (menopause usually occurs at age 50) where they begin to willingly (or reluctantly) accept aging and the shift away from the societal ideal (Tiggemann & Lynch, 2001; Tiggemann & McCourt, 2013).

“It's just something we go through silently”: The challenges of body image and menopause experiences

This quote summarizes this theme well as it describes how difficult women’s experiences (of menopause, body image, and health concerns) were and that they lacked personal support (from family and South Asian community) and tended to deal with them alone and in silence. Two primary themes emerged: 1) lack of support from family and South Asian community; and 2) betrayal of one’s body.

Lack of support from family and South Asian community. This subtheme speaks to the overall lack of personal support (familial and South Asian community) pertaining to menopause for South Asian women. Although several references to body image were made, the general focus in this subtheme was towards the participants describing their difficulty understanding and interpreting menopause.

A few participants mentioned speaking to their mothers and some family members about their menopause experiences, however, it was often after they had already gone through the menopause transition. Most participants felt they could not seek out advice during menopause as they were unsure who to turn to; it was only after their own experiences with menopause that their mothers and other family members would openly
speak about their own menopause experiences. This lack of communication within a household is quite common; as a South Asian woman, I have experienced this. There is an overall sentiment of ‘keeping things to yourself’ and a ‘not sharing women’s issues’ culture within the household and community. By airing out such concerns, it is seen to bring unnecessary attention, and cause unwanted gossip about the woman or her family. Channa et al. (2019) conducted a case study that explored bulimia nervosa experiences in a young British Indian woman. The study similarly highlighted family, community, and culture as barriers for support and seeking help. There was the fear of stigmatization, lack of knowledge, and discomfort approaching family. The participant felt that she was unable to confide in her family about her needs and concerns, and therefore struggled with bulimia on her own and often isolated herself, causing further physical and emotional distress.

Discussions with the participants around this issue were quite interesting, as many tended to almost whisper and speak in a timid voice when it came to speaking about their families and the South Asian community. Their body language tensed, some showed anger and resentment, while others were saddened, because they were unable to find the support they needed. Participants felt that overall, the attitudes and support of the South Asian community was nonexistent. Davinder explained, “I think it's ignored, totally. I have to say, you know, none of the aunties or my older cousins even wanted to speak about it. It's just something we go through silently”. Similar to Davinder, Gagan had strong opinions on the lack of community support,

I don't think it's talked about. I hope that it's talked about more like amongst my family and friends, like I've got three sisters... Like it's just, yeah, everything is
just really it's it's open circle that I hang out with it. Yeah, it's, it's openly discussed, like, Oh, yeah, I'm going through menopause, or Yeah, I hit menopause. But it's not like the symptoms of or there's no in depth, you know. So I think that I think it's changing, which is good with my generation. I'm hoping that the next generation can take it to the next level, where they're just like, so like, Oh, yeah, you know, this is what's going on and, and think about it so freely, that you don't even think twice about it. Like I'm talking not just amongst the women, I'm talking across the board. Because, because, I mean, if you're with a man, and you have a family, and even if you're not with a man, and you don't have a family, people need to realize that you know what, this is not something that you just make up. And it actually is something that's going on in your, with you like mentally, physically, it affects everything in your life. It really, really does. And I don't think that that's prevalent, and not to be not to bring up my family side. But if it was a man going through this, I'm sure that there would have been a whole lot of research done on this. And, and oh, my gosh, you get to take three years off because you're going through menopause. Oh, yeah. Or five and you still get paid and your pension doesn't go anywhere and this and that, but because you're going through a major life change here. Yeah. Whatever.

As previously noted, the South Asian community has an influential role in families and individuals. Although not explicitly mentioned, Gagan hinted at the patriarchal nature of the South Asian community. Most often, the men are the leaders of the community, and as such, dictate cultural norms and practices for the community. Consequently, the overall way of thinking of the community trickles into the individual
families. It became clear that the South Asian community, although an integral influence for South Asian individuals (Ahmad et al., 2012; Hilton et al., 2011), can be considered a barrier to resources for women’s health and wellbeing.

An overarching pattern that emerged in this theme and between the subthemes was a need for a cultural embrace and education on menopause and body image for not only women, but for their families and the South Asian community more broadly. Overall, menopause and body image are virtually ignored and undiscussed in South Asian communities. When asked about her menopause knowledge or education, Simran explained not knowing much, saying, “Everybody [the South Asian community] should know what’s menopause, you know? Everybody should have to know everything about this. I was going through so much, so much.” In addition, the importance of positive body image (e.g., intuitive eating, healthy exercise behaviors, body appreciation) is not taught, and that is not necessarily the fault of the community.

In terms of family, participants felt that they lacked support from their families when experiencing health concerns. For instance, in this study, Kiran, who suffers from chronic migraines, noted that her husband is aware of her condition, and is empathetic towards her, but he struggles with providing meaningful support, such as easing household responsibilities and understanding the medications she requires to control her migraines. Moreover, a few participants did acknowledge that their husbands were overall supportive but did not necessarily have the understanding, experience, or knowledge on how to support their partners, especially through menopause. Harinder explained the importance of educating South Asian men and women,
I mean, especially in our culture, I think, you know, there are, there are women still who are not as educated, right? So I think for them, they're probably struggling. And, you know, I'm sure they talk to their other family members, and they maybe understand, but I think if there was some help available, even for the husbands to make them understand that, you know, your woman, your wife is crying. Because, you know, it's because of this, you can't help it right. Rather than, you know, not understanding. I mean, my husband was fine understanding it, but some, some men may not right. So there should be a little bit more of like a holistic education rather than focusing on women. (Definitely) Okay. Anything like, you know, like in the community centers, if they can offer any education seminars, that'll be great.

When there is little to no understanding of the concerns women face, there is little support available for women. Thus, it is important to educate the men/husbands so that women do not feel like they are experiencing menopause alone. Ahmad et al. (2012) examined barriers and solutions to mammography for South Asian women. The study highlighted several barriers, including dependency on family (e.g., not wanting to burden family members for financial, transportation burdens), lack of access (to mammogram centre, doctors), and lack of knowledge (e.g., importance of breast screening). Solutions included community-based programs that provided transportation, education, and bilingual health professionals. These barriers are similar to many women in the present study highlighted as barriers to support for their menopause experiences.

It is interesting that, although she did have the support of her husband, Harinder thought education for the whole community and family was best suited for the South
Asian community. This education would not only focus on South Asian women’s health, but also the health and wellbeing of men, younger adults, and children from this community, given the significant influence of family in this community. The education would span across the lifespan and be available to those of all ages and genders. This would be consistent with Halliwell (2015), who reviewed existing positive body image research and outlined directions for future research that highlighted need for research that considered the influence of ethnicity. Further, she suggested that early positive body image interventions targeting younger populations may impact their body image. In this study, interventions are particularly important, especially when it comes to creating an open dialogue, without stigma, about overall health and wellbeing, and women’s health in particular. By starting at a younger age, some of the stigma around these issues may be reduced. The most suitable way of conveying this information agreed on by participants was through open forum or seminar-type gatherings. In addition, several participants advocated for support groups where they could speak with like-minded individuals experiencing similar health concerns as themselves.

**Betrayal of one’s body.** A unique subtheme that emerged from the data was this sense of betrayal by one’s body. Participants spoke about being confused, and not knowing what was happening with their bodies throughout and after the menopause transition. When I asked Simran about whether she felt more connected/disconnected with her body after menopause, she mentioned, “I feel [like] lost, still confusing, and I still I don't know what's going on with my body”. Simran’s overall menopause experience was long term and negative; at the time of the interview, she was about 6 months postmenopause, but she was still navigating through the changes (i.e., weight change,
health issues) she had experienced. Pearce et al. (2014) highlighted the ongoing confusion of changes that occurred with menopause, and how often these changes overlapped with aging. Regardless of the cause of changes, they had the potential to affect body image. Similar findings were noticed in this present study, for instance, the emotional and physical toll of menopause, aging, and additional health issues were quite visible in Simran. It was evident that, although she mentioned a supportive family, she was still struggling. Similarly, Davinder provided an interesting perspective to the connected/disconnected question;

**Davinder:** Yeah, I feel like it's a trait…, like it's [my body] become a traitor (that's interesting). Why is it working against me?

**Tirath (I):** Yeah. No, that's an interesting perspective. Yeah. (Yeah)

**Davinder:** I feel like it's not doing what my brain is telling it to do. Yeah. And, you know, like all these problems that we get and issues that come up. When we get older, it's just is it menopause? Is it just old age right?

This was such a strong statement from Davinder – aging is inevitable, but in what way does it affect the body, and how does it relate to or is it different from menopause? There was that sense of betrayal from her body.

Davinder reached a certain point in her life where menopause, aging, and other health concerns (e.g., weight gain) all began to emerge at the same time, and, in a way, she could not ‘keep up’; she felt she was ultimately let down by her own body. Davinder very much struggled with the changes she endured, and it was evident throughout her interview. She often sighed and took long pauses, almost to reassure herself that it was ok
to talk about these things; and in a way she felt safe to speak on her experiences when I reminded her to take her time and that the virtual interview room was a safe place.

**The push and pull of South Asian and Western cultures**

This theme focuses on the often conflicting influences of the South Asian and Western cultures on South Asian women’s body image and menopause experiences. Although the participants lived in a Western country, and were immersed in the Western culture, South Asian traditions and practices continued to play important roles for these women, especially in their attitudes and understanding of menopause and body image. Two primary subthemes were produced: 1) conflicts between South Asian and Western practices; and 2) cultural influences on beauty standards, body image, and aging.

**Conflicts between South Asian and Western practices.** This subtheme focuses on the conflict between South Asian and Western practices pertaining to the knowledge and resources of menopause. Overall, participants felt that at the beginning of their menopause transition, they were not prepared or educated enough to detect or cope with their body’s changes and symptoms. Interestingly, many participants mentioned either letting “nature take its course” or refraining from using Westernized medicine practices (e.g., hormone replacement therapy), and instead opting to use naturopathic and herbal practices to mediate their menopause symptoms. When asked about symptom management and the use of Western medicine practices, Kiran explained,

No, I, I let nature take its course. I didn't take anything. No, I would just I let it be basically, you know, just magnesium, perhaps maybe I still take magnesium, right time to just relax myself. But yeah, nothing, nothing out of the I wasn't prescribed any medication. Like, you know how sometimes people doctors put on what they
call the supplement, hormones replacement. None of that I was not on it. And it's kind of lived through.

Other participants mentioned their attempts to use a medicalized approach to menopause symptoms but were either unsuccessful or unconvinced of the treatment’s benefits. Manvinder explained her hesitancy,

Manvinder: I don’t know, I didn’t know much about it [hormones/other medicalized options]. I had read about it (where?) – Google, I think. But I wasn’t sure about hormones.

Tirath (I): Did you speak to a doctor or other healthcare professional about options? Or even hormones?

Manvinder: I think I might have, or she had mentioned it. But I don’t know why I didn’t take them or what happened. They didn’t seem safe.

Manvinder’s account of her medicalized experience was common with other participants. Many participants who attempted to try the medicalized approach to menopause often rejected it because they lacked education on the approach. Heena, despite having a background in health, had a strong hesitancy for hormone replacement therapy, as she explained:

With my experience with that hormonal shot, I have decided not to take even if anything, like I'm not going to take any kind of replacement hormone replacement therapy or any kind of synthetic hormone shot or any sort of those medicines…but I will refuse those hormonal things they I feel it's I don't know
people I think they might be using for the family planning purpose mostly but they… they literally ruin your health.

The participants’ views on Western medicine were both consistent and inconsistent with the literature. Hunter et al. (2009) suggested that migrated women would take on Western beliefs and adopt a medicalized perspective of menopause, however, that notion was challenged by the UKA women. Similarly, women in this study who did attempt to use a more Western medicalized perspective, as mentioned, ultimately rejected the use of Western practices. It seems that the biomedical approach to menopause may be culturally incompatible and dismissed by women, and therefore, a more biopsychosocial approach may be required (see Hunter & Randell, 2007) to menopause care for this group.

Furthermore, there was clearly a knowledge and/or communication gap between the participants and their doctors. When I asked participants about their relationships with their doctors, the answers varied; some participants went to female physicians, while others to one of the same ethnicity, as they felt they would be better understood, and therefore, felt they could trust and confide in their physician. However, other participants did not feel comfortable or think their physicians would be resourceful or informative sources for their needs. When asked about education and knowledge on menopause prior to experiencing it, Lakhwinder explained,

I didn't read about [it] I didn't talk to anybody about it, I was a shy person too, I don't know whom to ask if I… (*pauses*) when I go to my doctor I just tell her how I feel but she doesn't say anything and she didn't mention anything to me either…

Gagan echoed similar sentiments,
Gagan: Absolutely not. Absolutely not. You go to your doctor and they say, Oh, you know, you might be in... You might be going through menopause or perimenopause and you're like, Okay. And then that's it like that. You know or your symptoms might be? Yeah, you might, we'll probably go into perimenopause. But it's like, Okay, what do you trust on the internet? Everything that you Google and I don't trust too much on the internet. So it's like, and you don't know you're going to the right websites and all of that, right. So I usually go to Web MD or something or other or I don't know. A lot out of the states anyways, just seeing if my symptoms sounds like Yeah, I got this. I got this. I got this. I got this. I got this, you know. So yeah. I don't think that there's a good education plan out there for menopause and I think that they should be spoken about. This is just an opinion. I think it should be spoken about I think that people should very clearly say menopause or perimenopause is this this this this you could have and coming from a professional coming from somebody that you trust. For example, your doctor, coming from them and saying, these are the things that you're going to be experiencing, it could last from here to there. These are your options, like nothing was discussed. Nothing. And I have a good doctor. I like her. It's just like, Oh, yeah, you know, probably just menopause. And you're like, well, what do I do with this? I'm not feeling right. I'm not feeling well, no, there's definitely a lack of lack of support and a lack of education out there.

Lakhwinder and Gagan highlighted the overall lack of direction and knowledge to menopause and potential symptoms associated with it from their physicians.
Aside from the common symptoms cited in the literature, the overall menopause experience is not as clear, and tends be individualistic, which was evident in the participants’ experiences. Overall, a common pattern that emerged in this subtheme was the conflict between South Asian and Western practices. More often, Western practices (i.e., medicalized approaches) were perceived to be harmful or dismissed in favour of South Asian cultural practices and influences/beliefs (i.e., use of naturopathic/herbal medicines), often due to the lack of beneficial resources that could highlight and inform the benefits/effectiveness of Western medicine.

The majority of the participants immigrated while young and grew up in Canada or immigrated at the time of their marriage. Regardless, each participant’s individual experience highlighted the influential role both South Asian and Western cultures played in their childhood and into adulthood. Both cultures affected each participant’s lived experience, leading to internal and external conflicts within themselves and with their families/community, which ultimately had an influence on their body image, and understanding and experience of menopause. A first-generation Sikh participant highlighted that, although content with her current body (i.e., appearance, shape), there was this struggle to “fit in”, especially at an earlier age:

**Gagan:*** And generally, my body image has been okay, when I was younger, very, very different. Just felt like I never really fitted. But then I started cutting my hair. And then I started wearing makeup and all of that sort of stuff. So that kind of helped me fit in, I guess you could say yeah, but before… before that, I was, it was very, I just never felt that I fit it. Now. I mean, I… I like clothes, I like makeup, I like hair, all of that sort of stuff. I try to try to keep up with the times.”
Tirath (I): Just to go back to when you were younger, was it kind of classmates influenced to try to fit in? Or was it just the media and things around you at the time.

Gagan: I just really felt like I never fit in. In fact, I still sometimes feel like I don't fit in anywhere I like inside on the outside, it looks like I do. But on the inside, I generally feel like there's the whole I lived a double life. Basically, growing up, I lived a double life. We were my parents were very strict. We weren't allowed to cut our hair, we were ਅੰਮ੍ਰਿਤ ਚੇਵਾਂ (baptized). Went against that. I remember like an incident, I think I have been great for where like my mom used to do ਦੋ ਬ੍ਰਾਇਡਜ਼ (two braids), you know, the braid… braids on the side. And she used to grease our hair down... I knew I didn't fit in... Yeah, so I mean, maybe somewhere along the lines, I'd kind of figure it out. Okay, so this is not what I'm supposed to do. And I got into a lot of crap, like a lot of shit from my parents. Like, why are you doing that, like don't cut your hair, you cut your hair. I didn't start like really cutting my hair until after I got home, which was 24 when I left home there was that cultural or pressure at home as well. Oh, there was huge pressure. I wasn't allowed to dress the way I wanted to. I wasn't allowed to look the way that I wanted to. I didn't have that freedom at all. And it really bothered me.

This was an impactful statement from Gagan. Beyond aging and menopause, women noted their body image was challenged by being part of both the South Asian and Western cultures. Most often, young South Asian girls and women, in attempts to fit in with the Western ideal, will adopt or internalize Western practices, such as wearing
common fashion and make-up trends. However, this attachment to two cultures, which is known as the ‘two-world hypothesis’ (Katzman & Lee, 1997), often leads to conflicts between Western and South Asian norms. In the Sikh religion, cutting of hair is not an acceptable practice, and women are expected to dress modestly; however, as expected, when adopting Western practices, most women steer away from these practices and this causes tension in families and within the community.

Although the resistance to acculturate (Grogan, 2017; Swami et al., 2009) was evident, the inclusion and participation in Western practices showed a certain degree of acculturation. As evident in a study by Ahmad et al. (2012), those deviating away from South Asian cultural practices and embracing Western practices over their cultural norms are neither accepted nor encouraged. This push and pull between the South Asian and Western cultures is difficult to balance, however, as the South Asian culture generally dominates women’s lives. The concern is that since South Asian women, as evident in the literature, are more susceptible to negative body image than other ethnic populations (e.g., Caucasian, African-Caribbean, Asian-American, Hispanic-American; Grabe & Hyde, 2006; Swami et al., 2009; 2013), the South Asian culture’s influence on women becomes problematic and harmful (e.g., negative attitudes and perceptions, implicit and explicit comments of others body image).

**Cultural standards of beauty, body image, and aging.** As discussed in the first chapter, the South Asian culture plays an integral role in an individual’s life; it dictates and influences many factors, including beauty standards, body image and aging. As noted in the literature review, skin tone dissatisfaction is common in young South Asian women (Sahay & Piran, 1997), with a preference for light/white skin tones; the desire to attain
that ideal remains, especially when there are explicit and implicit pressures to be light skinned (Sahay & Piran, 1997; Swami et al., 2013). For instance, products such as ‘Fair & Lovely’ (now known as Glow & Lovely), a skin-lightening product line that is directed towards South Asian women in South Asia, promotes lighter skin ideals. Due to the implicit discrimination and misguided messages, which referenced ‘whiteness’ and ‘lightening’, the company was forced to rebrand their product. Although Kiran did not necessarily mention a lighter skin ideal explicitly, along with a few other participants, the need for a fair, clear, and wrinkle-free face was important. To achieve this ideal, most participants used home/desi remedies; Kiran explained her skin care routine, which consisted of a combination of “gram flour… and little bit of milk, spoon of milk and then aloe vera gel” or a facemask with beetroot and lemon. The incorporation of home remedies for one’s skin is a common practice for the South Asian community. It is important to note that the effect of colonialism in South Asian countries (specifically India in the context of this study) had and continues to play an influential role in beauty standards and body image of South Asian populations. The degree of influence specific colonizing countries (e.g., British, French, Portuguese) had on parts of India affects how culture (e.g., body image – weight, thinness, colourism) is shaped, viewed and understood (Chatterjee, 1989). For instance, cities and states (e.g., Bengal, Calcutta; Chatterjee, 1989; 1993) in India that model the design of Western cities, are more likely to promote Western body image ideals than smaller cities and towns where Western influence may be minimal.

The importance of skin tone/clarity exists in many forms; in explicit forms, young children, especially girls, are told not to play outdoors, otherwise their skin will become
darker. This type of commentary was often heard from my grandmother, mother, and aunts, when I was growing up; there was a strong stigma against dark/tanned skin. The stigma does not disappear; rather, it manifests into cultural practices throughout women’s lives. For instance, the ‘Haldi’ (turmeric) ceremony, a wedding ritual which consists of applying turmeric paste on the face, neck, arms, and legs of the bride and groom, holds cultural significance, such as warding off the evil eye and blessing the couple with prosperity and a new beginning. Yet, there is an underlying emphasis on beauty (i.e., skin tone/clarity) as haldi is known for making the skin more ‘clear and fair’, which is often associated with the Western female ideal (see Cash & Smolak, 2011).

An influential factor that promotes negative body image, and requires mediation, was the South Asian community. As evident in the literature (Ahmad et al., 2012; Swami et al., 2009), and through my own lived experience, the South Asian community plays quite an intrusive role in individuals’ lives. Traditional customs and norms of older generations tend to be kept intact with little to no change and set a precedent for current and future generations. Therefore, certain attitudes and feelings of entitlement and obligation to provide comments/advice on personal matters (e.g., health, family relationships, appearance) stem from individuals facing similar experiences in the past. As such, advice related to appearance is quite common. Participants spoke of several instances where implicit and explicit commentary on their bodies and appearance negatively affected them, and showed how strongly others (i.e., South Asian community) influence body image. It was interesting that even though she had accepted the changes to her body, Kiran still felt the negative effects of what others thought of her. At times where she had not noticed physical changes or was content with her body, Kiran felt she
had to justify changes that had occurred to her appearance, weight, and body size. This is where that societal pressure, which is common in the South Asian community, to look a certain way and/or feelings of insecurity tended to emerge. Swami et al. (2009; 2013) noted that those with high ethnic identity attachment and degree of acculturation tend to struggle with their body image, and often feel pressured to conform to the dominant, in this case, Western, standards of beauty. As such, these factors make them question their bodies, which leads to negative feelings and attitudes towards their bodies (Swami et al., 2009). Simran explained how she felt, “Sad. Some people say, you look fat now, you're very fat, you know… Then somebody say that you feel like a very, very sad and mad and everything, you know?” In fact, South Asian community members do not hold back from inappropriate questions and comments. Tejinder explained, “[People say] I look old, I act like I'm old… (*Pauses*) I say that's how I am, I can't change.”

The South Asian community is known for being blunt with their comments, and explicit comments similar to what Simran and Tejinder experienced are common. The sad truth is, their experiences are not unique; most, if not all, South Asian girls and women have dealt with and continue to hear comments about their appearance and body. As mentioned, these comments are both implicit and explicit – I, myself, have heard comments of “you’re not eating enough” or “you should watch how much you eat, are you exercising?”, and these comments are squarely directed towards a visible change in my body weight/shape. At a younger age, these types of comments would have negatively affected me, but with age, my research background, and being equipped with how to deal with these comments, I am able to deflect and change the conversation
surrounding body image. As such, comments from others about my body image no longer affect me.

Most often, community members believe these comments to be helpful, as they may have had similar comments said to them or feel as though they are giving ‘meaningful advice’ that might push women to alter their lifestyle. However, they come across as inappropriate and hurtful, especially to an individual struggling with body image, in this case, Davinder. For example, if someone were to comment on another person’s weight (e.g., “looks like you’ve gained some weight”), that individual may change their exercise and eating habits; however, it may also cause an onset of negative body image thoughts, feelings, and behaviors about one’s body. Restrictive eating, dieting, and excessive exercising often stem from body dissatisfaction (see Cash & Smolak, 2011; Fredrickson & Roberts, 1997; Fredrickson et al., 2011), which can lead to negative psychological outcomes (e.g., depression, shame, low self-esteem; evident in Slevec & Tiggemann, 2011). As such, the South Asian community was emphasized as a problematic factor for body image, with which women must cope and overcome.

As mentioned in the first theme, the idea of retaining youthfulness is very much ingrained into women and in the South Asian culture, however, that notion is very much challenged as women begin to age. When asked about body image comments specific to themselves, aging becomes a relevant and frequent subject of discussion pertaining to their body image. Kiran explained,

*Kiran:* Oh, my god, oh, I get that all the time. At work. Oh my god, because I've been working in that particular organization for about 30 years, and I have a lot of clients build up over the customer see me and they say, ‘oh, my God, you lost so
much weight’. And I tell them, I immediately turn around and say, ‘you know what? I never gained weight’. So I, this is what I was, if you saw me 25 years ago. That's how I… I looked. And yes, of course I’m not I’m not losing weight. But I'm all I tell them I say this age factor. If you see me being a little bit more slender, and mostly people notice me and my face. Why are you so thin? But that's age. (Yeah). Right. So, does it bother me? At times. Yes. But then at the same time, I don't let it bother me as much as they wanted to the way it is. And that's fine. And I tried to you know, make up more, I guess, more effort on the having that nice glowing skin. So I use just home remedies stuff, to just make sure that my skin stays healthy. And yeah, so I do that everything like I can do to look younger. Yeah, but then other than that, accepted that this is real life, you know, the age.

It was clear that age greatly impacted Kiran’s body image – at the end of this quote, despite saying she was content with her body image, she reverted back to ‘maintaining the younger female ideal’ (consistent with the literature – see Cash & Smolak, 2011) that Western culture upholds, by using home remedies to look youthful.

Consistent with the literature (in predominately White samples; Hurd, 2000; Liechty, 2012), aging women still face that pressure to conform to societal ideals; however, in this case, South Asian women may not only face Western cultural pressure to conform but this pressure often conflicts within the South Asian culture. For example, in North America there is often pressure to retain youthfulness, as evidenced by practices such as cosmetic procedures (e.g., fillers), dying hair and the use of make-up, often designed to look young. By contrast, South Asian culture may promote more of a
subdued aging, where it may be more appropriate to maintain and practice conservatism (e.g., dressing in South Asian clothing, which is more modest). However, this practice of conservatism is often met with resistance because complying to this lifestyle suggests either refraining from participating in North American practices or accepting aging (which is perceived, in the South Asian community, as a shift away from youth, motherhood, and femininity). Jankowski et al. (2016) qualitatively explored aging and body image in older White British and South Asian men and women (age range 65-92 years). The authors reported contradictory cultural pressures to aging — there was resistance to look youthful (e.g., acting one’s age), yet pressure to conform to the youthful ideal by practicing anti-aging routines (i.e., dyeing hair colour). The study noted that participants’ responses to body image, aging, and sociocultural pressure were similar across the genders and ethnic groups, especially with regard to the importance of appearance and function (i.e., shift towards function and health as they aged).

Additionally, rather than being a protective factor (Swami et al., 2009), ethnicity and South Asian practices often uphold the Western ideal, which causes women consistent dissatisfaction with their body image. In the studies that focused on ethnicity and body image, South Asian women were often the most dissatisfied (i.e., with skin tone, body size, weigh, appearance) and had more negative body image than other ethnicity groups (Caucasian, African-Caribbean; Råberg et al., 2010; Sahay & Piran, 1997; Swami et al., 2009).

In another instance, as Heena got older, she explained, “I hear that people, some kids they call it [me] aunty, aunty and so that I don’t like aunty, aunty (Yeah) No means like it's not like that aunty but I would like to say that whatever and then I think it's
because of mother and my aunts.” From a cultural standpoint, as a sign of respect, South Asian women or girls are referred to ‘didi’ or ‘bhenji’ (sister), however, as these women become older, regardless of a familial relationship, they are considered ‘aunty’. At this point, a woman is considered to be losing her youth and moving into mid- and/or older adulthood. In a Western context, the equivalent to ‘aunty’ is ‘ma’am’; for most women being referenced as either would cause discomfort because these terms are associated with middle-aged or older women.

The idea of accepting aging needs to occur not only internally by the individual themselves, but also by external factors. The negative connotation ‘aunty’ reflected onto women creates negative attitudes about aging, which in turn reflects poorly onto their body image as changes to their appearance become more apparent. The dislike towards the term ‘aunty’ seemed to be exacerbated by Western culture and media, which tend to promote the ideas of youth or younger-looking ideals. This is consistent with research (Hofmeier et al., 2017) exploring body image and aging experiences in women 50 years of age and older. As women age, there are physical (e.g., weight changes, wrinkles, graying hair) and psychological (e.g., depression, anxiety, confidence, feelings on content) changes, along with societal pressure (e.g., to maintain youthfulness; Hofmeier et al., 2017; Hurd, 2000; Liechty, 2012) and challenges to their roles as women in society. Jankowski et al. (2016) reported similar findings, where there were tensions between aging gracefully versus retaining youthfulness. Participants noted that there is this pressure from media and advertising to resist aging, as it is viewed unattractive and unacceptable, yet at the same time, older individuals should look appropriate for their age and not attempt to recover their youthful appearances. In the present study, similar
feelings were experienced when the women faced changes to their body and health. As evident in the literature, with menopause, which signals a change in a women’s reproductive life, emotional and physical changes (e.g., changes in mood, weight gain, wrinkles, graying of hair; Pearce at al., 2014) occur. This shift in health and wellbeing was generally equated to aging; this sense of ‘becoming old’ caused negative feelings towards oneself and their body. Culture clearly plays an impactful role in South Asian Canadian women’s lives, however, the extent of its influence on body image, menopause, and aging is yet unknown.

**General Discussion**

The themes highlighted above, and the links to current literature, show that the South Asian Canadian women’s experiences are both consistent and inconsistent with the current body image and menopause literature that has primarily investigated White women. However, it is also important to consider these findings more broadly.

Every individual has experiences that can impact body image; however, body image research primarily focuses on young, heterosexual, Caucasian women, and often overlooks more diverse populations, including ethnic communities (e.g., South Asian population). The participants did interpret body image as a multidimensional construct (consistent with the literature; see Cash & Smolak, 2011), however, their personal body image perceptions, attitudes, and behaviours were inconsistent with this definition. Noted in the themes, participants’ own body image often focused on appearance and they equated positive body image behaviours and attitudes to appearance and particularly weight. For instance, participants often engaged in healthy behaviours, such as exercise and healthy eating, which can lead to positive body image, to reach a goal related to the
appearance/body size/weight ideal. Although, the participants’ experiences of body image were complex, their understanding of body image and its concepts was distorted and inconsistent with the current literature, highlighting yet another conceptual gap between the public and researchers (Bailey et al., 2017).

As highlighted in the previous sections, there is limited research on body image in the South Asian community, especially in Canada. The research that does exist focuses on younger South Asian Canadian women in a more negative body image context (Sahay & Piran, 1997). Studies in a Western context that include South Asian women highlight that they experience higher levels of negative body image and body dissatisfaction than other ethnic populations. Swami et al. (2009) suggested that ethnicity may act as a protective measure against negative body image. However, when examining the current literature and comparing the data in this present study, it seems that ethnicity may act as a supplementary factor that contributes and exacerbates negative body image in South Asian women. Additional Western-based studies, including Jankowski et al. (2016), a UK-based study that explored body image and aging in older White British and South Asian older adults, noted changes in body image perceptions and attitudes with age. Specifically, although there can still be a desire to maintain an ‘ideal’ appearance, there is a shift from appearance towards health and functionality because they become relatively more important as we age. Jankowski et al. (2016) highlighted that although there is still fear of aging and how it impacts their abilities, participants are often willing to accept changes that occur to their appearance, health, and function, as they understand there is no way to recover what has been lost.
The final overarching finding was the barrier of the South Asian community and importance of culturally appropriate approaches to body image. As mentioned, the South Asian community is viewed as a barrier as health experiences are not openly discussed (see Ahmad et al., 2012; Bottorff et al., 2011; Hilton et al., 2011) with these conversations considered taboo. However, at the same time, it is important to acknowledge that culturally appropriate education and resources for body image and menopause are lacking. Since these conversations are not considered important, the majority of South Asians, including women, do not know who to approach or where to find support and resources. Hall et al. (2007) explored perceptions of cultural and psychosocial influences in menopause management in traditional, immigrant, and modern women (important to note that the study’s participant cohort did not include South Asian women). The researchers suggested that menopause management (e.g., symptoms) and access to resources may be dependent on several personal factors, including education level and socioeconomic status. They found that immigrant women who lacked education and had access to limited financial resources were more likely to face menopausal distress compared to well-educated, working, and highly acculturated women (Hall et al., 2007). In this study, it is difficult to determine whether education level influenced their understanding of body image and menopause (e.g., definitions of body image, menopause management) as participants’ education level was highly diverse (i.e., high school, college, bachelor’s, and master’s graduates); yet all of them had distressing menopause experiences, and almost equally lacked access to appropriate resources and support.
CHAPTER 5: CONCLUSIONS

Limitations and Future Directions

As with all investigations, this study included several limitations. Due to COVID-19, recruitment methods were strictly moved to online platforms (i.e., social media posts, connecting with organizations via email). In addition, the data collection process was completely moved onto an online platform, and thus, conducted virtually. Although the online interviews yielded few challenges, it is important to note that as a novice researcher, my interview style may have presented a possibility of errors (i.e., standard of how interview questions and probes were asked). Furthermore, due to COVID-19 restrictions and the time-constraints for this study, there is a possibility potential participants were unreachable or overlooked. Since recruitment strategies and interviews were completely online (e.g., social media), participants who were not on social media platforms or uncomfortable/novice with the online platforms may have been unable or unwilling to participate. Several participants were recruited via snowballing/word of mouth to mitigate this issue, but it is likely that our sample did not truly represent this diverse population.

Participant recruitment was difficult as quite a few individuals did express interest, yet hesitated to participate due the topics that were being discussed. Although the women understood that their interviews and identities would remain confidential and quoted via pseudonyms, many women expressed being embarrassed and uncomfortable about speaking about their menopause and body image experiences, and therefore, refrained from participating. This was understandable; from my own lived experiences, and as evident in the literature (Bottorff et al., 2001; Hilton et al., 2001), specific health topics (i.e., menopause, body image) are considered taboo and/or unspoken of with one
another and within the South Asian community. However, it also means that women less comfortable talking about these issues may not be represented in this studies’ findings.

Based on the results of this study, there are a few potential directions for future research. As mentioned, the research on body image in ethnic groups is limited, and therefore, further assessment of body image knowledge (e.g., definitions, healthy vs unhealthy behaviours) and the exploration of the influence of culture on body image is warranted. Throughout this study, constructs of body image (i.e., positive and negative body image; health behaviours such as exercise and eating habits) were experienced concurrently, misunderstood, and/or contrastingly defined (compared to extant research) via the participants’ lived experiences. Although noted as a potential protective factor (Swami et al., 2009), and as consistently seen via participants’ experiences throughout this study, cultural practices and factors seemed to supplement and worsen body image experiences for South Asian women, specifically negative body image experiences. Once factors affecting body image are determined, potential interventions to mediate negative body image or promote positive body image can be designed and tested.

In the final theme, there was notable disconnect between the women and their physicians and specialists; as such, future studies could examine the interactions between family doctors and gynecologists and their ethnic patients, and their approach when providing information about menopause to their patients, to determine successful strategies for engaging such patient populations.

**Implications**

Consistent throughout this study was the influence of culture on body image. Swami et al. (2009) mentioned the influence of cross-cultural factors on body image (e.g.,
cultural attitudes), and although they argued ethnicity may play a protective role against negative body image attitudes and dissatisfaction, the data in this study show that specific to middle- and older aged first generation South Asian immigrant women in Canada, this might not be the case. Rather than ethnicity acting as a protective factor (as noted in Swami et al., 2009) against negative body image, it may further exacerbate negative body image experiences and behaviours. The South Asian community lacks sensitivity around body image, and their comments on appearance, body size, and weight, can be harmful. Channa et al. (2019) highlighted how culture negatively impacted the participant’s feelings towards bulimia and her help-seeking behaviours. The fear of ostracization and overall discomfort to confide in family and individuals within the community prevented early intervention. It is critical to develop interventions that focus on social factors affecting body image that include culture, especially in a Western context, as concepts of acculturation may play a more impactful role on body image than previously noted.

The participants spoke about the importance of education targeting the whole community and family, however, specifically to this study, interventions, such as peer support and informational seminars pertaining to menopause may be beneficial for women and the community prior to and during the menopause transition. As highlighted in the results and discussion, knowledge gaps exist (through my own lived experience, body image is neither known of nor spoken about in the South Asian community) and there is a need for appropriate knowledge translation on body image concepts that are linked to current research. The implementation of interventions, such as positive body image programs, which includes helping South Asian women steer away from appearance- and weight-centric attitudes (which tend to be culturally sensitive topics)
towards developing a positive, multidimensional definition of their own body image, along with a focus on the influence of cultural and familial factors (which is highlighted in the literature; Swami et al., 2009) in a Western context, may yield positive attitudes and behaviours towards one’s body image.

Throughout the interviews, all the participants mentioned the importance of access to ethnically-appropriate education and knowledge pertaining to menopause and body image. However, they felt that they lacked appropriate resources and support from their community, families, and physicians on body image and menopause. To mediate these issues, several recommendations can be implemented. The first recommendation is to start education and providing resources on body image and menopause to younger age cohorts (e.g., teens or younger adults). The South Asian community needs to embrace and speak openly about health and wellbeing; since the community is patriarch-centric, educating the men is just as important as women. Culturally appropriate resources (e.g., resources on colourism/skin colour, menopause transition – stages and expectations in different languages) and support groups (e.g., therapy, women’s groups, couple/family support) can assist in improving knowledge gaps and translating research findings to the community. It is apparent that several methods of dissemination (e.g., workshops, seminars, pamphlets, online resources) would be appropriate to facilitate meaningful conversations surrounding menopause and body image.

Based on the results, menopause information disseminated to patients needs to be more consistent, and specific to their needs. This includes information pertaining to 1) the different stages of menopause (premenopause, perimenopause, menopause, postmenopause); 2) potential symptoms and experiences; 3) menopause care options
(medicalized and alternative options, such as hormone replacement therapy, naturopathy); and 4) support options (e.g., therapy, women’s support groups).

Additionally, the perceptions (e.g., negative attitudes, equating menopause with older adulthood, loss of function, appearance, and identity) and language (e.g., treatment, condition, medications, aging) used around menopause require re-examining.

Contradictory to the several theories from the literature (Hunter et al., 2009), that migrated women would take on Western beliefs and gain a more medicalized perspective, most of the participants in this study refrained from using medicalized options for managing changes due to menopause, and often chose naturopathic or herbal/home remedies for their menopause care. Participants felt that they lacked appropriate resources and support from their doctors. Of all the participants, one participant was born in a Western country, and even she felt ill-equipped with the knowledge of how to cope with menopause. It seemed that the approach to menopause by physicians is solely biomedical and it is viewed as a condition that requires treatment. Harinder, who regularly uses naturopathic products, mentioned, “She's [family doctor] totally against, not totally against it, but she would basically say, I don't know anything about that”. It is possible that physicians may be hesitant to refer alternative options to their patients due to their lack of knowledge or expertise. To contrast, other researchers (Ballard, Elston, & Gabe, 2009; Dillaway, 2005; Pearce et al., 2014), including myself, suggest a more biopsychosocial approach to menopause. Rather than focusing on a treatment plan, doctors and patients should work towards a holistic ‘menopause care plan’, which focuses on physical and emotional wellbeing, a range of care options (e.g., medical and naturopathic options for symptoms), and support programs (e.g., therapy, women’s
Menopause should be viewed as a more positive experience, a time point that should be embraced with the changes that occur.

As highlighted throughout this study, through the participants own words, the literature (see Halliwell, 2015), and my own words; knowledge dissemination of current body image and menopause research is needed. It is important to note that creating culturally appropriate resources, workshops, seminars, and support groups will not necessarily create change or better inform the South Asian community. For successful knowledge translation, a diversity of stakeholders need to be involved, including community members, researchers, and public health and medical professionals from the South Asian community. Misinformation and distrust are common in ethnic communities; for example, with the current pandemic, there has been a lack of appropriate COVID-19 and vaccine information directed towards the South Asian community, and that has led to vaccine hesitancy (Reid & Mabhala, 2021; Robinson, Jones, Lesser, & Daly, 2021). Several South Asian professionals founded the ‘South Asian COVID Task Force’, which focuses on breaking down barriers (i.e., language, information on testing, isolation, and vaccines), and supporting the community during the pandemic. As such, community-specific initiatives (i.e., interventions, workshops) with South Asian leaders assisting in knowledge translation of body image and menopause research may yield positive results.

Reflexivity: Reflection of Study

When I started this study, I had a few preconceived ideas to which direction the study would go and what the results may yield. As a South Asian Sikh woman, I knew there was an overall stigma around openly discussing certain matters, such as community,
family, and health concerns within the South Asian community, especially women. As such, I was unsure whether I would receive meaningful responses to the interview questions, however, the use of IPA showed to be appropriate for this study. However, after the interviews and data analysis process, I realized I had underestimated the complexity of South Asian women’s body image and menopause experiences. Their experiences were not unidimensional; they were interconnected and multidimensional. As I alluded to in the literature review, there is minimal research that focuses on body image and menopause in South Asian women, and as a South Asian woman, representation is important. It is important to understand how these concepts of body image and menopause are interpreted and understood by South Asian women, and whether particular interventions are needed.

As mentioned in the limitations, due to COVID-19, the study was completed remotely via online video-conferencing platforms. The greatest challenge was recruitment; prior to beginning the study, my supervisor and I were aware of the potential recruitment issues, however, I believe changes in recruitment strategies (due to COVID-19 restrictions) and gatekeepers caused more difficulty finding participants. Several organizations and gatekeepers of organizations I spoke with were unresponsive, unhelpful, or refused to allow me to engage with their organization’s members or post recruitment information about the present study. Gatekeepers had difficulty understanding the importance of the study, and how body image and menopause related to South Asian women.

An additional challenge was the participants – the study, via snowballing/referrals and social media boosts from organizations (listed in the methods’ section), generated a
lot of interest, but when it came to actually participating and speaking on the topics of this study, there was significant hesitancy. Many women felt embarrassed, anxious, and shy about having an open discussion, especially via an online platform; it is difficult to say whether more participants would have agreed to participate had interviews been in-person, but it is something I will keep in mind as I continue to build upon the findings of this study (e.g., providing both online and in-person interview options).

As a South Asian Canadian women and bi-cultural researcher, the results of this study highlighted not only the conceptual gaps of body image and menopause between researchers and the public, but the need and importance of appropriate methods for knowledge translation of the research. As I continue to conduct research in these areas, I must be aware of and ensure the dissemination of my research reaches the target populations (i.e., culturally-appropriate reading material in various South Asian languages). Moreover, these results showed the amount of influence and involvement the South Asian culture and community has on individuals. The culture and community still requires support from internal experts (e.g., South Asian researchers, doctors) in medical, research, and education fields to ensure individual, or in this case, South Asian women, are able to make informed decisions about their health and wellbeing.

**Conclusion**

Overall, as the first study to explore body image and menopause experiences in South Asian Canadian women, this study highlights the need for the inclusion of South Asian women in body image and menopause research. The themes that were generated provide insight to the complexity of body image and menopause experiences in first generation South Asian immigrant women in Canada. Findings show that the women’s
understanding of body image (e.g., distorted definition of body image concepts) and menopause (e.g., lack of culturally appropriate resources) requires the implementation of community-based interventions and resources (e.g., workshops, seminars, support groups). Moreover, the themes highlighted the implicit and explicit effect of the South Asian culture, along with underlying influences of colonialism, on the experiences of body image and menopause in South Asian Canadian women. As noticed throughout this study, the South Asian culture and community acts as a barrier that prevents women from seeking support and care, and therefore, requires mediation. As such, results show that more research, resources, and interventions are needed to support South Asian Canadian women through these important time periods (e.g., menstruation, aging, menopause) in their life.
References


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https://doi.org/10.1007/s10746-013-9282-0


APPENDIX A: Certificate of Ethics Clearance

Brock University
Office of Research Ethics
Tel: 905-688-5550 ext. 3035
Email: reb@brocku.ca

Social Science Research Ethics Board

Certificate of Ethics Clearance for Human Participant Research

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<tr>
<td>STUDENT:</td>
<td>Taranjot K Dhillon</td>
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<tr>
<td>SUPERVISOR:</td>
<td>Kimberley Gammage</td>
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<tr>
<td>TITLE:</td>
<td>Understanding the relationship between body image and menopause in South Asian women</td>
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ETHICS CLEARANCE GRANTED

Type of Clearance: NEW
Expiry Date: 8/1/2021

The Brock University Social Science Research Ethics Board has reviewed the above named research proposal and considers the procedures, as described by the applicant, to conform to the University's ethical standards and the Tri-Council Policy Statement. Clearance granted from 8/21/2020 to 8/1/2021.

The Tri-Council Policy Statement requires that ongoing research be monitored by, at a minimum, an annual report. Should your project extend beyond the expiry date, you are required to submit a Renewal form before 8/1/2021. Continued clearance is contingent on timely submission of reports.

To comply with the Tri-Council Policy Statement, you must also submit a final report upon completion of your project. All report forms can be found on the Office of Research Ethics web page at http://www.brocku.ca/research/policies-and-forms/research-forms.

In addition, throughout your research, you must report promptly to the REB:

a) Changes increasing the risk to the participant(s) and/or affecting significantly the conduct of the study;
b) All adverse and/or unanticipated experiences or events that may have real or potential unfavourable implications for participants;
c) New information that may adversely affect the safety of the participants or the conduct of the study;
d) Any changes in your source of funding or new funding to a previously unfunded project.

We wish you success with your research.

Approved:

Lynn Dempsey, Chair
Social Science Research Ethics Board

Robert Steinbauer, Chair
Social Science Research Ethics Board

Note: Brock University is accountable for the research carried out in its own jurisdiction or under its auspices and may refuse certain research even though the REB has found it ethically acceptable.

If research participants are in the care of a health facility, at a school, or other institution or community organization, it is the responsibility of the Principal Investigator to ensure that the ethical guidelines and clearance of those facilities or institutions are obtained and filed with the REB prior to the initiation of research at that site.
APPENDIX B: Informed Consent

Date: ________________________________

Project Title: Understanding the relationship between body image and menopause in South Asian women.

Principal Investigator:
Kimberley L. Gammage, Associate Professor
Department of Kinesiology, Brock University
905-688-5550 (ext. 3772)
kgammage@brocku.ca

Principal Student Investigator:
Taranjot K. Dhillon
Faculty of Applied Health Sciences (Kinesiology), Brock University
td14lf@brocku.ca

Invitation
You are invited to participate in a study that explores South Asian women’s body image throughout the transition of menopause.

What’s Involved
As a participant, you will meet with the principal student researcher via an online platform, such as Lifesize (in a passcode protected private meeting room), Skype, or Facetime, according to your preference. You will be asked to provide verbal informed consent, participate in a one-on-one interview pertaining to your body image and menopausal experiences as a South Asian woman, and verbally complete a demographics questionnaire after the interview session. Interviews may be completed in either English or Punjabi. **Total time for the individual interview session will be 45-60 minutes.**

An email with a general summary of the interview will be sent to your private email for clarification within three weeks of the interview. We ask that you reply with any clarifications, concerns, or questions regarding the summary within two weeks of receiving the email, otherwise the initial interpretations will be used in the study (approximately 20 minutes). We ask that you please delete the email immediately after clarifications have been completed to protect your confidentiality. Total time for the individual interview session and interview summary is approximately 1hr and 20 mins – 1 hr and 45 mins.
At the completion of the one-on-one interview, and in the email with the interview summary, you will be invited to also participate in a focus group with other participants as a follow-up to the interviews.

**Potential Benefits and Risks**

There are no direct benefits for participating in this study. The final case report will be utilized to better understand the relationship between body image and menopause in South Asian women. This study offers the scientific community an opportunity to better establish frameworks that may provide South Asian women improved ways of maintaining wellness during menopause. Due to the nature of the study, there are psychological and social risks present. You may feel distress or discomfort when discussing personal experiences. The following resources are provided for you if you experience discomfort or you may contact your physician. You may also decline to answer any questions you are not comfortable with and can withdraw at any point of the study until the data has been analyzed.

**Niagara Region Mental Health**
1-800-550-5205  
https://www.niagararegion.ca/living/health_wellness/mentalhealth/default.aspx

**Canadian Mental Health Association**
Monday-Friday: 9am–5pm  
1-877-451-2123  
https://cmha.ca/

**Compensation**
You will be given $10 CAD via e-transfer as compensation for your time.

**Confidentiality and Anonymity**
Private interviews will be audio recorded, and as such, will not be anonymous but will be confidential. You will be given a pseudonym (cover name). A master list will be created to connect your identity with your data for the remainder of the study. The master list will be kept on a locked device separate from the rest of the data and will be destroyed upon the completion of data analysis. Only the research team will have access to these files.

Any themes, quotes or descriptions utilized throughout the study, analysis, and dissemination of this study will be generalized to prevent direct identification of participants. Where direct quotes are used, no identifying information will be included, and a pseudonym will be used.

The pseudonym master list that include the participants’ names will be kept separate from any of the data that may connect your identity to your responses. The pseudonym master list will be kept on a password-locked device. In addition, participants will be asked to
provide a compensation acknowledgement email to the researcher to ensure compensation was received by the participant via e-transfer.

The master list will be deleted/destroyed upon the completion of data analysis. Audio recordings will be destroyed after the data is analyzed. All hardcopies of transcripts will be shredded after the completion of data analysis. Electronic data and transcripts will be kept indefinitely if permission is given for the possibility of exploring other aspects of body image and menopause in South Asian women such as, ‘How healthcare perceptions affect menopausal experiences in South Asian women’, otherwise they will be destroyed 5 years after the publication of the study.

**Voluntary Participation**
Participation in this study is voluntary. If you wish, you may decline to answer questions or participate in any part of the study (e.g., focus groups). If you wish to withdraw from the study, please email or inform one of the investigators in person. You will be asked if you would like your data to be destroyed or if we can still use the data we collected from you. If you wish to have it destroyed, all electronic copies will be deleted, and physical copies shredded. The choice to participate or withdraw from this study will not affect any compensation to which you are entitled. After completion of data analysis, the pseudonym master list and audio recorded data will be destroyed, and you will no longer be able to withdraw your data as it will be unidentifiable.

**Publication of Results**
The findings of this study may be published in theses, professional journals and/or presented at conferences. No personal identifiers will be utilized, pseudonyms will be used to protect your identity, and no identifying information will be included. Upon completion of this study, feedback will be available. Upon your request, a summary of results may be mailed to you in hardcopy or emailed to you electronically by contacting Dr. Kimberley L. Gammage starting August 2021. The results will also be posted on our lab website, [www.exerciseandbodyimagelab.com](http://www.exerciseandbodyimagelab.com) in 2021 in English and, if requested in Punjabi.

**Contact information and ethics clearance**
If you have any further questions pertaining to this study or your participation, please contact the investigators using the contact information provided above. This study has been reviewed and received ethics clearance through the Brock University Research Ethics Board (file #20-032). If you have questions or concerns regarding your rights as a research participant, please contact the Research Ethics Office @ 905-688-5550 ext. 3035, or reb@brocku.ca. Thank you for considering partaking in this study. Please keep a copy of this form for your personal records.

**Consent**
This study has been reviewed and received ethics clearance through Brock University Research Ethics Board (file #20-032)

Please confirm the following **verbally**:

- I agree to participate in the study described above. I have made this decision based on the information I have read in the Consent Form. I have had the opportunity to receive any additional information I wanted about the study and understand that I may ask questions in the future. I understand that I may withdraw this consent at any point until the completion of the data analysis of the private, one-on-one interviews.

- I agree to have my anonymized data kept indefinitely and to be used in future body image related research outside the scope of the present study by the researchers listed above.

We would also like to contact you in the future for potential studies from our lab. Please indicate verbally (yes or no) the following:

- I agree to be contacted by the researchers listed above for future research studies.
APPENDIX C: Interview Guide

**Individual Interview Guide**

**Part 1: Body Image Experiences**
1. How would you describe your appearance?
2. How would you describe the functioning of your body?
3. Describe to me what you consider the ideal young female body to be?
4. What have you felt/heard from others that has affected how you experience your body?
5. In your perspective, how does the South Asian community view the body image of women?

**Part 2: Experiences of Menopause**
1. What is your current menopause status?
2. What does menopause mean to you?
3. What are some menopausal symptoms you have experienced?
4. Do you feel you were educated enough about menopause prior to experiencing it?
5. In your perspective, how does the South Asian community view menopause?

**Part 3: Interaction of Body Image and Menopause**
1. How has body image affected your experience of menopause?
2. How has your cultural upbringing affected the way you view body image and menopause?
3. How do your menopausal symptoms make you feel and think about your body?
4. Can you explain to me if you feel more connected or disconnected with your body since going through your transition of menopause?
APPENDIX D: Demographics Questionnaire

(*Verbally completed at the end of interview)

1. What is your age? _____________

2. What is your height? ____________

3. What is your weight? ______________

4. What is your ethnic background? __________________________________

5. What is your highest level of education completed?
   
   a. High School
   
   b. College Diploma/Bachelor’s Degree
   
   c. Master’s Degree
   
   d. Doctoral Degree
   
   e. Other: _______________________________/Prefer not to answer

6. For your healthcare needs, what options do you use?

   a. Family doctor/walk-in clinic
   
   b. Naturopath (i.e., Homeopathic medicines)
   
   c. Home remedies (i.e., Herbal medicines)
   
   d. Culture leaders (i.e., Pandits, Granthis, Babajis, etc.)
   
   e. Other: _______________________________

7. Menopause phase

   a. Perimenopause
   
   b. Menopause
   
   c. Postmenopause