A qualitative exploration of the experiences of clinically very severely obese women during pregnancy and the postnatal period

By

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Declaration

I declare that

(a) this thesis has been composed by myself.

(b) the work presented in this thesis is my own.

(c) this work has not been submitted for any other degree or professional qualification.

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Abstract

Very severe maternal obesity (BMI >40kg/m^2) increases significantly the risks of poor pregnancy outcomes for both mothers and babies. In light of the limited success of behavioural interventions to date in improving outcomes in very severely obese women, this study sought to gain an understanding of women's beliefs and experiences regarding weight, health and pregnancy, within the context of their everyday lives.

Qualitative serial interviews were conducted with eleven very severely obese women during pregnancy and the postnatal period. Seven partners of the women took part in one semi-structured interview during the woman's pregnancy. Analysis took place in several stages using a thematic approach. Themes were identified within and between individual women's accounts, as well as within and between the accounts of members of couples. Participants' narratives demonstrated the ways in which they navigated the experience of high-risk pregnancy, and stigma emerged as a key theme.

This research contributes new knowledge about the complex ways in which women experience 'very severe obese' pregnant embodiment, relating to both formal and informal discourses around weight and health in pregnancy. Most undertook 'moral accounting' in response to stigma, and several accounts resonated with Monaghan's (2006) categorisations of *excuses, justifications, contrition* and *repudiation*, in both accounting for their weight and in demonstrating their 'fitness' for pregnancy and motherhood. Following birth, high levels of motivation to enact behaviour change were expressed, in some cases alongside repudiatory accounting regarding the associated risks and the medicalisation of very severe obesity. Participants experienced a lack of formal healthcare support in the postnatal period. Future approaches to policy and practice should consider ways in which to engage women and partners during pregnancy, exploring ways which in which stigma can be acknowledged and neutralised, in order to provide support and advice during and after pregnancy and birth, and into parenthood.

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Underlined text *in participants’ quotes indicates a participant’s emphasis*

“...” indicates where text has been omitted from a quote.

Chapter One

Introduction

In this section, I begin by introducing myself, describing my background and my interest in this topic. I move on to outline the health issues surrounding maternal obesity and very severe maternal obesity. I then explore the particular complexities of obesity as a complication of pregnancy, and which render it such a challenging issue to address. Finally, I present the broad structure of the thesis.

1.1. My background and interest

As a midwife and a public health researcher, my aim in undertaking this research was to provide new evidence to improve the maternity experiences and outcomes of women who have a body mass index (BMI) of greater than $40kg/m^2$, who are classified as 'very severely obese'.

I qualified as a midwife in 2001, and have a long-standing interest in the causes of health inequalities and their impact upon pregnancy and women's health. This led me to undertake an MSc in Public Health Research between 2006 and 2008. During that time and afterwards, I worked clinically as a research midwife at a Scottish university, and as part of my role I was based within a research clinic which provided 'high-risk' hospital-based antenatal care to pregnant women with a BMI greater than $40kg/m^2$. The women underwent additional screening and were cared for by a multi-disciplinary team, including obstetricians, anaesthetists, endocrinologists, dietitians, and both hospital-based and community midwives.

I reflected on the juxtaposition of the striking physical presence of the large bodies of the women, immediately identifiable as 'obese', with the (almost exclusively slim) bodies of the

health professionals, in particular the medical staff (exclusively slim). Although I built good relationships with the women, and felt confident regarding the safe, effective care we provided, I wondered how it felt for the women to attend and receive care at the clinic. These women had opted to attend the high-risk clinic; the service was offered as an option for their care. Thus, on one level, they were acknowledging their high-risk status, caused by the 'problem' of their weight. However, many women were often, or always, accompanied by a partner, other family member or friend, which in my extensive experience of working in antenatal clinics was not very common. Some of the women attending the clinic were young and of low socio-economic status (SES), thus unemployment was more common among them and their family members, allowing perhaps more time for them to attend appointments. However, this was by no means the case for all women. I suspected that, regardless of social class, the women brought another person for support, anticipating a difficult experience, and indeed numerous women expressed relief that they had wrongly expected to 'get a row' (regional colloquialism) about their weight from health professionals during their visit. Over the preceding decade or so, I had grown increasingly aware of obesity as a social and cultural problem, as well as a clinical problem. In addition, I frequently noticed casual 'fat prejudice' expressed by people in my everyday life, including by professional colleagues. I reflected often upon the deeply stigmatised condition of obesity.

Reflecting upon the stigma associated with very severe obesity, and the common presence of a family member or friend with the pregnant women, made me wonder what they talked about together on their way home and in the days after, during their pregnancies; what was thought about, but unspoken, within those medical encounters? How did they relate to, and make sense of the care they received and the information they were given?

I reflected more broadly on the tensions inherent within and between the highly medicalised framing of obesity as problematic to health in the context of pregnancy, the cultural view of obesity as evidence of deviance or weakness, and the everyday, and the beliefs and lived experience of obese pregnant women. These tensions were what drew me to this topic, and are broadly what I attempt to explore within this thesis.

Having a background as a midwife, in clinical research, and as a novice public health researcher, I wanted to undertake my own research, exploring women's socially embedded experiences of very severe obesity in pregnancy. I developed a research proposal, and in 2013 I was awarded a Public Health PhD scholarship by Edinburgh Napier University.

1.1.(a) A note on terminology: use of the term 'obesity'

Throughout my thesis, I use the term *obesity* when referring to medico-scientific discourses, in order to delineate the ways in which women's bodies have been categorised. As such, I refer to categories of weight in pregnancy as *obese*, *severely obese*, and *very severely obese* (see Table 1). Obesity is a commonly used term, used to define clinical categories, and this is acknowledged here and the term used appropriately. I approach the term tentatively, however, and recognise that its use, both as an everyday word and as a clinical categorisation to imperfectly classify excess weight or adiposity, remains controversial on a number of levels (Cohen, Perales and Steadman, 2005; Gard and Wright, 2005; Gray et al, 2011; Monaghan, 2006; Volger et al. 2012; Wadden and Didie, 2003). Reflecting this, in my capacity as a clinician and as a researcher, I will never use the term *obese* in discussion with women about their bodies.

I considered the repetitive use of inverted commas within the text, but concluded that my acknowledgement here of both the term and the category as problematic remove the need for what might be jarring repetitive punctuation. In addition, I considered the use of other terms, but could find none that would not potentially present problems, be confusing, or have potential of their own to cause offence to the reader.

I thus use the term *obese*, without inverted commas, appropriately, to refer to clinical categories and public health and biomedical discourses. Its use, or non-use, by study participants, and its meanings within everyday life and clinical settings is explored within the main body of thesis.

1.2. Obesity: an epidemiological overview

Obesity is clinically classified as having a BMI of greater than >30kg/m^2 (World Health Organisation (WHO) 2014), with sub-categories of class I (BMI 30-34.9kg/m^2 - obesity), class

II (BMI 35-39.9kg.m^2 – severe obesity) and class III (BMI >40kg/m^2 - very severe, or morbid, obesity) (see Fig 1). In recent years obesity has been increasingly regarded as a medical condition, or disease, as levels of obesity rise globally (WHO, 2014). A BMI of 30kg/m^2 is used as a cut-off point to define obesity, as this is level at which adiposity becomes associated with significantly elevated disease risk in studied populations (Brewis, 2010). There exists strong biomedical evidence that adult obesity is associated with increased risks of developing non-communicable diseases, such as type 2 diabetes, hypertension, cardiovascular disease, musculoskeletal disorders, some cancers and premature death (WHO, 2000). As such, recent years have seen a wide range of and national agencies activity across Government within Scotland and the rest of the UK to address the problem of obesity and its long-term consequences.

Classification	**BMI(kg/m^2)**	
	Principal cut-off points	**Additional cut-off points**
Underweight	**<18.50**	**<18.50**
Severe thinness	<16.00	<16.00
Moderate thinness	16.00 - 16.99	16.00 - 16.99
Mild thinness	17.00 - 18.49	17.00 - 18.49
Normal range	**18.50 - 24.99**	**18.50 - 22.99**
		23.00 - 24.99
Overweight	**≥25.00**	**≥25.00**
Pre-obese	25.00 - 29.99	25.00 - 27.49
		27.50 - 29.99
Obese	**≥30.00**	**≥30.00**
Obese class I	30.00 - 34.99	30.00 - 32.49
		32.50 - 34.99
Obese class II	35.00 - 39.99	35.00 - 37.49
		37.50 - 39.99
Obese class III	≥40.00	≥40.00

Table 1: Classification of Body Mass Index. Source: WHO 2016
http://apps.who.int/bmi/index.jsp?introPage=intro_3.html *(accessed 06/02/17)*

1.3. Maternal obesity: a growing problem

In line with general population trends of rising obesity prevalence in developed countries in the past fifty years, the size of childbearing women in the UK has increased (Centre for Maternal and Child Enquiries (CMACE), 2010). There are no pregnancy-specific BMI ranges, and as such, maternal obesity is understood to be obesity during pregnancy. UK National Institute for Health and Care Excellence (NICE) guidelines (2010) recommend that a woman's BMI is calculated based on a weight measurement taken at the first contact between health professional (usually a midwife) and the pregnant woman, and this occurs during the first trimester in most cases.

The incidence of maternal obesity doubled in the UK between 1989 and 2007 (Heslehurst, Lang, Rankin, Wilkinson and Summerbell, 2007). It is estimated that 2% of pregnant women are very severely obese with a BMI >40kg/m^2 (Fitzsimons and Modder, 2010; Heslehurst et al. 2007), while over 30% of the antenatal population in the UK has a BMI of 30kg/m^2 or more (Fitzsimons and Modder, 2010), and are thus defined as clinically obese (WHO, 2014). Estimations of obesity among pregnant women suggest that the UK has the highest levels of obesity in Europe (Devlieger et al., 2016).

1.4. Clinical Implications: 'arguably the biggest challenge facing maternity services today'

Maternal obesity is understood to significantly increase the risks of a high number of pregnancy and birth complications, and there is increasing evidence of multiple adverse long- and short-term health effects associated with obesity in pregnancy, both for the mother, during pregnancy and longer term, for the fetus, and for offspring health in childhood (Denison et al., 2009; Heslehurst 2011; Poston et al., 2016). There are complications that can arise as a result of pre-existing obesity-related medical conditions, such as type 2 diabetes, which increases risks of pregnancy loss, perinatal mortality, fetal macrosomia, and congenital malformations (Inkster et al., 2006). But for all women who are obese, including those without pre-existing, chronic conditions, there are increased risks of complications. These include, for the mother: taking longer to conceive than women of normal weight, as women who are very severely obese are almost seven times more likely to take more than 12 months to conceive than are women of normal weight (Gesink-Law, Maclehose and Longnecker, 2007). Once pregnant, obese women are at greater risk of:

spontaneous first trimester and recurrent miscarriage (Lashen, Fear and Sturdee, 2004; Lewis 2007; Tennant, Rankin and Bell, 2011); developing pre-eclampsia and pregnancy-induced hypertension (Kim et al., 2016; Lewis 2007; Rajasingam, Seed, Briley, Shennan and Poston, 2009;); gestational diabetes and subsequent development of type 2 diabetes (Lewis 2007; Torloni et al., 2009); and cardiac disease (Lewis 2007). They are more likely to undergo induction of labour and to not progress in labour (Scott-Pillai, Spence, Cardwell, Hunter and Holmes, 2013); to give birth by caesarean section (Poobalan, Aucott, Gurung, Smith and Bhattacharya, 2009); to suffer postpartum haemorrhage (Scott-Pillai et al 2013); and to develop a thromboembolism (Lewis 2007). For their babies, risks include: stillbirth and neonatal death (Lewis 2007; Marchi, Berg, Dencker, Olander and Begley, 2015; Scott-Pillai et al 2013); congenital anomalies (Marchi et al. 2015; Stothard, Tennant and Bell, 2009); and both low and high birth weight with associated complications (Heslehurst et al., 2008; Marchi et al. 2015; Rajasingam, Seed, Briley, Shennan and Poston, 2009). As such, maternal obesity is considered to be an independent risk factor in pregnancy which requires more intensive antenatal surveillance than for women of normal weight (Heslehurst et al., 2015).

Obese women are less likely than normal weight women to initiate breastfeeding and are more likely to stop breastfeeding earlier than women of normal weight (Amir and Donath, 2007; Turcksin, Bel, Galjaard and Devlieger, 2014). The reasons for this are unclear, but may involve a combination of; physical difficulties associated with obesity (Walker 2006); high rates of caesarean section, which is known to be associated with lower breastfeeding rates (Ahluwalia, Li and Morrow, 2012); psychological factors related to body image (Hauff and Demerath, 2012); and delayed onset in lactation (Nommsen-Rivers, Chantry, Peerson, Cohen and Dewey, 2010).

There is no robust evidence regarding the body weight at which an individual becomes ‘at risk’ due to ‘obesity’; however, there is evidence that there exist thresholds at which the risk of pregnancy complications significantly increase. For example, in addition to the multiple maternal risks highlighted above, women with a BMI >40kg/m^2 or very severely obese are at further increased risk of preterm delivery, having a baby who is stillborn, having a baby who

requires admission to a neonatal unit (Scott-Pillai et al 2013), as well of shoulder dystocia and jaundice in the baby (Heslehurst et al., 2008).

There is evidence that obese women do not return to their pre-pregnancy weight after their baby's birth. Most women tend to gain rather than lose weight between pregnancies (Poston et al., 2016) and in subsequent pregnancies progressively become more obese (Rooney and Schauberger, 2002). Pregnancy has itself been identified as an independent risk factor for long-term obesity (Poston et al., 2016). There is, in addition, a growing body of evidence linking maternal with offspring obesity (Poston, Harthoon and Van der Beek, 2011; Reynolds et al., 2013).

The increased risks and challenges associated with maternal obesity led CMACE (2010, p.xiii) to describe the issue as 'arguably the biggest challenge facing maternity services today. [It is] ...a challenge not only because of the magnitude of the problem… but also because of the impact that obesity has on women's reproductive health and that of their babies', thus emphasising the strong case for urgent and effective action to address this maternal and child health problem.

1.5. Gestational weight gain

In addition to the risks posed by pre-pregnancy obesity, there are additional increased risks associated with excessive gestational weight gain. These include, for women; high blood pressure (Cedergren, 2006; de la Torre et al., 2011); diabetes (Mamun et al., 2010; Thorsdottir, Gunnarsdottir, Kvaran and Gretarsson, 2005); caesarean section (Crane, White, Murphy, Burrage and Hutchens, 2009); and postpartum weight retention (Mannan, Doi, and Mamun, 2013; Nehring, Schmoll, Beyerlein, Hauner, and von Kries, 2011; Siega-Riz et al., 2009). Babies are at increased risk of: being born large for gestational age (Herring, Rose, Skouteris and Oken, 2012; Lucia Bergmann et al., 2007; Mamun et al., 2010; Nohr et al., 2009), which carries risks of trauma at birth and asphyxia (Nesbitt, Gilbert and Herrchen, 1998); gastroschisis (Yang, Carmichael, Tinker and Shaw, 2012); pre-term delivery (Han et al., 2011); and increased risk of metabolic disorders and higher weight later in life (Hinkle et al., 2012; Poston, 2012; Sridhar et al., 2014). Internationally, there is evidence that many women gain more weight than is recommended in pregnancy (Chung et al, 2013; Durie,

Thornburg, and Glantz, 2011; Kowal, Kul and Tamim, 2012; Park et al., 2011; Simas et al 2011). However, guidelines for recommended gestational weight gain vary between countries and there are no UK guidelines for what constitutes safe or recommended weight gain in pregnancy.

Nevertheless, the increased prevalence of obesity among women of childbearing age in the UK, alongside growing evidence regarding increased risks associated with excessive gestational weight gain, and associated complications, has led to the development of clinical guidelines regarding weight management pre-conceptually and during pregnancy (NICE, 2010). These provide recommendations such as that women delay conception until their weight is below 30kg/m^2, that pregnant women with a BMI >35kg/m^2 (severely obese) seek advice from a dietitian, and that all pregnant women undertake 30 minutes of physical activity per day, in order to prevent excessive gestational weight gain (NICE, 2010).

Weight monitoring in pregnancy was routine practice in the UK until the early 1990s when doubts about its value within pregnancy management led to its discontinuation (Amorim, Linne, Kac and Lourenco, 2008). Prior to this, the routine weighing of pregnant women was carried out primarily to assess fetal growth, and it was the value of routine weighing of women for this purpose that was questioned. In light of the increasing levels of maternal obesity, it has been suggested more recently that the reintroduction of routine weighing of pregnant women might be useful (Fitzsimons, Modder and Greer, 2009; Krishnamoorthy, Schram and Hill, 2006). However this may be of limited value in the absence of healthy pregnancy weight gain guidelines. Current CMACE/RCOG (2010) guidelines are limited to recommending that maternal BMI is measured at booking and that weight is re-measured in the third trimester of pregnancy, to inform and determine personnel needs and equipment requirements for labour and delivery, should a woman be very severely obese. Current NICE guidelines make recommendations for giving healthy lifestyle advice to women (2010), but do not provide guidance regarding the appropriate level of gestational weight gain. Some authors have suggested that the use of US Institute of Medicine (IoM) weight guidelines may be appropriate in the UK (Amorim et al. 2008; Williams, 2012); however, NICE has questioned the validity of these guidelines, which are based on observational evidence and

which may not be applicable in the UK, where the population differs from the US in its ethnic composition (NICE, 2010).

Traditionally, pregnancy has been a time when women are expected to gain weight, as a result of the growing fetus, placenta, amniotic fluid and extra circulating blood volume. Heslehurst (2011) identifies the use of the BMI to monitor weight gain in pregnant women as therefore problematic, as it was developed for use in the non-pregnant population, and is thus limited in its use in the later part of pregnancy. Despite this, and in the continued absence of recommended guidance for safe and appropriate gestational weight gain, an increasing number of women are now classified as being at high risk of pregnancy complications solely because of 'excessive' weight gain during pregnancy (Heslehurst., 2008).

1.6. Causes and explanations: what is obesity?

Obesity is increasingly defined as a chronic disease (Allison et al., 2008; Jutel, 2006; Jutel, 2009; Kerrigan and Kingdon, 2010). The WHO has officially defined 'obesity' as a disease since the 1990s (Murray, 2008) and it has further been described as 'probably one of the most complex diseases in respect to its aetiology' (Jebb, 1997, p.281): its causes are believed to be a mixture of medical, genetic, environmental, social and psychological factors (Carpenter and Bartley, 1994; Jung, 1997; Soltani and Fraser, 2002). Reduced to 'the simple physics of energy input and output' (Throsby, 2007, p.1563), obesity results from habitually consuming more food than the body requires to survive, and maintain good physical health. However, in order to explore the limited success of recent interventions in pregnancy, it is necessary to move beyond the construction of obesity as a 'condition' or a 'disease' with an 'aetiology', to explore the multiple interweaving social and cultural factors which may contribute to obesity in greater depth, in order to observe its complex underlying causes within women's everyday lives.

Analyses of medicalisation, the pathologisation of a range of aspects of human experience, and their management through medical influence and supervision (Zola, 1983), constitute a significant area of study within the sociology of health and illness. It has been argued that the medicalisation of an increasing range of facets of human lives and experiences (Zola, 1983; Conrad 2007) has led to behaviours once understood in terms of *deviance* acquiring the status of *sickness*. Foucault argues that such shifts in the

classification of these experiences did not just depend on enhanced understanding of conditions or improved treatments, but represent efforts to transform the framing of behaviours or experiences as 'medical' in order to exert power and control (Foucault, 1989). Thus, certain conditions or behaviours come to be described as 'medical', and this transforms everyday experiences; for example through altering understandings and definitions of acceptable bodies and behaviours (Conrad, 2007). Several critics of the biomedical approach to obesity management have drawn upon these explanations of the origins of medicalisation to inform their arguments, as they question the current framing of obesity as a 'medical' condition that poses a threat to the health and wealth of society (Campos, Saguy, Emsberger and Oliver, 2006; Gard and Wright 2005). In line with this, it can be observed that there has been a broad shift within modern capitalist society in recent decades, towards viewing health, and specifically the prevention of non-communicable diseases, as an individual responsibility. Obesity is thus further framed as a 'condition' or 'disease', certainly a personal health matter, and individuals are assigned responsibility and blame for their own weight gain and retention (Aphramor and Gingras, 2011). Health interventions which rely upon such individualistic approaches make rationalist assumptions that individuals should navigate health advice and make the 'right' choices regarding their personal health, whereas in reality, individuals may make decisions and enact behaviours for a multitude of complex and interweaving reasons, including psychological, social, familial, cultural, financial, structural and environmental (Aphramor and Gingras, 2011; Petersen and Lupton, 1997).

It is argued that there has been an increase in the monitoring and regulation of individual behaviours, rather than scrutiny of the potential role of public health interventions and the role of the lived environment, the 'obesogenic environment' and infrastructure to address the issue (McNaughton, 2011; Petersen and Lupton, 1997). The landmark Foresight Report strongly emphasises wider societal influences on the increasing levels of obesity seen today, questioning to some degree the biomedical focus on personal responsibility (Butland et al., 2007). They argue that, as society has altered radically during the last 50 years or more, so there have been major changes in work patterns, transport, food production, marketing and availability. It has been suggested that such changes 'have exposed an underlying biological tendency, possessed by many people, to both put on weight and retain it' (Heslehurst, 2011,

p.440). The dominant analysis within public health discourse has been expressed more strongly as 'an inability of people to mount effective psychobiological or behavioural counter-responses to an increase in the societal forces that promote excess weight gain' (Hanson et al., 2016, p1), thus drawing attention both to individual responsibility and the impact of the 'obesogenic environment' upon human bodies.

1.7. Stigma and Moral Responsibility

The human body can be described as central to the modern individual's sense of self-identity (Shilling, 2005). Social and cultural forces, underpinned by biomedical discourse, continue to place the responsibility for body size and weight firmly with the individual, highlighting their personal moral deviance (Copelton, 2007; Murphy, 2000). Social theorists have observed the increasing centrality of the body in the construction of social identities within the last 50 years (Bordo, 1993; Brewis, 2014) and as such obesity is a highly visible physical state and one that is highly stigmatised (Brewis, 2014; Puhl and Brownell 2006). As obesity rates across the globe continue to rise, there is a 'profound global diffusion of negative ideas about obesity' (Brewis, Wutich, Falletta-Cowden, and Rodriguez-Soto, 2011, p.269e). In modern western society, an overweight body speaks of gluttony, lack of self-discipline, self-indulgence, and can be viewed as 'grotesque' in its failure to conform to dominant norms of behaviour and appearance (Lupton, 1996, p.19). This stigma has been described as a "moral discrediting" (Brewis, 2014) and a "social death" (Yang et al., 2007), due to the negative social meanings attached to overweight and obesity. Unlike some other causes of stigma, obesity cannot be hidden, and it attracts personal blame and responsibility. Thus, the lived experience of obesity has been described as '... highly oppressive in everyday life' (Rich, Monaghan and Aphramor, 2011, p.7). Women and girls have reported higher levels of obesity stigma and weight discrimination than men (Puhl, Andreyeva and Brownell, 2008). The stigma attached to obesity can permeate all aspects of social and cultural life, including media, family, work, school (Puhl and Brownell, 2006; Puhl and Heuer, 2009; Puhl and King, 2013): and a recent review found that very high levels of weight bias are recorded among health professionals (Brewis, 2014).

The rising prevalence of obesity has not led to a relaxation of cultural expectations towards body size and weight (Brewis et al. 2011). The obese individual was described more than 40

years ago as '[representing] a complex mixture of medical fact and socio-cultural values' (Maddox and Liederman, 1969, p.13). Today, obesity is morally constructed and viewed as a problem to be solved (Throsby, 2007): obesity at the population level is routinely referred to in biomedical and public health discourse as an 'epidemic', and there are frequent references and debates within the popular media about the issues surrounding the health implications of obesity, but also the financial burden it poses, in terms of the economic costs to society in general and specifically in relation to healthcare costs (Parry, 2014). Against this background, obese childbearing women have received increased attention from the biomedical and public health communities in recent years, due to the cost burden associated with their high-risk pregnancies.

1.8. Social, Cultural and Economic Factors

Obesity is strongly associated with social class, gender and age (Carpenter and Bartley, 1994; Department of Health, 2005): a report commissioned by the European Commission examining obesity and socio-economic groups in Europe found that '[T]here is a consistent and profound social gradient in the prevalence of obesity in countries in Western Europe for which data are available. Women and children in lower socio-economic groups are especially likely to show high levels of obesity compared with the rest of the population and lower SES is shown to be associated with maternal obesity' and, further that, '[i]n general the evidence suggests that the difference between socio-economic groups is widening, i.e. the gradient is becoming steeper... 40-50% of the obesity found in women can be attributed to differences in socio-economic status' (Robertson et al. 2007, p.15). In Scotland, government-commissioned research has concluded that 'there is a clear linear patter of increasing obesity with increasing deprivation in adult women' (Scottish Government, 2010). As noted above, the authors of the landmark Foresight Report summarise that a broader societal approach to tackling obesity is needed, requiring change at personal, family, community and national levels (Butland et al., 2007). However, current clinical care guidelines on maternal overweight and obesity in pregnancy continue to neglect the social contexts that place some women at risk and which are a likely impediment to effective intervention (Sutherland, Brown and Yelland, 2013).

1.9. Obesity and Pregnancy in the 'Risk Society'

It has been argued that, due to the condition of late modernity, which through economic and technological development, has produced previously unknown risks (Giddens, 1991; Beck, 1992), individuals in the early twenty-first century have a highly developed 'risk consciousness'. This increasingly shapes the ways in which they think, behave and make decisions (Giddens, 1991). As such, routine aspects of everyday life are characterised by anxiety regarding risk, ever-increasing and sometimes unknowable (Beck, 1992; Lupton, 2012). Beginning in the latter half of the 20th century, pregnancy has been viewed as a time when women are particularly susceptible to risk. Within this context, birth medicalisation theorists draw upon feminist, governmental and risk theories in arguing that medicine understands women's bodies through an androcentric, mechanistic model, and that this forms the foundation of an oppression of women through their pregnant bodies, (Murphy-Lawless, 1998; Oakley, 1984; Rothman, 1982). Pregnancy has become increasingly medicalised and monitored, to the extent that it is no longer viewed as a *normal* physiological event, but rather a *medical* event (Armstrong, 1995; Arney, 1982; Lane, 1995; Oakley, 1984), always potentially risky, and as such it is characterised by efforts to assess, detect and manage such risk (Lupton, 2011). Pregnancy and birth can thus be viewed as normal only after the event (Oakley, 1984).

Increasing pregnancy surveillance has extended the positioning of women as responsible for the wellbeing of their children as mothers back into pregnancy. The widely accepted biomedical view is that individual women are responsible for the health and development of the fetus, and have a duty to enact healthy behaviours and avoid consumption of substances considered harmful, such as alcohol and tobacco, or foods considered to be unhealthy (Bell, McNaughton and Salmon, 2009).

It has further been argued that women's bodily autonomy has been challenged and subverted as the fetus has increasingly been afforded personhood, due most notably to the development of ultrasound technology in the 1960s, and rapidly increasing knowledge about the properties of the placenta and its permeability (Lupton, 2013). Longhurst (1999) argues that pregnancy now takes place much more in the public sphere and as a result, women are continually subjected to advice from the media, healthcare professionals,

partners, family members, work colleagues and even strangers regarding their behaviours in pregnancy. Within this context, a woman who is very severely obese, constantly open to society's scrutiny due to her size, is constantly visible, recognisable as imposing risk to her fetus through her choices and behaviours, and failure to control herself and her body.

In the case of maternal obesity, there are currently many biomedical risk factors to consider; for example, the fetus may grow too big due to maternal diabetes, or not grow enough due to maternal hypertension (Heslehurst et al., 2008; Rajasingam et al. 2009). Thus, the biomedical gaze focuses not on the ways in which the fetus is protected within the womb, but instead on how it may be at risk of harm from the maternal body (Tsing, 1990). Increasingly there is evidence that these risks may follow the infant into both childhood and later life. Recent biomedical investigations have focused on the idea that 'programming' can occur within the womb. The roots of this theory can be seen in Barker's 'fetal origins' hypothesis - that the origins of chronic disease may be found in early life, in childhood and indeed *in utero* (Barker, 1991; Barker and Osmond, 1986). In the case of maternal obesity, there is evidence that the mother's excess weight in pregnancy may contribute to obesity in their offspring through intra-uterine factors that alter fetal metabolism regarding growth, fat deposition, and insulin regulation (Oken and Gillman, 2003). However, there remain gaps in the evidence base for this theory when applied to obesity in pregnancy (Warin, Zivkovic, Moore and Davies, 2012). Researchers have urged caution when attempting to generalise from current evidence, and there are critical voices within the sociological literature regarding the link between obesity and medical conditions such as type 2 diabetes and offspring health (see McNaughton, 2011). Nonetheless, there is considerable interest in such theories within the scientific and public health communities, and increasingly within the popular media. It is now common to see newspapers and television programmes which report the likelihood of giving birth to a big baby if you are overweight, or of increasing the risks of the baby being obese in childhood, and of developing diabetes or heart disease later in life (Warin et al. 2012). Thus, evidence that the obese maternal body may impact on offspring health from the moment of conception, through pregnancy and birth, into childhood, adult life and beyond, and may potentially affect future generations, sharpens the focus on women as culpable, responsible for imposing risk, and to be monitored to mitigate the effects of their failings. Indeed, it has been argued that the credence lent to the

shift in focus of Barker's hypothesis from the potential lifelong impact of underweight mothers to the 'programming' of a generation of obese individuals via fetal over-nutrition, is because it diverts attention from the social determinants of health, to individual large, problematic, female bodies (Jette and Rail 2014; McNaughton, 2011).

1.10. Current and recent pregnancy interventions

As I have outlined, obese women's bodies are increasingly under scrutiny, and a debate has developed in recent years within biomedicine, public health, and nutritional sciences, regarding the most appropriate approach to addressing the issue of maternal obesity, with strategies favouring either individual responsibility or social determinants approaches. A number of RCTs have sought to examine the efficacy of pregnancy intervention approaches in order to limit gestational weight gain and improve pregnancy outcomes. These have included diet or exercise programmes, or a combination of both, alongside psychological behaviour change components, such as cognitive behavioural therapy (CBT), and social (cognitive) learning theory (Agha, Agha and Sandall, 2014; Campbell, Johnson, Guillaume and Goyder, 2011; Dodd, Grivell, Crowther and Robinson, 2008; Oteng-Ntim et al., 2011; Smith and Lavender, 2011; Thangaratinam et al., 2012a). In addition, the drug Metformin, which is used to treat diabetes in the non-pregnant population, has been tested in drug trials to assess its efficacy at improving insulin sensitivity in obese pregnant women (Chiswick et al., 2015; Syngelaki et al., 2016); however, it was not shown to have a beneficial effect on birthweight, gestational weight gain, or the incidence of gestational diabetes.

One systematic review of pregnancy behaviour change interventions found a significant reduction in gestational weight gain in women who received an intervention, compared to those who did not (Thangaratinam et al., 2012a). In addition, it appears there may have been an impact upon clinical outcomes such as pre-eclampsia, gestational diabetes, caesarean section, pre-term birth and induction of labour (Thangaratinam et al., 2012b). However, the limitations of these studies – mostly small samples, heterogeneous in terms of interventions delivered, with poor reporting in terms of BMI categories (Hanson et al., 2016) - lead to difficulties in drawing generalisable conclusions, and subsequent studies and reviews have questioned the effectiveness of pregnancy interventions in terms of reducing the incidence of pre-eclampsia and gestational diabetes (Allen, Rogozinska, Sivarajasingam,

Khan and Thangaratinam, 2014; Rogozinska, Chamillard, Hitman, Khan and Thangaratinam, 2015). Additionally, a further systematic review and meta-analysis which compared the efficacy or effectiveness of a particular behavioural intervention in pregnant or pre-conceptual women with standard maternity care, and included 15 studies and 3426 participants, concluded that behavioural interventions had no effect on pregnancy weight gain, postnatal weight loss or retention, or on infant birthweight, in very severely obese women (Agha et al. 2014).

Two large recent UK RCTs (LIMIT and UPBEAT) demonstrated that supported behavioural interventions can limit gestational weight gain, but did not demonstrate significant differences in pregnancy outcomes between study groups. The LIMIT trial recruited 2212 women who were pregnant and overweight or obese, and randomised them to either an intervention or standard care group (Dodd et al., 2014). The intervention, using the 'stages-of-change' model (Prochaska and Diclemente, 1982), provided guidance and support with goal-setting, problem-solving and self-monitoring, through the delivery of six support contacts during pregnancy, either face-to-face or via telephone. No difference was detected between the two groups in the primary outcome measure, which was the proportion of babies born large for gestational age, although women in the intervention group were significantly less like to give birth to a baby of more than 4kg than were those in the standard care group (Dodd et al., 2014).

The UPBEAT study recruited 1555 women, who were randomised to intervention or control (standard care) groups. Those in the intervention arm received an initial interview, then eight tailored support sessions during pregnancy. There were no differences between the groups in terms of numbers who developed gestational diabetes or babies who were born large for gestational age, although women in the intervention group gained less weight, an effect that was modest but statistically significant (Poston et al., 2015). The authors of this study concluded that changes to diet and lifestyle as a result of successful intervention might not be sufficient to influence pregnancy outcomes, in terms of improving insulin sensitivity or reducing the risk of developing gestational diabetes (Hanson et al., 2016; Poston et al., 2015).

Low uptake (Atkinson, Olander and French, 2016; Heslehurst, et al. 2011b) and poor compliance (Poston et al., 2013) have been identified as limitations of lifestyle intervention programmes, indicating such programmes are not acceptable or accessible to some women. Thus, although gestational weight gain has featured in over twenty UK national reports since 2003 (Heslehurst, Moore, Rankin, Ellis, Wilkinson and Summerbell, 2011a), a 2011 NICE-commissioned review of interventions concluded that “[t]here is a lack of sufficient evidence to conclude that interventions are effective in reducing gestational weight gain” (Campbell et al, 2011, p.491). The authors of the UPBEAT RCT go further, concluding that dietary and lifestyle changes in pregnancy may in any case not be effective in improving pregnancy outcomes for women and babies (Poston et al., 2015).

Pregnancy has been identified in the past as potentially a ‘teachable moment’ - a time when women may seek to adopt risk-reducing behaviours, due to increased perception of personal risk and outcome expectancies (McBride, Emmons and Lipkus, 2003; Phelan, 2010). However, the usefulness of ring-fencing pregnancy as a time in which healthy behaviour changes might be enacted has recently been questioned, as successive authors have stressed the importance of seeking to reduce weight and improve health via a life course approach to healthy behaviours and weight reduction (Hanson et al., 2016; Poston et al., 2015). As a result, the focus for research has begun to move away from concentrating efforts in pregnancy, looking instead to the pre-conceptual and postnatal periods as a time when women might access support to enact changes which may improve lifelong health (Dinsdale, Branch, Cook and Cooksmith, 2016). As yet, however, there is a lack of evidence regarding the most timely and effective ways to intervene and offer support in these time periods (Dean, Lassi, Imam and Bhutta, 2014; Opray, Grivell, Deussen and Dodd, 2015; Van der Pligt et al., 2013).

Previous studies of women’s perceptions and experiences within the healthcare system and with individual health professionals, have tended to rely almost entirely on individual behaviour change approaches to health. These have been shown to be largely ineffective in the case of maternal obesity, thus, as noted above, there are calls for a new focus on exploring ways of offering intervention and support, in different ways and at different time points (notably in the pre-conceptual and postnatal periods). A recent review of pregnancy

interventions concluded that “an ecological approach to risk reduction’ is required, one which moves beyond concentrating efforts within primary care, broadening out to include ‘personal, societal and cultural influences” (Hanson et al., 2016, p.1). These authors call for public health approaches that move beyond one-to-one interactions with individual health-care providers, which are reliant upon the psychological capability and will-power of the individual to enact behaviour change, and acknowledge the ways in which individual behaviours interact with social, cultural and environmental systems (Hanson et al., 2016). This would require a shift away from an emphasis on individual lifestyle regulation, including “attention to lifestyle, healthy eating, attention to exercise, preventive testing…and other measures” (Petersen, Davis, Fraser, and Lindsay, 2010, p.394). Such an approach, it is argued, has been promoted as a means of establishing control over one’s life, and as a path to freedom and ‘wellbeing’, and has been critiqued in sociological literature as ignoring the socio-economic, cultural or environmental determinants of maternal obesity (Aphramor and Gingras, 2011; Warin et al. 2008). Clinical intervention models have been critiqued as being based on an assumption that, regardless of social or cultural factors, pregnant women will seek to prioritise their health and that of their babies over other considerations, and make reflexive use of expert systems (for example nutritional science) to regulate their everyday lives (Petersen, 1997). Zinn (2008) argues that, while experts may prescribe cognitive-rational strategies as the most effective response to risk, such experts must acknowledge that individuals may disregard expert advice, or absorb and transform it within their own experiences and perceptions regarding risk. Thus, obese pregnant women may experience the discourse around body size, pregnancy and risk at an individual level (Berlant, 2010) and as such may choose to accept or reject certain aspects of competing forms of knowledge, in their quest to be both healthy and accepted members of the societies, communities and families within which they live. In so doing, they may interweave ideas from the medical and social worlds to inform their perceptions and understanding of the meaning of obesity in pregnancy, depending on a multitude of factors, such as geographical location, education, economic standing and inter-generational ties (de-Graft Aikins, 2011). The current evidence regarding women’s experiences of weight management services is explored within chapter two.

1.11. Summary

As outlined above, obesity is an increasing problem in the UK and elsewhere, and results from many complex causes. In addition to the increased risks of multiple morbidities in the general population, maternal obesity is now known to increase the risks of a high number of pregnancy complications for mothers and babies. Authors from a range of disciplines, including public health, dietetics, sociology and biomedicine, acknowledge the need for broad, ecological approaches to tackling the pressing and growing problem of maternal obesity. This will necessarily entail an exploration of the perceptions, beliefs, experiences and behaviours of pregnant women.

Obesity is a highly stigmatised, constantly-lived physical experience, and its origins can be strongly related to socio-economic status. Pregnancy and birth are embodied, as well as socially embedded experiences, as are food and eating, which are steeped in social and cultural rituals (Bordo, 1993; Caplan, 1997). Authors highlight the need for research to take account of the psychosocial and cultural context of women's weight and pregnancy (Atkinson, Olander and French, 2013; Heslehurst et al., 2013). Heslehurst et al. (2013) argue that there are strong associations with women's lived experiences and engagement with antenatal weight management services. An exploration of women's socially-embedded experiences of pregnancy, and of maternity care, is now required in order to inform broad approaches to care (Furber and McGowan, 2010; Heslehurst et al. 2013). High-risk labelling, an emphasis on personal responsibility and increased surveillance in pregnancy, the results of the biomedical approach to obesity in pregnancy within the wider context of a culture which views pregnancy as inherently risky, may impact profoundly upon the pregnancy experiences of women, all of whom experience pregnancy and obesity within the contexts of their everyday lives. It is necessary to form an understanding of the experiences of women, their views, perceptions and beliefs about these issues, in order to inform future approaches to improve women's health. In addition, as outlined by Hanson et al. (2016) in a recent review of pregnancy interventions, an exploration of the views and experiences of significant individuals within women's lives will broaden understandings of the ways in which relate to and perceive concepts of health and health messages.

1.12. Structure of the thesis

In chapter two, I summarise what is currently known regarding women's experiences of obesity, and very severe obesity, in pregnancy, including how they engage with discourses regarding health, weight, pregnancy and risk. With reference to broader societal and cultural contexts, l focus on the evidence regarding the socially-embedded experiences of pregnancy, relationships with family and friends, health professionals and experiences of maternity care. I also review what is currently known about the views and perceptions of significant individuals within women's social networks regarding weight, pregnancy, risk and health. With reference to relevant sociological and public health literature, I refer to current discourses around the social and cultural meaning of obesity and pregnancy, in order to situate what is known about women's experiences, as well as identifying gaps in the evidence.

In chapter three I outline the methodology used in this research, which broadly aligns itself with a critical realist ontology, which acknowledges the existence of an independent reality, but that which can only be accessed through situated accounts (Maxwell, 2012; Williams, 1999). The chapter outlines my rationale for the use of qualitative interviews, and a serial interview approach. I discuss the need for critical reflexivity throughout the design and execution of the study. I describe my sampling and recruitment approaches, the interviews themselves, and finally, my analytical approach and explication of the structure of the findings chapters.

I then provide a brief description of my eighteen participants, eleven women and seven of their partners/husbands. This is intended to demonstrate their diverse circumstances and backgrounds and to contextualise the discussion within the chapters that follow.

Chapter four is the first findings chapter. In order to provide context to the experiences women describe during pregnancy, how they understand health and account for their size, I focus on the accounts they give of their pre-pregnant selves, and details of their everyday lives, including the perceptions and views of partners. Key topics included within this chapter are: accounting for weight and 'battling' with the body; the impact of moving through the life course and becoming partnered; accounts of food and eating within

coupled relationships; home-cooked food, mothering and morality; defending health; and issues pertaining to fertility and becoming pregnant.

Chapter five is the principle findings chapter of the thesis. Here I explore women's experiences in pregnancy, focusing on embodiment, beliefs about health and health behaviours, and their experiences of pregnancy health care. Key topics within this chapter are: lay beliefs and changes in attitudes and behaviours regarding food and eating; experiences of pregnancy care and formal dietary advice; the role of stigma and social class; experiences of multi-disciplinary care; and experiencing and conceptualising 'high-risk' status, expressing resistance and seeking reassurance;

In chapter six, the final findings chapter, I focus first on women's beliefs about their future health, explored during pregnancy. I then include a summary of the pregnancy and birth complications the women reported. I move on to present findings from women's accounts during the postnatal period, which were obtained between four and six weeks after the births of the babies. Key topics explored here are: focussing on physical fitness and being a role model; delaying weight loss efforts or enactment of behaviour change; resistance to 'dieting' behaviours; retrospective repudiatory questioning 'high-risk' status; and the role of health professionals.

In chapter seven I present a discussion, highlighting the contribution to knowledge I make within this thesis. I argue that, for most women the experience of pregnancy had been one of negotiating *stigmatised risk*. Women wanted to experience pregnancy as a positive embodied experience and as a 'pause' from the pressure to lose weight and the shadow of stigma. To this end, they wished to be perceived within both healthcare settings and everyday life as primarily 'pregnant' rather than 'obese'. Their attendance at a high-risk clinic and experiences of pregnancy care, however, constantly reinforced 'obesity' as their primary health state, and risk as the primary health focus. This perpetuated feelings of stigma in some, due to an expectation of complications embedded within the structure of their healthcare. Women drew reassurances regarding this from various sources, including their social worlds, and their partners. I argue further that, following pregnancy, a lack of support and advice from health professionals added to, and in in some cases reinforced,

repudiatory responses to the high-risk status associated with maternal very severe obesity, and that this represents a missed opportunity at a time of high motivation among women and some partners to enact behaviour change. I conclude this final chapter with suggested implications for policy, practice and future research in this area.

Chapter Two

Literature Review

2.1. Introduction

In this chapter I review the current evidence pertaining to women's experiences of obesity (BMI >30kg/m^2), and very severe obesity (BMI >40kg/m^2) in pregnancy, childbirth and the postnatal period. In so doing, I draw from a range of literatures, primarily from qualitative studies which explore the pregnancy experiences of women who are obese. This includes academic papers which report on the qualitative component of an intervention studies. It further includes any papers which report on the views and experiences of partners and other significant individuals within women's lives. In addition, in order to contextualise and critique the findings of the primary research regarding experiences of maternal obesity, I refer to the large sociological literature relevant to the issues of pregnancy, weight and health. I address four key themes which speak to the data drawn from the qualitative studies of pregnancy experiences: first, women's embodied experiences in pregnancy, or experiences relating to food and eating, in the context of family and social life; second, women's experiences and perceptions of obesity and risk in pregnancy, including current evidence regarding women's experiences of maternity care, their interactions with health professionals, and their experiences of 'high risk' care pathways; third, women's experiences of stigma within everyday life in pregnancy, and within maternity healthcare settings; lastly, I explore literature pertaining to the psychosocial context in which obesity in pregnancy is experienced. I then consider the extent to which current knowledge can address my broad research aim, drawing upon the themes identified to generate research questions which pertain to how obesity and pregnancy are experienced by women in the context of the culturally and socially embedded knowledge of their everyday lives, and to explore the interplay between their lived experiences of obesity and pregnancy, their perceptions and beliefs regarding health and pregnancy, and their experiences and perceptions regarding formal healthcare.

2.2. Methods

The initial literature search focussed directly on obesity and pregnancy. I intended that the search strategy I employed would be rigorous and systematic, enabling me to undertake a narrative review of the existing literature. I sought academic papers and texts focussing on original research relating to overweight and obese women's perceptions and experiences of pregnancy, health and pregnancy care, as well those of partners, husbands and other individuals from women's social networks, in order to provide a broad review of the evidence regarding the issues surrounding maternal obesity and pregnancy care. I included studies of qualitative or of mixed-methods design, as some randomised controlled-trial (RCTs) incorporated a qualitative component within their design.

Databases for this review were selected after consultation with a specialist librarian on the basis of their scope and relevance. Searches were carried out using Medline, CINAHL, Cochrane, Social Sciences Citation Index and PsychInfo databases. Advice on search terms was sought from the specialist librarian. The search terms used were: obesity, weight, pregnancy, (truncated also to pregnan*), women, psychological, psychosocial, family, partner, diet, exercise, experiences, interventions, , stigma, risk, body image, health professional, midwife (truncated to midwi*). Studies were included if they reported qualitative or mixed-methods (including randomised controlled trials (to capture the qualitative research findings) in relation to obese women's experiences or views on obesity in relation to pregnancy and/or pregnancy health care, or those of their partners or husbands, or other individuals from social networks, or a relevant intervention in relation to delivery and/or uptake. I included all papers which were of relevance, only excluding those which, after initial reading, were judged not to be of relevance to my topic. The initial literature search was undertaken in February 2014 and this was updated in August 2015 and in November 2016.

A quality appraisal tool, designed to aid critical appraisal of qualitative evidence, was used (Walsh and Downe, 2006). Notes were taken by hand under the following category headings; design, sampling; analysis; interpretation; reflexivity; ethical dimension; relevance

and transferability (Walsh and Downe, 2006). The tool provides narrower subheadings for consideration within each category, which were particularly useful in critically appraising individual aspects of the research.

To broaden the depth and scope of the review, and in order to employ an iterative approach to the data, the literature search was extended to include wider evidence relating to pregnancy, body image, risk and obesity. Electronic searches were again carried out using the databases above and combinations of the following search terms: pregnancy (truncated to pregnan*), risk, weight, body image, midwives (truncated to midwi*), health professionals, obesity (truncated to obes*) and stigma. In some cases, works regarded as seminal, relevant and useful, particularly within the sociological literature, were recommended by research supervisors. The search was extended further as citations from key relevant texts were accessed and reviewed.

2.3. Results

I found 25 studies which reported on original research, were qualitative in their design, or were RCTs with a qualitative component, or used mixed methods and included women with a BMI >30kg/m^2 (obese) (see Appendices I & II). Only one of these papers had BMI >40kg/m^2 (very severely obese) as an inclusion criterion (Denison, Weir, Carver, Norman and Reynolds, 2015). One paper was found which explored the views and experiences of women alongside those of their partners, family members and other significant individuals within obese women's lives (Thornton et al., 2006). These studies form the core focus of this review. I found no studies which focussed solely on the views of partners and no studies which explored the views of other individuals from social networks.

All but one of the studies was conducted in either the UK, the Scandinavian countries, the US or Australia. The ethnic mix of participants was either unreported, or reported as largely Caucasian. The exception to this was one study conducted in Canada, which explored Cree women's views and experiences of pregnancy (Vallianatos et al., 2008) and one American study which explored attitudes among Latino women and their husbands to food, eating and exercising (Thornton et al., 2006).

All studies used qualitative interview methods alone or as part of a mixed methodology. All but four studies interviewed women on one occasion, during or following pregnancy. Four were longitudinal studies, interviewing women several times (Furber and McGowan, 2010; Jarvie, 2016; Keenan and Stapleton, 2010; Wiles, 1994)

In addition to the 25 original research papers, three systematic reviews of women's views and experiences of pregnancy and/or pregnancy cared were found (Johnson et al., 2013; Smith and Lavender, 2011; Vanstone, Kandasamy, Giacomini, DeJean and McDonald, 2016). I refer to these within the literature review, indicating that these were not reporting on original research. I also make reference to studies of women's experiences pertaining to weight, diet and exercise in pregnancy, where 'overweight', or 'obesity' were not included in the eligibility criteria. Again, this is intended to provide context and I make clear the eligibility criteria in each case.

Four main themes emerged from a review of the current evidence. These are: the embodied experiences of obesity in pregnancy (section 2.3.1); maternal obesity and risk (section 2.3.2); stigma (section 2.3.3) ; psychosocial factors (section 2.3.4) . Below, the literature review is organised according to these prominent themes.

2.3.1. Embodied experiences of obesity in pregnancy

Pregnancy is an embodied experience, in that it is an inherently physical experience, characterised by bodily changes as a fetus grows within. Shilling describes bodies as 'constitutive of the self' (2003, p.3) and it may be expected that a woman's sense of identity may be altered during pregnancy, when dramatic changes occur and their bodies become 'for the baby' (Bailey, 2001, p.120) As a resultwomen may experience associated , psychological and emotional changes (Devine, Bove and Olson, 2000; Skouteris, Carr, Wertherheim, Paxton and Duncombe, 2005), as part of the *rites of passage* of becoming a mother (Oakley, 1986). Bordo (1993, p.25) argues that a woman's life is largely centred on the body, claiming that, 'culture's grip on the body is a constant, intimate fact of everyday life'. Thus pregnancy is a highly embodied experience (Schmied and Lupton, 2001), which takes place within the context of women's everyday lives, their families, communities and workplaces. Pregnant embodiment has been described as representing a change from

locating femininity in the size and shape of the body, to locating it in the biological imperative of pregnancy: that during pregnancy, the body is, in effect, occupied by two beings, one of which (the fetus) is changing the shape of the maternal body (Bailey, 2001).

As such, regardless of body size or shape, women have discussed experiencing altered perceptions of the body, with some perceiving a relaxation of the pressure to be slim (Bailey, 2001; Nash, 2011). Indeed, pregnancy has traditionally been a time when weight gain is expected (Fox and Yamaguchi, 1997). In her research into overweight and obese women's body image in pregnancy, Wiles (1994) found that the majority of the women she interviewed had been dissatisfied with their pre-pregnancy weight, and that many of them experienced a positive body image change during pregnancy. For example, many took part in sports and social activities they had previously felt excluded from because of their weight. A more recent study found similar attitudes among participants, who felt more positively about their bodies during pregnancy, as a larger body at this time was perceived as socially more acceptable than at other times (Keely, Gunning and Denison, 2011). Fox and Yamaguchi (1997) studied body image change in pregnancy, and found that many overweight or obese women felt they had become more physically attractive during pregnancy. Others, however, experienced a negative change and continued to feel the social stigma of being overweight. Elsewhere, evidence suggests that, regardless of their weight, many women continue to be concerned with their body image during pregnancy (Earle, 2003; Skouteris et al. 2005). Thus, it may be that it is not a woman's pre-pregnancy weight, but the value she places on slimness in general which determines how she will perceive her body in pregnancy (Fox and Yamaguchi, 1997).

Society's scrutiny of the pregnant body, and of pregnant women's behaviour in pregnancy, has increased in recent decades, with conflicting cultural constructions of pregnancy, when a woman's body is viewed as out of control, or 'unruly' (Dworkin and Wachs, 2004, p.616), but that nevertheless she should not 'let herself go' (Jette and Rail, 2014, p.203). The expansion of consumer culture within the realm of conception, pregnancy and childbirth, reflected in the growth in the maternity clothes market for example (Earle 2003), has meant an increased pressure on women of all sizes to conform to a slim *pregnant* ideal, or "pregnancy chic" (Longhurst, 2008, p.51). This associated shift in society's expectations of

how a pregnant body should look means that displaying a pregnant stomach on an otherwise slim body has become a cultural ideal, most famously exemplified by the Hollywood actress Demi Moore when she posed naked whilst pregnant for the fashion magazine *Vanity Fair* in 1991. Longhurst (2008) observes that, in addition to enacting 'healthy' behaviours in pregnancy, women are expected to mimic these pregnant celebrity role models. In her study of women's experiences of pregnancy, Earle (2003) found that weight gain on the breasts was associated with the ability to breastfeed and was thus identified as acceptable, whereas weight gain around the arms and face, for example, was not.

It appears that, although changes in body shape, and indeed weight gain, are seen as inevitable, there are increasingly strict standards to which society expects the pregnant woman should conform. The failure of the very severely obese woman to conform to such ideals leads to the taint of association with negative social and cultural characteristics.

Two further areas pertinent to embodied experiences are evident within the literature; food and eating in pregnancy; and physical activity in pregnancy. I consider these below.

2.3.1.(a) Food and eating in pregnancy

An understanding of the complex relationships that very severely obese women have with food requires an acknowledgement of the fact that eating is more than a process of nourishing the body. Very severely obese women may be understood as greedy and lacking in self-control (Lupton, 1996), however, women eat (or over-eat), gain and retain weight, for many different reasons (Cataldo, 1985). Warin, Turner, Moore and Davies' (2008) study explored overweight Australian mothers' experiences of food, motherhood and nurturing, within the family structure. It found that participants' beliefs and perceptions were enmeshed in their taken-for-granted, everyday practices. The authors highlighted differences in how food, eating and the body are viewed by women from different social backgrounds. They found that, for many women, food provision and practices were central to constructs of mothering and that these relational identities could be at odds with the promotion of individual behaviour change (Warin et al. 2008). In her study of obese pregnant women with co-existing diabetes, Jarvie (2016) found that comfort eating was

common among participants, as a response to stress or emotional difficulties; and that this was often a lifelong habit which continued in pregnancy.

Pregnancy weight gain is traditionally regarded as a sign of a thriving fetus, and evidence suggests that weight gain is seen as natural and inevitable by obese pregnant women (Smith and Lavender, 2011). However, as pregnancy has become increasingly medically managed, the discourse of maternal responsibility for the health of the baby asserts that women need to eat the 'right' foods in the 'right' amounts to gain the 'right' amount of gestational weight. In Jette and Rail's (2014) study of low income pregnant women in Canada, only some of whom were obese, participants placed an emphasis on the importance of 'feeding' their unborn babies good foods via the consumption of a healthy maternal diet. However, these women also often struggled to reconcile the discourse of maternal responsibility with their embodied experiences of pregnancy (nausea and exhaustion) as well as structural constraints (lack of time and money) (Jette and Rail, 2014).

In Western culture, women often have the primary role within the family of buying and preparing food. Lupton (1996) suggests that, despite their role as the major food providers and preparers, many women lack control over what they eat, often catering to the preferences of others (usually their husbands or partners) over their own. In their large study of food and eating practices, Charles and Kerr (1988) found that food practices reflected the patriarchal structure within the household. As Warin et al (2008, p.98) point out, the preparing and eating of food is "an elaborate performance of gender, social class and identity". In Murcott's (1982) study of pregnant (non-obese) women, the author found that women tend to think of food in terms of its domestic organisation and a focus of family life, and do not relate to medical dietary advice, which focuses on nutritional value. In one recent study, overweight and obese pregnant women cited a favouring by family members of high-fat, high-calorie foods as hindering their own efforts to enact changes and eat healthily (Anderson et al., 2015). In pregnancy, lay and cultural beliefs about food and eating can be pervasive and can be seen by obese women as superior to medical advice (Vallianatos et al., 2008; Wiles, 1994).

2.3.1.(b) Physical activity

Pregnancy for women of all BMI ranges tends to result in a decrease in physical activity, and levels diminish as pregnancy advances (Dufour, Reina and Spurr, 2002; Evenson, Savitz and Huston, 2004). Reasons for this have been cited as experiencing pregnancy symptoms such as nausea or tiredness, as well as fear of harming the fetus, or of causing pregnancy complications (Gaston and Cramp, 2011). There is evidence that women who are obese or severely obese (BMI 30-39.9kg/m^2) reduce exercise more markedly than women with lower BMI during pregnancy (Seneviratne et al., 2014). In their 2015 study, Denison et al suggest that very severely obese women may differ in their perceptions of activity and in issues surrounding their body size and image, when compared to women of normal weight, or those in the overweight or lower obesity categories. Their study explored possible barriers to physical activity that may be specific to women with a very high BMI; for example, some participants expressed a fear that their excess fat might damage their baby during exercise (Denison et al., 2015). However, the authors did not explore women's views regarding broader issues regarding pregnancy health and weight. The evidence regarding women's attitudes to exercise in the postnatal period is limited to one study of Latino diabetic women, who were not all obese, where authors found that physical activity levels remained low for some time following pregnancy (Kieffer, Willis, Arellano and Guzman, 2002).

2.3.1.(c) Summary

Pregnancy can be regarded as a supremely embodied experience (Bordo, 1993). Additionally, food and eating practices are, for many pregnant women, embedded within, and shaped by, family and domestic circumstances. In addition, although pregnancy weight gain is still viewed as inevitable, recent years have seen an increasing pressure on all women to continue to conform to slim ideals in pregnancy. Against this background, there is a lack of evidence regarding the perceptions and beliefs of very severely obese women, and their partners, regarding health, pregnancy and weight, set within the context of their everyday lives.

2.3.2. Maternal obesity and risk

As I outlined within the introductory section, maternal obesity in pregnancy is associated with multiple increased risks to both mother and fetus. In the following section, I review

what is currently known about obese women's understandings of the clinical evidence regarding pregnancy risks associated with maternal obesity.

2.3.2.(a) Obese women's perceptions and experiences regarding risk

The potential risks of obesity in pregnancy posed to maternal and offspring health have been investigated and disseminated in recent years and a number of studies have explored women's understandings of these risks. Emerging awareness of risks among obese women is evident within study findings over the past two decades. For example, in one older study, interviewees did not cite risks to health as a reason for dissatisfaction with being obese while pregnant (Wiles, 1994). A more recent study, examining health professionals' perceptions of the impact of maternal obesity on care provision, found that interviewees reported that among pregnant women, 'there was a general lack of awareness about the effects of obesity in pregnancy, of the complications it causes' (Richens, 2008, p.17). However, these studies were conducted several years ago, in particular in the case of Wiles' study. There has been a huge expansion in clinical research regarding maternal obesity in the last ten years, leading to the development of clinical guidelines for the care of obese pregnant women, and considerable interest from the mainstream media in the subject of obesity in pregnancy. Several authors have recently highlighted the concern that many obese women feel regarding the implications of their weight on their health in pregnancy, and that of their babies. Sui, Turnbull and Dodd (2013a) surveyed 464 overweight and obese women via questionnaires, of which 75% identified excessive gestational weight gain as associated with complications or negative pregnancy outcomes. One study, in which 14 obese women were interviewed about their experiences in pregnancy and of pregnancy care, found that women stated they were aware that they were overweight and were concerned about their weight and how to manage it (Mills, Schmied and Dahlen, 2011). Similarly, Stengel, Kraschnewski, Hwang, Kjerulff and Chuang (2012) interviewed 24 overweight and obese women regarding the advice they received about gestational weight gain from midwives and other health professionals. Many expressed concern about weight and weight gain in terms of the risks this may pose to their health and that of their babies. The accounts of several obese women in a study by Heslehurst et al. (2013) concurred with these findings, with many women expressing a strong desire to make changes to their diet

and lifestyle, with some viewing pregnancy as an ideal time to make changes that would impact on their children's health and that of the wider family. However, this study highlighted a wide range of views, with some women reporting a lack of concern, others a defensiveness about their weight. In addition, a further study that examined reasons why obese women declined referral to a weight management service summarised 'no need for help' as one of its four main themes (Atkinson et al. 2013).

There were contradictory and complex overlapping views within some women's narratives. For example, some obese women reported feeling concerned about their weight, but also a belief that they were nonetheless 'healthy' (Heslehurst et al., 2013; Keely et al., 2011), or that they were not 'high risk' (Jarvie 2016; Keely et al. 2011). However, the authors did not present evidence of what being 'healthy' or what being 'high' or 'low' risk meant to participants. Obese women in a further study differed in their views and concerns according to their parity (Heslehurst et al., 2013), with those having their first babies more likely to focus on the nutritional properties of their diet for their health and their babies' health, while those who already had one or more child and had gained weight during that pregnancy were more likely to focus on the avoidance of excessive gestational weight gain. Some women described becoming aware of the risks of maternal obesity only during pregnancy, which led to them feeling self-conscious, embarrassed and concerned for the health of their babies (Heslehurst et al., 2013) Elsewhere, women described becoming aware of the risks only after the birth of their babies, and then feeling responsible or 'blamed' for any complications or adverse outcomes that had occurred (Furber and McGowan, 2010).

In a longitudinal study of 30 women with co-existing maternal obesity and diabetes in pregnancy, Jarvie (2016) described how participants focussed on - and sought to deny or neutralise - the risks specifically of giving birth to a big baby, whilst not referring to other risks or complications or poor outcomes. Indeed, the social and moral opprobrium associated with obesity in pregnancy was seen as a more salient concern than risk, as defined in the biomedical/epidemiological paradigm. Elsewhere, Jette and Rail (2014) explored the ways in which their participants, low income pregnant women in Canada, not all of whom were obese, related to the discourse of maternal responsibility in relation to

food choices, behaviours and gestational weight gain. They explored how participants were critical of formal healthcare provision and advice, which was often irreconcilable with their embodied experiences of pregnancy, financial circumstances and/or religious beliefs.

The perceptions and experiences of women with a BMI greater than 40kg/m^2 have been under-explored to date, with only one study focusing on this category of women, and these authors focused on beliefs and behaviours regarding exercise in pregnancy (Denison et al. 2015). BMI categories are clinically constructed, and were not designed for use in pregnancy, thus their use remains problematic. However, they are used routinely within maternity care and women who are clinically obese generally know they are labelled as 'high-risk' in pregnancy, which may inform and shape women's experiences of pregnancy and their perceptions of risk. Women who are severely, and very severely obese are considered at greater risk, are recommended to receive obstetric-led care in pregnancy and in labour, and their choices for birth are routinely restricted. In addition, due to their size, they may experience different levels or types of stigma, in everyday life, and in pregnancy. Whether or not the experiences and perceptions of these issues differ in women who are very severely obese compared to women with lower obesity categories has not been explored to date.

2.3.2.(b) Summary

Pregnancy and childbirth are acknowledged as a time of transition (Miller, 2005; Oakley, 1986). As the number of very severely obese women continues to increase in the UK and elsewhere, there remains a lack of evidence regarding how they relate to risk discourse, in constructing their identities as pregnant women and as mothers. It is clear from the evidence reviewed here that there is a wide variation in women's perceptions and understandings of the risks of obesity in pregnancy. The narratives of some women point to a complex mix of anxiety about their weight, alongside limited evidence which suggests a resistance of the discourses which position them as at risk and as posing risk to their babies. These accounts echo those seen in the wider obesity literature, where individuals may engage with weight loss intervention programmes, whilst simultaneously resisting the notion that they are responsible for their size, or put at risk as a consequence (Throsby, 2007; Webb, 2009).

However, most studies focus on health care delivery, and women's experiences of this, hence they lack an exploration of women's lived experiences, their social and cultural backgrounds. In addition, no authors have included an exploration of the perceptions and experiences of pregnant women's family members and/or wider social networks, which would deepen understandings of women's social and cultural influences.

The ways in which women understand health information and translate this into their everyday practices and beliefs are complex and may be deeply socially and culturally embedded. Although it is clear from the evidence reviewed here that there is a lack of information-giving regarding risk within the healthcare setting, and that there is a lack of knowledge regarding what women understand about the risks posed by maternal obesity, the experience of maternal obesity as characterised by risk within the context of stigma has been under-explored.

2.3.3. Stigma

In his seminal essay on stigma, Goffman (1963) suggests that the stigmatised individual may believe that, despite what is said, she/he will never be fully accepted within society. Stigma has been differentiated as either *felt* or *enacted,* to demonstrate the ways in which, due to a constant awareness of the stigma associated with obesity within western society, and the subtle ways in which it is embedded within social structures, individuals may anticipate and *feel* stigma within day-to-day encounters (Scambler, 2009). In addition, this may be felt particularly strongly within situations where a past stigmatising encounter occurred, such as within medical settings (Harvey and Hill, 2001; Puhl and King, 2013). More recently, Link and Phelan (2001) make much of the need for the exercise of power in order for stigmatisation to occur, resulting in labeling, stereotyping, separation, status loss, and discrimination. This too resonates with the power relationship inherent within the medical encounter. Green (2009) suggests that the nature of felt stigma is changing and that those with chronic conditions increasingly refuse to be defined by their condition. However, as obesity rates continue to rise, authors elsewhere argue that the associated stigma is strengthening and spreading (Brewis, 2014; Puhl et al. 2008). The nature of obesity as a source of stigma means that it is regarded as a 'personal, private trouble' to which solutions can – and must -

be found (Rich et al. 2011, p1). Thus biomedical and public health approaches focus on individual behaviour change in order to lose weight and improve health, placing the responsibility for the problem and the solution firmly with the individual.

Obesity is highly visible, and the experience of obesity a 'miserable, chronic predicament' (Brewis, 2014, p.152). This may influence and shape the ways in which women relate to risk and otherwise experience pregnancy. In this section I appraise the current evidence regarding obese pregnant women's experiences of stigma within everyday life generally and maternity health care specifically.

2.3.3.(a) The *unsaid*: stigma and tension within the medical encounter

A prominent theme in all studies which explored the experiences of women who received standard maternity care (as compared to specialist, high-risk care, or who participated in a targeted intervention) was the tension, frustration and a lack of information-giving within interactions between pregnant women and health professionals. This dynamic has been observed in studies exploring the experiences of pregnant women *and* of health professionals (Heslehurst et al., 2013; Keenan and Stapleton, 2010; Mills et al, 2011; Schmied, Duff, Dahlen, Mills and Kolt, 2011). It has been linked to a lack of open communication due to the stigma and sensitivity surrounding obesity (Mills et al, 2011). Many women reported that they wanted health professionals to raise and discuss the issue of weight in pregnancy in an open and sensitive manner, but perceived that this often did not happen (Heslehurst et al., 2013; Keenan and Stapleton, 2010; Mills et al, 2011;). Some women felt that, although they had expressed concern during pregnancy about their weight, health professionals appeared not to share this concern, and in some cases offered reassurances regarding the associated risks (Keenan and Stapleton, 2010). Consistent with this lack of open communication, women reported that the implications of obesity-related screening tests, such as a BMI calculation and glucose tolerance test, as well as referrals to obstetric specialists, such as anaesthetists, had not been adequately explained (Furber and McGowan, 2010; Keely et al, 2011; Lindhardt, Rubak, Mogensen, Lamont and Joergensen, 2013; Mills et al, 2011). In addition, participants in some studies complained of a lack of guidance from midwives regarding diet and exercise (Mills et al, 2011; Smith and Lavender, 2011; Stengel et al. 2012).

Although unsaid during face-to-face consultations in pregnancy, several women were distressed by references to obesity in their written notes (Furber and McGowan, 2010) One woman described how she kept hand-held maternity notes through her pregnancy (as is common practice in the UK) and her family were interested to read them, causing her embarrassment. Elsewhere, poor communication and a lack of information-giving impacted upon women's pregnancy and also birth experience. Some reported being unprepared for the restricted options they were offered during labour and birth (not being allowed to use birth pools for example), as policies regarding care of obese women had not been discussed (Keenan and Stapleton, 2010). In addition, women were upset by discussions with health professionals about risks and restricted options associated with obesity which occurred only after the births of their babies (Keenan and Stapleton, 2010).

2.3.3.(b) Language

In addition to the '*unsaid*', the stigma and sensitivity associated with obesity in pregnancy is evident in what *is* said, in particular in the language used. This has led to tension within encounters between women and health professionals. Women have described alienation from medicalised language, such as 'body mass index', used by midwives and others, and a desire for health professionals to discuss weight in an open, respectful and sensitive manner (Heslehurst et al, 2015; Mills et al, 2011). As an indication of the disconnection between women's perceptions and experiences within healthcare encounters, and those within their everyday lives, women used formal terms when describing their experiences of healthcare, such as 'BMI' or 'overweight' and used informal terms when referring to their weight status in everyday life ('overweight' and 'my weight') (Heslehurst, Ellis and Wilkinson, 2011b).

Nyman, Prebensen and Flensner (2010) conducted qualitative interviews with 10 women about their encounters with maternity health professionals in Sweden. In addition to problems of poor communication, these women reported feeling they were not taken seriously (birth plans being rejected, for example) and trying to ignore receiving negative treatment by health professionals. In addition, a Danish team conducted qualitative interviews with 16 obese pregnant women (Lindhardt et al, 2013). They report their main

themes as the experience of an ‘accusatorial response’ from caregivers, and receiving inadequate advice. Several women felt they faced prejudice or a lack of respect from maternity health professionals. In another study, the issue of maternal obesity was raised for the first time with some women by a health professional immediately following the birth of their babies, when it was suggested that birth complications they had experienced were the result of their weight. This caused offense and upset to several women (Keenan and Stapleton 2010). The women in Mills et al’s (2011) Australian study identified being labelled as ’different’ or ‘high-risk’ as having a negative effect on their experiences of pregnancy and birth. In the US, the women in DeJoy and Bittner’s (2015) study reported on women’s responses to negative treatment and, in some cases, bullying, at the hands of medical professionals. Most of the women in the study described both expecting and receiving negative treatment from health professionals. In addition, they shared feelings of self-blame and guilt for putting their fetuses at risk, as well as humiliation and anger towards health care providers. Studies which analysed data from the internet report a high number of incidences of negative treatment discussed by women within online fora (Arden, Duxbury and Soltani, 2014; Jarvie 2016)

Smith and Lavender’s (2011) meta-synthesis of women’s maternity experiences concluded that women often feel stigmatised by the treatment they receive from healthcare professionals. However, Heslehurst et al. (2015) critique recent studies, pointing to the lack of direct quotes provided to illustrate these negative encounters. These authors cite only one example of negative treatment provided by a pregnant participant in their own study. The lack of direct examples and quotes may suggest that women perceive stigmatising treatment in subtle ways that are not readily captured in an interview setting. The ways in which stigma impacts upon women’s experiences of pregnancy and their engagement with health messages have been insufficiently explored in research to date, which has focussed almost exclusively on the interface of medical encounters between women and health professionals.

2.3.3.(c) Obesity stigma: damaging to maternal health?

Currently, more than 30% of women in the UK are classified as obese during pregnancy (Fitzsimons and Modder, 2010), and it has been suggested that by focussing on absolute risk

at the expense of an exploration and understanding of women's perceptions and experiences, pregnancy and birth experiences for these women may be negatively affected (McGlone and Davies, 2012). A growing body of work suggests that obesity stigma can impact negatively upon health in a number of ways, including promoting poor coping mechanisms, mental health issues, comorbidities of obesity, avoidance of health care, and negative interactions with health care providers (Puhl and Heuer, 2010). In line with this, it has been suggested that obesity stigma can impact negatively not only upon women's experiences and their psychological health during pregnancy, but upon broader maternal health and upon pregnancy outcomes. DeJoy and Bittner (2015) propose a theoretical model to explore the impact of weight bias on maternal and child health

These authors point out that, aside from the physiological factors resulting from maternal obesity which may cause poor birth outcomes, from a social determinants perspective, experiencing stigma in everyday life may be a downstream cause of stress and social disadvantage. Stigma in pregnancy may contribute to poor coping strategies, such as over-eating, and stress may contribute to impaired metabolic function (DeJoy and Bittner, 2015). These authors conclude that research is required in order to quantify the extent to which weight bias is encountered and internalised by pregnant women during the preconception and perinatal periods, and in medical settings. In addition, they suggest an exploration of the impact of pregnancy upon women's experiences of obesity stigma.

2.3.3.(d) Experiences of maternity care and pregnancy interventions

There are a number of studies which identify stigma in relation to women's experiences of health care, maternity services and pregnancy interventions. However, a complex picture emerges from the evidence. Several specialist antenatal weight management services have been established in the UK and elsewhere in Europe in recent years. In related studies, and in contrast to the studies reviewed above of women receiving standard antenatal care, many women receiving these interventions have reported positive experiences. One potential reason cited by the authors of these studies is that women have reported valuing the opportunity to discuss their weight in an open way (Atkinson et al. 2016; Claesson et al., 2008; Heslehurst et al., 2015). However, uptake and engagement with many services has been low (Atkinson et al. 2013; Heslehurst. 2011b), indicating poor acceptability in general.

For example, in their study, McGiveron et al. (2015) compared outcomes of 89 severely obese women (BMI >35kg/m^2) who took part in a pregnancy intervention incorporating diet and lifestyle advice, and one-to-one guidance and diet monitoring, with those who declined the service. Although they observed significantly lower gestational weight gain in the intervention group, the implications of the high numbers of women who declined are two-fold. First, they indicate poor acceptability of the service to high numbers of eligible women. Second, the low numbers of women who participated presumably precluded the undertaking of a randomised controlled trial, which would have controlled the potential for bias in the findings, as women who participated may have been more motivated to enact positive behaviour and dietary changes.

Atkinson et al. (2013) conducted interviews with seven obese women who declined referral to a home-based service and eleven obese women who engaged initially, and then disengaged. The reasons given by women for not attending or disengaging were that the service was poorly explained, that they were offended by the offer of such a service, or that they had negative expectations of the service or felt their needs would not be met. However, these reasons were not explored or reported in greater detail (Atkinson et al. 2013). The authors later interviewed women who had used the service to explore its acceptability. Several women experienced home visits positively, due to convenience and the privacy it allowed. However, of 67 eligible women who had used the service and were approached, 20 agreed to be interviewed. Therefore, the views of those interviewed may not be generalisable to both the high number of women who declined to be referred to the service, and those who were referred but were not interviewed.

In contrast to Atkinson et al's (2016) study, Poston et al., (2013) found that obese women experienced positively the group support component of their intervention. Atkinson et al (2016) critique the design of this study, noting that women who failed to reach their target weight gain reported feelings of guilt or failure. The evidence regarding the efficacy of either individualised or group approaches is insufficient to advocate the widespread use of either in pregnancy. Therefore, as 'highly individualised' approaches have been advocated elsewhere in the literature (Sui, Turnbull and Dodd, 2013b), there is no convincing evidence

for a ‘one-size-fits-all’ approach in respect of providing support and information via either one-to-one or in group sessions.

Claesson et al. (2008) report on consumer satisfaction with a weight-gain intervention programme for obese pregnant women in Sweden, in which a high number (n61=67%) of eligible women participated. They conclude that the pregnant woman herself must be involved in setting her own goals to prevent excessive weight gain during pregnancy and that considerable effort and support must be placed on discussing strategies, pitfalls and risks (Claesson et al., 2008). However, it is noted that a high proportion of the participants in this study were in employment (90%; n=45), and only five (10%) women were not working. In addition, no demographic details were available for those women who declined to participate or who were not eligible due to inability to understand Swedish, and thus study findings may not be applicable to women from all socio-economic and ethnic groups.

Heslehurst et al’s (2015) evaluation of a high-risk care pathway for obese pregnant women combined qualitative and quantitative methods to explore women’s experiences of the service, to assess health professionals’ attitudes to delivering the service, and to audit delivery of the service and outcomes. They found that women reported positive experiences of interactions with, and communication from health professionals, but this was framed as an absence of negative or disrespectful treatment. In addition, pregnant women valued highly receiving supportive weight-related feedback from health professionals. However, in common with studies conducted with women experiencing standard NHS care, a high number of women also reported being given conflicting advice by health professionals, experiencing depersonalisation, and inadequate risk communication (Heslehurst et al., 2015)

Those studies which report on experiences of pregnancy interventions and high risk care pathways found some women valued the acknowledgement of their weight as a risk factor, while others felt frightened by communication from health professionals regarding risk, which they perceived as inadequate, and thus sought extra information elsewhere (although the authors do not specify the sources used for this). This was reported as leading to increased feelings of anxiety regarding pregnancy (Heslehurst et al., 2015). The study

authors do not provide further detail about the nature of the information sought, or the ways in which women interweaved and understood the information they were given. They include quotes from participant which suggest they felt stigmatised by their health care experiences; for example one woman who stated health professionals had said to her 'you're gonna have a massive baby' (Heslehurst et al., 2015, p.10). The discussion section reports that most women described positive experiences. However, the possibility that women can experience care both positively and negatively, valuing high risk care whilst simultaneously experiencing stigma, is not explored by the authors.

Some women have described the centralised hospital-based location of interventions as a barrier to attendance, for example due to travel and parking costs or childcare difficulties (Heslehurst et al., 2015). A recent intervention (Maternal and Early Years Healthy Weight Service (MAEYS)) offered a home-based support service to obese women, aimed at reducing pregnancy weight gain and childhood obesity, which included support and advice during pregnancy and for the two years following (Atkinson et al. 2016). Authors report women experiencing this positively, and feeling more at ease to discuss weight and food matters in their own homes and being more honest about their lifestyles. However, the reasons for this are not explored in depth. In addition, some participants received support with other issues, such as smoking cessation and family issues, suggesting relationship-building and broader support may have been an important factor in the positive experiences of participants (Atkinson et al. 2016).

However, in studies of the type critiqued above, authors report descriptively on 'positive' and 'negative' aspects of the intervention experienced by participants (Atkinson et al. 2016; Heslehurst et al., 2015). Women's lived experiences and perceptions, within the context of stigmatised risk, may be far more complex than can be summarised in this way; such reported 'negative' experiences may be as a result of *felt* rather than *enacted* stigma, arising not from the actions of an individual health professional, but informed by previous stigmatising events or interactions, for example. In addition, building a relationship with a health care provider has been cited as a 'positive' experience for participants in some studies, but the characteristics and nature of these relationships, and what informed the

positive experience, within the context of multi-disciplinary 'high-risk' care, have not been explored in depth.

2.3.3.(e) Summary

It appears from existing evidence that experiences of 'stigmatised pregnancies' are not confined to incidences of overtly negative or disrespectful treatment, and indeed although stigma features strongly as a theme across most studies, only a small number of specific examples of this *enacted* stigma are reported upon. Recent findings suggest that women's experiences are characterised by the presence of *felt* stigma, which may be more subtle in its forms, being indirect, defined as that which may be anticipated and/or perceived (Lewis, Thomas, Blood, Castle, Hyde and Komesaroff, 2011), hence the lack of examples cited by research participants. Sources of stigma may be embedded within the subtle power dynamics which characterise medical encounters and within the structures and infrastructure pertaining to health care more broadly. These experiences may be informed by women's everyday experiences of obesity over years, and within their social worlds. This indicates that many women, although they may not experience overtly negative treatment by health professionals, may experience a more subtle and nuanced stigmatised journey through pregnancy and healthcare. These experiences have not been explored with very severely obese women in sufficient depth within the existing literature, which has led to a lack of understanding of the complexities of stigma within pregnancy and how this might impact upon experiences of maternity care. As I have demonstrated, due to the narrow scope of recent studies, which focus on the interface within which healthcare takes place, during consultations and childbirth itself, there remains a lack of evidence regarding the personal, societal and cultural influences on pregnant women regarding weight and health. As such, research is now required, in order to provide a richer and more nuanced understanding of women's experiences, to inform the broadening out of public health interventions necessary to adequately address the issues associated with maternal obesity,

2.3.4. Psychosocial factors

As I have outlined, most pregnancy interventions to date which have sought to promote behaviour change in pregnancy have been limited in their accessibility, the compliance and retention of participants and, crucially, their impact on pregnancy outcomes. However,

despite a widespread acknowledgement that evidence regarding women's lived experiences of pregnancy is required in order to plan and design effective intervention, studies to date have focused on women's experiences of care, examining their views and experiences through that lens.

2.3.4.(a) Cultural and social context of weight, health and pregnancy

The social and cultural underpinnings of women's understandings of concepts such as 'health', and their experiences of obesity and pregnancy, within the context of their daily lives, their familial, social and cultural influences, are under-explored within the literature. As a result, health and social inequalities have also been largely ignored in the maternal obesity literature, thus there is a continuing lack of evidence which is needed to inform the design of interventions (Lavender and Smith, 2016; Sutherland et al. 2013). One notable exception to this can be found in Jarvie's (2016) study which explored the experiences and perceptions of pregnant women who were obese and diabetic, focussing specifically on the stigma associated with the risk of giving birth to a large baby. The author observes the ways in which women feel anxious and judged by society, and resist responsibility for exposing their unborn babies to risk. This was particularly the case for women with low SES. The author observes that those participants from middle class backgrounds enjoyed a protection from stigma, whereas, those from more deprived backgrounds experienced a "layering of stigma" brought about by being obese amid other stigmatising circumstances, such as material deprivation (Jarvie, 2016, p.27). However, the author makes little reference to partner's views or of other social and cultural influences.

A recent meta-synthesis of the qualitative evidence on women's experiences of obesity in pregnancy explored the barriers and facilitators to appropriate weight gain in pregnancy (Vanstone et al. 2016 p2). The authors conclude that weight gain in pregnancy takes place in a complex social environment, influenced by intrapersonal, interpersonal, social, structural and environmental variables. To date there is a lack of evidence which explores in-depth the interplay of these complex factors.

2.3.4.(b) Family and social support

As noted above, pregnancy takes place within the context of women's everyday lives, and the ways in which they perceive health and risk in pregnancy may be highly influenced and shaped by their social and familial circumstances and their support networks. Social support is known to be a determinant of psychological and physical health (Sarason, Sarason and Pierce, 1990; Thoits, 1995) and is linked to health related behaviours in pregnancy, such as drinking alcohol, drug use and smoking (Dunn, Pirie and Hellerstedt, 2003; Hutchins and Di Pietro 1997; Lindenberg, Strickland, Solorzano, Galvis, Dreher and Darrow, 1999). However, the psychosocial context of pregnancy has been neglected in the literature on maternal weight. One US study explored women's experiences beyond the narrow parameters of maternity care experiences, exploring the views of recently immigrated Latina women, together with a significant individual from their lives (partner, husband or friend) (Thornton et al., 2006). However, it is noted that, although the authors drew attention to the significant disparities in prevalence of obesity among Latina women of childbearing age, compared to non-Hispanic white women, the BMI ranges of participants, or whether they identified themselves as 'overweight, 'obese' etc. is not made clear. The authors found the values, views and perceptions, which were often shared within the dyad, and the level of support offered, were highly influential with regard to food choices, health beliefs and behaviours. The views of husbands or partners were considered most influential. Commonly stated beliefs among couples included the benefits of following pregnancy cravings, eating freely in order to produce a large 'healthy' baby, avoiding exercise, and the importance of losing weight, exercising and regaining a slimmer figure following birth. In all of these respects, husbands and partners were found to be vital with regard to levels of informational support (e.g. regarding health matters), emotional support and instrumental support (e.g. providing childcare during postnatal exercising). The study authors conclude that forms of social support are important in shaping beliefs and behaviours related to weight, diet and physical activity, and that acknowledging this may help to inform better, more culturally relevant intervention strategies (Thornton et al., 2006). However, there may be specific cultural circumstances which limit the generalisability of the findings; for example the fact the women were recently immigrated, their husbands had mostly been in the US longer than they had, and many had a relatively small female social network.

Elsewhere, women have described social and familial circumstances, and work commitments as highly influential factors in terms of their food choices and pregnancy weight gain (Garnweidner, Pettersen and Mosdøl, 2013; Groth and Morrison-Beedy, 2013). A recent meta-synthesis of women's views regarding barriers and facilitators to healthy weight gain found factors related to high incomes and supportive family members, as well as a trusting relationship with an informative health professional, were identified by women as key facilitators to achieving a healthy weight gain. In addition, a Swedish study reporting on the prevalence of overweight and obesity among expectant parents, found that the odds of being overweight or obese increased relative to a partner's overweight or obesity, and that a woman was six times more likely to be obese if her partner was obese in comparison with those who were of normal weight (Edvardsson et al., 2013).

There is, however, a dearth of evidence on the views and beliefs of partners and husbands regarding maternal obesity, pregnancy diet and health behaviours, and the ways in which they might influence and shape women's pregnancy experiences and perceptions. One qualitative study briefly reported that some participants found partners to be supportive of their efforts to eat healthily during pregnancy, while others did not (Heslehurst et al., 2013). Elsewhere, participants in a study which explored the attitudes of women with a history of gestational diabetes to engaging in physical activity reported that lack of partner support was a barrier to perceived healthy behaviour change (Graco, Garrard and Jasper, 2009). Campbell et al. (2011) observe in their meta-synthesis of interventions that the lay beliefs among women's family members and friends regarding resting and increased eating in pregnancy may be more influential than advice given by health professionals. In two more recent UK studies, key barriers or facilitators to healthy behaviours have included the family and social circumstances in which the women lived, with some women finding partners and wider families supportive of efforts to eat healthily and undertake exercise during pregnancy, while others were less supportive, referring to myths such as avoiding physical activity and increased intake, described as 'eating for two' (Heslehurst et al., 2013; Petrov Fieril, Fagevik, Olson, Glantz and Premberg, 2017). However, little evidence is provided by these authors; for example in Heslehurst et al's (2013) qualitative study, intended to better understand factors which need be considered when developing services, the section within the paper regarding families is short and approximately half is in fact devoted to the theme

of food and nutritional matters rather than with family and the social context of food, eating and weight.

Another study, conducted in the US with an ethnically diverse sample of obese pregnant women, used focus groups to explore beliefs and behaviours with regard to physical exercise in pregnancy. The authors found women reported partners as discouraging them from engaging in everyday chores and activities, in addition to discouraging leisure activities, indicating a belief among partners that activity might harm the pregnancy, while rest will be beneficial (Evenson, Moos, Carrier and Siega-Riz, 2009). Back in the UK, Khazaedezadeh, Pheasant, Bewley, Mohiddin and Oteng-Ntim (2011) conducted their research in an economically deprived, ethnically diverse area of South-East London. They interviewed twelve women, whom they purposively sampled to represent the population in terms of ethnicity. The importance of any weight management advice being culturally sensitive and for traditional foods to be considered is highlighted in the findings, as some women reported feeling unable to avoid these foods - some of which have a high fat content - due to family eating patterns. However, no details of participants' ethnic backgrounds are provided. A further study evaluated the acceptability of an intervention targeted at women in pregnancy and for two years following (Maternal and Early Years Healthy Weight Service (MAEYS)). The authors found that several participants retrospectively suggested that the inclusion of partners in the intervention delivery would have improved the service (Atkinson et al. 2016). In addition, when participants in the LIMIT RCT were interviewed about enablers and barriers to behaviour change, they did not refer to the support of health professionals as important, but they did cite family support, or lack thereof, as a key enabler or barrier to enacting healthy behaviour change (Dodd et al., 2014). The study authors thus recommend widening the scope of health promotion efforts to include partners and friends. A further study of Swedish women interviewed participants three years following a pregnancy weight gain intervention. These women also gave examples of ways in which their partners might encourage or discourage healthy lifestyles (Dencker et al., 2016). Two further studies emphasised the importance of social support in enabling women to enact and maintain changes (Furness et al., 2011; Smith, Taylor and Lavender, 2015).

The majority of reviewed studies were conducted in the UK, Australasia or Scandinavia. One further study, conducted in Canada, was designed to explore young pregnant Cree women's concerns about gestational weight gain (Vallianatos et al., 2008). In light of the increasing prevalence of maternal obesity within the Cree population, qualitative interviews were conducted with young childbearing women and also with female Cree elders, to provide historical and cultural context and to give some insight into culturally appropriate responses to the public health challenge posed by rising obesity levels. The authors found that, although young Cree women understood traditional cultures surrounding food and eating practices, they tended not to put their knowledge of what constituted a healthy lifestyle in pregnancy into practice, due to a variety of individual and societal barriers. The authors concluded that interventions must be culturally meaningful, valuing traditional Cree concepts. One suggested example was the development of traditional Cree cooking classes, to address the time, energy and knowledge constraints that younger participants spoke of, and to build social support networks.

The three studies discussed above (Atkinson et al. 2016; Khazadezaedeh et al. 2011; Vallianatos et al., 2008) drew attention to the need for culturally sensitive information, highlighting data which suggests partners from minority ethnic groups may not be knowledgeable or supportive regarding healthy eating in pregnancy. However, there is a dearth of evidence regarding the perceptions and knowledge of men from any ethnic background, regarding diet in pregnancy, and more broadly regarding weight and health in pregnancy. The evidence available within the reviewed studies suggests domestic food arrangements are strongly influenced by partners, including during pregnancy. Evidence regarding the beliefs and experiences of partners, considered within a social and cultural context, is required in order to provide an understanding of women's experiences of food, eating and wider issues in pregnancy.

2.3.4.(c) Summary

There exists a lack of evidence about the psychosocial aspects of obesity in pregnancy. With the exception of those by Jarvie (2016), Vallianatos et al., (2008) and Wiles (1994), the studies reviewed here did not explore this theme in any depth. Of the studies which explored these themes in depth one was conducted over twenty years ago (Wiles, 1994),

when far fewer women were obese in pregnancy, thus the women's experiences and views may have been quite different compared to those of childbearing women today, and in addition, the body of evidence regarding associated risks and awareness among the general population was much more limited. One other study was conducted with Cree women in Canada (Vallianatos et al., 2008) and although family, and social and cultural life, as well as food and eating arrangements, were explored in depth, the findings cannot necessarily be generalised to populations elsewhere. As I have outlined, in the UK and other western countries, obesity is strongly associated with social class, (Carpenter and Bartley, 1994), with women and children of lower social classes being most likely to be overweight or obese (Robertson et al. 2007). Jarvie (2013) explored obese diabetic pregnant women's understandings of health discourses and experiences of pregnancy, with participants who were predominantly from lower socio-economic groups. The author demonstrated participants use of strategies to resist biomedical and public health discourses regarding maternal obesity and risk, but explored only women's perceptions of 'social support' , hence did not explore, either directly or in depth, the views of family members, or the role they might play in informing women's experiences.

The views of partners have been acknowledged elsewhere in pregnancy-related research as important influences in terms of attitudes and practices regarding smoking in pregnancy (Flemming, McCaughan, Angus and Graham, 2014) and breastfeeding (Renfrew, McCormick, Wade, Quinn and Dowswell, 2012). In the general population, weight is a common conversation topic for many couples (Bove and Sobal, 2011), and recent evidence has identified health behaviours and values shared between partners as a greater contributor to increased weight than other factors, such as the influence of parents and upbringing (Xia et al., 2016). In recent study found that having a partner (spouse) become obese more than doubles the risk of becoming obese (Cobb et al., 2016). In addition, however, it has been demonstrated that partners can offer each other support in managing their weight **(**Elfhag & Rössner, 2005).

Pregnancy and obesity are experienced within the context of family and community. Thus, an in-depth exploration of women's lived experiences of obesity in pregnancy, including an

exploration of the views of partners, with reference to important social and cultural influences, could inform effective future intervention strategies.

2.4. Chapter summary

In this literature review, I have explored the current evidence regarding obese women's views and experiences of pregnancy and pregnancy care, as well as the views of partners and other significant individuals from obese women's social networks. The main themes identified upon reviewing the literature were: embodied experiences of obesity in pregnancy; maternal obesity and risk; maternal obesity and stigma; psychosocial factors. An appraisal of the current evidence, with reference to broader literatures has helped to identify key gaps in the evidence base regarding this increasingly important public health issue.

In light of the limited successes of pregnancy interventions to date (Agha et al. 2014), there is a need for research evidence with regard to 'what works' with obese women, based on a robust understanding of women's experiences. Obese women are not a homogenous group and obesity is a complex condition. Socio-economic and cultural backgrounds influence health because they shape the way women live their everyday lives. This may include every aspect of food purchasing, preparation and consumption, as well as physical activity and mental and emotional well-being (Lupton 1996; Warin et al. 2012). It also influences the way women interact with the health care system, including their participation in programmes of prevention and health promotion, their interpretation of health information, their health-related lifestyle choices and priorities, and their understanding of health and illness (Blaxter, 2010; Vallianatos et al .,2008). In addition, as Petersen (1997) argues, enacting 'healthy' - thus risk averting - behaviours has come to be a signifier of moral worth, while those engaging in 'risky' health behaviours are met with opprobrium and experience stigma.

In light of the above, there is a need for evidence regarding women's embodied experiences of pregnancy, their understandings of and beliefs about the implications of their body weight, and the sources and influences from which they draw information and support. There were complexities and contradictions evident within individual women's accounts of

their own body weight in the studies included in this review; however, in the main these were not unpacked or explored by most authors in any depth. The analysis in most studies does not move beyond the descriptive level, for examples only citing individual reported examples of partners' behaviours or attitudes without a deeper exploration of the role that this might play in women's experiences and understandings of health, weight and pregnancy. In addition, with the exception of the US study cited above (Thornton et al., 2006), which explored the views of partners and others, no other study was found which explored directly the views and perceptions of partners and/or friends of pregnant obese women, thus there is a lack of evidence regarding the best approaches to education and health promotion that might be implemented to inform and support partners and other family members.

Elsewhere in the wider obesity literature, it has been observed that obese individuals may resist responsibility for their weight, citing a 'fat-prone' body, childhood events, and disruptive life events (Throsby, 2007; Webb, 2009). A further study of overweight Australian mother's experiences, focussed on their perceptions and practices regarding food, and the ways in which they constructed their identities as mothers and their roles within the family structure. The authors observed that obesity is enmeshed in participant's taken-for-granted, everyday practices, rooted within their social backgrounds (Warin et al. 2008). However, although the prevalence of obesity in women is higher in those of lower SES (Robertson et al. 2007), there is a paucity of evidence from the UK regarding the lived experiences of obese pregnant women, and their understandings of the meaning of obesity in pregnancy, focussing on social, economic and cultural factors. Additionally, there is a lack of evidence about the construction of risk in obese women's own discourse about childbirth.

In addition, no studies have been undertaken which widen the research focus to include directly the views of family members and friends. Several authors highlight the need for research in this area, as it would provide context and background of the real life experiences of women, as food, eating, exercise and other lifestyle factors are highly influenced by families and the wider social and cultural contexts within which women live and rear their children (Hanson et al., 2016). Exploring the views of individuals who play a significant role in the women's lives alongside the women's own accounts will enhance the depth of

understanding of the complexities surrounding the social meaning of pregnancy and obesity, in order to inform appropriate intervention strategies, which might include partners and other family members (Campbell et al. 2011; Dencker et al., 2016).

NHS risk management strategies are designed to promote safety by predicting and averting risk. However, this reliance upon the biomedical model, which focuses on absolute risk and the possibility of poor outcomes, disempowers women through the depersonalisation of care (Smith and Lavender, 2011) and fails to measure or value individual experiences of pregnancy and birth (Walsh, El-Nemer and Downe, 2004). There exists a lack of evidence regarding many aspects of the impact of maternal obesity on pregnancy outcomes; for example, despite acknowledgement that it was designed for use in pregnancy, the BMI calculation continues to be used to assess risk (Heslehurst, 2011).

Knowledge of biomedical risks associated with obesity in pregnancy will continue to develop and researchers may continue to assess women's understandings of these risks; however, to date this has not resulted in the development of successful interventions or behaviour change models. The stigma some women have reported associated with their engagement with maternity services may cause them to be resistant to, or disengage from, discourses around risk, and seek information elsewhere. The complex interweaving of the biomedical, personal, cultural and social aspects of pregnancy, and the advice and information they access and receive from numerous and varied sources, must be unpacked in order to understand the experience of very severe maternal obesity in pregnancy.

The Foresight Report (Butland et al., 2007) and the 2010 NICE guidelines identify pregnancy as a naturally occurring critical opportunity for intervention in obesity and initiating behaviour change. As was highlighted by CMACE (2010), evidence is needed in order to plan and develop appropriate and acceptable maternity services for the growing population of very severely obese women in the UK. The lack of success of individualistic/behaviourist pregnancy interventions point to a need for evidence which takes account of women's experiences and views, their lived experience of risk (Lupton, 1999).

Pregnancy has been identified as a time when women may seek to adopt risk-reducing behaviours, due to increased perception of personal risk (McBride et al. 2003; Phelan, 2010). In this chapter, I have presented an appraisal of the large number of RCTs which have sought to examine the efficacy of pregnancy intervention approaches in order to limit gestational weight gain and improve pregnancy outcomes, and I have argued that their lack of success in limiting weight gain and improving pregnancy outcomes is due to a continued narrow focus on individuals, with a lack of attention given to maternal, social and cultural circumstances.

It is clear that food and eating during pregnancy are related to issues and behaviours which are embedded within family life, as women's choices and enact behaviours may be shaped by their social, cultural, economic and domestic circumstances. These may contribute to, and intersect with, other complex reasons which lead to increased weight. In pregnancy, there is a lack of evidence regarding how these factors influence women's understandings, perceptions and behaviours. Specifically, there is a lack of evidence regarding the beliefs, understandings and experiences of the 2% of women considered most at risk associated with obesity – those with a BMI >40kg/m^2 (very severely obese) regarding pregnancy, weight and health. In addition, there is a lack of evidence about how partners and husbands, acknowledged as a key influence in shaping women's choices and behaviours in general domestic life, impact upon women's perceptions, behaviours and choices in pregnancy; existing evidence relies upon reports from pregnant women themselves regarding the views and perceptions of their partners.

2.5. Aims of the study

In light of the above review of the current literature pertaining to very severely obese women's experiences and perceptions regarding pregnancy, specifically my research aims were:

1. To explore the experiences, attitudes and health-related behaviours of very severely obese pregnant women and to identify the factors and considerations which shape their beliefs, experiences and behaviours, and how these may change during and after pregnancy.

2. To gain an understanding of women's experiences of maternity health care and the impact, if any, of their interactions with maternity health care providers on their beliefs and practices in relation to very severe obesity and pregnancy.

3. To explore the beliefs and attitudes of partners/husbands of very severely obese women, and the impact, if any, upon the women's experiences, attitudes and health-related behaviours in relation to obesity and pregnancy.

I outline in the following chapter a report of the design, data collection and analysis of a serial interview study with eighteen participants: eleven women; seven partners and husbands of index women, designed to attend to these research objectives.

Chapter Three

Methodology

3.1. Introduction

In this chapter I discuss the methodological considerations pertinent to my research project. These stem directly from the research aims outlined at the end of the literature review chapter. I begin by outlining in more detail the background to my interest in the topic, moving on to describe the process of conceptualising the research questions and methods, and issues relevant to conducting qualitative interviews, before detailing the analysis and writing up process.

The process of designing and conducting my PhD research project has required the use of self-reflection and reflexivity throughout. I was meeting women (and their partners or husbands) and asking them to participate in research at a unique time in their lives: during pregnancy. This presented particular ethical and epistemological considerations, both in terms of my clinical background, in terms of individual participants' coupled relationships, and the relationships formed between me as a researcher and them as participants. The complexities inherent in these issues will be described within this chapter.

3.2. Qualitative Methods

This was a serial interview study, involving eleven pregnant women with a BMI >40kg/m^2 at the start of pregnancy. Initial interviews took place during pregnancy, and one follow up interview following the births of their babies. In addition, partners/husbands of seven of the pregnant participants took part in a single interview, during their partners' pregnancies.

3.2.1. Epistemological and ontological standpoints

I was interested in understanding and representing the 'lived experiences' of my research participants (Ritchie and Lewis, 2003, p.8), thus it was clear to me that qualitative methods were most suitable for my project. At the outset of choosing my methods, data collection,

and analysis, I was aware of the importance of fostering an understanding of the philosophical standpoints which underpin qualitative research, in order to best address my research questions.

Epistemology is a branch of philosophy which deals with the nature of knowledge and how it can be acquired (Ritchie, Lewis, Nicholls and Ormiston, 2013), and can help researchers choose a viewpoint from which to approach their work. In considering the relationship between myself and the research participants, I take an interpretivist standpoint. I was aware that they may be affected by the process of being studied, and by being asked to make an account of their weight and, by implication, themselves and their behaviours. In addition, I was aware that I could not produce a completely objective account, but must aim to achieve ‘empathic neutrality’ (Ritchie and Lewis, 2003, p.13) acknowledging that my research would not be value-free and I would therefore undertake to make my assumptions transparent.

Ontology is concerned with the nature of being; what there is to know about the world, with its central debate focussed on the nature of reality, and its construction. Whereas a realist standpoint recognises a tangible reality, relativism acknowledges that the world is perceived, and constructed by individuals who are influenced by language, history, and social and cultural factors (Swift and Tischler, 2010). My standpoint in considering the issue of maternal obesity in pregnancy recognises both the existence of an external reality, as well as the meanings that may be applied to this reality, which is socially constructed. This is consistent with a critical realist position (Ritchie and Lewis, 2003; Williams, 2003), which engages with various interpretive, social structural and biological debates (Monaghan, 2006). I consider that an engagement with scientific disciplines, such as biology, and an acknowledgement of *facts*, or *realities*, is necessary in order to undertake qualitative research. However, my interest was in embodied experiences, which are more complicated, can be fluid and can depend upon context, therefore an in-depth exploration of women’s accounts of their thoughts and experiences was necessary, in order to explore these complexities. My research draws upon phenomenology, which attempts to access these ‘lived experiences’ of participants, through their own words and narratives, focusing on the meaning that specific events hold for them (King and Horrocks, 2010). It is the meanings and

interpretations which individuals attach to events and circumstances within their lives which are explored via qualitative research, which acknowledges that these are informed by culture and circumstances, and can be fluid (Ritchie and Lewis, 2003). As such the qualitative paradigm acknowledges the existence of multiple realities, and embraces subjectivity and inductive reasoning (Cresswell, 2012). As a clinician, I have many times been struck by the subjective, socially constructed nature of reality with regard to pregnancy and health; that it is, to an extent, 'what people perceive it to be' (Kvale and Brinkman, 2009, p.26).

In-depth qualitative interviewing was the most appropriate method for generating data about this topic as this method helps to explain how and why culture is created, evolves and is maintained (Rubin and Rubin, 2005). This study was exploratory in nature, and as such I did not formulate and test hypotheses, but rather I planned to use the data to generate explanations about participants' views and experiences. The domain of the study was interpretive, because the focus of the interviews was on the participants' personal stories and lived experiences.

An emergent design was used, and data analysis began as interviews commenced. This allowed the research to progress iteratively, with initial findings informing further research questions and sampling. This process is outlined in more detail below.

This in turn led me to the issues which arose from acknowledging that the research process cannot be value-free, and that the researcher cannot be entirely neutral (Rubin and Rubin, 2005). This necessitated a consideration of my role as a researcher and my background as a midwife and what this would mean in terms of my presence in the research, and my role in creating the data. A summary of the process of reflection, which occurred throughout the planning and execution of my study, is presented throughout this chapter.

3.3. Ethical Issues

Ethical approval was sought and gained from Edinburgh Napier University Research Integrity Committee, NHS Lothian Research & Development Office and NHS Research Ethics Committee North West (REC reference number 14/NW/1413: approval granted

18/12/2014).The applications for ethical approval to these bodies helped me to formalise and address several ethical issues which arose during the planning of my study. These included obtaining informed consent, handling sensitive topics, minimising participant distress, interviewing individual members of couples, and maintaining confidentiality, and are outlined in detail below.

For all participants, I was mindful of the time burden imposed by agreeing to take part in a series of qualitative interviews. In addition, in view of the sensitive and stigmatising nature of the subject matter, I was concerned regarding the potential for participants to become emotionally distressed during interviews, or for the interview process itself to lead to anxiety about their pregnancies or health more generally.

In addressing these issues, I arranged interviews at times and venues most convenient to them, always stressing that I would be happy to re-arrange an interview time, even at very short notice (in fact this did happen several times, in particular once participants had given birth). I made it clear at the outset of each interview that we could take a break or conclude the interview at any point, should the participant wish to do so. In addition, I offered participants the opportunity to debrief following interviews, and was prepared to offer to arrange for a counsellor to undertake this, if appropriate. In the event, however, no participants stopped an interview or sought de-briefing beyond a short discussion. Although some participants were at times mildly distressed during interviews (somewhat tearful at times, for example), they commented during de-briefing that they found talking during interviews helpful. I discuss this issue further later in this chapter.

I gave careful consideration to the management of those issues which may require a referral to other agencies, for example a disclosure of domestic abuse or discussion of clinical complications. I planned to discuss any issues of concern with my supervision team and to contact other agencies if necessary. In addition, I carried a list of key telephone numbers (local obstetric triage, domestic abuse support services) to give to women in appropriate circumstances. In the event, I did not need to use these.

3.3.1. Interviewing couples

The focus of my study was pregnant women, their experiences of childbearing and understandings of health and risk. As I planned for my study to explore their social and cultural circumstances, I anticipated that the inclusion of significant individuals from their social and familial worlds might enhance my understanding of their circumstances. Initially, I requested index women to nominate individuals from their social and family lives, not specifying partners or husbands. This resulted in the nomination and participation of seven husbands/partners (all male) and three female friends. As I embarked upon interviewing partners, I noted early on during data collection that the data concerning the experiences and beliefs of each male partner concurred closely with those of their pregnant partner with regard to accounting for weight, and lay beliefs regarding food and embodied experiences of pregnancy. These closely concurring views, and collaborative resistances of risks and stigma form a key aspect of the novel findings of my study.

In addition, the data generated from interviews with pregnant participants' nominated friends was rich and interesting. However, as only three friends were nominated, and this small number could not have been foreseen at the conception of the study, I judged that analysis would be difficult with this small dataset. This led to my decision to exclude these data from the analysis. It is intended, however, that the interesting data from this small sample of friends might form a sample for a pre-pilot for future research in this area.

In my approach to interviews, I considered the merits and drawbacks of interviewing couples separately and individually. However, I wanted to give individuals the freedom to express their own views, mindful that weight can be a highly sensitive topic, and I was conscious that issues concerning weight, health and pregnancy have the potential to be contentious within couples. Valentine (1999) argues that the disagreements and correcting that can occur within couples' interviews can be valuable in terms of facilitating explorations of moral positioning and negotiation. However, as I knew nothing of the dynamics within couples, and my research focus was primarily on women, and included sensitive topics such as weight and pregnancy, I decided that separate interviews would be most appropriate. I wanted interviews to focus on the views and perceptions of each participant individually, for

them to feel they could speak freely, unchallenged and uninterrupted, and planned to consider and compare accounts within and between couples during the analysis process. I was mindful of the potential for the process of participation in the study causing difficulties or disputes within couples. To this end I did not make any attempt to ask pregnant participants to pass on study information to a partner if they initially expressed doubts about this (as Carrie did). I treated all discussion within the interview setting with absolute confidentiality (Forbat and Henderson, 2003), never referring to any comment made by one participant in discussion with a partner, in order to avoid causing confusion or upset. On occasion this was difficult, as in the context of serial interviewing it was sometimes hard to recall which member of a couple had disclosed certain information, particularly if it had appeared trivial or mundane at the time. However, I carefully re-read relevant interview transcripts before subsequent interviews in order to bring that prior knowledge to the fore, so that I could avoid inadvertent disclosure. In addition, in reporting my findings I have been careful not to include information which I judged had the potential to cause distress to any participant or partner.

In addition, I considered my approach to what have been described as “hot” topics (Forbat and Henderson, 2003, p.1459), meaning an issue which is identified as of importance and one which might be important within the relationship. I pursued a deliberate avoidance of raising these topics, for example any specific subject which caused conflict within the relationship, leaving it to the individual, who I judged would raise the matter themselves if they indeed considered it to be of importance to them (or indeed wished to discuss it). As such, I hope I avoided making assumptions regarding participants’ perceptions and beliefs, allowing them more freedom to shape the data.

3.4 Sampling and recruitment

3.4.1 Sampling

I hoped to recruit a study sample which would reflect the diversity of women within the population who normally attend the specialist clinic, with respect to social background, age and ethnicity. However, due to the number of eligible women and, of those, the small number who agreed to participate early on in the recruitment phase, and in view of the limited study timeframe, I took a decision to approach all eligible women, using a

convenience sampling approach. However, this included taking account of demographic characteristics during the early recruitment stages, and a plan to consider purposive sampling if the sample was populated by an over-representation of women from a particular group. In the event, the sample of eleven women provided a range of demographic characteristics which did broadly represent the general child bearing population in the region, with the exception of age (I present a brief description of participants at the end of this chapter). The youngest pregnant participant in the study was 26 years old, which meant I was unable to explore the experiences and perceptions of younger pregnant women who have a BMI >40kg/m^2. In addition, the women who participated were of higher SES than expected, in view of the social gradient associated with maternal obesity. Women opt to attend the high-risk hospital-based clinic, and it may be that younger women and women of lower SES are less likely to attend, through choice or restricted access due to financial or personal constraints. I discuss this further in section 7.9.

3.4.1.(a) BMI >40kg/m^2

Several inter-related factors informed my decision to include only women with a BMI of 40kg/m^2 or greater. First, although I acknowledge that there exists evidence regarding the multiple risks associated with maternal obesity (Poston et al., 2016), there remains a lack of evidence regarding many important aspects regarding these risks, including regarding at what weight/BMI such risks begin to increase. Thus, the use of the BMI remains controversial, particularly in pregnancy. I, thus, judged that, by sampling women with a BMI >40kg/m^2, I would be including women whose weight is acknowledged even by those who urge caution regarding discourses around obesity and risk, as at an '[extreme] of weight where health risks may be amplified' (Campos, 2004; Monaghan, 2006, p.131) Perceptions and understandings of risk was a theme identified within the literature review, and it is well established that such risks increase incrementally (CMACE/RCOG 2010); at a BMI of greater than 40kg/m^2 there is good evidence of multiple increased risks (Poston et al., 2016), and this is reflected in CMACE/RCOG guidance (2010). I wished to explore the experience of being labelled 'at risk' in this context, which resulted in a referral for high-risk care.

As stigma was a key theme identified within my literature review, I felt it was important to explore the perceptions and experiences of this group of women specifically, as this has

been under-explored in the literature to date, which has focussed largely on 'obesity' in pregnancy, without differentiation between the experiences of women within different BMI groupings. At a BMI of 40kg/m^2 or more, adipose tissue will be considerably more visible than at a lower 'obese' BMI. In addition, many more women within the UK population have a BMI of 30kg/m^2 than they do of 40kg/m^2 for example, where there may also be a normalising effect due to the increased prevalence of obesity within the population. The experience of stigma may therefore be somewhat different, but in addition, specifically the clinical categorisation of 'very severely obese' may impact upon these women's experiences in particular ways, which I wanted to explore.

Related to this, I considered that approaching women with a BMI lower than 40kg/m^2 to participate in research about increased weight during pregnancy may risk causing offence, or psychological harm to women who may not perceive themselves to be 'obese'. There is of course a risk that, regardless of her weight or size, a woman might not consider herself to be 'obese'; however, as the women I approached had already been offered, and had accepted, a referral to a specialist high-risk clinic as a result of their weight, I judged it was less likely to cause offence in this context to ask if she would consider taking part in research into increased weight in pregnancy. CMACE/RCOG (2010) guidelines state that women with a BMI >35kg/m^2 should be offered a specialist medical review in pregnancy. However, women with a BMI >40kg/m^2 fulfil the referral criteria for the clinic from which my sample was recruited, a specialist antenatal clinic which provides high-risk antenatal care, based within a large university teaching hospital. Due to ease of access, participants were recruited via this specialist clinic. Approximately 50% of eligible women attend the specialist clinic, while those who are not referred, or who decline referral, attend for antenatal care at community clinics at multiple sites within a wide geographical area. It was originally intended that women would be accessed to participate at these multiple locations also, in order to make comparisons between women's understandings, beliefs and experiences. However, it proved too difficult to identify women via electronic records within a realistic timeframe in order to approach them, and too time-consuming to attend clinics at multiple geographical locations, in order to recruit sufficient women, thus all participants were recruited via a specialist clinic antenatal clinic based at a large university teaching hospital. This is discussed further in section 7.9.

I selected a convenience sample of women, in that participants were chosen on the basis of features particular to them, which would help to address my research aims (Mason, 2002). All pregnant women with a BMI calculated at the start of pregnancy as greater than 40kg/m^2, who met the further eligibility criteria and who attended the high-risk clinic, were approached to participate in the study. I was aware that my sample would be relatively small and wanted to ensure it would reflect the range of women who attended this clinic, with regard to age, ethnicity, parity and SES. Thus I was aware of the potential need to manipulate the data generation and analysis and sampling activities interactively during the research process in order to achieve this.

3.4.1.(b) Further inclusion criteria: women and partners

Further inclusion criteria for pregnant women and their partners or husbands were: aged at least 18 years, and able to speak English (study funding did not extend to cover the costs of use of interpreting services). It is important to acknowledge that this latter criterion had the potential to impact upon the scope of the study to adequately explore social and cultural issues. However, the regional population from which the sample was drawn is predominantly white Scottish and, during recruitment, no women were excluded on the grounds that they did not speak or understand English.

My research questions focussed on women's and partner's individual and lived experiences, therefore I believed it was important to conduct serial interviews, during pregnancy and following birth, rather than only during the postnatal period for example, to capture participants' feelings and experiences 'in the moment' rather than relying on recall.

3.4.2. Recruitment of pregnant women

I approached and spoke face-to-face to all women who were eligible, offering them a participant information sheet (see Appendix II) to take home with them. This took place in a private area within the clinic. In this way, fifty-three women were provided with a recruitment pack about the study.

I felt it was important during visits to the clinics that I distanced myself from clinical staff. I made it clear to every woman I spoke to that I was not affiliated to the clinic, and that my study contained no element of audit or health service research, that findings would not be fed back directly to clinical staff, and that they would not be identifiable from information contained within my PhD thesis or any related published work. In addition, although I knew several members of staff there, and it was customary for staff to congregate in corridors between seeing patients to chat informally, I was careful not to join them in this, as I might be witnessed in doing so by potential participants.

Of the fifty-three women I spoke to, fifty-two accepted a study information pack. I contacted women via telephone once they had had at least 24 hours to consider the information they have been given. During the phone call, they were given the opportunity to ask questions. 14 women responded to a follow-up telephone call and 12 women agreed to participate in the study. However, one woman had a miscarriage prior to her interview taking place. Therefore, 11 women took part in an initial antenatal interview. Twenty-eight women did not respond to follow-up telephone calls, and the two who declined on the telephone cited time constraints as a reason for declining to participate.

When a woman indicated she was willing to take part in the study, an arrangement was made for a time and a venue for the first interview, which could be in their own homes, or another location of their choice, or in a private room at the university. Formal consent was obtained immediately prior to the first interview taking place (see Appendix III).

3.4.3 Recruitment of husbands and partners

Following initial interviews, each index woman was asked to nominate an important person, or people from her family or social network to be approached to take part in an interview. It was anticipated when designing the original study protocol that this would result in a range of individuals being nominated, whom the index woman considered played a significant role in her day-to-day life, with regard to food and eating, daily activities, routines, commitments etc. However, of the eleven women, eight nominated a husband or co-habiting partner and seven of these took part in the study. Of the remaining three women, two did not have a partner and one did not live in the same part of the UK as her partner and did not wish to

approach him to participate. These women remained in the study, therefore eleven women and seven men took part.

Index women who had nominated a partner or husband were asked to provide him/her with information about the study (see Appendix III) and to ask if they would be willing to be contacted by me to discuss taking part in an interview. I then contacted the index woman after 72 hours (or longer if necessary), to ask if they had given permission to be contacted and, if so, to obtain their contact details. I then telephoned the individual to discuss the study and make arrangements for an interview if they wished to participate. Formal consent was obtained in person immediately prior to the interview taking place (see Appendix V).

Seven of a potential nine husbands/partners participated in the study. Although a small sample, it was reasonably diverse in terms of social class and ethnicity. However, the youngest male participant was twenty eight years old (the youngest woman was twenty six), therefore the study sample lacks representation from younger women and/or couples.
I stopped recruitment following interviews with eleven women and seven partners/husbands, as I had by then collected enough data to address my research questions, no new themes or categories of data were continuing to emerge, therefore saturation had been reached (Glaser and Strauss, 1967).

3.4.4. Gratuity

Following a discussion with my research supervisors, it was decided that pregnant women would be offered a £10 gift voucher following their first and final interviews (£20 value in total) and that partners would receive a £10 gift voucher following their individual interview.

3.4.5 Duration of recruitment and interviewing

Recruitment to the study began in March 2015 and interviewing began the following week. The final interview took place in February 2016. In total, I conducted 32 interviews with women and partners.

3.5. Disclosure of professional status

In this section, I summarise the process of reflection which I undertook when considering whether or not to disclose my background as a midwife to the research participants.

3.5.1. Disclosure or non-disclosure?

In undertaking this piece of research, it was necessary for me to consider whether disclosing that I am a midwife in the research setting might lead to me being perceived as *part of the problem* by respondents. My initial interest in the issues surrounding maternal obesity developed from working with this group of women in a clinical setting. All participants attended a high-risk clinic due to their weight, acknowledging on one level that they were 'at risk' and weight was a 'problem'. My review of the literature demonstrated that obesity in pregnancy is a source of stigma within healthcare settings. Despite my belief that the specialist clinic provided an environment where women received excellent clinical care, I perceived that still much was *unsaid*, by health professionals, pregnant women, and family members or friends who accompanied them to clinic visits. This, I reflected, on appraising the literature and reflecting on my interactions with patients, was due, at least in part, to the stigma of obesity, in addition to the inherent power dynamic present within interactions between patients and health professionals. My literature review established that weight prejudice exists among health professionals, and I had witnessed it myself. I reflected upon the powerless position of very severely obese women within the high-risk clinical setting.
I wished to know what was *unsaid* by these women within the clinical setting, what they talked about in the car or on the bus on the way home; what they read about later on the internet; how they felt, what they believed, and about the behaviours they enacted. I wanted to represent their views, in order to contribute to efforts to improve the care that is available to them. As I demonstrated in the previous chapter, weight stigma is complex in how it is interpreted and perceived, and many obese women anticipate, experience or perceive negative treatment from health professionals. Disclosing my background would risk being identified as primarily *a midwife*, and therefore associated with negative experiences and perceptions, which would in turn shape the data I collected through the accounts participants gave of themselves.

In addition to this, disclosing that I was a midwife may have led to an entirely different focus to the interview. I wished to explore those experiences women had away from maternity care, within their everyday lives. Knowledge that I was a midwife may have led to a clinical focus, perhaps even questions about my opinions about their care. I wished to avoid these influences upon the interview process.

In considering this and in discussion with my research supervisors, one advised me, 'You are not a midwife, not in this context'. I reflected upon this, and the ways in which researchers may emphasise aspects of their personalities or backgrounds during interactions with research subjects, in order to minimise 'social distance' (Oakley, 1981a, p.55), Mindful that people may provide 'public' or 'private' accounts of themselves, depending on who they are talking to (Cornwell, 1984), I judged that, in the context of stigma and risk, women may feel more comfortable revealing their 'private' selves to a social science researcher than to a midwife, as the latter is associated with the medical gaze more broadly, and they may perceive judgements upon their pregnant bodies. Thus, although I was less experienced and less comfortable in the role of a researcher, this was how I initially decided to present myself to participants.

However, as Oakley (1981b, p.41) observes, 'in most cases, the goal of finding out about people through interviewing is best achieved when the relationship of interviewer and interviewee is non-hierarchical and when the interviewer is prepared to invest his or her own personal identity in the relationship'. I related to this, but experienced it as paradoxical; my personal identity is strongly connected to my professional identity as a midwife (Hunter and Warren, 2014), but to reveal this may have imposed a hierarchical dynamic upon the interaction.

Starks and Brown-Trinidad (2007, p.1376) note that the researcher 'must be honest and vigilant about her own perspective, pre-existing thoughts and beliefs, and developing hypotheses . . . engage in the self-reflective process of ''bracketing'', whereby they recognize and set aside (but do not abandon) their a priori knowledge and assumptions, with the analytic goal of attending to the participants' accounts with an open mind'. I reflected upon what my background as a midwife would mean in terms of my role within

the interview interactions, how to guard against *thinking like a midwife*. Vigilance in bracketing, as far as possible, my clinical knowledge and experience – or at least being aware of when my thoughts and reactions were the result of clinical knowledge and experience - was essential within these interactions, as I wished to access participants' understanding and interpretation of events rather than make a judgement upon their understanding of clinical categories or definitions, or upon a clinical scenario that was described to me, for example.

However, I also considered the advantages my background provided, and how this might enrich the collection and analysis of data, as my knowledge could inform pertinent questioning and probing during interviews, for example. In practice, this meant a delicate balancing and careful phrasing at times, in order to not 'blow my cover'. However, I am also a mother, and have experienced NHS pregnancy care as a patient, and was open about this when asked, and I judged that women may attribute any clinical knowledge I did articulate to my own experiences of pregnancy and childbirth.

3.5.1(a). Pilot interviews: confirming my decision

During initial interviews, I piloted my decision to not disclose my background as a midwife. The respondent in my very first interview, Eva, was upset several times during her narrative. When we talked about the advice she had received from health professionals, she became tearful:

> *Eva: "You know, and I understand it's like, you know, they're just doing it because they're trying to help and… but you're like, well, what's the point in telling me… that 'you're pregnant, so you can't diet… but you're fat, so you're just kinda like…[tearful, whispering]… really bad', you know what I mean? And they tell you like, 'Well, you're pregnant, so you shouldn't try to lose weight, but you shouldn't be this fat'. You're like, well what's the point in telling me that when I'm already pregnant? Like, I can't do anything about it, so you're making a person feel - you know what I mean? - bad about something they've already got an issue with."*
>
> [Eva 28, 3rd baby, 1st interview, gestation 18+2]

When I interviewed Eva's husband Eric a few days later and we also discussed health professionals, he expressed anger and frustration on behalf of his wife:

Eric: "She just feels like they're just… judging her, you know like, 'Look at the state of you', you know? Or… you know, that type of stuff. It's never anything helpful, is it? [whispers] 'You must lose weight…' You know? How do you lose weight when you're pregnant? It's not gonna happen is it? No-one ever went on a diet when they were pregnant. It's the most ridiculous thing I've ever heard of. I mean, after the baby, fair enough. But I mean… during the birth? Do you want to put the baby at risk? No. So yeah. It's ridiculous [laughs]. People generally tend to gain weight during pregnancy, I mean… why would you want to lose it? Nah, I don't agree wi' it. So they can…" [laughs]
Alice: "You can say what you like!"
Eric: "I tried not to swear, but I was saying they can shove it, you know? Their stupid advice."

[Eric 30, Eva's husband, gestation 18+6]

As I stated earlier in this chapter, my motivation in conducting this research was to explore the views of women who I believe are at risk, but who may additionally be powerless and stigmatised within the health care system. The anger and disengagement expressed by both Eva and Eric separately during pilot interviews strengthened my commitment to withhold my clinical background from participants. It became clear during their interviews that they had not expressed these views during clinical consultations, demonstrating their lack of power within that context. I hoped that my study might contribute to giving voice to individuals who felt stigmatised, judged and unable to express these perceptions and experiences elsewhere. My decisions and the representation I made of myself within interviews were ethically and practically challenging, but ultimately were undertaken in order to best achieve this. Thus, I felt that withholding my identity as a midwife was justifiable. However, I would not have lied outright, had any participants asked me directly if I had a background in health care, although in the event none did.

3.6. Data collection

Data were collected in a series of in-depth interviews with the women and in one interview with their nominated partners. Initially it was intended that women would be interviewed three times: initially between 14 and 24 weeks of pregnancy; after 34 weeks of pregnancy; a third time 4-8 weeks following the birth of their baby. Checks on the well-being of the index woman and/or the outcome of the pregnancy were undertaken via accessing electronic maternity record, between each interview with each woman, and between interviews with

her and her nominated partner or husband. It was intended that all women would be contacted, even in the event of an adverse outcome, to provide them with the opportunity to decide if they wish to continue to participate in the study. No adverse events or outcomes were identified via this method, however, one participant did contact me via text message after giving birth to inform me that her baby had been diagnosed with Downs Syndrome, and that she wanted to continue to participate in the study.

I asked participants to choose a venue for their interview, offering a private room at Edinburgh Napier University as one option. However, all interviews took place in participants' own homes, with the exception Amy's interview, which took place at Edinburgh Napier University in a private room, at her request, and Graham's interview, which took place in a meeting room at his business premises.

3.6.1. A qualitative serial interview approach

In order to capture any changes which may occur, in terms of positioning, beliefs, practices and experiences, during pregnancy and following childbirth, I judged that serial interviews was the most appropriate for my study aims. I wished to observe or interpret developments as they occurred, as change can best be understood contemporaneously rather than retrospectively (Mason, 2002). I wished to prospectively follow women through their pregnancy and birth experiences, to capture perceptions and beliefs as close as possible to the event, capturing how women's positioning, beliefs and practices changed or did not change over time, and in response to interactions with health professionals and influences from their everyday lives.

Thomson and Holland (2003) theorise that, although a longitudinal approach cannot be claimed to offer the *truth* about an individual, it does allow for a better understanding of them. Similarly, Saldaña (2003) states that the longer a researcher engages with a person, the more likely they are to become knowledgeable about matters personal to them. I do not consider my study to be *long* enough to be 'longitudinal', in particular as the majority of pregnant participants were interviewed only twice. I nevertheless hoped that, through an engagement with women through pregnancy and afterwards, meeting them on more than one occasion, I might establish rapport, trust, and thus the opportunity to gain a better,

more nuanced understanding of their socio-cultural circumstances, specifically in considering how formal health advice might be related to, and applied, in day-to-day life. Some women were open, or even keen, to talk about their weight from early on during initial interviews; with others it took longer, with initial waiting, and subsequently more prompting from me. Some were clearly more upset by discussing the issue than others. To highlight this, I present below two contrasting interview exchanges. First, during my pilot interview with Eva, we discussed her family history in depth, and she mentioned her weight briefly at points. However, it took more than 30 minutes before the subject of her weight was discussed in depth, when I asked a direct question:

> Alice: Could we go back and talk about… could you tell me the history of your weight?
> *Eva*: [*looks upset*]
> Alice: If it's difficult, we can talk another time… Or not talk about it.
> *Eva: [laughs] It's alright.*
> Alice: If you want to, can you tell me the story or your weight? The history?
> *Eva: Mm-hm. Umm… let's see… I started my period when I was like... thirteen, fourteen... and it was like… like when I was a kid I was like... tiny. I was a tiny wee kid. And then I started my period and, you know, you start getting boobs and a butt and then everything else just kept going... ha!.. basically… [crying] like, you know what I mean? Like, even when I was doing… in high school I was doing track or whatever, like... and I still kinda had like a… well everybody likes the term 'a black girl butt', which I think is very racist, but that's what they call it. A 'bubble butt'".*
>
> [Eva 28, 3rd baby, 1st interview, gestation 18+2]

This experience during a pilot interview, prompted me to question my approach to the issue of women's weight. Was is ethical to ask women so directly about their weight, a topic that was sensitive and potentially distressing, as it so clearly was for Eva?

Shortly afterwards, I interviewed Martha, who was chatty, friendly, joked often, usually in a self-deprecatory way. I present here the opening to her interview, which began very soon after my arrival at her home, after she had made me a cup of tea, and told me she had been nervous prior to my arrival:

> Alice: So I've put the tape on now…
> *Martha: "That's fine."*
> Alice: And thank you for the tea…. So you said you were nervous?

Martha: "Yeah….. [pause] Do you know what? Certainly with the weight issue, there's always a… kind of… idea that people have preconceptions…"
Alice: Mm-hmm..?
Martha: "... and quite negative ones. And I've lost weight in the past and put it all back on again... so I feel a bit… embarrassed almost… for being like this, when I know… what to do not to be like this, if that makes sense?"
Alice: Yes
Martha: "So that's… part of why I was nervous…"
Alice: Yeah…
Martha: "Cos I do get a bit… Nobody wants to talk about being… Cos I do kinda make light of it a lot.. about being forty, fat and diabetic and that's the thing… and all the rest of it, so… Yeah, if I'm kinda getting in there first, I'm kinda putting the armour up a bit…"
Alice: Mm-hm?
Martha: "...but now I'm having to be honest and… it's quite vulnerable in a way. If that makes sense?"
Alice: Yeah. It does. And thank you very much for… since you've explained that, thank you very much for agreeing to talk to me anyway.
Martha: "I think it is important."
Alice: Yeah, I think it's important. That's why I'm doing it. Why do you think it's important?
Martha: [sighs] "Obesity is such an issue nowadays, and you see… obviously, I see it a lot… errmm… and I'm aware of it, very much so… and I think that people need to know more about… our story rather than making assumptions, so that's pretty much why I thought I'd do it."
Alice: Great, you want to tell me your story then?
Martha: [laughs]

[Martha 41, 1st baby, 1st interview, gestation 15+5]

In their respective interviews, both women began talking about their weight by discussing the misery and stigma they had experienced due to their size. Their different reactions and level of willingness to talk brought home to me the importance of maintaining a flexible approach, using the utmost sensitivity in discussing these matters. As Ribbens notes (1989, p.586), a research interview is not intended to be a counselling or therapeutic intervention, due to the nature of its structure, 'listen[ing] empathetically and creating rapport, the researcher intentionally invites emotional engagement', implying reciprocity. Thus, the potential existed for participants in my study to experience positively the opportunity to speak about their experiences and perceptions, my interest and close attention to what they said demonstrating the value I placed upon them (Rubin and Rubin, 2005). Eva and Martha both participated in three interviews in total, and I interpreted their continuation in

the study as indicative of their experiencing positively the interview process. I believe that, for them and others, interviews might have been experienced as somewhat therapeutic. Mindful of obesity as a stigmatising and sensitive issue, I continued to approach each interview with flexibility from its outset. For example, I opened each one willing to talk about any topic the participant felt comfortable with, beginning most interviews with broad questions about each woman's background, domestic and personal circumstances, moving on flexibly to talk about pregnancy and weight only when I judged a rapport had been established. I used broad topic guides (see Appendices IV & V) which I had developed following my initial review of the literature, and also tentatively drew on my own experiences of working with women with a raised BMI. I took care to ensure that questions were appropriately but flexibly framed, and were designed to explore and gather data on women's everyday lives, lifestyles, views, experiences and behaviours. More specific questions then focussed on weight history and general health, diet and eating, and pregnancy, as well as support and advice they have received and from whom. As such, I combined both structured and unstructured approaches while introducing topics ("Can you tell me about your pregnancy?") and asking more specific questions ("What did you and the midwife/doctor talk about?") Follow-up interviews took place later in pregnancy, and were intended to explore whether participants' views had changed during pregnancy. After four follow-up interviews however, and after beginning initial analysis of the data, I judged that these interviews had not produced sufficient new and rich data, as compared with first interviews. I discussed this with my supervisory team and decided not to proceed with follow-up interviews during pregnancy, reducing the number of interviews from three to two with the remaining participants, one during pregnancy and one following birth (see tables 2 and 3 below for numbers of interviews and gestation/age of babies at the time of individual interviews).

The third interviews included questions designed to explore the women's experiences in pregnancy, of the births of their babies and their views on the maternity care they received. In addition, questions were framed to explore any process of change that had occurred during pregnancy, how they positioned themselves and constructed their experiences. Finally, further questions explored their views and plans for the future.

During interviews with partners, I included general questions about their lives and their lives together and their coupled relationships, exploring domestic arrangements, social and cultural beliefs and practices. Specifically, questions were then used to explore participants' views and perceptions about health, body weight, diet and exercise, as well as their perceptions regarding pregnancy and health behaviours.

Interviews were digitally audio-recorded with consent and transcribed in full. All digital voice recordings were stored on my password protected computer, to ensure personal information was in no way compromised. Identifiable information was removed or anonymised within transcripts.

Name	Age at start of study	Parity at start of study	Gestation at interview 1	Gestation at interview 2	Age of baby at interview 3
Eva	28	2	18+2	35+4	4 weeks
Mary	38	0	16+0	34+4	5 weeks
Rachel	38	1	19+6	36+1	5 weeks
Martha	41	0	15+5	35+0	4 weeks
Anne	32	0	17+1	-	4 weeks
Carrie	38	0	18+5	-	6 weeks
Rebecca	46	1	21+4	-	4 weeks
Ruth	27	0	22+6	-	7 weeks
Babs	27	1	24+2	-	4 weeks
Amy	26	0	16+3	-	-
Louise	32	0	23+5	-	5 weeks

Table 2: pregnant participants' gestation/age of baby at time of interviews

Name	Age	Gestation of partner's pregnancy at time of interview
Eric	30	18+6
Adrian	28	17+6
Ben	40	23+0
Ian	32	18+0
Graham	32	25+2
Jim Bob	30	25+4
Vincent	32	24+1

Table 3: gestation of pregnancy at time of partner interviews

3.6.2. Withdrawal from the study

Participants were informed via the participant information sheet, and were reminded immediately prior to each interview, that participation was voluntary at all times and they

were not obliged to answer any questions they did not wish to, and could withdraw from the study at any point, and that they did not need to give a reason for this. Permission was gained to use previous interview data should a participant wish to withdraw from the study. One participant, Amy, did withdraw from the study as I was unable to contact her following her initial interview.

3.6.3. Confidentiality, data handling and storage

Each participant was assured that their identities would be kept confidential. Participants chose their own pseudonyms, and identifiable information such as work places, memorable events, names of other family members or friends were changed. Confidentiality was ensured by storing participants' personal data in a separate location (using an encrypted file) to interview transcript data. Interview transcripts did not contain any identifiable information. Files were identified using pseudonyms. All electronic files were stored on my password protected computer.

3.7 Data analysis

I conducted a thematic analysis of my interview data, using the methodological framework outlined by Braun and Clark (2006), designed for use within and beyond qualitative psychology research. These authors argue that thematic analysis offers a theoretically flexible and useful research tool, which can potentially provide a rich, detailed, and complex account of data, providing a six-phase tool to doing thematic analysis which I found was invaluable in guiding me through my analysis. Their approach appealed to me in addition due their acknowledgement of the active role the researcher plays in creating the data, as compared to other authors, who have offered more passive descriptions of themes emerging from the data (Rubin and Rubin, 2005). I wished to remain aware of the significance that my background and experience represented in shaping the data throughout the research process. The steps of analysis are outlined below.

3.7.1. The process of analysis

The process of analysis began during the interviews themselves. I asked each participant for their permission to make notes while they spoke, and intended to take notes regarding

points I wished to return to later, in order not to interrupt an individual narrative. However, I found from very early on that, during interviews, I made a very small number of notes. I felt it was important to give participants my full attention, making appropriate eye contact, indicating my attention with my body language and gestures (Rubin and Rubin, 2005), in particular as they were often discussing deeply personal matters. Immediately following interviews, back in my car, I made notes about observations I had made during interviews, about the respondents body language or demeanour for example. I also made notes about small events that had occurred during the visits that might evoke a strong sense of memory of the interview later. These took the form of written notes, and also of verbal memos, recorded on a digital voice recorder. These were then transcribed later, and recordings were deleted. Initially, I listened to the interview recording as soon as possible following the interview; on several occasions the first listening was on the drive home, as most participants lived a considerable distance from my home. I listened to recordings at least twice, making notes once at home, prior to beginning transcription.

Each interview was transcribed as quickly as possible, usually within 72 hours. Twenty-four interviews were transcribed by me and eight by a professional transcription service (the use of professionals services was due to me sustaining an injury during data collection and transcription and being unable to touch type for several weeks). I listened to and read through each transcript that was professionally transcribed, to check each transcript and make small edits. Following transcription, I made notes on reading through each transcript, composing a precis of each interview, making general observations, without attempting to formally group these into themes.

After all of the interviews had been transcribed, I transferred transcripts and field notes to NVivo 10 software for ease of access and use. I had not previously used NVivo, but had attended training sessions delivered at the University of Edinburgh. I was familiar with the data at the point of transfer into NVivo, and I was uncertain at this stage as to the role the software would play in my analysis. In the event, I adopted a ‘piecemeal’ approach to its use, and found it facilitated cross-sectional analysis of the dataset. However, I used it alongside a colour coding manual method, with written pencil notes, using multiple copies of interview transcripts, in addition to using Windows 10 tools to copy and paste extracts

between Word documents. In this way I developed a coding frame gradually as initial codes were identified.

In searching for themes at this stage (Braun and Clarke, 2006), I spent some considerable time at the descriptive level, considering what might be themes and sub-themes between the accounts of individual women, between the accounts of male partners, and within and between couple relationships. I recognised that, at this stage, the process might be 'messy' and tried not to rush the process of conceptualising broader analytical themes and sub-themes. It was at this stage that stigma emerged as a key theme, as it was during re-readings and cross-readings between participants and across couples, that it became clear that stigma had informed their beliefs, relationships and experiences with others.
I cross-compared interview transcripts for initial identification of themes, and referred back to my research questions frequently for guidance. I felt it was important, in order to do justice to the data, that I became very familiar with it, using a 'sequential analysis' approach (Ritchie and Lewis, 2003). As I have noted, this process took place concurrently with continuing data collection and this allowed for initial themes to inform further interviews and amendments to the topic guide.

As I have noted above, I used a serial interview approach in order to capture any change which might have occurred during pregnancy and following childbirth. I thus compared data from earlier and later interviews, comparing subsets of data from pregnancy and postnatal accounts. Analysis took place in two directions: cross-sectionally (synchronically) and longitudinally (diachronically) (McLeod and Thomson, 2009; Neale and Hanna, 2012). Diachronic analysis was undertaken by making notes immediately following initial interviews, to encompass my thoughts and reflections on the participant's demeanour, body language, events which may have occurred during the interview itself. This was compiled into a case profile for each participant once I had listened to the interview and transcribed it. Earlier interviews with each woman were reviewed prior to follow-up interviews, notes were made, and the topic guide tailored accordingly, to identify previously identified 'hot topics' (Forbat and Henderson, 2003, p.1459); particular experiences or perceptions, which I might return to for clarification or probing in a subsequent interview. Case profiles were

updated after each successive interview. Thus, I was able to examine each case through time, considering continuity and change.

I examined the narratives of each woman and her partner both separately and together, exploring the ways in which they told similar stories, their views in common as well as differences and tensions, and the ways in which they might be conflicting, or complementary, in their accounts of health behaviours and beliefs. From my initial interviews and early analysis, I was struck by the extent to which most couples provided concurring accounts of their beliefs about both pregnancy behaviours and health, and regarding their plans for future health and lifestyle changes. Indeed this was the case both within and between couples. This seems to me one of the most interesting and the novel aspects of my study. To reflect this, I have structured the findings chapters to focus on the women's pregnancies as experienced in their social worlds, embedded within their everyday lives and these personal relationships. In so doing, I have not excluded for convenience any aspect of accounts which did not fit readily with my coding frame, but have attempted to explore differences and nuances within these broadly concurring accounts.

I then reviewed the themes (Braun and Clarke, 2006), attempting to explore the discourses and beliefs that participants had drawn upon to construct their ideas regarding concepts of health, experiences of pregnancy and key relationships, in order to define themes at a more analytical level. I aimed to build upon themes identified at the descriptive level, exploring them from different angles, collapsing some themes together, re-defining others. In this way, by comparing accounts of individual women through two or three interviews, and by comparing the accounts of different women and different couples, I was able to build upon descriptive themes and develop an understanding of their accounts and experiences. Gradually, in this way, new themes were defined, specifically regarding couples' shared views about dieting behaviours and pregnancy, eating and health, shared stigma and the experience of pregnancy as high risk, in addition to the moral work undertaken by women and also their partners, in relation to being a 'fit' parent.

Finally, I considered how to present my data most coherently and concisely, and in an interesting way (Braun and Clarke, 2006). I believe that my participants have generated data

which is fascinating, rich and informative. Most challenging was providing the analytic narrative, in order to tell the story of my participants, make an argument about the accounts they gave, and fully address the research questions. I initially drafted reports (early chapter drafts) which focussed on major themes. This process was useful in aiding my thought processes regarding themes and their connectedness. However, returning to consider the longitudinal design of the study, and the patterns of commonality and diversity which were identified within the data, I favoured a chronological approach to presenting the data, focussing on participants recall of experiences prior to pregnancy, capturing change (if any) during pregnancy and their thoughts about the future (including those of partners), and their beliefs and perceptions following childbirth, during early parenthood. Chapters are therefore structured to reflect this.

3.8. Chapter Summary

In this chapter, I have outlined the philosophical and theoretical approaches which informed my data collection and analysis. Throughout the process, attention to my research questions has guided my use of qualitative methodology, from my research questions to the methods used for data collection and analysis.

I have outlined the convenience sampling and recruitment strategies used within the study to select and recruit pregnant participants and several of their partners. I have summarised the ethical considerations pertinent to undertaking this research, including those relating to my dual professional identity as a midwife and as a qualitative researcher, and to interviewing individual members of intimate couple relationships. Finally, I have detailed the transcription, coding, analysis and presentation of my data.

Prior to the presentation of my data chapters, I provide below a brief description of each of the research participants. This is intended to illustrate their diversity in terms of their individual characters and circumstances and provide some background to contextualise the quotes used within the following chapters.

3.9. Eighteen research participants

Eva & Eric (3rd baby)

At the start of our first interview, Eva described in detail her younger life, which became chaotic following her parent's divorce when she was 2 years old. She subsequently moved several times during her childhood, living at times with either parent, as both formed several further relationships which subsequently broke down. Eva's father had died shortly prior to our first interview.

Originally from overseas, Eva met her husband Eric via the internet more than ten years ago when they were teenagers and moved to the UK to live with and subsequently marry him. She was pregnant with her third child during the study, being the mother of a girl and boy, aged 4 and 2 years. At the time of her participation in the study, Eva was a full-time mother and a part-time student.

When I interviewed Eric, he was working full-time and was a part-time student, and in addition undertook voluntary work related to his vocational course. During his interview, he talked about his own commitment to physical fitness, and referred several times to his perception that the family were 'moving up in the world', and his desire to be 'self-made'. He spoke about past periods of financial hardship and his impatience to qualify in his chosen career specialism, in order to leave low-paid work and stop claiming supplementary state benefits.

At the time of the study the couple lived with their children in a privately rented house.

Rachel & Ben (2nd baby)

Rachel was a university graduate, and had a successful career working in the arts, which she described to me in very positive terms. During our first interview, she described becoming depressed while on maternity leave after the birth of her first child, which she attributed to her perceived loss of confidence due to not working. She and Ben had lived in several different cities and both had spent much of their working lives travelling frequently, although Rachel had not done so since the birth of her first child.

Rachel contacted me via text after her index baby's birth to tell me he had been diagnosed with Down's syndrome following his birth. She described this as having been 'a big shock'. She nevertheless agreed to participate in a third interview.

Rachel's husband Ben also worked in the arts, where the couple had met. Ben described himself as 'overweight', and, alongside Rachel, had undertaken efforts to lose weight and improve their individual fitness in the past.

At the time of the study, Rachel and Ben lived in a city centre flat which they owned.

Mary & Adrian (1st baby)

During three interviews, Mary spoke about many aspects of her life, at length, with very little questioning or probing. Originally from overseas and educated to postgraduate level, she worked in the care sector and was the main wage earner in the household. She had met her husband Adrian via the internet.

Mary was physically the largest participant in my study. Having tried to conceive in the past with a previous partner, she had believed she could not become pregnant, and described this pregnancy as a 'miracle baby'. Mary described her history of depression during her first interview, and she became depressed and extremely anxious as her pregnancy progressed. This was evident during her second interview, when her manner had changed and she was very tired and subdued and told me she had been referred to a psychiatrist via the specialist clinic. Her anxiety centred on her fear that something would be wrong with her baby. When I interviewed her following the birth of her baby, Mary appeared mentally and emotionally much improved, continuing to refer to her 'miracle baby'.

Adrian was originally from a low to middle income country and had casual, unskilled part-time work at the time of our interview. Mary and Adrian were from different religious backgrounds and both had a strong faith. Adrian referred frequently to his belief that God would protect their baby, and Mary described his prayers being a comfort to her at times of extreme anxiety.

At the time of the study, Mary and Adrian lived in a privately rented flat.

Martha (1st baby)

Martha was single during her pregnancy, having discovered she was pregnant shortly after ending a relationship with an abusive partner. She spoke at length about the decision she had made not to tell him about the pregnancy.

Martha's mother was very ill during her pregnancy, and she juggled working full-time in the service industry with travelling to visit her mother frequently in hospital. In addition, she had pre-existing diabetes and had to use insulin during pregnancy to control it.

Martha spoke candidly about her long history of depression and during her pregnancy she felt anxious about the prospect of experiencing problems after her baby's birth, due to the social isolation she feared she might experience whilst on maternity leave. However, when I interviewed her when her baby was five weeks old, she said she was mentally and emotionally well, going out, receiving visitors and socialising frequently, and adapting well to new motherhood.

Martha lived in a housing association flat at the time of her participation in the study.

Anne & Ian (1st baby)

Anne and Ian had met when they both worked in local authority jobs. She is from a large family who all lived nearby. Ian's family was smaller and also lived in the same area.

Anne was fashion-conscious, well-groomed and her flat was immaculately presented. She referred many times during her two interviews to the ways in which she spent money, on her wedding, holidays, clothes, pregnancy and baby items and socialising, saying of her and Ian, 'we like nice things'. In addition to her extended family, she had a large network of friends.

Ian worked as a manager at a local authority. He referred to Anne as being 'in charge' within their relationship.

Anne and Ian lived in their own flat at the time of the study.

Carrie (1st baby)

Carrie worked for a local authority at the time of the study. She met her partner via the internet, and during the pregnancy, he was living in a different UK city. He relocated during the pregnancy, to live with Carrie. Carrie was the only pregnant participant who was in a relationship but did not wish to ask her partner to participate in the study.

Carrie spoke at length about the online research she had done into issues around fertility, age, body weight and pregnancy. She had a very large social circle and frequently drew on examples of the experiences of friends during pregnancy within her account.
Carrie lived in her flat, which she owned, during the study. Carrie's partner moved from a different UK city late in her pregnancy to move in with her.

Amy (1st baby)

Amy was single and lived alone during her participation in the study. Having previously been a care worker, she was unemployed at the time of her interview. Like Mary, Amy was considerably larger than the other participants in the study, and her account indicated that her physical size had made it difficult for her to carry out her duties at work. In common with several other participants, Amy described a history of mental health problems.

Amy had family living nearby but described relationships with them which was at times strained, in particular with her mother. She had not planned to become pregnant, and was uncertain regarding the support she would receive from the father, who she described as her 'best friend'.
Amy lived in a rented council flat at the time of her interview. She had requested to move, as she did not feel the accommodation was suitable for herself and a baby, as it only had only one bedroom, and was up several flights of stairs with no lift.
Following our initial interview, I was unable to contact Amy to arrange a further interview, thus she participated in only one interview.

Babs & Jim Bob (2nd baby)

During the study, Babs worked long-term on night shifts as a care worker. She said this worked well for her and her family, as her husband Jim Bob worked during the day and this allowed them to easily manage caring for their young child. Babs described herself as physically very inactive, saying she hated the gym, and 'walk[ed] as far as the car, that's about it'. Her mum and small circle of friends lived nearby.
Jim Bob worked in an unskilled administrative job. During his interview he talked about his decision to not seek promotion, saying he would rather spend time with his family than have added work commitments. Previously a keen sportsman, Jim Bob described how he

now rarely participated, as this would mean travelling and spending time away from his family.
The couple rented a housing association house at the time of interviews.

Louise & Vincent (1st baby)

Louise worked in IT and had met her husband Vincent whilst at university. Following the birth of her baby, she planned take up a job working from home for her father's business, in order to spend more time with her child. She told me following her baby's birth that she planned to have another baby soon.
During our postnatal interview, Louise also told me she had been diagnosed with obsessive compulsive disorder (OCD) during her pregnancy, after having been referred to a psychiatrist.
Vincent's sister was terminally ill at the time of our interview, and he described frequent visits to her and other family members, leading to chaotic domestic arrangements for the couple.
Louise and Vincent had just bought their own house at the time of their participation in the study.

Rebecca (2nd baby)

Rebecca worked in a managerial position, and had worked for several companies, travelling widely, before getting married and having her first child. Following this, she worked freelance in order to manage her workload to suit her and spend more time at home. She described her work as rewarding and easy. She spoke at length about domestic arrangements and the family's routines, providing a lot of detail regarding food planning and preparation, and the family routines, focusing on her first child's extra-curricular activities.
Rebecca agreed to approach her husband to participate in the study, and said she was confident he would agree to participate. However, in the event he declined, saying he did not want to discuss her weight or health in an interview setting.
At the time of the study, Rebecca had been living with her husband and first child in their own home for several years.

Ruth & Graham (1st baby)

Ruth was a nurse and lived with her partner Graham, who owned his own business. Ruth planned to stop nursing in order to work for Graham's business following the birth of their baby. During interviews, she provided a lot of detail, and joked a lot, about her health and fitness.

Graham travelled a lot for work, and said this meant his lifestyle was not very healthy, describing how he ate fast food on a daily basis.

Ruth and Graham lived in a rented housing association flat at the time of the study.

Chapter Four

Pre-pregnancy

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4.1. Introduction

In this chapter I explore the experiences of women in relation to weight and health prior to their becoming pregnant, drawing on the perspectives of both the women and their partners. Pregnancy care approaches focus primarily on the risks to health posed by the very severely obese maternal body, thus it is important to explore in depth the attitudes and perceptions of participants to their bodies and how they conceptualise health during the life course, and prior to pregnancy. Such beliefs and perceptions develop over a lifetime of embodied experiences, resulting from a range of complex, sometimes interweaving social and cultural influences. It is intended that this chapter will provide a contextual basis for the exploration of their experiences and perceptions about weight and health during pregnancy and after birth, exploring any changes that may occur.

Though their physical size, was undeniable, most pregnant participants repeatedly attempted to distance themselves from associated negative characteristics, which their accounts demonstrated they understood as deeply ingrained within society. Time and again, without explicitly stating the case, most participants subtly highlighted and resisted stereotypes that they associated with the stigma of very severe obesity.

4.2. Accounting for size

All participants talked at length about their weight, demonstrating its importance in their everyday lives. Most said they had been overweight for all of their adult lives, and many had attempted to lose weight on numerous occasions. Although all endorsed to some extent the neoliberal view of individual responsibility for body weight, they also offered alternative explanations, attempting to resist the burden of that responsibility. They offered sometimes contradictory explanations for their weight, simultaneously holding themselves responsible for it, but also resisting the negative traits associated with such responsibility, such as gluttony or stupidity.

4.2.1. Battling with the body

Several represented their size at times as beyond their control, and offered a range of explanations for this. Amy for example discussed her perception that her large size was hereditary; a family trait:

> Amy: *"My dad's side of the family, all the females were larger set. My mum's side they were all very thin, but my dad's side they were larger. And I take after my dad. Like, there's no confusing me, my brother, and my dad for who we are"*
> [Amy 26, 1st baby, 1st interview, gestation 16+3]

Here, Amy attempted to present her size as something she inherited, thereby resisting responsibility for it.

Others identified other external factors as underlying their size. Several women linked events related to puberty and contraceptive use in their teenage years and young adulthood

to weight gain. Eva was one of these. She described her weight gain, along with other bodily changes in puberty, as out of her control, with a momentum of its own:

> Eva: *"I was a tiny wee kid. And then I started my period and, you know, you start getting boobs and a butt, and then everything else just kept going… And then… I don't know, you just slowly get… fatter and fatter" [tearful]*
>
> [Eva 28, 3rd baby, 1st interview, gestation 18+2]

According to Eva's representation of herself, she was 'tiny wee kid' to whom changes happened. She presented her weight gain as a teenager as something that *happened to* her, her body as separate to her *self*, its actions as beyond her control. The uncontrollable and inevitable physical changes during puberty led to weight gain, which 'kept going', unconnected to her choices and behaviour.

Similarly, Amy and Louise both highlighted using hormonal contraception in their teens as a catalyst for weight gain:

> *Amy: "…but then I got on birth control around about 13, 14 and then my weight just started piling on every year since then, it just increased… so… yeah."*
>
> [Amy 26, 1st baby, 1st interview, gestation 16+3]

> *Louise: "Yeah. I've always battled with my weight. I gained a significant amount when I got put on the contraceptive implant when I was 21. And I was only on it for a short time, but I gained about six stone and that is something that's never come off. That has always just… since then I have struggled a lot…. It's just something I've never shifted since I've put it on, just totally screwed up my body, I think."*
>
> [Louise 32, 1st baby, 1st interview, gestation 23+5]

Both women cited contraceptive use in adolescence or young adulthood, with Louise explicitly phrasing this as something that was done *to* her, as leading to weight gain, thereby tacitly resisting the notion that they were responsible, via their decisions or behaviours, for the weight gain that occurred. Louise's use of the well-known phrase, 'battled with my weight' again portrays a sense of the person as pitted against the body, in combat with its actions. Thus most women resisted the felt stigma implicit in the cultural judgement that they were responsible for their size, due to their inability to control their actions, offering instead explanations which were external, done *to* them, or beyond their control.

Several participants reported experiencing stigma and shame due to their weight, and this was recalled as particularly distressing during teenage years and young adulthood. For most participants this was prior to them having become partnered. Martha described experiencing bullying and misery in her teens because of her weight. She talked about this and her subsequent weight loss attempts:

> *Martha: "But I've always had an issue with my weight since I was… probably at high school. You kinda got picked on for being a chunk…*
> Alice: Mm-hm?
> *Martha: "…and so forth, so I lost quite a lot of weight when I left school, but I didn't do it sensibly. Lots of cigarettes and alcohol. So yeah, total yo-yo. I've been everything from a size ten… to now I'm back up at my heaviest, which is quite… miserable"*
> [Martha 41, 1st baby, 1st interview, gestation 15+5]

Eva also described feeling distressed and ashamed at school because of her weight:

> *Eva: "Like even when I was doing… in high school I was doing track [running] or whatever, like… and I still kinda had like a… a 'bubble butt', whatever, like… [pause]*
> Alice: Mm-hm?
> *Eva:* [*tearful*] *That's where I carry my weight, you know?"*
> [Eva, 28, 3rd baby, 1st interview, gestation 18+2]

It has been observed that appearance-based teasing can lead to depressive symptoms, which can in turn lead to binge-eating (Haines, Neumark-Sztainer, Eisenberg and Hannan 2006; Jackson, Grilo and Masheb 2002).

Most women emphasised how difficult it was for them to lose weight, and talked about their efforts to achieve this. For most this had been on multiple occasions and over prolonged periods, with several describing a near-constant cycle during adulthood of losing and regaining weight, using phrases such as '*I've just kind of constantly yo-yoed…"* (Rebecca), *'I've always been quite a, sort of, yo-yo dieter'* (Babs)*, 'For years, I've always been a wee bit up and down.'* (Anne).

Eva described her weight cycling, or 'yo-yoing' in detail, describing her perception of why dieting did not 'work' for her. During three lengthy interviews, Eva discussed struggling with her weight since she was a teenager. Now a mother of two and studying part-time, she described searching for 'the answer' to her weight problems, having tried many different extremely restrictive, or 'fad' diets. When we discussed her weight, she again invoked an image of her body working against her, 'rebounding' naturally when her efforts at weight loss were relaxed.

> *Eva: 'You know… you're gonna, like… you can lose weight… but you can also rebound to exactly where your body wants to stay. If your body wants to stay at a… kind of… a relaxed level.... if that makes sense? So, you… you starve yourself, you're kinda gonna lose weight. But once you start eating it's gonna try and get back isn't it? It's gonna try and get to where it wants to be. And I know, like, if you're a little bit lax, it's gonna go the other way. Like, get a bit fat, whatever. I don't know. You know, that's why I have what I call a 'rubber band' effect…'*
>
> [Eva 28 3rd baby, 1st interview, gestation 18+2]

Here again, Eva invoked an image of her body as working against her; that while she was prepared to 'starve herself' to achieve the slim ideal, her body would win this battle eventually each time.

Mary also described how losing weight was very difficult for her, due to the way she believed her body functioned. She said:

> *Mary: "I know it's hard to believe, but I don't eat a lot. I probably don't eat what I should eat or whatever, but as a quantity I don't eat a lot. There are things that… my body doesn't metabolise the way it should be. So like for example if I eat more carbohydrates or something… or proteins. I don't think I eat a lot for my size."*
>
> [Mary 38, 1st baby, 1st interview, gestation 16+0]

Acknowledging her awareness of social and cultural judgements about her body and her behaviour, and demonstrating felt stigma by preceding her statement with, 'I know it's hard to believe', Mary suggested that a physical deficiency, specifically related to her metabolism, accounted for her size, Thus, like Eva, she highlighted her morally restrained behaviour, and her efforts to improve her health, mitigating the effects of her 'defective' body and prolong her life:

Mary: "That's the way that I was built, you know? And the problem is that my body doesn't process the food in the way that…you know...other people's bodies do, because the metabolism is slow or… whatever is the medical explanation...but unfortunately I have to live with that and I have to do something about it in order to…. you know… live longer"

[Mary 38, 1st baby, 1st interview, gestation 16+0]

4.2.2. Emotions: over-eating; comfort eating

Several participants described troubled histories with food and eating, and for some this was discussed within the context of difficult childhoods and teenage years, depression or other mental health issues. As has been observed by other authors (Jarvie 2013; Throsby 2007), food and eating were frequently described as often linked to emotions, for example over-eating or 'comfort' eating being triggered by emotional distress. Martha was one such woman. She described herself having a long history of depression, and as a 'secret' eater. She talked about the history of this, going back to her teens:

Martha: "I would hide in my room and I would just kinda… [pause]. And the larger you get, you don't eat in front of people. And I'm still quite a secretive eater. You know, if there's buffets and that, I'm, like, the last one up and I'll just have a small plate, but I'll be like… go home and… cheese on toast and… things like this. So it's just trying… and it… it's always been like that, so… And I've also got a history of depression, and a lot of that… over-eating, we've now worked out was so that... I could become invisible almost"

[Martha 41, 1st baby, 1st interview, 15+5]

The 'we've' Martha referred in this quote to was herself and her counsellor, who she saw for several years with regard to her depression and associated over-eating. She described what happened when she experienced what she called 'a dip':

Martha: "Yeah, the dip affects…yeah, if I have a dip then I eat far more, because I just hide myself away, and things can spiral because I don't care about what's going in me and things like that. Whereas, most of the time, I try and keep a handle on it and say, right, okay, if I'm going to have something then it's much more sensible. Whereas, with the dip, I just gorge, basically. I literally am like a hoover, that's the best way of putting it. It doesn't matter what it is, I'll shovel it in my gob"

[Martha 41, 1st baby, 1st interview, gestation 15+5]

Eva described being neglected by her father and step-mother in her teenage years, when food was not routinely available in her house:

> *Eva: "I mean… my dad… there was a time in my life for years, I ate one meal a day. And because you're eating one meal a day you're stuffing your face cos you were starving, like…*
> Alice: And how was that? That you only had one meal a day?
> *Eva: "Because of my dad's work. And then… He'd work 14 hour days. He owned his own company…. And he would come home and he would probably bring in… Taco Bell or takeaway or whatever. And then... you know, big burrito bag, kinda… you know… discount pizzas and whatever, like. They'd bring in… because they didn't have time to cook, so they'd just bring in whatever takeaway there was. And then you're stuffing yourself because there's not going to be any breakfast in the morning, you know what I mean?"*
> [Eva, 28, 3rd baby, 1st interview, gestation 18+2]

Eva went on to explain how she believed this had led to her developing long-term unhealthy binge-eating habits.

Several other women linked food and eating behaviours to their emotions, describing engaging in 'comfort eating' at emotionally difficult or stressful times. Rachel described 'comfort eating' when she had felt isolated and depressed whilst on maternity leave following the birth of her first child, and when it had taken a long time to conceive a second time. Her husband Ben also spoke about her comfort eating:

> *Ben: "And Rachel also tends to eat when she's not particularly happy, or when she's not sleeping. We had quite a rough patch after [1st child] was born for about a year during which Rachel was really down, and so there was a lot of comfort eating and that kind of thing going on then, as well. It was… kind of… more about her being happy than about weight or anything like that"*
> [Ben 40, Rachel's husband, 2nd baby, gestation 23+0]

4.2.3. Summary

Most women offered coherent narratives in accounting for their size, and had clearly considered the matter in depth. For many, weight and body size was experienced as a 'battle', characterised by troubled relationships with food, and adult years had been spent in cycles of dieting, losing and then regaining weight. Several had experienced difficult

teenage years and young adulthoods, and some suffered periods of mental health problems, linked to food and eating. However, in common with Throsby's non-pregnant obese participants, some participants simultaneously cited a 'fat-prone body' (2007: p1564) as being responsible for their size, thereby attempting to resist moral responsibility and distance themselves from cultural stereotypes, instead highlighting their high levels of self-discipline.

4.3. Growing older and partnered relationships: changing perceptions

In this chapter so far I have presented, several participants' descriptions of the difficulties they experienced during their teenage years and early twenties, due to the social and cultural stigma associated with their size. However, some described a relaxation of such pressure occurring as they got older, during their twenties or thirties, due simply to getting older for some, and for others due to the protection provided by a coupled relationship.

4.3.1. Normalising obesity

Several women experienced a change in their feelings about their weight and their bodies as they grew older, and this was described as linked to wider social networks and friendships. Babs described how her increasing age and her relationships within her social circle had meant a shift in her attitude to her body:

> *Babs: Yeah, I've got quite a lot of fat friends, it's always handy. Yeah. No, I do, I've got quite a lot of friends and it's quite… it's quite good, because we're all at that age now where weight doesn't really… It is an issue, and we know it's an issue, but it doesn't bother us as such, if that…? It does and it doesn't. It's like, you know, I know I'm overweight… It doesn't affect my everyday life*.
> Alice: Do you mean in terms of, for example, if you were in your late teens going out all the time and…?
> *Babs: Yeah, I think that makes a… I think maybe then you don't like to discuss your weight when you're that… well I certainly didn't like to discuss my weight when I was that age. Now I'm kind of like, well what difference does it make, you know?*
>
> [Babs 27, 2nd baby, 1st interview, gestation 18+2]

Babs recalled the pressure to be slim, felt most acutely as a teenager, subsiding as she became an adult and felt less uncomfortable with her size. She perceived a normalisation of

women with large bodies, having a lot of 'fat friends'. The stigma and shame that she felt had reduced, allowing her more openness within her relationships with friends.

During Carrie's interviews, it was clear that she too perceived a normalising of increased body weight. Carrie was unusual among participants in her emphasis on her positive body image. She described a busy social life, discussing numerous friends during her interviews. She said:

> *Carrie: "But yeah, I think there's a stereotype where you must not be happy with the way that you look and you must want to lose weight. And I think… I've got loads of fat fabulous friends. Like I remember… when it was – I'm going back a few years now but – when it was [friend]'s hen night, we went to [city], and I think the smallest person there was probably a size 14. And so we were like mostly 16, 18 and 20s. We looked bloody brilliant! Like, we really did"*
> [Carrie, 38, 1st baby, 1st interview gestation 18+5]

Carrie referred directly to, and rejected the cultural stereotype of a miserable 'fat' person. She returned to this theme several times during her interviews, and it was clearly important to her to establish that her size did not make her unhappy; that *she*, not *it*, was in control.

4.3.2. Partnered relationships

Becoming partnered or married for several women was associated with a perceived relaxation of the pressure to be slim, and a settled cohabiting relationship brought changes in common within several participants' accounts. During their individual interviews, all participants discussed their views about their own and their partner's weight (four of the seven partners interviewed described themselves as 'overweight'). Anne described her relationship with her husband Ian, their shared love of food, and the relaxation she felt in the pressure to conform to the cultural slim ideal:

> *Anne: "I think it's hard because we're happy. If I was single, I probably wouldn't eat it. I would be like, 'I'm never going to get somebody if I'm fat. I'd better get skinny and lose weight'. But I know that Ian loves me, and I love him, and we're comfortable with each other, and we're happy, so I don't have a lot of incentive".*
> [Anne, 32, 1st baby, 1st interview, gestation 17+1]

Several partners' accounts concurred with those of their pregnant wife or partner, with regard to their moral integrity, ruling out gluttony or lack of self-control. For example, again acknowledging perceived stigma in her denial that she ate take-away food, Mary told me:

> *Mary: "I'm not an over-eater. I don't have sweets in the house. I don't eat every single day chocolates and.. I don't have that. Like, if I eat an ice cream, I eat an ice cream, like a cone or… [some]thing. I don't eat a whole tub of ice cream, you know? And that was… most of my life, because I'm not a big eater of take-aways or McDonalds or... because I've been born and raised in a family, in a country where we... we eat from scratch. We eat quite natural ingredients as I said, and cook in quite a… healthy way"*
>
> [Mary 38, 1st baby, 1st interview, gestation 16+0]

In his interview, Mary's husband Adrian's account supported this:

> *Adrian: "She eats healthy, like. Since we've been together, she eats the healthy food, because I like healthy food, and then like… Whenever we go for shopping like, you see our basket is like… veg, fruit, more veg [and] fruit than any other thing."*
>
> [Adrian 28, Mary's husband, 1st baby, gestation 17+6]

Eva and Eric also both referred to - and resisted – their perceived social and cultural judgements about their eating habits:

> *Eva: "Cos they [health professionals] just… like… cos they give you these pamphlets, like, [bored monotone, listing] 'make sure you're eating… dairy and'… you know… 'your meats and your vegetables and your fruits and don't eat sugary snacks' and it's like, well, if I was sitting here eating… a cake a day… piece of cake a day, stuffing it down, I would know that that was my problem and I could stop eating the cake… like…" [tearful]*
>
> [Eva 28, 3rd baby, 1st interview, gestation 18+2]

Eric referred to his belief that although some people ate badly, accounting for their size, but that this was not the case with his wife:

> *Eric: "Cos they just go… they <u>presume</u> that everybody's stuffs their face wi' cake all day, cos you… if you look online, it's like… a person who's lost… like… 10 stone and they're like, 'I used to sit and I used to eat crisps all day', and I'm like, 'you're full of cr…?' Who even does that? You know what I mean? That is ridiculous! But I've never once seen her do that. She has the odd biscuit or something, but you*

can check her cupboards, you'll no' find any cake or anything like that… You know what I mean?"

[Eric 30, Eva's husband, gestation 18+6]

In highlighting this perceived *other, deviant* individual, as represented by the popular media and by now firmly established in the cultural consciousness, Eric attempted to resist this characterisation of his wife Eva, and to present her as doubly a victim, behaving in a morally acceptable way, eating healthily and not too much, but nevertheless overweight, and in addition, misunderstood and morally castigated. The anger Eric felt on behalf of his wife as a result of this was evident at several times during his interview.

4.3.2.(a) The impact of dieting within relationships: support and sabotage

Above I outlined some of the complex ways that partners and husbands appeared to experience and resist stigma on behalf of their pregnant partners, several accounts also included references to the emotional and practical impact that increased weight and serial dieting had on their lives together. Some women described their partners as supportive of their weight loss efforts, and indeed some couples had dieted together. Anne and Ian were one such couple, who described dieting together, enjoying mutual support, as well as collusion in 'breaking' their diets. Anne said:

Anne ".. we both know we're fatties and we need to lose weight so…[laughs]. So we do talk about it…"

[Anne 32, 1st baby, 1st interview, gestation 17+1]

Ian said:

"And I think what we tend to do when we're on a diet is…one gives permission for the other one to sort of…break their diet. So if you're on your own, you're less likely to do it, less likely to go off your diet…but…maybe I say 'I could really fancy…this tonight', and maybe Anne, sometimes she'll be like, 'No, you can't have that, stick to your diet' and other times it'll be 'Let's have that', and vice versa, so…"

[Ian 32, Anne's husband, 1st baby, gestation 18+0]

Rebecca, who had lost weight several times whilst attending Weight Watchers, regaining it subsequently each time, said about her husband:

Rebecca: "We do talk about it. His thing is, 'Oh, you're fine, don't worry about it', and I'm like, 'Well…' but it does, it gets to the point where it gets me down, but he is really good when I'm then on a diet and I am trying hard, he's really supportive. He doesn't come home with…finishing at ten o'clock at night and kind of going, 'I'm just going to get a takeaway on the way in', he doesn't do that sort of thing, or he won't come home with just a random bag of sweets or something that he's decided to buy and things like that. So he is quite good in that respect. But no, because like that, that's what he always says to me, he says, 'I know you can do it because you've done it before'"

[Rebecca 46, 2nd baby, 1st interview, gestation 21+4]

Babs' husband Jim Bob described how he supported her when she attended Slimming World:

Jim Bob: "I'd be having the same meals as her. I'd be having more of it [laughs] because that was what it was, three or four tablespoons of this or that. Errmm… so again, I'd have a lunch, but I'd take a packet of crisps and a chocolate bar to work with me… which she wouldn't be allowed. But when I have my meal with her, it would be the same thing"

[Jim Bob, 30, Babs' husband, 2nd baby, gestation 25+4]

Other couples described undertaking weight loss efforts together. Short term goals such as weddings and holidays were common reasons for undertaking a diet for several weeks or months, followed by subsequent weight gain once dieting behaviour stopped.

The tension and conflict that could be caused by dieting behaviour was evident within some accounts. Rachel described how she and Ben (who described himself as overweight) had taken it in turns to go out and exercise while the other looked after their son the previous summer. However, she sometimes found Ben to be unsupportive in other ways:

Rachel: "I think the problem is that it tends to fall very quickly in to the realm of nagging as opposed to, you know, talking."
Alice: Who's nagging?
Rachel: "Him nagging me. Tutting and… you know, being judgemental as opposed to actually helpful."
Alice: So if it's possible, can you describe to me, like, a typical conversation that you might have when he's said that…does that…it can descend in to nagging or it's…if you…?
Rachel: "Mmm… I don't know. Just like, I guess, I might say, 'Oh, can you get me some chocolate?' And, you know, he's like, 'Oh do you really think you should?' And then you're just like, 'Oh don't bother then!' It's like, 'No, no, I will!'"

[Rachel 38, 2nd baby, 1st interview, gestation 19+6]

In a later interview, she discussed Ben's views about her approach to eating healthily:

Rachel: "Ben always thinks I do things, kind of, like not in a sensible way, that I'd be better off eating less generally rather than saying, 'Right I can't have it'. For me it's the case of going, 'No, I can't have it', because I can't – you know. If there is a packet of biscuits in the cupboard, then I'll eat a packet of biscuits"

[Rachel 38, 2nd baby, 1st interview, gestation 19+6]

Some participants perceived their partners as discouraging them from dieting. Ruth said about her weight:

Ruth: "[I]…always talk to Graham about it. He's like, 'I prefer you with curves anyway. If you lose too much weight, I would just be like, "Have a hamburger!"'. I was like, 'Right, okay then'. He prefers… like…he's always had a thing for Mariah Carey. He likes curves. And he was like… he said to… he always said to me, 'If you get down to, like, eight and half stone or nine stone, I would end up murdering you.'"

[Ruth 27, 1st baby, 1st interview, gestation 22+6]

A little later in the same interview, she said:

Ruth: "See now, I can't be bothered. I'm too lazy to even care about my… yeah. I'm just, kind of like, if I lose weight, I lose weight. If not, then I'll just deal with it"

[Ruth 27, 1st baby, 1st interview, gestation 22+6]

Echoing Ruth's account of her partner's views, another participant, Eric, described his preference that his wife Eva did not become 'skinny':

Alice: Does she talk about why she wants to lose weight?
Eric: "Yeah. She feels self-conscious".
Alice: Uh-huh.
Eric: "But to fair, I told her, she was big when I met her… I don't want her to get skinny. I don't like skinny women. I keep telling her. She never listens" [laughs].

[Eric 30, husband of Eva, gestation 18+6]

The tension that her dieting caused within their relationship was also evident within Eva's account. She said:

Eva: "I'm constantly, as they say, 'cry-and-diet girl', like I go on a diet and try and lose weight and…"
Alice: A what? A what-and-diet girl?
Eva: "A cry-and-diet girl [laughs] That's what my husband calls me."
Alice: I've never heard that one before.
Eva: "That's just his term cos I'm like, you know, always on like… tried like… like… pale-e-o, like eatin' just meat and fruit and veg and…. I've tried low carb-ing and I've tried… bloody… juice fasting, which probably nearly gave me an eating disorder. I think that's the closest I've ever been to actually being a fat girl with

an eating disorder. Like seriously! Like, for two weeks I did nothing but drink cabbage juice and bloody eat carrots and apples and… you know, whatever. And we moved in here and, I'd had… I had [two children] at the time and we moved from [small village] to here and my husband is starving and he ordered a pizza and he's in here eating a pizza and I'm in the kitchen crying my face off cos I'm like, 'I just wanna eat food!' [drums fingers fast on table]

[Eva 28, 3rd baby, 1st interview, gestation 18+2]

Eva described a cycle of embarking upon very low calorie 'crash diets', which are generally experienced as unsustainable, following the diet for a number of weeks, then stopped and regained weight. Embedded within this, she attempted to subvert the health benefits of weight loss-seeking behaviours, linking 'dieting' ('which probably nearly gave me an eating disorder'), with disordered eating. Eric's description of his views and experiences of Eva's dieting further demonstrated the tensions it caused between them:

Eric: "Oh, I've been there through every diet, every… thing and… I'm probably just… I hate them. I despise diets. I hate them beyond belief, because she becomes an absolute cranky b…. sorry… [laughs]… an absolute cranky bugger… on it. I cannot stand diets… in any way, shape or for. I know why she does it, cos obviously she's not happy with her weight…'

Later he said:

"I try to be helpful. I just try to be supportive, but there's not much you can do. You can't force someone to do something. You can say to them, 'Oh, are you gonna do that? But if you're only gonna do it for a month or something, what's the point?' I only step in occasionally, if she's gone on some stupid diet that annoys me, and then err…I'm just like, 'Look, that's enough'. [laughs] 'Here's a bit of cake.'"

[Eric 30, Eva's husband, gestation 18+6]

Martha, who was single during the study, talked about her ex-partner's abusive behaviour towards her regarding her weight:

Martha: He said it wasn't [an issue] but then he'd make digs…. [pause]
Alice: Uh-huh?
Martha: Errm… like poking the tummy and stuff like that. Just… little niggles and stuff like that…
[a little later]
"… at the beginning… you know, I stayed about the same [weight] during the time that we were together. But… at the beginning he was like… didn't bother him, but then when I was talking about going back to the slimming club he was

like, 'Yes, I think so. Look', [points to tummy]. You know, there's nicer ways of dealing with it"

[Martha 41, 1st baby, 2nd interview, gestation 35+0]

4.4. Home-cooked food and morality

Food choices, eating habits and the social and cultural meaning of food were prominent themes in all participants' accounts of their everyday lives, their domestic circumstances and their weight. Participation in the study to some extent compelled them to provide an account of their size, an explanation for it, due to its deeply stigmatising nature. In a range of different ways, they sought to ensure that their accounts preserved their moral integrity and an important component of this, for all women, was that of food and eating. Thus, within most women's accounts – including those quoted above who also described troubled relationships with food - there was a strong emphasis within narratives on the consumption of 'good' food. This was related to a belief that wholesome, home-made food would have health-giving effects on the body, and may have informed the assertion by the women that they were healthy despite their weight, that they were big in a *healthy* way, because of what they chose to put into their bodies (I discuss further concepts of health later in this chapter). Certainly it was important for many participants to make clear that they knew what foods were healthy, and that they ate those foods. Despite most participants defending their choices, rejecting the notion they ate 'bad' food, several disclosed that they ate what they considered to be 'too much'. This appeared to be perceived as socially more acceptable, if it was home cooked, wholesome food.

4.4.1. Too much of a 'good' thing? Food and social class

Almost without exception, participants drew attention to their consumption of 'good' food. For many, this meant an emphasis on their commitment to preparing home-cooked food, whilst admitting to eating 'too much'. Louise said:

"I've always been a big cooker, and been able to eat healthy meals, because I put a lot of effort in to cooking"

Later she added:

> *"I think for me it's not what I'm eating, it's how much I eat…"*
>
> [Louise 32, 1st baby, 1st interview, gestation 23+5]

Similarly, Babs said:

> *"So I might have pasta for dinner, but I'll eat enough to feed four people. 'It's pasta, it's healthy, what's the problem?' I know that it's… I know that I shouldn't eat that much"*
>
> [Babs 27, 2nd baby, 1st interview, gestation 18+2]

In common with other participants, Anne sought to resist her perceived assumption that she ate junk food, and did not know what 'healthy eating' meant. She told me:

> *"Ian and I are fat because we both love cooking. It's not that we don't eat healthy. We love to cook and we love to make big lovely dinners and treats. 'Let's have some potato dauphinoise', and…. we love cheese…. and we have nice tasting food. We don't just eat crap, but we probably eat too much bad stuff. We like to go out and we like cocktails. We like nice stuff. When we want to lose weight we can, but I think we're quite happy really anyway"*
>
> [Anne, 32, 1st baby, 1st interview, gestation 17+1]

In his interview, her husband Ian also resisted the stereotype that he ate 'bad food', or did not know how to eat healthily:

> *Ian: "So no, I don't think the things I'm eating are particularly bad. We don't sort of have masses of processed food or takeaways or stuff like that. I mean we do occasionally, but what we're eating mostly is, you know, we're cooking from scratch…"*
>
> [Ian 32, Anne's husband, 1st baby, gestation 18+0]

He concurred with Anne that their social life as focused around food, whilst also acknowledging stigma:

> *"Yeah, I mean, we do, we like to go out for dinner, go nice places to eat. So yeah, it does. It has played a role. We both like nice things. So yeah, if we go out, that's usually what we do…. It's always been the case [quietly]. Makes me sound like a big fatty" [laughs a lot]*
>
> [Ian 32, Anne's husband, 1st baby, gestation 18+0]

4.4.2. 'Good' food and 'good' mothering

For most of the women, provision of food was regarded as the locus of family life, both for those women who had existing children and for those having a first child. It was clear from interviews in pregnancy and in particular after birth, that they regarded their role in food purchase, preparation and provision as central to that of a mother. Four women who participated in the study had existing children, and all gave examples of the wholesome, home-cooked food they provided, appealing to ideals of 'good' mothering, conscious of their health and that of their children, and highlighting the wholesome, nourishing nature of the food. Take-aways were spoken of as an occasional treat or eaten when life was particularly busy or chaotic, and were identified and acknowledged as less healthy than home-made food. Thus most women accounted for their obesity as being a result of an over-consumption of this 'good' food. For those with existing children this was consumed primarily in the context of family life.

Rebecca was one such participant who described how eating together and cooking from scratch was important in her family:

> Alice: So do you manage to eat all together as a family?
> *Rebecca: Yeah, generally do. There's the odd thing that we don't, but it's things like we'll try and make those things from scratch. We don't buy much. So we make things like homemade steak pie on Sunday. I make quite a big lasagne, again from scratch, so that would do Sunday and then it does again Tuesday, kind of thing, because it makes about six portions out of it"*
> [Rebecca 46, 2nd baby, 1st interview, gestation 21+4]

She talked at length about her seven year old son's likes and dislikes, and that he enjoyed preparing food together:

> *Rebecca: "[H]e does a lot of the cooking with me. He always has done since little. We make homemade bread at the weekends because we've got the garden room as well. It's ideal. We make the dough and we put it in there to rise and he loves watching it rise. And usually we call Saturday nights 'pizza night', but we make it all from scratch. So we make the dough in the morning before we go to his gymnastics class. We leave it in there to rise and then kind of do it and everything, so he's kind of made it from the beginning and he's rolling it out and he's putting his toppings on…"*
> [Rebecca 46, 2nd baby, 1st interview, gestation 21+4]

Rebecca's account – and her body language and tone as she spoke - illustrated the satisfaction she derived from sharing these experiences with her son, passing on her knowledge and watching his enjoyment of performing food preparation tasks. She described how food preparation and consumption shaped their family life and routines, and happily spoke at length about this.

For Rachel, becoming a mother for the first time three years previously had meant that fulfilling this role as homemaker became important for the first time. She talked about choosing a 'baby-led' method, popular among middle-class parents in recent years, when her first child was weaning onto solid food:

> *Rachel: "..the reason why we went for baby-led weaning as opposed to just waiting 'til six months and doing the puree and finger food technique was about learning to cook. I couldn't cook. And it was about me learning to cook and us all eating healthily and eating as a family"*
>
> [Rachel 38, 2nd baby, 2nd interview, gestation 36+1]

Home-cooked meals, eaten together, were perceived as healthy meals and this was important to all four participants who had existing children. Eva, who was expecting her third baby, spoke about her two young children:

> *Eva: "But… they eat fruit and veg all the time, like... I can't bloody believe how much fruit we have to buy [laughs]… and yeah, it's questionable on the veg, but you know, that's what it is like most of the time, you know? That's why you hide it in the spaghetti. But... we definitely eat very healthy… like, family meals. There's nothing... not a lot of… You know, we probably have… a dessert, two… maybe three times after dinner. I don't know, like… in the week, y'know? And it's something like… a wee bowl of custard or an ice lolly. You know, it's something like that. It's not like… and elaborate giant something. You know?"*
>
> [Eva 28, 3rd baby, 1st interview, gestation 18+2]

Such identity work allowed Eva to convey several messages about her role as a 'good mother'. She demonstrated, like Rebecca and Rachel, that she understood and upheld the cultural importance of the family meal, and her role in providing it; that she is a 'good mother', aware of the importance of her children's consumption of fruit and vegetables for good health, indeed alluding to ways in which she ensured, in her preparation of the family

meal, that they consumed 'hidden' vegetables when they will do not do it willingly. She went on to highlight the lack of sweet sugary food in their diet, describing their consumption of simple puddings, stressing their small size. In this way she anticipated and resisted cultural perceptions of her as an 'obese mother', unable to control her impulses, ignorant of what constitutes a healthy diet, and thus feeding her children unhealthy food. This theme of 'mothering through food provision' was later drawn upon by the first time mothers who participated, in constructing their roles as new mothers once they had given birth, and I return to develop this further in Chapter 6.

4.5. Understanding, representing and defending 'health'

So far in this chapter, I have explored the ways in which women accounted for their size within interviews, describing the moral accounting they undertook, and have included an outline of the ways in which being in a partnered relationship might impact upon their experiences of weight, stigma and weight-loss seeking behaviours.

Conspicuously absent from most women's discussion of weight loss efforts were references to health in the context of weight. Their discussions of dieting behaviour were described as being driven by a desire to improve the look of the body. Partners in turn spoke of how their wife or partner wanted to look, or how they preferred their wife or partner to look, rather than expressing concerns about their health.

The women's accounts did demonstrate that they thought about their health, and what it meant to be 'healthy'. Here for most, as with dieting behaviour, views and accounts about health were underpinned by the presence of stigma, requiring them to make an account of, and defend themselves, their physical size, their health and by implication, their moral integrity. The word 'obese' is a clinical term, widely regarded as a 'health condition'. It is also culturally deeply stigmatising, and is associated with negative assumptions regarding individuals. None of the women or their partners routinely referred to themselves as 'obese', using instead words like 'chubby', 'bigger', 'overweight', 'fat' or 'plus-sized'.

4.5.1 Health as an absence of problems

Although improving health was not cited as having driven past weight loss efforts, participants did refer to health directly in talking about their pre-pregnant selves, with most asserting their belief that they were 'healthy'. This was defined as an absence of health problems, with heart disease and diabetes specifically highlighted, presumably as increased risks of these are widely associated with increased weight. Implicitly rejecting the idea that her weight could cause her any increased risk of heart disease, Rebecca described what she was told when she had an ECG:

> *Rebecca: "So he said, 'Your heart is perfectly normal. There's no problems at all'. He said, 'I wish they all looked like that. It's literally perfect'"*
>
> [Rebecca 46, 2nd baby, 1st interview, gestation 21+4]

Amy was another participant who referred to an absence of specific health problems as evidence of health:

> *Amy: "I've always been generally, actually, really healthy, no matter what weight I was. Like, I've never had any heart issues, diabetes or blood pressure problems. Like, I've always just been bigger... and that's just my frame."*
>
> [Amy, 26, 1st baby, 1st interview, gestation 16+3]

Later, however, she discussed her lack of fitness, saying:

> *Amy: "For as much I might be healthy, I'm definitely not fit"*
>
> [Amy, 26, 1st baby, 1st interview, gestation 16+3]

Most participants gave similar accounts, defending their health status, but separating the concepts of *health* and *fitness* when describing themselves as unfit. Babs said:

> *Babs: "I walk to the car and back, that's about it [laughs]. No, exercise is really… I don't do any exercise at all"*
>
> [Babs 27, 2nd baby, 1st interview, gestation 18+2]

Despite her professed lack of fitness, both Babs and her husband Jim Bob described a belief that she was 'healthy'. However, Jim Bob described his perception that, although she was fit enough at her present size to go about her daily life, his wife's ability to carry out everyday tasks would be impaired if she were to gain more weight. He said:

Jim Bob: "[I]f she continued to put on weight I think she would continueto become more and more unhappy, because… she would struggle to do things. She would struggle to put the washing out. She would struggle to take [daughter] shopping round [the supermarket]. She would eventually go to the park and not be able to run after [daughter]"

[Jim Bob, 30, Babs' husband, 2nd baby, gestation 25+4]

In her interview, Babs said she already felt less able to play actively with her young daughter, due to her lack of fitness:

Babs: "Well, [daughter] is now on her feet. I can keep up with her but, you know, I don't… If she's at the park I'd rather stand and watch her run around, do you know what I mean?...than me run round with her. And I just feel like that's not what I want her to remember. I want her to remember, you know, we're all running round and we'll all playing with the ball or whatever."

[Babs, 27 2nd baby, 1st interview, gestation 18+2]

Thus, in complex ways, most participants resisted suggestions that their increased weight was detrimental to their health, separating one aspect of their embodied experiences of health - fitness – from the concept of health. 'Health' was presented as the absence of problems, as a physical state independent of fitness, while fitness might be improved over and above *good health.*

Martha was different: she had been diagnosed with diabetes four years prior to her pregnancy. She said:

Martha: "It's my health. The diabetes changed it. When I joined the Slimming World, which would've been about 4 years ago, it was because of the health. It was because…. I was feeling out of breath when I was walking up stairs and things like that… and I was feeling rubbish about myself…. the health is the issue. And I think… my mum doesn't keep very well, and I'm conscious… definitely I've always been conscious of the fact that I don't want to be one of these people that's constantly got one thing after the other… wrong with them"

[Martha 41, 1st baby, 1st interview, gestation 15+5]

Martha's diagnosis with a recognised health condition had led to her to engaging with her embodied experiences of her weight, as she described above, as well as to consider the prospect of future health problems in a less stigmatising way, due to a shift in focus to a less

stigmatising health ‘condition’: diabetes. When she was diagnosed, improving her health became her incentive for weight loss.

Not all participants represented health and fitness as separate. Two women, Anne and Carrie, did describe themselves as physically active and fit. However, they expressed their belief that it was possible for them to be fit and ‘fat’. Anne said:

> *Anne: “I'm quite a healthy fat person, even though I'm chubby I can run, and I don’t get too out of breath or anything”*
>
> [Anne 32, 1st baby, 1st interview 17+1]

By describing herself as a ‘healthy fat person’, Anne signalled her awareness that excess body weight is associated with a lack of fitness, a deviant body that cannot function optimally; she highlighted this in order to reject it in her own case.

Carrie said she had dieted at times, but she rejected the notion that being large restricted her in any aspect of her life. Referring to clinical BMI categories, she described being aware that her BMI had reached above 40kg/m^2. She said:

> *Carrie: “I think when you hit a BMI of 40, which is what happened when I got the car and things, I realised that you fall into the, ‘my God, you're not just obese, you're morbidly obese, you might drop dead any minute’ category. But it's not really…”*
> Alice: Did you become more worried at that point?
> *Carrie: “No, not at all. I'm just aware that… I mean, it's never caused me any problems. I've travelled the world and lived in random places like Thailand and Brazil and it's never really been an issue. It's not that it stops me health-wise from doing anything”*
>
> [Carrie, 38, 1st baby, 1st interview, gestation 18+5]

Carrie expressed the view that she could be fit and healthy whilst being overweight. She demonstrated her belief that this did not accord with dominant biomedical discourse in her description of a consultation with her practice nurse when she registered with a new GP surgery:

> *Carrie: “[A]t the time, I was going to salsa twice a week and I was going swimming. Obviously I don’t smoke, I don’t drink a lot, I've not got any existing health conditions, and the nurse was like, ‘We’re not particularly concerned. Diets don’t work. You're exercising regularly. You seem to have knowledge about*

healthy eating, so I'm not going to say that you need to lose weight'. I was quite shocked because I was like… that's not the reaction that I'd expected"

[Carrie 38, 1st baby, 1st interview, gestation 18+5]

Carrie continued:

Carrie: "I'm not somebody who's going to sit and say I've struggled with my weight all my life, because if you take the sense that I have always been overweight – yes - but I wouldn't say I've <u>struggled</u> with my weight, because I've just been the weight I am. It's not stopped me from doing anything. It's not stopped me from wearing a bikini on a beach or going out dancing on a Saturday night. It's never really been an issue"

[Carrie 38, 1st baby, 1st interview, gestation 18+5]

During her two interviews, Carrie drew upon all five definitions categorised by Blaxter's large UK Health and Lifestyles study (1990). This study posed the question: 'What is it like when you are healthy?' and drew up five broad definitions to categorise the answers given by respondents. These are: health as the absence of illness; health as physical fitness; health as social relationships; health as function; and health as psychosocial well-being, Indeed, although other participants cited a belief that one can be healthy regardless of body weight, Carrie emphasised a holistic approach to health, including psychological well-being, and was exceptional in her attitude, in that she highlighted and rejected the cultural expectation that she should experience shame related to obesity. Instead she rejected the expectation that she should either lose weight or cover up, referring to her confidence *with* rather than *despite* her weight.

4.5.2 Resisting and subverting the 'skinny' ideal

Several women attempted to subvert the ideal of slimness, referring to negative, extremely low weight examples in order to highlight associated negative characteristics. Some emphasised the fact that they did not want to be 'skinny'. This corroborates the evidence presented by Jarvie (2013) in her study of obese diabetic women's experiences of pregnancy. Ruth talked about when she had been slim in the past:

Ruth: "Because like even… See at my slimmest, I was tiny. I was like skin and bone. You'd always feel my hip bone. And I actually miss being able to just feel my hip bone, like, sitting prodding at it. So I was like… it hurt. It actually hurt

when you did it. But I liked having the feeling that I can actually, like, touch my rib. And, like, touching my hip as well. But see now, I'm, kind of, like… that's just anorexic really"

[Ruth 27, 1st baby, 1st interview, gestation 22+6]

Ruth described her partner Graham as 'preferring curves', and by juxtaposing the derogatory terms 'skin and bone' and 'anorexic' with the more favourable term 'curves', she thus depicted her size as more aesthetically attractive, to her partner in any case.

Rebecca talked about her sister, who she said had a long history of anorexia nervosa:

Rebecca: "I've only been to the doctor when I got gallstones when [1st baby] was about two, and they said that can actually be quite common after you've been pregnant. Your body overproduces calcium and it just doesn't stop. So I had my gall bladder removed, and other than that, I'm never at the doctor…. I have a sister, an older sister, she's struggled with anorexia since she was about 13, and she's constantly… one thing or another in the hospital or at the doctors"

[Rebecca, 46, 2nd baby, 1st interview, gestation 21+4]

Referring obliquely to popular media references to 'obese' patients imposing significant cost burden to the NHS, here Rebecca highlighted her own good health, and also the potentially negative consequences of conforming too far to the slim ideal, pointing out that, within her own family, it is this behaviour which in fact has caused greater damage to health, and greater cost to the NHS and the taxpayer. As such, she employs 'othering' as a tactic, used by most participants, including partners, in different ways, in particular during pregnancy. This is explored in depth in chapter five. In addition, Rebecca highlights pregnancy, not obesity, as responsible for her gallstones. This tactic of highlighting pregnancy complications as unrelated to weight, was also employed by several other participants, and again is explored in the next chapter and discussed within chapter seven.

Thus participants resisted stigma within their accounts of their health status, highlighting their lack of health problems, delineating *health* as a separate physical experience to *fitness,* and aligning the idea of being *slim* with that of being *skinny,* thereby attempting to subvert the condition as ideal for physical health.

4.5.3. Obesity: a 'health condition'?

The definition of obesity as a 'health condition' was not acknowledged by the majority of participants in relation to their own bodies. As such, although, 'obesity' was regarded as a health condition by some participants, only very few acknowledged or described themselves as 'obese' at any point during interviews, and none described themselves as 'very severely obese'. Rather, in describing it, they drew on cultural notions of 'the other'. Both Eva and her husband Eric referred to 'obesity' as a health condition when they spoke about Eva's mother, who they described as anthropomorphically much larger than Eva. Eva said:

> *Eva: "And mom is like… you think I'm overweight….. Holy Jesus. She's like morbidly obese, like. She's like… had two knee replacements and… like, I was actually shocked the last time I seen her because… my mom's always been overweight and then… she just doesn't like… Whereas I try to diet and I try to exercise and I try to… at least not get bigger [laughs]… she's just like, 'whatever, I'm fat and that's just how it is and that's life'. It's like… I seen her and I almost didn't recognise her and I was like… you know that way when you're like, 'Oh my god'? And it wasn't because she was so big, it was, I was thinking…'She's gonna die'".*
>
> [Eva 28, 3rd baby, 1st interview, gestation 18+2]

When I interviewed Eric, he also spoke about Eva's mother:

> *Eric: But her mum doesn'ae really keep too well…*
> Alice: Oh, right… What sorts of problems does her mum have?
> *Eric: Ah, just… really bad obesity. She's on like.. twenty five different medications. And ermm… but it's not just like obesity, it's like… obesity, like… I mean like… ridiculous, y'know? I'm not saying that in a bad way but she's in like a… one of those stupid wee chairs and stuff, you know"*
>
> [Eric, 30, Eva's husband, gestation 18+6]

In this application of 'obesity' as a clinical term, Eric and Eva do not draw accurately upon clinical categories, but rather draw their own boundaries around what they define as 'obesity', re-classifying what is a stigmatising condition. Eva was clinically 'very severely obese' at the time of her interviews, but describes herself as 'overweight'. Eva's mother's 'obesity' crossed over to what Warin et al (2011, p.31) refer to as 'the other side of fat'; the 'crossing of an imaginary line whereby people do not conform to bodily and moral boundaries of personhood'. In her relating this story of her mother, Eva classified herself as on the 'right' side of this line, to avoid the associated moral discrediting of 'obesity'.

Amy referred to herself as ‘obese’ on one occasion, however this was to describe her former, larger self:

> *Amy: “Errm... and it wasn’t until… I think it was about two years ago, I sort of like stopped and thought, ‘No, I need to lose weight, like it’s getting’… I was getting… verging on 28 stone...”*
> Alice: Mm-hm?
> *Amy: “And I was like, ‘I need to stop doing this’”*

She went on:

> *Amy: “I... before I fell pregnant I had actually lost about five stone… anyway. I was really morbidly obese before. I mean I still am, but I was really… bad... last year”*
>
> [Amy 26, 1st baby, 1st interview, gestation 16+3]

Amy’s use of the clinical term ‘morbidly obese’ demonstrated that, at 28 stone, she had reached a weight and size that caused her concern for her health, prompting her to lose weight. In addition, although she stated within this excerpt, ‘I still am [obese]’, elsewhere in her narrative she referred several times to her simply being ‘bigger’ and that ‘that’s just me’, demonstrating the conflicting discourses she drew from in making sense of her size, her health, and in defending her moral integrity.

Elsewhere, references to ‘obesity’ as something ‘clinical’, something ‘bigger’ and something ‘other’ were made with more subtlety within participants’ accounts, as they acknowledged and resisted this stigmatising clinical label. Broadly, although all participants’ BMI calculation had led them to be classified as having class III obesity (WHO 2000) or being ‘very severely obese’, and participants were aware of this, acknowledgements of this were rare, indicating the deeply stigmatising and problematic nature for them of the terminology used to describe and categorise their bodies.

4.6. Fertility and pregnancy: in defence of the self (again)

Trying to conceive, and becoming pregnant, was described by several women as a time when health was considered more consciously. Thinking about fertility had brought two important changes for most participants: one was considering health behaviours or indeed undertaking changes in health behaviours (i.e. healthy eating and/or exercising) when trying to conceive and once pregnant: the second was engaging with notions of *risks* to health

posed by their weight. These two are connected in ways I go on to explore; however, I will first explore the behaviour changes discussed by women in relation to their weight and their plans to conceive, and the feelings they described upon discovering they were pregnant, before moving on to discuss in more depth their engagement with notions of risk in the next chapter.

4.6.1. Planning a pregnancy

According to Earles' (2004) four-fold typology of planning/intention in the context of pregnancy, eight of eleven women had what are defined as 'planned pregnancies'; the pregnancies of the two single women, Amy and Martha, could be described as 'accidental'; Eva's as 'laissez-faire'. For several women who had planned their pregnancies, this 'planning' period, which incorporated thinking about when to get pregnant and trying to conceive, was described as a time of change in their attitudes to their bodies, their weight and health. One woman, Ruth, had been under the care of a fertility specialist prior to conceiving, due to her polycystic ovarian syndrome (PCOS) and had been trying to conceive for some time. Mary also had been trying to conceive for some time prior to getting pregnant and had been in discussion with health professionals about undergoing gastric surgery when she conceived. Others said they had been concerned about their weight, health and fertility prior to conception. This was particularly the case for women who had been planning a first pregnancy Louise described how she tried to lose weight and get fitter:

> *Louise "I mean, I've spoken to Vincent about it before we conceived, saying, you know, I want to lose weight. Started really working towards it last April, you know… really making a big push to work out and to eat well and to lose weight, so that when the time to have a baby came, I would be in a better position"*
> Alice: And so when you were planning a baby, did you think about your weight? Did you think weight would be an issue?
> *Louise: "Yeah. I mean, I've been… when I was working with the personal trainer, that was… the end goal was I wanted to get pregnant fairly soon. So I was working towards that"*
> Alice: Uhm-hmm. And is that… did you think that you may need to lose weight in order to conceive?
> *Louise: "Yeah… That was one of the goals, but the other goal was to have a lower risk pregnancy. I knew that there would be risks attached"*
> [Louise 32, 1st baby, 1st interview, gestation 23+5]

Rachel, who was pregnant with her second child said about her current pregnancy:

Rachel: "Why we didn't start trying for our first earlier was that we wanted to see if we could manage to become a bit fitter and healthier. So we were definitely aware that there were risk factors there. And then we talked about it before the second pregnancy that we weren't going to try and have a second until we were both a bit fitter and healthier. But on both occasions our lives, kind of, got in the way of actually that happening"

[Rachel 38, 2nd baby, 1st interview, gestation 19+6]

Rachel's comments illustrate the complex, and at times competing, factors at play in relation to decision-making around health and pregnancy. Indeed, Rachel described time going by, worrying about her advancing age and implications for her fertility, added to not conceiving quickly, as a trigger for comfort eating, which led to weight gain. Several other women described experiencing a tension between believing they should lose weight prior to trying to conceive, and worrying that their age might make it more difficult to conceive, therefore feeling that they should not wait.

4.6.2. Becoming pregnant

Becoming pregnant was regarded by most participants not only as confirmation of fertility, but of good health more generally. Several women used having conceived as a grounds to subvert or dismiss biomedical and public health messages. Carrie was one of these, who described engaging with formal health information and advice regarding her health and fertility. She described how she set out to seek information and advice about conceiving, referring to the widely accepted risk factors which may affect her fertility:

Carrie: "It was, 'Okay, I'm 38 and everybody tells me I'm not going to get pregnant because I'm 38 and I'm overweight, so I'm going to read all about it and find out all the things I need to do'"

[Carrie, 38, 1st baby, 1st interview, gestation 18+5]

Carrie described worrying about her fertility. She saw her GP and looked online for sources of information and advice. She got pregnant after a few months of trying. She said:

Carrie: "Ironically, I think I got so stressed thinking that my weight was going to be an issue, because I was so convinced that I was infertile, that I put weight on

> *and got pregnant. I got pregnant at the heaviest I've ever been. There's some irony in that…. I think because so many of my close friends have had to get IVF and have had problems, it almost feels a little bit too good to be true. I think it's kind of made me realised that you actually have no idea what the factors are that lead to pregnancy, or pregnancy problems"*
>
> [Carrie, 38, 1st baby, 1st interview, gestation 18+5]

Carrie constructed an account within which she acted responsibly, seeking and following health advice, before realising that she did not need to do this, as the advice was inaccurate, and may even have been damaging to her health and fertility. She presented the fact that she conceived at a high BMI as evidence to support her belief that weight is only one of many possible factors which can affect fertility, expressing her view that too much emphasis was placed on weight as a risk factor with regard to fertility and pregnancy. She drew on this several times during her interviews, as well as being critical of official health information and individual health professionals. In the quote above she implied that the advice she received caused her to feel stressed, which she believed may have impacted on her fertility: in so doing she resisted personal responsibility for potential problems.

Similarly Ruth perceived her ability to conceive as negating any advice she had been given about her weight and fertility. She said:

> *Ruth: "…because what I kept on getting told by numerous people is, 'You're not getting pregnant because you're too fat'. Whereas I'm quite fat just now and I'm pregnant. So that's obviously a lie. Because I kept on having it in my head like, 'I must not be getting pregnant, because I'm too fat'. I kept on thinking that"*
>
> [Ruth, 27, 1st baby, 1st interview, gestation 22+6]

Ruth misinterpreted - or misrepresented - the advice she was given as that she would be *unable* to get pregnant with a raised BMI. She may have believed people *lied* to her, or perhaps that she was given misinformation, or over simplified advice; and her description revealed her bitterness about this. It is likely that Ruth was paraphrasing in her recounting of being told 'you're too fat' – indeed she used flippancy and humour often in her interviews. However, it illustrated what was alluded to, both by her and other participants; the stigma they perceived within medical encounters, and the unspoken negative thoughts and stereotyping they attributed to health professionals.

Thus, some participants attempted to undermine and subvert the idea that increased weight is - or can be - a problem for fertility, within the context of weight as a 'correctable problem' (Monaghan 2006), and one of individual moral responsibility. Most presented themselves as good 'mothers-in-waiting', approaching conception as a 'project', prepared to follow health advice, which some perceived to be lacking or to have misinformed them regarding their chances of conceiving. By holding up their pregnancies as demonstrating their good health, these participants resisted the discourse that obesity leads to sub-fertility; that weight loss is necessary in order to conceive. In the following chapters I demonstrate how participants continued to draw upon this and other discourses as they continued through pregnancy and birth.

4.7. Chapter summary

In this chapter I have explored the views and perceptions of women as they recalled their lives and experiences prior to their index pregnancies, and their experiences over the life course in the context of weight, health, and health behaviours, and the impact of their relationships with their partners on their experiences and beliefs, as well exploring the views of partners themselves. I have explored their experiences of weight-related stigma, and have highlighted the important role of food and eating within participant's constructions of themselves, as morally worthy and, for some, as good mothers, resisting associated stereotypes of gluttony and stupidity. Most participants' accounts were imbued with tensions and contradictions regarding their weight, their health and their food choices, both acknowledging and resisting the notion of their weight as a 'problem' for health, and their own responsibility for it.

Most participants' accounts revealed a deep dissatisfaction with their weight, experienced over many years, and characterised by repeated weight loss efforts. Concerns for health had not driven historical efforts to lose weight, but rather a desire to change the way they looked had been the key motivation. The presence of stigma – and, in some cases, shame - within their everyday lives was demonstrated in a number of ways, and informed their perceptions and beliefs regarding their bodies and their health.

A relaxation of pressure was experienced by some in the context of getting older and

settling in a long-term relationship. However, most participants, including some partners, described a lifetime cycle of yo-yoing; losing weight and regaining it – never achieving weight maintenance. Several partners identified themselves as overweight, and their accounts revealed that food, weight and diet were salient topics among the couples. It was clear that some individuals at times derived support in weight loss efforts from their partners, but that these behaviours may also result in tensions.

In building a defence of their moral integrity, the women used strategies such as defending their good health, portraying themselves as at odds with a body which was 'different', had something wrong with it, or let them down, despite their enactment of healthy behaviours. Accounts of why they were overweight shared similarities between women. Accounting for their weight in the right way was important in terms of resisting stigmatising explanations. Several talked about eating healthily, defending the type of food they ate, rejecting negative traits associated with social class and obesity. Home-cooked food was regarded as healthy by all women, with or without existing children. Many participants disclosed their belief that they ate too much. Common within many women's accounts was a representation of 'good' health behaviours; making the 'right' choices about food, thinking about the health of themselves and family members.

Most women defended their good health, in the absence of a diagnosed health condition – and 'obesity' was viewed as a 'health condition' only as applied to others. Despite their recognition of the clinical category of obesity, participants resisted the label for themselves due to its associated moral failings, instead attempting a re-categorisation which normalised their own size, medicalising and demonising those who were larger. Only participants who were significantly the largest in the study did not draw upon images of 'the other' to neutralise and normalise their own size. Most women's accounts contained numerous examples of the ways in which they resisted both the demonisation of their size, and its cultural associations, and the suggestion that it may be detrimental to their health. Having conceived was offered as an exemplar by several of their good health.

As I will demonstrate in the following chapters, for most participants in this study, the experience of pregnancy was characterized by 'stigmatised risk'. These experiences will be

explored within the thesis, and the impact of their partners' views will be considered, as well as the ways in which these impacted upon women's perceptions and beliefs about pregnancy and health, and their engagement with formal health messages and experiences with health professionals.

Chapter Five

Pregnancy

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5.1 Introduction

In this chapter, I present an exploration of participants’ beliefs and understandings regarding their weight and their pregnancies. This includes how they perceive changes to their bodies, and their beliefs regarding health behaviours in pregnancy. I explore

participants' experiences of care and their perceptions of their 'high-risk' status due to their increased weight and BMI, how they relate this to their everyday, embodied experiences. I include the views and understandings of partners in my representation of the constructions of women's accounts and experiences.

Most women's accounts demonstrated that they experienced the labelling of their pregnancies as 'high-risk' as challenging, and were driven by this to account for their weight, which, due to the stigmatising nature of obesity, necessitated a moral defence. As stated in the methodology chapter, all pregnant participants had accepted a referral to a high-risk antenatal clinic, and attended several times during pregnancy, thereby at one level they accepted their size as a 'problem'. I consider the tension within the narratives of women, and also their partners, due to a simultaneous acceptance of, and resistance to, biomedical representations of their bodies as posing risk to both themselves and their babies. As I outlined in the previous chapter, most participants were undertaking 'moral work' in discussing their weight, defending their health and their behaviours, and resisting associated stigma. I explore the complexities of the experience of stigma during pregnancy, as both *felt* and *enacted* within everyday life and in medical encounters, where risk becomes stigmatised, and the ways in which women and partners attempted to perceive and present themselves as 'normal'.

In addition, I explore their experiences of receiving multi-disciplinary care within this context, shared between hospital and community-based appointments, their perceptions of the care they received and accounts of interactions and events which occurred in the healthcare setting.

5.2 Embodied experiences of pregnancy

All participants described pregnancy prompting changes in the ways they perceived and experienced their bodies. Some described changing perceptions of the form as well as the functions of their bodies, and their embodied experiences pertaining to food and changes that they had made in their health behaviours. The most prominent of these were dietary changes.

5.2.1. Stopping the diet

Most women described the knowledge that they were pregnant as marking a change in their experiences and behaviours relating to food and eating. Pre-conceptual health guidelines for overweight and obese women advise weight loss prior to trying to get pregnant. However, dieting and weight loss during pregnancy is not recommended, as it is not known to be safe (Poston et al., 2016). This guidance was referred to by several participants, and in this context, an immediate change for some was a ceasing of weight loss efforts. Rachel was one such participant. She had described having wanted to lose weight prior to becoming pregnant, as this was her second child and she had felt physically unfit during her previous pregnancy, when she had been a similar weight. She described a 'yo-yo' approach to dieting (common to many women's accounts, and outlined in the previous chapter), but then stopping her weight loss attempts altogether when she discovered she was pregnant:

> *Rachel: "And then, of course, as soon as you get pregnant, you have to knock that on the head anyway…"*
>
> [Rachel 38, 2nd baby, 1st interview, gestation 19+6]

Through her account of pre-conceptual weight loss attempts and use of specific language, 'of course', and 'you have to', Rachel drew attention to her morally good behaviour, following medical advice to achieve pre-conceptual weight loss, then stopping dieting in order to preserve the safety of her fetus. Presenting it thus demonstrated that she was not responsible for the decision not to diet. Several other participants also referred to this medically sanctioned cessation of efforts to lose weight in their accounts of their pregnancy health behaviours and experiences.

However, whereas Rachel constructed her behaviour solely as sensible and rational, following medical advice, in her account Babs referred to both medical advice and social sanctioning of pregnancy weight gain. Discussing her first pregnancy, she said:

> *Babs: "[I] lost a lot of weight for my wedding, and then three days before my wedding found out I was pregnant, so from then on I just, kind of, took advantage of the fact that I was pregnant…"*
>
> [Babs 27, 2nd baby, 1st interview, gestation 18+2]

For Babs, ‘taking advantage’ referred to a perceived relaxation of social pressure to lose weight in addition to medical advice to stop dieting. She had wanted to be slimmer for her wedding, a highly significant social occasion, but referred repeatedly to pregnancy as a time when she felt comfortable being overweight.

Babs was one of five participants who had been attending a commercial slimming club (Slimming World) when they got pregnant; all stopped attending, despite being aware it was considered safe and recommended to continue to attend, following a modified eating plan during pregnancy. When asked about her reasons for leaving, Babs said of eating in pregnancy and gestational weight gain:

> *Babs: “Oh, I think it feels like it gives you a free pass. Mmm… yeah, I do. And I shouldn’ae feel that but I do. Mm-hmm. You just think, ‘Oh, I can deal wi’ it after’… I just think, well, I’m gonna... this is likely to be my last baby, I can lose the weight once I’m done”*
>
> [Babs 27, 2nd baby, 1st interview, gestation 18+2]

Here again, Babs referred to social and cultural perceptions regarding the inevitability of pregnancy weight gain. Unlike Rachel, who referred to health concerns in her discussion of pre-pregnancy and pregnancy weight management, Babs focussed on the social context of the large body, which she presented as acceptable in pregnancy, but unacceptable afterwards, hence stating ‘I can lose the weight once I’m done’.

Other participants who had been attending slimming clubs described similar reasons for leaving during pregnancy; as weight loss efforts would cease during this time, they didn’t perceive any potential benefit in attending.

Only Martha said she would have liked to have continued to attend her slimming club during pregnancy, which she had been a member of for several years. Martha was single during her pregnancy and had attended with her best friend. She said she missed the camaraderie and support she received there:

Martha: "…you know, we had a group of friends that would support each other and… that made a difference emotionally because, we're all in the same boat. We all have out trials and tribulations emotionally…"
[Martha 41, 1st baby, 1st interview, gestation 15+5]

Martha had been advised by health professionals at the specialist antenatal clinic not to attend the slimming club during pregnancy, as they would 'keep an eye' on her weight. Martha accepted this advice and indeed was weighed routinely in pregnancy at the high-risk clinic, although her gestational weight gain was not discussed with her.

5.2.2. Partners stopping the diet

Several partners discussed their concerns about their own weight during interviews, and for some, a partner's pregnancy offered a perceived relaxation of the pressure to diet for both members of the couple. Using verbatim the words Anne used in her interview '*we both know we're fatties and we need to lose weight…*', Ian talked about his efforts with Anne to lose weight prior to pregnancy:

Ian: "We've always sort of... we go through periods where we're dieting, or we'll do weight watchers and stuff like that together. So yeah we do… we both know we're fatties and we need to lose weight so…" [laughs]
[Ian 32, Anne's husband, 1st baby, gestation 18+0]

He went on to describe how Anne's pregnancy had meant a relaxation in his own efforts to lose weight, outlining their joint plans to return to dieting once their baby was born:

Ian: "I started doing the sort of 5-2 [diet] thing last year, and I lost a couple of stone on that. But Anne wasn't keen on doing it to start with but she had started doing it before she got pregnant and she quite liked it… so maybe once the baby comes we'll go back to doing that"
[Ian 32, Anne's husband, 1st baby, gestation 18+0]

Anne also talked in her interview about Ian's current habits, and her intention that they make changes together once their baby was born:

Anne: "I'm sort of letting Ian do what he wants just now though, because when the baby's here he's not allowed to eat in the living room anymore, we have to

sit at the kitchen table. There will be more vegetables. There will not be two dinners. There will not be treats. I'm like, 'Get it all in now, babe'"

[Anne, 32, 1st baby, 1st interview, gestation 17+1]

Similarly, Louise's husband Vincent talked about his fluctuating weight:

Vincent: "I can go through phases where I will exercise constantly for two or three months and I'll lose loads of weight and then I'll put it all back on again. Because I get to a point where I'm like, I'm quite happy with how I look, the job's done – which is a terrible attitude but just unfortunately how I am…. I don't know. I think I just get to a point where I've done all this hard work and I've lost the amount of weight that I was looking to lose and then I start wanting all the things that I've not been having for all that time, like chocolate and the drinks and things like that"

[Vincent 32, Louise's husband, 1st baby, gestation 24+1]

Following the birth of their baby, Louise talked about Vincent's 'pregnancy' weight gain:

Louise: "Vincent is really keen to lose his baby weight as well [laughs].So we're meal-planning."
Alice: Has he gained weight?
Louise: "Oh yeah! He ate for two the last trimester. He's like me, he fluctuates. When I was really sick, he was eating mine. He had a bump before I did basically [laughs]. So he knows that he's been not very healthy either"

[Louise 32, 1st baby, 2nd interview, baby 5 weeks old]

Thus within several couples, both individuals described themselves as overweight, described dieting together and experiencing dietary changes together in pregnancy, with individual eating behaviours impacting within the partnership. All participants who spoke about this subscribed to normative behaviour change messages about the need to diet when overweight, and male partners described the 'weight cycling, or 'yo-yo' behaviour that was common to many women's accounts. Within these couples, support and dieting together, as well as breaking diets together, were important. However, although several men described serially dieting, none continued weight loss efforts during their partner's pregnancy.
They perceived a relaxation which extended to both individuals within the couple during pregnancy.

5.2.3. Beliefs about food and embodiment

Participants all expressed views about food and nutrition in pregnancy. There were commonly held beliefs by most participants and concurring views were expressed by individuals within couples. There was a strong orientation towards health within many accounts, as participants discussed their embodied experiences of pregnancy and eating behaviours.

5.2.3.(a) Cravings: giving the baby 'whatever it needs'

Early pregnancy was characterised for many by nausea and, for some, a loss of appetite. This had resolved for all participants by the time of interviews, but many recalled a disruption in 'normal' eating due to these symptoms. Carrie described how she coped with nausea:

> *Carrie: "I was eating so much sugar, cos it was the only thing that didn't make me feel sick. I've never had so much full fat coke in my life and Haribo sweets, cos they eased the sickness"*
>
> [Carrie 38 1st baby, 2nd interview, baby 6 weeks old]

Anne's husband Ian recalled being concerned as her nausea, vomiting and loss of appetite caused her to lose weight:

> *Ian: "I think… for the first sort of... 14, 15 weeks, it's been difficult to eat anything really. So yeah, I think she was more conscious of when she could eat, making sure she was eating something that was... healthy".*
> Alice: Yeah?
> *Ian: Ermm… but equally, as she wasn't eating anything… I think she lost about 2 stone… Sometimes she just had to eat something so... it didn't matter what it was really, cos it was the only thing she'd've eaten that day."*
>
> [Ian 32, Anne's husband, 1st baby, gestation 18+0]

Participants all referred to a belief that a healthy diet was important in pregnancy; several women, and partners, cited pregnancy healthy eating advice as well as referring to commonly-held lay beliefs about eating in pregnancy. Thus, some described increasing their intake of fruit and vegetables, as well as calcium-rich foods, such as milk and cheese, and

also expressed a view that the pregnant body would alert the woman, via physical cravings, to what it required to nourish the baby. Ruth described following her cravings**:**

> *Ruth: "Because, I mean, I have been eating healthily. I've been eating a lot more fruit and things, because I keep on getting craving for certain fruits…[] Because they say whatever baby fancies is what you're neglecting, or what you're missing in your diet. And I was like, 'Right, OK'"*
>
> [Ruth 27, 1st baby, 1st interview, gestation 22+6]

Her partner Graham described the different foods Ruth was craving:

> *Graham: "No, no, no. she's changed, she's eating loads of fruits and grapes and... She's eating a lot of shite as well to be fair.*
> *Alice: Shite?*
> *M: Yeah, rubbish. Takeaway crap"*
>
> [Graham 32, Ruth's partner, 1st baby, gestation 25+2]

Anne described following her sweet cravings, and described her belief that she was following the baby's signals:

> *Anne: "Although I haven't changed massively what I'm eating, I have a little bit. I love eating sweeties. That's probably not good for the baby, but [he] seem[s] to want it because I never ate this many sweeties before. Not chocolate. Like…. more like Mentos or fruity Polos or those stupid fruity sweeties, or sour sweeties as well, which I never ate before"*
>
> [Anne 32, 1st baby, 1st interview, gestation 17+2]

Thus Anne suggested here that the baby's preferences were responsible for changing her tastes during the pregnancy.

In this way, most women described responding to the physical symptoms of pregnancy, in terms of suppressing nausea or eating despite loss of appetite, as well as eating as a response to physical cravings, invoking the fetus in accounting for their embodied experiences. Within this context, some acknowledged that what they ate would not be recommended or considered to be healthy, but their descriptions indicated they responded more readily to their embodied experiences, which they accounted for by citing lay beliefs regarding pregnancy. I discuss this further below.

5.2.3.(b) Increasing intake, but 'not eating for two'

In describing their beliefs and behaviours regarding eating, several women described complex approaches, some demonstrating ways in which they exercised restraint, whilst simultaneously relaxing their attitudes towards restraint. Amy had lost several stone in weight through dieting prior to becoming pregnant. She described her desire for a relaxation of the pressure to avoid certain foods:

> *Amy: "….I wanna be able to enjoy my pregnancy. I'm not going to start this whole eating-for-two thing anytime soon, but at the same I want to be able to enjoy it. You know, if my body wants something then I'm gonna give it… you know, whatever it needs…"*
>
> [Amy 26, 1st baby, 1st interview, gestation 16+3]

For Amy, to 'enjoy' her pregnancy meant experiencing a release from restraint, but also from the guilt and stigma surrounding food, being able to eat something that she wanted, when she wanted. However, she acknowledged and resisted the idea that 'eating for two' in pregnancy was socially sanctioned, describing her intention not to follow such advice. As such, she expressed both an intention to exercise restraint, whilst simultaneously experiencing a *relaxation* in her perceived need to exercise restraint.

Martha, who was diabetic, and using insulin during pregnancy, described a similar attitude:

> *Martha: "Being pregnant, if anything I've made a conscious effort not to say, 'Oh, it's ok, I'm pregnant, I'll have that fifth bit of cake', and that. I'm being quite… yeah… more aware of it. But not beating myself up over it"*
>
> [Martha 41, 1st baby, 2nd interview, gestation 35+0]

In her second interview, close to the baby's birth she said:

> *Martha: "Everyone's like, 'Oh, you're ok, you're eating for two'. You're like, 'You're not eating for two' [pauses, then laughs]. So, yeah, if I've fancied something, I'll have something. And if anything I'm not eating as big a portion as well. My portion sizes have shrunk, because I feel fuller quicker, cos there's not as much room [laughs]. So…yeah, it's been… Yeah, I've felt less bloated and... kinda… So, I've enjoyed it. I've enjoyed eating because I've been less worried about, 'Oh, can't have that!' You know, or, 'It's wrong to have that!', and ticking yourself off about it. So… yeah…."*
>
> [Martha 41, 1st baby, 2nd interview, gestation 35+0]

Martha cited the example of being encouraged to 'eat for two' and her resistance to that message, to demonstrate simultaneously both her restraint and her ability to understand that such behaviour is not medically advised. Several women specifically referred to their awareness that the need to 'eat for two' was a myth, and represented it as allowing oneself unrestricted intake, associated with western cultural representations of gluttonous wanton consumption. Participants distanced themselves from this stigmatising image, instead describing allowing themselves occasional treats, as well as focusing on, and following signals from, the baby and the body, behaviours which they did not consider to be deviant or greedy, but rather to be socially sanctioned and appropriate in pregnancy.

Interestingly, not all women spoke about such 'signals' from their bodies or babies as something to give in to but rather as something to resist. Louise, who spoke at length during interviews about her focus on healthy eating, described being extremely tired and lacking the will to cook, thus eating more ready meals and take away meals. She referred to her body sending her 'unhealthy' signals, due to tiredness, signals that she tried to resist:

> *Louise: "I just don't have the energy or the inclination when I get home. I'm exhausted. And also I just… sometimes my body is just wanting something that's…you know, I'm trying…really trying to make the effort to eat better, but I think I eat a lot…I'm more likely to eat rubbish or sweet stuff. I've had really bad sweet cravings that I've been trying to fight and curb but, you know, I still give in to them sometimes"*
>
> [Louise 32, 1st baby, 1st interview, gestation 23+5]

Louise referred again here to the 'battling with the body' notion that was common among participants' accounts of pre-pregnancy dieting. She constructed an image of her fatigued body as at odds with what she considered as her *self*, that which was morally good and struggled against her cravings.

The women's partners also subscribed to the view that, on the whole, women should follow their pregnancy cravings, believing also that these were the body's way of signalling what it needed for the nourishment of the maternal body and fetus. Babs' husband Jim Bob outlined his view:

Jim Bob: "At the minute… she's eating Fray Bentos pies [laughs] and pork pies for her lunch and that, because that's what she's wanting and that's <u>her craving</u> *[Jim Bob's emphasis]. Is it bad? Is it good? It's not having any ill-effects on her, from what I can see and that… She's going to put weight on cos she's pregnant, there's no denying that. After her pregnancy she'll be like, 'Oh, look how heavy I am!'"*

[Jim Bob, 30, Babs' husband, 2nd baby, gestation 25+4]

Thus, Jim Bob clearly demonstrated his belief that gestational weight gain was inevitable for Babs, and that her pregnancy meant she should respond to her cravings, to fulfil the baby's needs. As he described elsewhere in his interview, Jim Bob did not believe Babs should lose weight, or that slimness necessarily equated to good health. His focus for Babs was on nourishing her body, gaining weight, to ensure the health and growth of the baby.

Conflicting viewpoints were commonly expressed within their individual accounts, as respondents described enacting morally good behaviour, exercising - or attempting to exercise - restraint, whilst simultaneously perceiving a relaxation of the need for restraint. This was linked to the perceived inevitability of weight gain.

5.2.3.(c) The inevitability of weight gain

Pregnancy weight gain was seen as inevitable by most of the respondents, and in particular by partners. Eric described Eva's weight gain and loss in relation to her previous pregnancies, demonstrating his view that weight gain was to be expected:

Eric: "She actually lost a lot of weight after the first baby. But then we got pregnant with the second one, she wasn't happy…." [laughs]
Alice: Was she not?
Eric: "Well, she'd lost quite a lot of weight, cos we'd been… obviously we'd been going to the gym and everything and… Aye, she lost quite a lot. She went quite a few sizes down, then she got pregnant again, then she went back up again. So, I think half the problem is the pregnancy. The weight just keeps coming back again. Cos you know, obviously we've had the two kids within… she'll lose it for a year, or… six months or whatever and then… get pregnant again"

[Eric 30, Eva's husband, gestation 18+6]

Here, Eric demonstrated his belief that Eva's weight gain would include gaining body fat in addition to the weight gain due to the growing fetus and other products of conception.

Jim Bob believed that Babs should eat as much as she wanted and whatever foods she wanted. He explained this:

> *Jim Bob: "If she wants to eat… and eat and eat… fine! It's gonna feed the baby. OK, there might be a McDonalds and a… a loada crap going in as well, I'm not saying it's all good food and nutrition but… the baby will take what it needs out of that. It'll take what it needs fat-wise, and it'll take the protein out of that burger that it needs… for it to grow... errmm… and all the vitamins that it needs. If they're… they're worried that the baby isn't getting enough vitamins, you can go down to Boots and get supplements to boost, you know… the iron and the…. You know? If they're worried about that. But… if she wants to eat, fine. She's obviously needing it, for herself and for the baby. I don't see an issue with that to me…. Yeah, she'll say she's no slim Jim, but she can get about, she can move, she can get to the bus. She can… perform what I call daily tasks fine. There's no problem. She can get out and about and do what she wants to do. I don't see an issue with… eating [laughs]"*
>
> [Jim Bob 30, Babs' husband, 2nd baby, gestation 25+4]

Jim Bob attempted to resist the stigma he perceived on Babs' behalf, regarding the size she was and the food she ate in pregnancy. He mentioned fast food, perhaps consciously choosing McDonalds due to its social and cultural connotations as an outlet favoured by those with lower SES, in order to acknowledge and subvert dietary advice. As such, he attempted to present Babs as 'healthy' in a functional sense, able to live her everyday life, and morally good, by not restricting her intake, but rather eating foods which satisfied her body's signals and directly 'nourished' her baby.

5.2.4. Dietary advice: patronising and stigmatising

The rich and detailed accounts of all participants demonstrated that food and the embodied experiences and beliefs about eating and gestational weight gain were highly important in women's everyday lives, influencing, and being influenced by, the views and behaviours of their partners. However, participants also shared negative experiences in common with regard to the formal advice they were given within the high-risk clinic.

The care package at the specialist clinic that the women attended included the opportunity to speak to a dietitian. There are no current UK guidelines regarding recommended weight

gain in pregnancy, regardless of a woman's BMI. Participants were recommended by dietitians at the high risk clinic to attempt to maintain their weight, or to gain as little as possible. However, historically, participants had described long-term struggles to maintain as well as to lose weight, experiencing the weight cycling, or 'yo-yoing' outlined in chapter four.

All the women accepted a consultation with a dietitian; however some were not seen at their initial visit and were not followed up via telephone, as they were expecting. Anne was one of these. She described feeling disappointed that she was not followed up, but her comment below highlights that she also felt stigmatised by the offer in the first place:

> *Anne: "We're not miserable old fat people or anything, and we do go out and walk and stuff. I don't think the clinic's going to tell me, 'This is what you should be eating' and 'This is what's good for your baby', because I'm bright and I know what's good"*
>
> [Anne 32, 1st baby, 1st interview, gestation 17+1]

Anne's reference here to her perceived stigma echoes those in the accounts of other participants. She suggested that the clinic staff might believe she did not know how to eat healthily and did not take exercise, and perhaps even that she was stupid. She referred to, and dismissed these prejudices, necessarily resisting the suggestion that she needed such advice.

Most women were seen at least once by a dietitian however, and several felt stigmatised by either the offer of a consultation or by the information given, or both. Eva was one of these. In tears, she said:

> *Eva: "You know… and I understand it's like, you know, they're just doing it because they're trying to help and… but you're like, well, what's the point in telling me… that 'you're pregnant, so you can't diet… but you're fat, so you're just kinda like…[whispers]… really bad', you know what I mean? And they tell you like, 'Well, you're pregnant, so you shouldn't try to lose weight, but you shouldn't be this fat'. You're like, 'Well what's the point in telling me that when I'm already pregnant? Like, I can't do anything about it, so you're making a person feel...' you know what I mean? Bad about something they've already got an issue with."*
>
> [Eva 28, 3rd baby, 1st interview, gestation 18+2]

Her husband Eric said:

> *Eric: "She just feels like they're just… judging her, you know like, 'look at the state of you', you know? Or… you know, that type of stuff. It's never anything helpful, is it? [whispers] 'You must lose weight, even though you... may [inaudible] the baby'. You know? How do you lose weight when you're pregnant? It's not gonna happen is it? No-one ever went on a diet when they were pregnant. It's the most ridiculous thing I've ever heard of. I mean, after the baby, fair enough. But I mean, during the birth? Do you want to put the baby at risk? No. So yeah. It's ridiculous [laughs] People generally tend to gain weight during pregnancy, I mean... why would you want to lose it? Nah, I don't agree wi'it. So they can…" [laughs]*
> Alice: You can say what you like!
> *Eric: "I tried not to swear, but I was saying they can shove it, you know? Their stupid advice"*
>
> [Eric 30, Eva's husband, gestation 18+6]

Eva and Eric demonstrated anger and a deep sense of stigma in discussing dietary advice. In addition, I would suggest the powerlessness and frustration Eva felt was evident in her choice of expression. She posed the questions regarding her treatment as if she were addressing the health professional directly: '...you're making a person feel… bad…' However, she did not question her treatment and the advice offered within the encounter at the time, presumably having felt unable make a direct challenge.

Amy also felt stigmatised by the consultation she had. She described her perception of patronising treatment, and her belief that the dietary advice wasn't delivered with complete openness. She said:

> *Amy: "They keep telling, 'It's not a diet, it's not a diet, we just don't want you to gain any weight'. But then, to me, that sounds like, 'hmm..' cos I'm gonna gain weight with a baby, so it almost sounds like, well, you are <u>kinda</u> telling me to lose weight while I'm pregnant, a little bit.. But you're wording it <u>very differently</u>" [sounds tearful]*
>
> [Amy, 26, 1st baby, 1st interview, gestation 16+3]

It is likely that the health advice they were given - to aim to maintain their weight – was stigmatising to some women, as weight maintenance was something which many of them had described struggling to do during many years of 'yo-yo' dieting.

Other women, who did not describe feeling stigmatised by the 'high-risk' label, did not feel they benefitted from their consultation in terms of gaining any useful advice or information, describing it solely as reassuring in terms of what they ate. Martha said:

> *Martha: "She* [dietitian] *was like, 'Tell me what you eat, food-wise', and I was like, 'OK' and things like this, so I kind of went through everything I eat on a day-to-day basis and she said 'You're kind of doing everything that we would say to do anyway', so I was like, 'Oh, it's not too bad'".*
>
> [Martha 41, 1st baby, 1st interview, gestation 15+5]

Rebecca, who had attended slimming clubs for prolonged periods during her adult life, felt frustrated at the lack of advice she felt she received:

> *Rebecca: "As soon as I went in and sat down, she was like, well, you know, it was not what you think, but it's kind of, well, what do you have, but there was no, well, that's right, that's wrong, you shouldn't really be having that. I mean, I know they probably don't want to be judgemental or whatever, but it was more… I thought I'd be given more structured advice or examples of, this would be a good combination, so this would be… just there wasn't that element to it, and there wasn't any of the kind of breakdowns in terms of… which you all know, but you kind of need reminding every now and again about carbs, proteins, all that kind of stuff, combinations, what you should be having, especially during pregnancy if it's different. You should be having more of one food group than another. I know there's elements to it that are common sense, but I just kind of felt I didn't come away with very much from that session"*
>
> [Rebecca 46, 2nd baby, 1st interview, gestation 21+4]

Eva also expressed frustration about this. She described the written information she was given:

> *Eva: "It's just a basic leaflet that says… 'Make sure you're eating… your meat is the size of a deck of cards', you know… 'you're having a certain amount of carbs on your plate'. You know, like… all of that kind of stuff, but as I said, that's everywhere. You know, that information is literally everywhere. It's not for… I don't feel like it's specifically targeted at pregnant women, I mean it does say*

> *like… 'Don't eat pate' [laughs], but… you know what I mean? It doesn't say, 'If you're overweight and pregnant, this is what you specifically need to do and…' It's just… basic generic information, without eating raw eggs. You know what I mean?"*
>
> [Eva 28, 3rd baby, 1st interview, gestation 18+2]

Thus, participants differed in their specific criticisms of the dietary advice they received, with some women resisting the suggestion that they needed information, while others felt they were not given enough advice (and Eva expressed both criticisms during the course of her interviews). In general, however, the lack of any evidence-based dietary advice, beyond standard nutritional information or pregnancy dietary advice, led to participants feeling frustrated or stigmatised by the suggestion that they needed help, when no specialist dietary advice was forthcoming.

In addition, although most participants spoke at length during interviews about the lay beliefs outlined above, including the benefits of responding to cravings, the complexities of perceiving both a need for restraint *and* a relaxation of the pressure to exercise restraint, the inevitability of weight gain, none described having discussed these with a dietitian during consultations, demonstrating a lack of openness and an unwillingness to discuss these lay perceptions in this setting.

5.2.5. Summary

The accounts of women and partners demonstrated commonly held views regarding the embodied experience of pregnancy and food and eating behaviours. These included: the need to cease weight loss efforts during pregnancy, the benefits of responding to the body's signals, invoking the fetus as at least partially responsible for cravings; increasing of certain foods, and a belief that weight gain was inevitable during pregnancy. Eating behaviours were presented as driven by the need to be a 'good' mother, nurturing the fetus. Partners who had been dieting alongside a pregnant partner pre-conceptually all reported also ceasing their weight loss efforts during pregnancy.

Despite several participants giving lengthy accounts of the beliefs described above, none reported discussing them with health professionals. All but two participants received dietary

advice during their attendance at the specialist clinic, and for most this was from a dietitian, but these were recalled as information-giving sessions about what, and how much, to eat during pregnancy, rather than as broader discussions . These were experienced as stigmatising and patronising, with no participants reporting having had a consultation that they found useful, while just one described the experience as reassuring. Criticisms varied however, as some women felt they did not need information about healthy eating, while others reported having wanted more guidance.

5.3. Risk and reassurance

The resistance expressed by some participants to the notion that they needed help or advice regarding food and eating in pregnancy extended to other aspects of their pregnancy care, to encompass broader concepts of risk. In the next section I explore the complexities and tensions inherent within accounts regarding risk, focussing on the ways in which some participants both engaged with, and resisted notions of risk as applied to their own pregnancies. This was exemplified by their attendance at – and in some cases their simultaneous questioning of the need to attend - the high-risk clinic. I consider the ways in which some participants accepted the notion of risk in the abstract, whilst employing strategies used to resist the notion of risk as applied them personally. I discuss the extent to which some participants perceived the notion of risk as stigmatising, while others did far less so, and the factors which contributed to this.

5.3.1. Negotiating Risk and Seeking Reassurance

The specialist antenatal service from which the study sample was drawn is offered as an option for care to women with BMI >40kg/m^2 within a region of Scotland, and typically around 50% of eligible women attend. Their care is designed to be shared between hospital outpatient and community clinics. Most participants presented their attendance at the high-risk clinic as the morally 'right' decision; neutralising risk and normalising weight in ways I will outline, and drawing on discourses of 'good mothering' to account for their decisions.

Participants contemplated their 'high-risk' label within their narratives, with some seeking variously to reject, or deflect stigma, to normalise their own body size, and to question biomedical constructs regarding weight, pregnancy and health, in order to position

themselves as close to 'normal' as they could, therefore as 'fit' to be pregnant and to be mothers.

Most participants were considered high-risk solely due to their obesity, with no co-morbidities or other risk factors. Their experiences and perceptions differed from others with complications and this will be explored. Most women welcomed the added surveillance that their high-risk care provided, in particular in the form of extra ultrasound scans, which were reported to be enjoyable and reassuring experiences in the main. However, they also simultaneously resisted the 'high-risk' label that their weight brought to their pregnancies.

High-risk status and monitoring meant increased surveillance to screen for adverse clinical events. The delicate balancing of welcoming the surveillance but resisting its perceived implications was evident in several women's accounts. Many of them spoke of the reassuring nature of 'keeping an eye' on the pregnancy. Several women said they valued high-risk care as they thought it was 'better' care. Carrie, for example, who forcefully questioned at times the notion that her weight resulted in increased risks for her, also wondered aloud why anybody would refuse consultant-led care, believing it to be 'safer'. Louise, who was to be diagnosed with OCD late in her pregnancy, said in her first interview:

> *Louise: "I tend to be, kind of, an anxious person anyway, so the more times I see a doctor and get to see the baby on a screen, the more it puts my mind at ease, so I'm pretty happy with it, to be honest.*
>
> [Louise 32, 1st baby, 1st interview, gestation 23+5]

Ruth said:

> *Ruth: "I'd rather know if something's going to wrong than find out about it when it's actually going wrong"*
>
> [Ruth, 27, 1st baby, 1st interview, gestation 22+6]

The beliefs expressed by these participants may be shared by many women, regardless of their BMI, regarding risk and surveillance in pregnancy, and these comments do not reflect an acceptance of 'high-risk' status due to increased weight. However, Anne talked about aspects of surveillance and screening which occurred in the clinic, and described her reasons for attending with reference to the increased risks specifically due to her size. She said:

Anne: "I am interested in them checking whether I can have… I'll have any problems with getting an epidural because I'm bigger. I am interested in the extra scans and I am interested that they'll pay more attention to check if there's any complications with my baby and it's growing, but that's mostly because my friend's had so many problem and I've heard so many horror stories that I'm a bit scared"

[Anne 32, 1st baby, 1st interview, gestation 17+1]

However, she went on to offer reasons why she felt reassured by comparing herself and her perceived health status to that of her friend:

Anne: "She just had a really difficult time, but she's got a weak cervix and stuff. I think we're different in some ways. We're similar probably in weight, although she's a wee bit…we look similar, although she's a little bit shorter than me so I might actually be heavier than her because I'm taller. But I think I'm healthier [because] I eat better than her. She eats pizza all the time. I exercise, where she's quite lazy. The minute she got pregnant she just decide that was her permission to eat pizza all the time and do absolutely no housework whatsoever, whereas I'm active."

[Anne 32, 1st baby, 1st interview, gestation 17+1]

Anne's is one example of many offered by participants, who focussed on reassurance rather than risk within their accounts.

5.3.2. Resistance strategies

Several participants did discuss their understanding of the risks associated with increased weight in pregnancy, including diabetes, high blood pressure and the increased likelihood of giving birth to a large baby. However, this discussion took place very much in the abstract, with a resistance to them as applied to their own pregnancies. Most participants constructed themselves, and their bodies, in so far as they could, as 'normal', engaging in what Jarvie (2016) describes as 'rhetorical neutralisation strategies' in order to distance themselves from these risk and/or the stigma associated with increased weight in pregnancy. These strategies shared common themes and are presented below.

5.3.2.(a) 'Othering'

Some participants employed a strategy of 'othering' in order to resist stigma (Thompson and Kumar, 2011). As such, they referred to perceived stereotypes of obese people, in order to highlight certain behaviours or traits as morally repugnant, thus acknowledging, and then resisting them as applied to themselves. Demonstrating that she understood the importance of exercise in pregnancy, and resisting the assumption that she was lazy, Anne said:

> *Anne: "I know how to eat healthy and I am taking care of myself. I am walking now that I'm pregnant, to try and be healthy"*
>
> [Anne 32, 1st baby, 1st interview, gestation 17+1]

Eric demonstrated his felt stigma on behalf of his wife, in his description of his perception of how she was judged by health professionals:

> *Eric: "…so it's no' like she sits and stuffs her face all day with crap. But that's what they make you feel like, you know? Like you have been doing that, you know? [Pause] And they won't believe you if you say, 'I'm actually quite healthy'. They're like, 'Sure you are'… But… that's pretty much the advice they give you, I guess…"[pause]*
>
> [Eric 30, Eva's husband, 3rd baby, gestation 18+6]

Carrie described how, as they were waiting to see the midwife in a busy NHS waiting room, her grandmother gave her some advice:

> *Carrie: "She said, 'Look at all these radges*, they've had children fine. You'll be able to do the same'"*
>
> [Carrie 38, 1st baby, 2nd interview, baby 6 weeks old]
>
> (*Radge: Scottish, informal noun: a wild, crazy or violent person. Source: Oxford English Dictionary)

Carrie referred to this as an amusing anecdote, however, it accorded with the representation she made of herself during our interviews; highlighting the deviance of others, to present herself by contrast as healthy, active and happy. She quoted her grandmother's comment as it supports her view that other women, who engage in stigmatised unhealthy behaviours such as drinking alcohol and drug-taking in pregnancy, are

less healthy than her, thereby providing reassurance about her own health and moral integrity.

In this way, several participants referred to common demonising characteristics associated with 'obese' pregnant women. This allowed them to signal their recognition of these traits, but as applied to others. In so doing they resisted such character traits as applicable to them, Reflecting this, they resisted the cultural associations with this 'grotesque *other*' (Braziel and LeBesco, 2001, p.3); they did not use the term 'obese' to describe themselves.

5.3.2.(b) On the threshold

Several women and their partners attempted to normalise their size by comparing it favourably to that of others. Several women, including Anne, Rachel and Babs, pointed out that they only just met the criteria for high-risk care. Anne said:

> *Anne: "I think they probably weren't that concerned with me. I noticed in the waiting room I might have been one of their slimmer customers, so I don't know if they just weren't that bothered. Plus, I seemed really healthy and I think when I was talking to them I was like,' I'm healthy, I'm good, I'm active. I know what's going on and this is…' so I don't know, I maybe just didn't seem like I was of any concern"*
>
> [Anne 32, 1st baby, 2nd interview, baby 4 weeks old]

In highlighting that she 'knows what's going on', Anne displayed resistance, through 'othering' strategies again, implying that there are other, obese women who require extra help and education regarding their health, and who do not 'know what's going on' but that she was not one of them.

Others too described a similar sense of reassurance from their perceptions of their relative 'normality'. Rachel demonstrated her awareness that she was smaller than many patients attending for high-risk care, and took her consultation with the obstetric consultant as reassurance about her level of risk:

> *Rachel: "When I saw Dr [], she's very nice but she is quite blunt in many ways. A number of times she made it pretty clear that I'd only just made it into their clinic; that I was one of the smallest ladies that she treats…"*

Alice: Oh, right?
Rachel: "The last time I saw her in the clinic, she made it pretty clear that she didn't expect to ever see me again. She gave me my plan of care: 'go and have a nice delivery'"

[Rachel 38, 2nd baby, 3rd interview, baby 5 weeks old]

In his interview, Rachel's husband Ben also compared her weight and associated risk with that of larger women:

Ben: "As well as, you know, people saying, Rachel is barely within the clinic that we're in at the moment in terms of risk factor, that there are women who are at much more risk. So, yeah, all of that has been..."
Alice: Is that in terms of weight that you've thought of that?
Ben: "Yeah, in terms of weight"

[Ben, 40, Rachel's husband, 2nd baby, gestation 23+0]

Babs' husband Jim Bob made a similar observation regarding her proximity to the threshold for referral:

Jim Bob: "I've not been to the meetings so I don't know exactly what's been said but… but they've done that BMI, and she's just over the… the range. I think it's 40… and she's measured at 41. So she's... I don't know if it's obese, or extremely obese or whatever. So she's literally just over. If she'd been half a centimetre higher, she'd be under that threshold and she wouldn't be having all these… growth scans and…"

[Jim Bob, 30, Babs' husband, 2nd baby, gestation 25+4]

Mary was considerably larger than most other women in the study. However, her husband Adrian also spoke about feeling reassured by her relatively smaller size:

Adrian: "…I don't really worry about that… her weight… because for me… like, I have seen women who are more overweight… bigger than her and… they have made it. And not… like especially…back home where our health care… is really poor… "
Alice: 'Mm-hmm?'
Adrian: "…and I have seen women who are more overweight than Mary and they have made it.'

[Adrian 28, Mary's husband, 1st baby, gestation 17+6]

Adrian, who originated from West Africa, believed Mary had the advantage of being smaller than others and from having the opportunity to give birth in a developed country.

5.3.2.(c) Second and subsequent pregnancies: personal experiences of 'normality'

Some participants who already had children understood the risks associated with their pregnancies from the perspective of their own previous experiences. Eva and Eric recalled Eva's previous experience, therefore perceived Eva to be 'low-risk'. Referring to her perception, expressed by herself and Eric during interviews, that her care was depersonalised, stigmatised, and that she was treated as 'a statistic' [Eric], she resisted biomedical discourses which link maternal and offspring obesity:

> *Eva: "Every time, you know… [begins to sound upset] Like every time you go there, they're like, 'Oh, you're fat, and you're…There's increased chance for… pre-eclampsia and high blood pressure [monotone- reeling off a list] and…' whatever else and… And I've had two healthy babies that… aren't fat"*
>
> [Eva 28, 3rd baby, 1st interview, gestation 18+2]

Her husband Eric said:

> *Eric: "The thing is, they always tell her… they always say, 'Oh, because you're fat you'll be like… you're going to have all these problems like diabetes, your cholesterol will be high…' She always gets scanned and she's always fine, you know what I mean? So it's not like… They're always saying, 'You'll get health problems when you're older', but everyone gets health problems when they're older, like… you know? I mean, look at me, I'm as slim as hell and I've got health problems, you know? So I don't see why they should just… make them feel like crap, you know? I mean, like, how many people are fat now, like… 60% of the population? It's just how it is, you know? [laughs]"*
>
> [Eric 30, Eva's husband 3rd baby, gestation 18+6]

Here, Eric constructed an image of ill-health as an inevitable consequence of ageing, and not necessarily the result of obesity, which he presented as a 'new normal' physical state. Thus, grounding his view firmly within their personal experiences of child bearing, and angered by the stigmatising treatment both he and Eva perceived she had experienced, he rejected the evidence regarding weight and pregnancy, and thus the advice and information they were given.

Babs' husband Jim Bob expressed his views about Babs' health and risk status:

Jim Bob: "Like, you need to know what your baseline is before you know what's going on, if that makes sense? You know, Babs' BMI might always have been 40. Can you say that's healthy or unhealthy? It indicates that it's unhealthy, but if she lives to a hundred … clearly not! [laughs] That was clearly fine for her. Each individual is different in how they're made up …"
Alice: So you think that what somebody weighs isn't necessarily …?
Jim Bob: "No"
Alice: …an indicator of good health?
Jim Bob: "No. I don't think so"
[Jim Bob 30, Babs' husband, 2nd baby, gestation 25+4]

Jim Bob and Eric perceived depersonalisation and negative judgements in the advice and treatment their wives received. Their representations were of the individuals they were married to, and their accounts demonstrated anger at the lack of acknowledgement of this within maternity care, which they perceived focused only on weight and risk, which led to them feeling demonised and anxious.

5.3.2.(d) First babies: reassurance from social networks and social media

Several participants who were pregnant with a first child, also questioned the risks associated with their weight, describing their attendance at the clinic as following a 'just in case' approach, valuing the extra surveillance and monitoring of pregnancy risks it provided. However, with no prior experience of their own to draw upon, they looked to examples from their social worlds or from social media, to reassure them regarding their personal level of risk. Carrie was one such participant: she discussed the pregnancy experiences of many of her friends during interviews, emphasising several times her belief that, as pregnancy is inherently risky, complications can happen to women at any size:

Carrie: "I've got friends who… are of average weight who... got gestational diab[etes]… and who got pre-ecl[ampsia]... and who got rushed into hospital and got kept in… Do you know, all these things that…? It can go wrong for anybody. It's probably just… genetics and the luck of the draw"
[Carrie, 38, 1st baby, 2nd interview, baby 6 weeks old]

She said later about another friend:

Carrie: "She's from a [Western European] family and her mum was 24 stone and had four daughters and popped them out like…you know? Not that you can go by

what happened to your mother but it's not unheard of in her family to have absolutely hassle-free pregnancies and be considerably overweight… I've also got very slim active friends who've had problems in birth and haemorrhaged"

[Carrie 38, 1st baby, 2nd interview, baby 6 weeks old]

Amy, who was single, unemployed and had a history of depression and anxiety, described social isolation and little family support during her interview. She described the man with whom she had conceived as her 'best friend' but did not know what level of support or involvement he would provide once the baby was born. Amy lived alone, and told me about her use of the internet for reassurance via online chatrooms when she became anxious about her weight early in her pregnancy:

Amy: "I ended up posting on a forum… I think it was like Netmums… for any sort of like positive [laughs] stories… cos I couldn't really find any... and loads of people did get back to me and they were like, "No, I was in a similar situation.." and stuff… so that was nice to hear…"

[Amy 26, 1st baby, 1st interview, gestation 16+3]

Amy continued to search online and but later found further information that worried her:

Amy: "I did the first… first trimester… I googled every single little thing that I felt and ended up having to phone my midwife about six times just cos I was just getting into like... panics… Everything that I was finding, that I was reading… was saying that it would either end in a miscarriage or it would end in a stillbirth, so that's why I had to stop, cos it was just starting to… every single ache and pain I then got, I was phoning my midwife and I was like, "I've got this…" and it was like, "No, that's natural, that's what's gonna happen. Like, your back will get sore…" Errmm… and things like that so… I just like… I think I had like... three outpatient appointments in the space of about two weeks, because I was just starting to panic"

[Amy 26, 1st baby, 1st interview, gestation 16+3]

She went on to describe how she stopped looking for information on the internet about obesity in pregnancy:

Amy: "Yeah, I still go on forums and stuff, but I don't look specifically for any sort of like overweight pregnancy related stuff, like I mostly like… swerve it. Errmm… I mostly go onto like… like if I'm feeling a certain thing I'll go and google that… and leave the weight out of it, because if you put the weight into it then… it comes back just… a terrible symptom… when in real life it's just a day-to-day symptom of being pregnant…"

Alice: So you'll just search something like… Netmums or google, but not mention weight..?
Amy: "Yeah, like 'backache and pregnancy', whereas if I done, 'overweight, backache and pregnancy', then it would just come back with loads of negative stuff, so I just leave out the overweight now"
[Amy 26, 1st baby, 1st interview, gestation 16+3]

Thus Amy, like other participants, sought support and reassurance from online sources to avoid her pregnancy being defined by her 'obesity', and associated risks. She wanted to perceive her symptoms as, in her words, 'day-to-day', and normal.

Amy described a negative experience at the high-risk clinic, shortly before our interview:

Amy: "It was just like… cos the only things I could remember… were the sort of… negative aspects of… like, even sort of telling me about like… how I need to have like an ECG and.. I need to have someone look at my back because of the … epidural… cos if I've to have one I'll need… them to look at my back, to make a plan if I do need an epidural, because of my weight and stuff. And that's the only points that I could remember were these negative ones, like… it's gonna be hard… and I might need assisted during labour. I might get induced and… I just left with all the sort of negatives and I didn't really feel that they gave me any… sort of… positives to counteract them…. so..." [sounding emotional]
[Amy 26, 1st baby, 1st interview, gestation 16+3]

She recounted how she then sought reassurance from a friend who she described as of a similar size to her and who had attended the high risk antenatal clinic

Amy: I was slightly panicked, but then I spoke to my friend and she was like, "You'll be fine"'[laughs]
Alice: Is this your friend that's pregnant as well?
Amy: Yeah, she's just had her baby so…
[Amy 26, 1st baby, 1st interview, gestation 16+3]

5.3.2.(e) Other 'pregnancy' complications as a focus

A further strategy used by some participants was to highlight a more tangible risk factor or complication, in order to divert focus from their obesity. Several participants discussed their experiences of pregnancy symptoms and complications which can occur in any pregnancy regardless of maternal weight. However, in addition to the evidence that obesity is a risk factor for multiple complications in pregnancy, obesity itself can lead to physical symptoms

similar to those experienced in pregnancy, due to carrying excess weight. My impression was that some women used these symptoms to normalise their weight, and present them as 'normal' pregnancy symptoms. In her interview at 18 weeks' gestation, when the fetus would not have been large, Amy said that her midwife had told her that having backache early in pregnancy was a normal symptom of pregnancy. She mentioned her 'soreness' several times:

> *Amy: "The other day there I was walking about the [cultural festival] all day and just my feet were swollen, my back was sore, my hips were sore, just everything was sore. I just needed my bed"*
>
> [Amy 26, 1st baby, 1st interview, gestation 16+3]

Carrie had painful oedema in her legs during her second trimester, but rejected the possibility that her weight was a contributory factor. She said:

> *Carrie: "So I've been wearing compression stockings. They're not very glamorous but they do make your legs feel less sore, at the end of the day. My legs are not normally a problem. I've only obviously got them because of pregnancy. I mean, I haven't really put any weight on yet. I think about four or five pounds, so it's not as if I'm carrying more weight, but I know you've got more blood and obviously your heart's having to work harder and all the rest of it".*
>
> [Carrie, 38, 1st baby, 1st interview, gestation 18+5]

In this way, although a combination of the physical experience of pregnancy with pre-existing very severe obesity may have led to these symptoms, participants referred only to pregnancy to account for their experiences of such health problems. This was perhaps in order to 'normalise' their pregnancy experiences, by pointing out the minor ailments they experienced, whilst drawing attention away from the possible consequences of their weight.

Partner participants used these strategies also. Jim Bob denied that his wife Babs' weight had caused her back pain:

> *Jim Bob: "Errm, yeah she's struggling mobility-wise to get around, but that's to do with her back. That's nothing to do with her being mega mega overweight"*
>
> [Jim Bob 30, Babs' husband, 2nd baby, gestation 25+4]

He believed rest was the best thing for Babs. He cited medical advice, thus resisting the stereotype of laziness, as the reason Babs was inactive:

> *Jim Bob: "I don't think they can do anything for her pain or what's happening with her back and her hips, well, obviously signed her off work, just giving her two week lines. Why try and aggravate it even more? Try and rest as best you can, is what they're thinking."*
>
> [Jim Bob 30, Babs' husband, 2nd baby, gestation 25+4]

Louise had asthma, which worsened during pregnancy. Although this may have been related to her weight, her husband Vincent did not knowledge the potential connection when he spoke about it. He said:

> *Vincent: "What concerns me more are her other health issues, like she has asthma and that concerns me, because she's not getting enough sleep through the night and things. That bothers me more than the weight thing does"*
>
> [Vincent 32, Louise's husband, 1st baby, gestation 24+1]

He went on:

> *"I think…. despite... despite the weight, I think she's reasonably healthy. It doesn't massively concern me in relation to the pregnancy or anything... I think she looks after herself so…"*
>
> [Vincent 32, Louise's husband, 1st baby, gestation 24+1]

5.3.3. Summary

Being referred for high-risk care meant participants negotiated a path between the risks they were aware of, and the reassurance they needed of their 'normal' pregnancy status. In so doing, they sought to normalise their weight, highlighting their relatively small size compared to others, or to question the risks associated with their size. Those who had given birth previously drew on their personal experiences of being 'normal', while those expecting a first baby sought reassurances elsewhere in order to, as Amy put it, find 'positives' to balance the 'negatives'. In addition, focus was shifted by some to tangible pregnancy symptoms or other health problems, presented as unrelated to obesity. In this way,

participants variously accepted and simultaneously resisted the ‘stigmatised risk’ that very severe obesity imposed.

5.4. Acknowledging weight as ‘risky’: the role of social class and stigma

So far in this chapter, I have highlighted the ways in which participants’ experiences in pregnancy were characterised by ‘stigmatised risk’. However, although in varying ways, all participants referred to, and attempted to resist stigma within their accounts, stigma was more evident in the accounts of women of lower SES, while participants from middle class backgrounds appeared to be significantly less stigmatised.

Rachel, who was a professional, middle class woman, spoke openly about her belief that she was at increased risk in pregnancy due to her weight. Although at times during her interviews she employed the strategies described above in order to present herself as enacting healthy behaviours, being a ‘good mum’, and also in attempting to normalise her increased weight, at times she acknowledged and openly discussed her understanding of her increased risk status, occasionally referring to herself as ‘obese’, which was highly unusual within participant’ accounts. She did not appear to view the high-risk label as stigmatising, and valued the increased surveillance, and the planning for pregnancy and birth that it meant. Rachel was pregnant with her second child during her participation in the study. Her first child had been born in a different major UK city and she had experienced a shoulder dystocia, followed by a massive postpartum haemorrhage during the birth. She spoke about her retrospective belief that this had been due to her increased weight, and how this led to her experiencing positively the additional surveillance at the high-risk clinic during her index pregnancy. She said:

> *Rachel: “It doesn’t bother me. Yeah. Just…you know, I’m… I am overweight and there are more complications. So I’d rather be being seen by someone than not. Yeah. It is what it is”*
>
> [Rachel 38, 2nd baby, 1st interview, gestation 19+6]

Rachel’s’ ‘it is what it is’, referred to her own experience of complications due to her weight leading to an acceptance of her high-risk status. However, other women, such as Babs and Eva, described above, experienced complications during their previous pregnancies but

resisted the connection with their weight.

Rebecca, another middle-class, professional woman, also spoke frankly about her attitude to risk. She too was pregnant with her second baby, and had previously had a caesarean birth, but did not acknowledge a greater risk of this associated with her weight. However, Rebecca and Rachel both undertook some, but comparatively far less, 'moral accounting' for their weight during interviews than other women. Rebecca spoke about her attitude to high-risk care:

> *Rebecca: "I kind of thought, well, you're getting more checks as you go along, so if there is anything that's of concern and that, you're finding out about it when you might not necessarily. Even things like the scan, there was the 20 week scan that you get now, which you didn't get when I had [1st child], you get that now, but then that would have been it. So you think, you're getting more regular checks, you're getting things like that kept an eye on instead of it just being kind of guesswork, and you think everything's alright or everything appears to be alright. So I kind of thought, from my own reassurance point of view and that. And I thought with all the different elements of weight and age and that, obviously this time around I was more worried about things and how things would be."*
>
> [Rebecca 46, 2nd baby, 1st interview, gestation 21+4]

Rachel and Rebecca's perceptions and attitudes to their previous treatment differed markedly from those of Eva and Babs, two women of lower SES. Eva, a house wife and part-time student, whose husband Eric worked in an unskilled, low-waged job, had had two previous babies and had experienced complications. She angrily rejected any association between this and her weight, and felt stigmatised by her high-risk pregnancy status. Babs, also from a working-class background, did not acknowledge her weight as a risk factor associated with the complications she had experienced (symphysis pubis dysfunction and a previous pre-term birth). Rachel, Eva and Babs all expressed criticisms regarding their previous pregnancy care experiences; however, where Rachel did not express anger about this, and took a pragmatic approach to her pregnancy risk status – 'it is what it is' – Eva and Babs, and their respective husbands, all expressed anger about their previous care during their interviews, and they talked about the judgements they perceived were made about them in their index pregnancies.

Rachel's and Rebecca's experiences were not of 'stigmatised risk'; they did not perceive judgements being made about them, in the way that Eva and Babs did. Eva was from a working class background, and her account demonstrated her 'felt' stigma associated with her social class and the associated judgement she felt might be made about the reasons for her very severe obesity. Other participants, pregnant with a first child and from working class backgrounds demonstrated a *felt* stigma similar to that experienced by Eva and Babs, employing distancing and 'othering' strategies much more commonly than middle class participants, for example in Carrie's reference to the Scottish derogatory colloquialism 'radges', and Anne's reference to 'miserable old fat people'. This 'stigma layering' was apparent in their descriptions of their interactions with health professionals and their engagement with – or disengagement from - the risk discourse around pregnancy and weight.

5.5. The experience of multi-disciplinary, high-risk care

As I have attempted to establish, to varying extents, the experiences and perceptions of all participants in the study were influenced by the presence of stigma. This impacted upon their engagement with risk discourses, their emotional well-being in pregnancy, and their relationships and interactions with health professionals. However, differences as well as similarities were evident within women's accounts of their experiences of engaging with high-risk, multi-disciplinary 'shared' care at the hospital-based clinic and also within the community. I consider these below.

5.5.1. 'Just a statistic': depersonalised high-risk care

Most initial interviews took place early in the second trimester of pregnancy, when participants had attended the specialist clinic only once or twice. Several women with no co-existing risk factors described a depersonalised experience of attending. Louise described her initial appointment:

> *Louise: "There wasn't much that was different to my normal midwife appointments. It was just a, kind of, initial appointment to get my weight and my blood pressure, listen to the baby's heartbeat and then get me ready to have all my subsequent appointments. So they gave me information about what*

would happen at the next appointment. So the next appointment I've got to go in, I've got to have an EKG done…"
Alice: Is that….?
Louise: "The heart… And the anaesthetist might want to speak to me"
Alice: Uh-huh? Do you know what that's for?
Louise: "Just about previous reaction to anaesthetic in case I end up needing an emergency C-section and then I'll get the scan and then I'll get another appointment. So I think the next appointment will have a lot more information, but the first appointment was pretty quick, to be honest. You saw the midwives, they did all the testing and everything and then saw the doctor who just, kind of, said, this is when I want your appointments booked and I'll see you next time. "
[Louise 32, 1st baby, 1st interview, gestation 23+5]

Similar experiences were recounted by other women, like Carrie, who described a depersonalised experience when first visiting the clinic. She saw several health care professionals and was unsure of individual roles. She also referred to a lack of communication and organisation between her hospital and community care:

Carrie: "So I had the normal community midwife the following week and she was like, 'How did it go?' I said, 'I don't really know. It was just a bit bizarre. Everybody was lovely, please don't get me wrong, but I kind of just feel a bit like I've got a brochure on healthy eating and exercise, but I'm assuming I find out a lot more at 28 weeks'. Then she was like, 'Are you not going to see them now until 28 weeks? I said, 'No', and she was like, 'Oh, right'".
[Carrie 38, 1st baby, 1st interview, gestation 18+5]

Several women's accounts demonstrated their perceptions of depersonalisation within the care given at the specialist clinic. Amy's first interview was the week after her initial consultation at the specialist clinic, and she too described a bewildering experience:

Amy: "I wasn't expecting... like the first appointment is a bit... information overload, like I think I saw about four people… and it was just firing information at me…. No, it was an overload of pure information and I wasn't really clear after I left. And it felt almost really, really rushed. Like, I was just like… I walked back to the waiting room and before I even got halfway back they were like calling me back and then rushing through their bit and then go back and called again. Just a lot of to-ing and fro-ing... on the first one. Errmm… [I] felt a bit dizzy [laughs]. It was just… cos I couldn't remember a single thing they told me after I left, just cos it was so quick and… so much in so little time, I couldn't remember a thing they told me. All I know is I had a leaflet… in my notes" [laughs]
[Amy 26, 1st baby, 1st interview, gestation 16+3]

Echoing other participants, Eva said:

> *Eva: "I don't feel like it was ever really particularly… like… personalised or good, or whatever. It was just, you know, they come in, they check you, they go… whatever, and I went to that clinic but… when I spoke to the dietitian, she was just like, 'oh you're doing everything ok', but they didn't, like, take anything about you into consideration. It was just very like, 'ok, your blood pressure's ok, your heart looks fine, baby looks fine', that's it. It wasn't particularly bad, or good, it was just very… systemised, I guess".*
>
> [Eva 28, 3rd baby, postnatal interview, baby 4 weeks old]

Some women described more positive experiences as they attended several times and met health professionals on several occasions. Another participant, Martha, was attending the specialist clinic very regularly due to her diabetes, receiving texts and occasional phone calls from a specialist diabetes midwife attached to the clinic. She said:

> *Martha: "Errmm… I was diet-controlled before I was pregnant so I'd never needed insulin. So this is... yeah, this is… since I was pregnant, this is the first time I've been using insulin, and the doses are going up and up and up and up [laughs]. But obviously with [specialist midwife], she's been amazing, cos she'll just text you and… she's so lovely. So that's good, yeah. It makes it a bit easier"*
>
> [Martha 41, 1st baby, 1st interview, gestation 15+5]

5.5.2. 'Shared' care

The referral process for most participants was initiated by a community midwife, and was described by most participants as having been characterised by little or no discussion. Some women were asked if they wished to attend the service, others were referred and informed via letter, but for most this was not embedded within a broader discussion about their weight or their health in pregnancy. Rebecca said:

> *Rebecca: "She* [community midwife] *kind of just gave me a sheet kind of thing, a bit what it was about. So she kind of just gave me that and said, 'Oh, if it's something you're interested in…'"*
>
> [Rebecca 46, 2nd baby, 1st interview, gestation 21+4]

Others, like Louise, had no discussion with their community midwife at her initial booking appointment about referral, but were informed of her referral later, via letter:

> *Louise: "And then…I think sometime before the 12 week scan I got a note saying that I would… was being referred to the [specialist] clinic as well, so… It just said 'cause of an elevated BMI that they would take extra precautions, that it wasn't mandatory but that they recommended it…"*
>
> [Louise 32, 1st baby, 1st interview, gestation 23+5]

Eva's husband described her referral to the high-risk clinic, describing his perception of the sensitivity of the subject of weight in pregnancy, the lack of open discussion about the reason for referral, and his broader views about depersonalisation within the medical encounter:

> *Eric: "Oh aye, well I went with her to the one at the hospital where the wee guy was talking about... he was doing her blood pressure and that, saying, 'You'll have to go to this... one [specialist clinic] to go get checked'. She actually said to him, she goes [laughs] 'Is it cos I'm fat?' [laughs] like, '…that I'm going to these places?' and he just sort of chuckled, you know? Like it was a bit… a nervous laugh. So yeah, I presume so".*
>
> Alice: Do you think it's something health professionals find hard to discuss?
>
> *Eric: "It would be awkward, wouldn't it? I mean, it is their job at the end of the day. They just see her as another person, another figure, you know? Nothing to do with the way her personal life is. They don't know what she does or where she is. She's just a… a statistic, at the end of the day".*
>
> [Eric 30, Eva's husband, 3rd baby, gestation 18+6]

Similarly, Anne's husband Ian noticed this lack of open discussion and, like Eric, referred to the sensitivity of the topic of weight:

> *Ian: "Yeah. They're always very… I think they're conscious of being maybe ermm… given what it is…. I think people are always conscious of not insulting people or whatever…"*
>
> Alice: Yeah?
>
> *Ian: "…so they sort of come at it in sort of roundabout terms and that. So, they are never particularly clear" [laughs]*
>
> [Ian 32, Anne's husband, 1st baby, gestation 18+0]

Thus, most women's initial referrals were characterised by a lack of information-giving and a lack of open communication.

Ruth had a different experience. She described her midwife in extremely positive terms throughout her interviews, reporting her to have said:

> *Ruth: "'Any time you even feel anything that you need to talk about, just phone me'"*
>
> [Ruth 27, 1st baby, 1st interview, gestation 22+6]

She went on to describe their discussion about a referral to the specialist clinic:

> *Ruth: "My midwife said to me, because my BMI was just on it, I could go to the clinic and they can, like, give me extra scans and just keep an eye on things as well, because, like, I'm on a high risk pregnancy anyway. She said to me it's best if I go there, so I said, right, okay, fine"*
>
> [Ruth 27, 1st baby, 1st interview, gestation 22+6]

Ruth's representation of herself as 'high risk' was due to her having PCOS. In common with several other participants, she emphasised this as her 'risk factor' (I discuss this further later in the chapter). Her description of her midwife's approach was one of reassuring her regarding her weight as a risk factor, but that she might benefit from undergoing extra scans, despite these reassurances regarding her relatively 'low' risk status.

Ruth also spoke positively about her introduction to the specialist clinic, which was via a phone call from the co-ordinating midwife there:

> *Ruth: "So she came on the phone and she me gave me all my appointments up until my 36th week. So I've got that all booked now. Just need to book my ultrasounds of each time. But she's really, really nice. She was really nice on the phone. Asked me how I've been getting on. Just asking, like, how baby is, how I am and things, and it's nice to actually have someone on the phone you can actually speak to"*
>
> [Ruth 27, 1st baby, 1st interview, gestation 22+6]

There were similar accounts of a positive interaction with a single health professional, in some cases seen just once, reported by several women. Ruth appreciated being asked how

she was, ‘how baby is’: being treated as an individual. Both her community midwife and her specialist midwife avoided focussing on her weight, reinforcing her sense of herself and her pregnancy as ‘normal’.

In contrast, Carrie described her booking appointment, her introduction to the clinic and initial experience there:

> *Carrie: “I kind of felt a little bit like, okay, it's my first pregnancy, I'm older, I'm overweight and there's probably some questions that I've got. But I kind of was a bit put off by the student being there. She kind of just jumped right in to asking questions, because we had to fill out that thing online”*
>
> [Carrie 38, 1st baby, 1st interview, gestation 18+5]

Here, Carrie summarised her experience of not having had the opportunity to ask questions which were pertinent to her health (her age and her weight), and of the depersonalisation which centred on completing an online record. She went on to describe her referral to the specialist clinic and the description she was given of her care pathway structure:

> *Carrie: “…obviously they took my weight and height and she was just quite matter of fact about the fact that I would be going to the metabolic clinic. Maybe I'm just being unfair to her, I'm not saying she didn’t tell me that much about it…. I think she just kind of said, ‘You'll meet with a consultant and they’ll talk to you about your birthing options and you'll see them…’ I remember her saying, ‘You’ll see them more than you see me. So you’ll be more consultant-led and we’ll be your main port of call but I’ll still see you for some of your checks’”*
>
> [Carrie 38, 1st baby, 1st interview, gestation 18+5]

Ruth and Carrie were referred via the same pathway, initially seeing their community midwife, and referred to the specialist clinic, but the ways in which referral took place meant differences in their perceptions and experiences. Through personalised treatment, which did not focus on her weight, Ruth was able to maintain her focus on a risk factor which was more real to her, her PCOS, normalise her weight, and resist stigma; whereas Carrie was treated impersonally, her BMI was discussed in an insensitive way and her referral not perceived by her having been presented as a choice. In addition, she was led to expect fragmented care.

5.5.3. Fragmented care

The accounts of several of the other women demonstrate that the shared care arrangement caused confusion in terms of the pattern and delivery of care, to both them and to community midwives. Amy described being unsure about when her blood tests would be done:

> *Amy: "They sort of coincide with each other, the meetings. But I'm not seeing my local midwife now until October. And I think the [specialist] clinic think I'm seeing her before I see them for bloods, so it's really confusing. So I don't know who's taking my bloods, but… I dunno... [I'm] sure someone will…"*
>
> [Amy 26, 1st baby, 1st interview, gestation 16+3]

There was also a marginalisation of the role of the community midwife described by several women. For example, as she neared the end of her pregnancy, Rachel described being confused about her appointment schedule:

> *Rachel: "I don't know what happens after the 36 week appointment, I don't know, and neither did my community midwife. They said… they were… kind of like, 'You might not see us again because if they see you every week at [specialist clinic] then there is no point you coming to us'. I just don't know."*
>
> [Rachel 38, 2nd baby, 1st interview, gestation 19+6]

The women's accounts demonstrated a perception in most cases that there was a lack of systematic communication, or a schedule of care which was easy for them to understand or manage. Anne also speculated that the shared care arrangement caused tension and difficulties for her community midwives, and she referred to her interpretation of their lack of cohesion:

> *Anne: "Obviously they've got your information on the computer, so occasionally she'd go, 'Yeah, they did that, didn't they?' I sort of felt like sometimes when you speak to them, it's like, 'Did they do this?' Maybe there's a wee bit of resentment or something, I don't know. 'What did they tell you?' I can't really think of an example but I just remember at one point it being like, 'Did they do that?' Not like they're all working together as a team, just like, 'Did they do that?' "*
>
> [Anne 32, 1st baby, 1st interview, gestation 17+1]

5.5.4. Disruptive care

Several women discussed the practical arrangements involved in attending community midwife appointments and the specialist clinic. This was based in a large hospital which served an extensive geographical area, and some women travelled long distances to attend, and all described long waiting times between seeing different health professionals whilst attending. They expressed different attitudes to this. Some were inconvenienced due to childcare issues, however, the extent to which women felt the care package and screening was worthwhile and beneficial was also a key factor in their attitudes to the screening schedule. Babs was one participant who questioned the benefits to her of extra screening. Babs was the only participant who lived within walking distance of the clinic. However, she spoke about the inconvenience of managing her appointment schedule:

> *Babs: "Yeah, trying to keep up with all the appointments. Because I see the midwife, and then after I see the midwife I've got to make an appointment to have another glucose tolerance test done. Which is really a whole morning, because you've got to have your blood taken at nine, then they give you Lucozade to drink but you're not allowed to move. So, you've really got to come home and just sit for two hours to go back to have your blood taken again"*
> Alice: "Okay."
> *Babs: "I had one done earlier in pregnancy because the blood sugar reading was slightly high"*
> Alice: "So, that's the diabetes test, isn't it?"
> *Babs: "Yeah. So I've got to get another one of them done. I've then got to try and get to the hospital to have an ECG done before my 28 week appointment and another scan at 28 weeks, which has got to be done before the appointment as well. Can't make that appointment until I've had my 20 week scan. So it's trying to fit all these in round work and child care and… Yeah, it's quite difficult"*
> [Babs, 27, 2nd baby, 1st interview, gestation 18+2]

Babs' use of words, 'keep up with appointments', 'not allowed to move' and 'it's quite difficult', demonstrated her negative attitude to managing this number of appointments. Due to her previous pre-term birth, Babs was preoccupied during her second pregnancy with the possibility of this happening again, and questioned her high-risk status due to her obesity, which informed her negative attitude to her serial appointments. Her husband Jim Bob expressed his frustration at the number of appointments she was asked to attend, as he believed that this heightened her anxiety, and that she should be resting due to her back pain. He said:

Jim Bob: "They are being over-cautious about everything… maybe because [1st baby] was early… they're covering their back a bit. But to me they're not doing anything. They're certainly not helping Babs any by, 'well, come on in for a scan, come on in for this, come on in for that...' She's having to go in when she could be just... laid on the sofa chillin' out'

[Jim Bob 30, Babs' husband, 2nd baby, gestation 25+4]

By contrast, Martha, who was single, described also spending many hours at the clinic when she attended, seeing several different health professionals. However, Martha described feeling well cared for by the clinic personnel, and she considered herself to be 'high-risk' due to her diabetes. She perceived a benefit in attending, and expressed a willingness to wait for long periods:

Martha: "Yeah, I could spend about five hours… I can leave work for an appointment at one o'clock. I leave at quarter to twelve to get the bus up. And when I get back, it's sometimes, like quarter past, half past five, and I'm like, 'Honestly, I have been at the hospital the entire time!'"
Alice: And do you mind that?
Martha: "No, I don't mind. Do you know what? It's… It is what it is. Work's not quibbled at all with any of my appointments. No, I don't mind waiting around. That's what they give you Iphones for!" [laughs]

[Martha, 41, 1st baby, 2nd interview, gestation 35+0]

A small number of women were additionally under the care of another consultant at their own local hospital, and several reported what they perceived as duplication of appointments and sometimes screening, such as blood tests. Graham commented on this regarding Ruth's care:

Graham: "She was giving blood a lot at the start. The [specialist clinic] was taking blood, the midwife was taking blood, the [local hospital] was taking blood. Again, it seems a bit pointless to me. And I'm assuming they'll all be for the same thing"

[Graham 32, Ruth's partner, 1st baby, gestation 25+2]

Rebecca described spending a lot of time attending appointments with several health care providers, and feeling relieved when her community midwife did not wish to see her again:

Rebecca: "…she was like, 'Right…' she was looking at… and she was… and she could see all the appointments, because she could see the scans at the Infirmary, she could see the clinic at the Infirmary, she could see Dr [consultant]. She could see Dr [consultant] sent me up to Ward [name]. She could see Dr [consultant] doing growth scans and that and everything as well. And she was just like, 'Right, OK', and she said, '…in all honesty', she said, 'it's not that I don't want to see you, but', she said, 'I think it's, kind of, overkill, everything that we're sending you for. 'So…' she said, 'if you're quite happy, basically I won't make any more appointments for you to come and see me, because…' she said, '…you're getting more than enough care that me as a community midwife can't add anything to what you're getting…..' She said, 'If you've got any questions or you've got any queries or you want to come back and see me…' she said, 'just phone and make an appointment.' But, she said, 'basically other than that, I will just leave it that I will see on the house visits once the baby's born'. And I was like, 'Right, that's fine', sort of thing… like that. That's one less appointment that you're trying to squeeze in, you know?"

[Rebecca 46, 2nd baby, 2nd interview, baby 4 weeks old]

Thus, although they spoke about different experiences of, and attitudes towards their care, all participants experienced serial appointments at multiple locations, long waiting times and saw many different health care professionals during pregnancy.

5.6. Said and unsaid: felt and enacted stigma

As described earlier, almost all participants referred to stigma within their accounts. There were no reports of overtly disrespectful treatment by health professionals; however, the care the women received was often experienced as stigmatising.

5.6.1. Anticipating/perceiving prejudice

Carrie described how she attempted to pre-empt and prevent negative treatment from health professionals, after reading about other women's negative experiences on a 'plus-sized mums' internet forum. She talked about her ultrasound scans:

Carrie: "I was blethering away to her and I've even joked about it sometimes. Like when the lady was saying it's technically difficult. No, she said I'm struggling to get it, and I said, 'my stomach doesn't help'. They've never said, 'Yeah, you're right'".

[Carrie, 38, 1st baby, 1st interview, gestation 18+5]

Later she added:

Carrie: "Maybe I've just been lucky, maybe I'm smiley and they don't want to say shitty things, because nobody's said anything negative, they really haven't. There's not anything in my maternity notes negative, there's just, matter of fact, that's what the BMI is. That's it"

[Carrie, 38, 1st baby, 1st interview, gestation 18+5]

Here, in a further example of both the felt stigma and the 'othering' I have discussed previously, Carrie implied that she believed health professionals may have negative ideas about her size. As such, she drew on – and thus resisted for herself – the cultural stereotype of the obese person who is unhappy or unfriendly.

Rachel's experiences were subtly different. As discussed above, she did not express a perception of stigmatising treatment, but recalled her frustration at the lack of clear communication that she had experienced in her previous pregnancy:

Rachel: "… you know, like, when… at scans, when they said that they were having problems seeing things and they'd write on the scan, 'adiposity'. And it's just like… you just, sort of… wish sometimes that they'd just say, 'it's because you're bigger'.

[Rachel 38, 2nd baby, 1st interview, gestation 19+6]

Rachel indicated here, and elsewhere, that open discussion was important to her. She objected to the use of the word 'adiposity', a clinical term, which may have been used by health professionals in the belief that Rachel may not understand – and thus not be offended by – the reference to her weight causing difficulty in the screening process. She felt patronised and insulted by the choice of word, indicating her preference for simple words and a more open approach.

5.7. 'Medicalised' pregnancies: diverting focus and valuing high-risk care

Three participants did not reject the notion of risk associated with their pregnancies, whilst successfully resisting any associated stigma and shame. These women valued the medicalised management of their pregnancies and the lengthy discussion and planning of their care that they had with specialist doctors.

One such participant was Mary. Mary was visibly much larger than most of the other women in the study. In her descriptions of her history and her beliefs regarding health and weight, she *medicalised* her obesity, presenting herself at points in her interviews as not responsible for her size, as she believed there was something 'different' about her body, specifically her metabolism. Unlike most other participants, she made no attempt to normalise her weight or highlight others as larger, or to neutralise her high risk status. Mary originated from a middle income country in Europe and said she valued the specialist services that had been offered to her, as these would not be available in her country of origin. She had been considering weight loss surgery prior to becoming pregnant (she had believed she could not conceive spontaneously due to her weight). She acknowledged that her weight might be dangerous to her health, telling me in our first interview that she needed to lose weight in order to 'live longer'. She had a history of depression and anxiety, and this worsened during pregnancy, until eventually she was referred to see a perinatal psychiatrist and prescribed medication. Mary was very anxious about her health and her baby throughout her pregnancy, and told me she was very happy to go the specialist clinic, undergo extra scans, and that she appreciated discussing her care with consultants, being presented with options for the birth of her baby, and having the chance to discuss potential risks and complications. She said:

> *Mary: "God forbid my blood pressure will be high… in the ceiling and… so I need to go to section because there's no other way and… [panicky voice] 'Oh, what that means? What will happen? Oh, I don't want to have this…' or…. You know what I mean? That will not help at all, especially an anxious person like me. So having everything in good time and explained and everything... gives me time to prepare. So I think that's very good as well."*
>
> [Mary 38, 1st baby, 1st interview, gestation 16+0]

Mary acknowledged the risks of obesity in pregnancy, indeed they made her anxious, and she felt better having her individual case discussed with experts and making a plan of care together. After the birth of her child, in her final interview, she told me about the special technique that was used to perform a caesarean section to deliver her baby (even showing me her scar), and gave an account of the discussion she had with the obstetrician about her options for birth:

Mary: "The natural birth is natural birth, anything could've happened or whatever, could've just go ok but… at the end of the day you have to look to the risks, and if it's worse to be facing a risky situation and something could go really wrong. The emergency section, the highest risk that I was facing was – again, based on the way I carry my weight – an emergency section would have mean to have someone that is trained to do the cut on a side and not underneath my belly, because they could not have done that, because of the way my belly is hanging, like the tummy weight, fat layers, they could have not have cut… under that. Like, they would have cut it… they would have had to pull... There would be a lot of people and it would have been a quite difficult operation anyway, but… it would have probably not heal… in ages. And that would have put me in bed for a long time. Because as soon as I stand up, the fat would have gone on top of the wound and that would not heal, because there's no way to heal. And there are not all of the obstetricians in that clinic know how to do the cut on the side"

[Mary 38, 1st baby, 3rd interview, baby 5 weeks old]

The decision about mode of delivery was difficult for Mary, and she described how she came to it:

"So she [obstetrician] had to tell me all the options that I have and what the risks are for each option that I have. It was too much information at once and I was alone. I don't know why, I just was alone. I usually had my husband or my friend with me. That day, it just happened that I was alone. So of course I said that I have to go away and speak to my husband, because…. like a long story cut short, she advised me to go for a planned section…"

[Mary 38, 1st baby, 3rd interview, baby 5 weeks old]

Mary was given a lot of information about her options, and she spoke about how she valued these discussions and having time to consider what she wanted to do. By presenting her extremely high weight as the result of a physical problem, beyond her control, she resisted stigma, engaged with, and valued highly the management of her pregnancy and birth.

Similarly, Rachel spoke positively of her experiences of care in pregnancy. Having had a very large baby and a complicated birth three years earlier in another UK city, Rachel compared her experiences of pregnancy and labour care. About her previous birth she said:

Rachel: "I guess in hindsight… I just wish that people were a little bit more, kind of like… there'd just been a little bit more discussion".

[Rachel 38, 2nd baby, 1st interview, 19+6]

Rachel and her husband Ben described lengthy discussions with a consultant obstetrician and anaesthetist in the specialist clinic, specifically regarding whether to opt for a caesarean delivery for her current pregnancy:

> *Rachel: "She [obstetrician] said that she wouldn't rule me out for a c-section, and that she would understand if I actually said on the basis of the experience I had last time, I would like to have a c-section. So, yeah… So, it's just good to know that we can have that conversation openly"*
>
> [Rachel 38, 2nd baby, 1st interview, gestation 19+6]

Ben also recalled the consultation they had and the choice they had to make:

> *Ben: "I think it'll probably end up being continually discussed. Because what they've all said is, you know, you don't need to make a hard and fast decision now. We just need to decide on which way you're leaning at the moment, so we've said that we're leaning – or Hazel's said that she's leaning – towards a natural delivery and birth, which will probably end up being induction again"*
>
> Alice: And is that because they want to deliver the baby early?
>
> *Ben: "So the way that it's been explained to me certainly is that they have found within this particular clinic that they get much better outcomes by aggressively inducing at term, or just before term rather than allowing the pregnancy to go on and inducing at 42 weeks where they would normally, or 40 plus 10 days or whatever it is where they would normally induce"*
>
> [Ben 40, Rachel's husband, 2nd baby, gestation 23+0]

Ben's use of medical language, 'aggressively inducing', to describe the plan of care for his wife demonstrated his engagement with the medicalised management of what he perceived as her high-risk pregnancy and birth.

In her final interview, Rachel described how she felt when the specialist consultant had come to see her after the birth of her baby, when he was diagnosed with Down's Syndrome:

> *Rachel: "But then she sought me out on the ward. She obviously checked to see her plan had worked, but then seen the unknown… that he had Down's. And she deliberately came up to see me on the ward <u>three</u> times She sat with me for… which I was incredibly touched by, you know… not just for a short amount of time. She sat and talked to me for quite a long time."*
>
> [Rachel 38, 2nd baby, 3rd interview, baby 5 weeks old]

Here Rachel was referring to her appreciation of the time the consultant spent with her, providing conversation and emotional support rather than clinical care, at a time that was difficult for Rachel. Rachel valued very highly this personalised approach.

A third woman who described a positive experience of attending the clinic was Martha. She attended more frequently than other participants, due to her type 2 diabetes. She told me she did not read anything about pregnancy, either in books or on the internet, and tried not to listen to friends and colleagues who recounted their experiences of pregnancy and birth. She said 'I don't want to scare myself'. Her description was one of placing herself entirely in the hands of the doctors and midwives regarding her care. She told me:

> *Martha: "… I guess I always think that… priority is baby and if it keeps baby safe... then I'll do whatever it takes. You know, if they tell me to do something and it's for the benefit of the baby, I'll do it."*
>
> [Martha 41, 1st baby, 2nd interview, gestation 35+0]

Martha medicalised her obesity by focusing on its consequences: diabetes. Thus she viewed her pregnancy as high-risk for a medical reason, and valued the specialist care she received. She said she did not always fully understand the clinical reasons underpinning her plan of care, but she was happy to trust the doctors nevertheless. During her final interview after the birth of her baby we discussed this again:

> Alice: Was that the reason for them wanting to induce you early?
> *Martha: "Because of the diabetes, that was the reason."*
> Alice: What about the diabetes? Do you know what their concern was?
> *Martha: "No, they probably told me, but they told me a lot and not a lot of it stayed in the end"*
> Alice: Sorry, it's not a test. Don't worry.
> *Martha: "I think as a rule if you are going to have a large baby or anything like that then, yes, there's added concerns. I don't know what the health risks to me going full-term were. I don't remember. It obviously wasn't stressing me out very much about it. No, I wouldn't have worried about it, I would have just gone with the flow, I think, and just trust them"*
>
> [Martha 41, 1st baby, 3rd interview, baby 4 weeks old]

Mary, Rachel and Martha acknowledged their 'high risk' status and reported positive experiences of care. However, they differed from other participants in that perceived or understood that they had risk factors in addition to, or not due directly to 'obesity'. They perceived not just a risk factor, but a tangible medical or pregnancy complication. This meant that they could focus their accounts on medicalised aspects of their pregnancies. Mary was perhaps unable to normalise her weight in the way that others did, due to her extremely large size, thus she sought to medicalise it by representing her body as having something wrong with it, not working properly, to be battled against. As such, health professionals could help her with this battle, to preserve her and her baby's safety.

Rachel had given birth previously to a very large baby, and believed that a lack of increased surveillance and scrutiny – that a high-risk care pathway might bring – had meant this was not detected and led to her baby's birth being very complicated. She and her husband Ben both gave long accounts regarding the detailed explanations and consultations they had had during Rachel's index pregnancy. Although Rachel acknowledged her weight as a risk factor for having a large baby, and associated risks, both were able to then focus on aspects of the medical management of her pregnancy and birth, whilst elsewhere down playing the issue of weight by comparing her size favourably to others that attended the clinic.

Although Martha linked her weight with her initial diagnosis of diabetes five years previously, pregnancy meant a shift in focus, as she became a 'medical' case. She spoke about experiencing stigma, but also described experiencing a relaxation of pressure to restrict her dietary intake during pregnancy, and did not monitor her gestational weight gain, which was recommended by the clinic (indeed she deliberately avoided observing the recording when she attended the clinic). In addition, her diabetes meant she experienced continuity of care and frequent contact via text messaging with a specialist midwife, something which she valued, and did not experience as stigmatising.

All three of these women placed value upon the expert care they received at the clinic and, although elsewhere in their accounts, all three accounted for their weight in similar ways to other participants, variously attempting to normalise, medicalise, and presented themselves

as undertaking healthy behaviours, they did not describe their experiences of care as stigmatising, as it related to mitigating the impact of specific medical risks.

5.8. Autonomy and care plans

In this section, I discuss the problems and tensions inherent within the relationship between the health professionals providing high-risk care, and the majority of participants in this study, who resisted the stigmatised risk that their 'very severely obese' pregnancies brought, and perceived that they did not experience any complications during pregnancy and birth. The high-risk care pathway was experienced precariously by these women. Their resistance of stigma, a lack of clear information, the lack of recognition of obesity as a 'health condition' and the absence of perceived complications in pregnancy, led to these women occupying an uncomfortable 'at risk' status, a 'liminal space' between normality and pathology.

5.8.1. The embedded expectation of birth complications

All participants described pregnancy care which was highly medicalised, and their descriptions conveyed the sense that problems were anticipated throughout pregnancy, risks were emphasised, and the prospect of complications was embedded within their interactions with health professionals. Those women who did not perceive that they experienced any complications gave more complex accounts in negotiating obesity as a risk factor: and some explicitly rejected it. These women experienced the fragmentation and depersonalisation commented upon by all participants more negatively than those who perceived their pregnancies as 'medical', and 'high-risk'. In addition, they expressed more frustration at the limitations that were placed upon them in terms of their options for labour and birth.

Several women outlined their experiences of a lack of opportunity to express their wishes and ask questions during consultations with health professionals. This was brought into sharp focus when they discussed their thoughts about birth during interviews. Several women had asked friends and family members about their own experiences, or searched the internet for stories, advice and anecdotes. Some talked about wanting a 'normal' (vaginal) birth, but few reported having had a discussion about this with a health

professional. Instead, although it is difficult to predict the likelihood of birth complications in the absence of other risk factors, many were aware quite early in pregnancy of an expectation that their fetuses may grow to be 'too big', and their births would be complicated. During our first interview, at 18 weeks' gestation, Amy said:

> *Amy: "I would love to go naturally. I understand that… obviously there is a big risk that I will get induced… and I'm fine with that".*
> Alice: And have they explained why they might..?
> *Amy: "Erm… the grow… like it would just depend on how baby's growing. If baby's growing too big then I would definitely get induced. Or if I develop pre-eclampsia, or if I develop diabetes, then I would definitely be induced. But, so far, touch wood, everything's going ok, so… I'm hoping they'll let me go to my… date…."*
>
> [Amy 26, 1st baby, 1st interview, gestation 16+3]

Amy's use of language, that she would 'get induced', and that she hoped health professionals would 'let her go' to her due date demonstrated the power relationship she recognised regarding the structure and decisions surrounding her care.

Several women said they were interested in using water for pain relief during labour and birth, but had not discussed this with a midwife or other health professional. Louise said:

> *Louise: "Well I had initially wanted a water birth, but I've read since, although no one has confirmed or denied to me, that at my weight, that won't be possible. But I did express that wish at my booking appointment with the midwife, so it is in my notes. So I'm just waiting for someone to tell me otherwise, but otherwise that's what I would like"*
>
> [Louise 32, 1st baby, 1st interview, gestation 23+5]

This is illustrative of Louise's lack of power in planning for her birth. Louise told her midwife she wanted a water birth, and her midwife did not pursue a discussion about this, thus Louise was left waiting for a decision from a medical practitioner about what will be 'possible'. Unable to initiate a discussion about her body and her baby's birth, she thus felt unable to make plans of her own.

Carrie also said she would like a water birth but, like Louise, believed her options might be restricted because of her weight. She said:

> *Carrie: "…..I don't know how it really works if they deem, 'There's not really anything wrong with you, you're just fat.' I don't know what they do. Probably I'd still need the same rules"*
>
> [Carrie, 38, 1st baby, 1st interview, gestation 18+5]

Carrie's reference to 'rules' demonstrates her perception of the care she received as depersonalised and paternalistic. In addition, her description of being 'just fat' refers to the 'liminal space' she and others occupied due to their size; considered 'high-risk', but with many not experiencing, or believing that they experienced any related complications.

> *Carrie: "I think in an ideal world, when I thought about childbirth I always thought that I'd like to have a water birth. But I know from, not any information that I had, but from information that came from reading on the internet, that it's just ruled out if your BMI's over 40, because if there's a complication and you're too tired they can't get you out of the birthing pool, is what I understand. Nobody's said that to me from the hospital or the clinic.*
> Alice: "Do you plan to… Are you expecting them to talk about it? Or do you plan to raise that with your midwife or the clinic?"
> *Carrie: "Yeah, I'll probably ask them about it but I'd fully anticipate they'll say it's not an option, so I'm not going to be disappointed. They've asked me if…I have been asked if I want an epidural and I had kind of said, no, not ideally. But obviously I realise that I might need to get one".*
>
> [Carrie 38, 1st baby, 1st interview, gestation 18+5]

During our second interview, conducted after her baby's birth, she spoke about her discussion with a consultant anaesthetist:

> *Carrie: "But it is… it was like, 'Because of your weight, we'll expect you to get an epidural as soon as you're in the labour suite'. And I was like, 'Well that's no' really… I was kind of hoping for…' Cos at this point, obviously, we didn't know that I was gonna be getting a c section. And I said 'Well. .. I don't really want to get an epidural unless I really, really have to. I was kinda hoping to do hypnobirthing'. Well, I'd been doing hypnobirthing. 'I'd like to be able to manage on gas and air', and he was just kinda like, 'Well, we'd advise you to get an epidural… as soon as you arrive'. And I was like, 'But isn't an epidural going to mean that I'd be basically bedbound and can't get up and prolong my labour?'*

And he's like, 'Well not strictly. You'll be able to move your legs'. And I was like, 'So, I can walk about?' and he was like, 'Well no, there is an epidural we give that does that but we wouldn't be able to do that for you because if your legs gave out we wouldn't be able to get you up'. And you're like, 'Oh right, great. Thanks for that.' [Said in a small voice] Like, he didn't mince his words. And I was like, well… and then he stuck this big sticker on my notes saying, 'As soon as this lady arrives at labour ward, call the senior anaesthetist', which pissed me off. And errm… So I just felt like he was just saying, 'You're getting an epidural. You should get an epidural, we're telling you to get an epidural, and it would make our lives a lot easier if you got an epidural'.

[Carrie 38, 1st baby, 2nd interview, baby 6 weeks old]

The descriptions above demonstrate the ways in which participants, although did not often experience enacted stigma , such as Carrie described above, nonetheless experienced a lack of power and autonomy, in that they were unable to plan their care, struggling even to express and discuss their wishes, and have them acknowledged.

Eva was another participant who struggled to have her wishes observed in the planning of her care. However, unlike the woman cited above, the index pregnancy was her third, and she expressed anger and resentment about her previous births. Referring to her previous experiences, when she described meekly following a plan of care, Eva described at great length her determination to have her wishes respected in this pregnancy. She questioned the advice she had been given in this pregnancy, to undergo an elective caesarean section due to risks associated with her previous caesarean births. Eva wanted to have a vaginal birth. She told me:

Eva: "….it's not uncommon. It's just that the NHS wants you to do it their way, you know what I mean? And they're like 'This is what we do, this is what you're gonna do, and you don't really have a choice' and I'm like, 'Well, actually… I do, so…' You know what I mean?"

[Eva, 28, 3rd baby, 2nd interview, gestation 35+4]

Like Amy, Eva had also sought reassuring accounts on the internet regarding other women's experiences of a vaginal birth after a caesarean birth. However, like Amy, in order to further represent her pregnancy and her plans for birth as 'normal', she did not make reference to her weight in this regard:

> *Eva: "All the midwives that I talked to seem to be supportive so it's like… and there's lots of stories online about women who had, you know, a vaginal birth after two sections or four sections, you know… there's all kinds of crazy stories out there."*
>
> [Eva 28, 3rd baby, 2nd interview, gestation 35+4]

She described the discussion she had had with her consultant:

> *Eva: "In the end he agreed. He said yeah, I could do it, but he had a lot of stipulations like… I couldn't be induced chemically, I would have to go naturally if I was going to try for a… a VBAC* or whatever…"*
>
> [Eva 28, 3rd baby, 2nd interview, gestation 35+4]
>
> [*VBAC: vaginal birth after caesarean section]

Eva had a third caesarean birth, but she felt satisfied that she had had her wishes respected and had negotiated a plan of care in which she was involved. However, although she felt satisfied that she had been included in planning her care, she felt she had had to fight for this, something which she continued to express anger about.

Although Eva, Carrie and Louise, and others, accepted in the abstract the risks associated with maternal obesity, they perceived, or presented their own pregnancies as 'normal', and did not perceive that they experienced problems associated with their weight. They wanted a 'normal' birth, but felt their autonomy was challenged and subverted, as the structure of their care, as well as interactions with individual health professionals consistently emphasised an expectation of complications.

A further criticism voiced within women's accounts was that the nature of 'high-risk' care necessarily meant a focus on associated risk, at the expense of a consideration of women's individual experiences. Babs spoke at length about the premature birth of her first daughter, and her subsequent long spell in neonatal intensive care. It was clear from her references to this in relation to her care in this pregnancy that, due to her previous experiences, she did not engage with the suggestion that her risk of giving birth to a large baby was elevated. She said:

Babs: "Growth scans, just to check because people with a higher BMI tend to have bigger babies. We'll see. Not being the case for me, but maybe..."

[Babs 27, 2nd baby, 1st interview, gestation 18+2]

Babs' use of 'we'll see', indicated that she held opinions about her own body, but had not discussed these with health professionals nor felt they were given due consideration.

5.8.2. Stigmatised bodies under scrutiny

Participants in the study experienced screening and examination of their bodies in a range of ways, including additional ultrasound scans. Women who attended the specialist clinic underwent five ultrasound scans in total (compared to the two offered within standard, low-risk care). Additional scans were carried out later in pregnancy and were intended primarily to monitor the growth of their babies. Participants underwent additional screening, including glucose tolerance tests, being weighed during clinic attendance, and physical examinations of their backs by an anaesthetist, to assess for ease of epidural insertion.

Several women described the opportunity to undergo serial ultrasound scans as the primary motivation to attend the specialist clinic. All of the women, particularly those having their first baby, referred positively to the extra scans they had, saying they enjoyed 'seeing' their babies and found the experience reassuring. All of the women had been told by health professionals or were otherwise aware of the higher risk of giving birth to a larger baby. Most participants placed a high level of faith in health professional's abilities to identify potential problems via ultrasound scans and also on the accuracy of fetal weight estimates (often a measurement upon which a decision to induce a woman's labour is based). However, here again, some women, like Anne, sought to play down their obesity as a reason for the extra surveillance from their obesity:

Anne: "I just was a bit like, it's good if I get extra scans and they keep an eye on me and everything's alright. So, really, that was kind of why I did it. More to keep an eye on the baby and less about me having a higher BMI and wanting to do something about it".

[Anne 32, 1st baby, 2nd interview, baby 4 weeks old]

Louise also felt reassured by having serial scans. She said:

Louise: "I've had two, but I'll have another two. And I'm really glad. I think that… I actually think if I was in a normal BMI I would be a bit weirded out that after [the] 20 week scan, that's it. You don't see your baby again until you see the baby, you know? I like it. I like to be able to see it up on screen and know that everything's fine… and everything's continuing to be fine and… I can understand why people pay for additional scans, because it is a level of reassurance later on in the pregnancy that things are still ok…"

[Louise 32, 1st baby, 1st interview, gestation 23+5]

After her baby's birth, she described having experienced a change in her attitude to her body and physical examinations, now that she perceived these were required in order to keep her baby safe. Her comments positioned her as submitting to screening and physical examinations preserving the safety of her baby, suppressing her embarrassment and discomfort in order to be a good mother:

Louise: "Having been someone who had been quite self-conscious before, I think when it got to pregnancy it was just like…'Do what you need to do'. Yeah. A little more relaxed about my body then. During the birth I mean, any kind of modesty goes out the window. Yeah, [laughs] I had I think about three sweeps in a matter of days…"

[Louise 32, 1st baby, 2nd interview, baby 5 weeks old]

Anne talked about having an ECG:

Anne: "She [obstetrician] was like, 'You can get the ECG whenever you want, just go along and you've got this wee sheet'. I thought, I'm here anyway, I'll just go and get it. I got this really young, hot guy who was like, 'Do you mind me taking you?' I was like, 'That's fine'. She told me they just stick stickers here [points to collarbone]. No, that's not what happens"

Alice: They stick them everywhere?"

Anne: "Yeah, he was like, basically, 'Strip from the waist up'. I hate my boobs. And then I had to sit on a table, which is the most unflattering position. This is not a flattering position for anybody's belly. I was like… my god, I was traumatised. I left in pure shock. But I had to kid on I wasn't bothered. He was like, 'Try and relax'. I was like, 'This is as relaxed as it's getting'"

[Anne 32, 1st baby, 1st interview, gestation 17+2]

Carrie explained how she was examined in the specialist clinic to assess her suitability to have epidural anaesthesia:

> *Carrie: "So… I mean, don't get me wrong, they were nice enough. They scan your back and prod at your back and everything and… they said my spine was fine. My weight is evenly dispersed, I'm not like an apple shape or anything… Maybe with them they've got problems with… knowing where to put the epidural but… So anyway, there was two men and you are… just… prodded and poked. And you're sitting just kinda having to pull yourself over and they're talking about you…."*
> [Carrie 38, 1st baby, 2nd interview, baby 6 weeks old]

Here, while Carrie described clinical staff being 'nice enough', but also that they 'prodded' and were 'talking about' her. Such a description of impersonal and degrading treatment differs starkly from that reported by Mary regarding being physically examined and scrutinised prior to undergoing and following an elective caesarean section:

> *Mary: "I think they just started using this procedure more often with very overweight women. It depends how you carry your weight. There are very overweight women, but they don't have a big belly down… so that's ok for them, they might be big in other aspects. But I was quite… interesting case, because I had an unusual case, because I had an unusual dressing with a pump and everyone was coming to see it. But I healed very well"*
> [Mary 38, 1st baby, 3rd interview, baby 5 weeks old]

Mary did not appear to feel stigmatised by the interest her body generated; instead, as described earlier, she felt positive about her experiences, which she felt had protected her health and that of her baby, and had allowed her and her husband respectful treatment and to participate in decision-making. In addition, this new procedure reinforced her account of herself as a 'special', *medical* case.

5.9. Chapter Summary

In the previous chapter, I provided context to participants' experiences in pregnancy, exploring their backgrounds, histories and beliefs regarding weight, the stigma they experienced and their beliefs about health. In this chapter, I have explored participants' beliefs and experiences about weight in pregnancy, with particular reference to their embodied experiences, and their beliefs about diet in pregnancy. Moving on to consider

their engagement with the notion of weight-related risk, I have presented evidence that participants wished to experience pregnancy as a 'pause', a time when the pressure to lose weight and the stigma associated with their size would diminish, meaning they could feel 'normal' and enjoy pregnancy. I have attempted to demonstrate how, for some participants, engagement with notions of risk, and in potentially enacting behaviour changes, was complicated by weight-related stigma, and the ways in which participants seek to resist the negative character traits associated with obesity.

I have presented evidence that, for all participants, pregnancy was an embodied experience that, in addition to inevitable physical changes, was also a time of change in their beliefs about health and health behaviours. A sense of happiness and relief to be free from the tyranny of dieting was experienced by several women, and shared within some couples. In the context of pregnancy, participants did not refer to their own health as of concern in and of itself. Instead they invoked the fetus, representing themselves as 'good mothers-in-waiting' in their efforts to eat 'well' responding to cravings and accept the inevitability of gestational weight gain.

It is noteworthy that there are no formal dietary advice guidelines for very severely obese women, or for recommended gestational weight gain, in the UK. The women reported receiving informal advice to maintain weight from staff at the specialist clinic, and a combination of standard pregnancy safe eating advice and 'healthy eating' advice (for example participants were advised regarding avoidance of certain foods, such as pate, and were shown the 'healthy plate' health promotion tool). No participants spoke positively about the dietary advice they received, with some reporting feeling patronised, judged or stigmatised by the advice they received, while others merely felt reassured that they were eating within recommended guidelines. Consultations with dietitians were described as information-giving sessions, with no consideration reported of the commonly held beliefs discussed at length during interviews.

As I demonstrated in the previous chapter which explored pre-pregnancy health and weight, in pregnancy too, 'obesity' was not acknowledged by participants as a 'health condition'; indeed the term 'obesity' was not acknowledged by most participants in reference to

themselves and their pregnancies. Most participants believed themselves to be ‘healthy’ due to their health behaviours, their dietary choices, or by comparing themselves favourably with others – be they individuals from their social worlds or stereotypical members of an obese, unhealthy ‘underclass’.

The women, and their partners, in my study did engage with discourses of risk, for example in discussion with health professionals or via the internet, accepted an elevated risk associated with maternal very severe obesity in the abstract, and thus opted for referral for high-risk care, but they both endorsed and subverted biomedical constructions of risk within our discussions of their pregnancies. Biomedical risk discourses dominate current approaches to pregnancy care, and several referred to their awareness of pregnancy as inherently risky, thus favouring a ‘just in case’ approach, one which would ‘keep an eye’ on their pregnancies. This was intersected by some women, and some partners, with a down playing of their own individual risk (and thus implied culpability for that increased risk) due to their increased weight, and several presented their pregnancies as ‘normal’. To achieve this they used a range of means, including; citing their own experiences of perceived uncomplicated pregnancies; drawing upon ecological fallacy; questioning the evidence regarding maternal weight and risk in pregnancy; normalising their body weight; highlighting other causes or health problems to account for complications in pregnancy; ‘othering’, by highlighting the negative traits or behaviours of others.

I have considered the extent to which different participants related to stigmatised risk, the reasons for this, including the role of social class. I have noted that ‘othering’ was employed more extensively by women of lower SES while women from middle class backgrounds employed ‘othering’ strategies only in relation to weight, presenting themselves as relatively ‘smaller’ than others. Those of lower SES invoked and resisted those demonising characteristics which are associated with a ‘layering of stigma’ (Lekas, Siegel & Leider 2011) attributed to those who are ‘fat, female and poor’ (Carpenter & Bartley, 1994, p.1715). Women’s and partner’s engagement with biomedical representation of risk was strongly influenced by their relationship with stigma and shame, and both these and other elements shaped their engagement with health messages and experiences of formal healthcare and health professionals. All of the women in the study had accepted referral to high–risk

services, and during their interviews many referred to their perception of pregnancy itself as inherently 'risky' as a reason for accepting the referral. However, although they referred to their acceptance of the risks associated with obesity in the abstract or as applied to others, all of them, simultaneously attempted to resist these risks as applied to themselves, in order to resist stigma, preserve their moral integrity and alleviate anxiety.

Those women who experienced more complicated pregnancies described more positive experiences with high risk care, as their complications led both to them valuing more highly the increased surveillance they experienced, and also to more individualised – and thus personalised – experiences of care and continuity of carers. In addition, they perceived their pregnancies differently, now occupying not a 'liminal space' of obesity, but a 'clinical category'.

By contrast, those women whose only risk factor was their weight and who did not perceive that they experienced associated complications expressed disengagement beliefs, attempting to resist the high risk label. They described experiencing poor communication, fragmentation, medicalisation and depersonalisation of their care, which focussed on screening, surveillance and limiting the effects of risk. This impacted upon their perceptions of their treatment and their relationships with healthcare professionals, leading in some cases to deeper stigmatisation, and to further disengagement from advice and information.

Within many of the women's narratives was a description of a lack of opportunity to plan their own care or to be involved in its planning. The effects of stigma and perhaps the fragmentation inherent within the care pathway appear to have prevented an open discussion about weight and health between the women and their community midwives, as many of the women reported midwives initially not discussing referral in an open way, and subsequently not discussing their weight or health. This manner of referral, without open discussion of health, weight and risk with the referring midwife, established a perception of a 'stigmatised pregnancy'. This was evident in several women's accounts, influencing their experiences of care, regardless of the characteristics, demeanour or views expressed by the health professionals they interacted with. They perceived that health professionals were thinking negative thoughts and making negative assumptions about them.

In addition, in some cases women were not able to exercise informed choice regarding their care, as options were not clearly explained and discussed with participants. This mattered more to some women than to others, depending on how stigmatised they felt by their weight more generally, and to what extent and how successfully they sought support and advice from socially and culturally embedded sources of information and support.

Some women's accounts were characterised by poor communication and a lack of discussion of their preferences and concerns. For many, this was due to feeling unable to contribute to discussions and a plan of care, due to feeling disempowered within the clinical setting. An expectation of complications, and a focus on the surveillance of the fetus characterised participants' accounts of their care. Although some descriptions of interactions with individual health professionals were reported positively, the felt stigma and that which was embedded within the system led to a dominantly negative reporting of experiences of care.

Some women found the fragmentation of care, centralisation of services and poor communication led to them being required to attend a high number of appointments, often involving considerable travel, with time and cost implications, and with inconvenience for some in terms of childcare provision for exiting children. Some perceived that duplicate screening took place, while others described being unclear regarding their plan of care, who should communicate with whom, and exactly who was responsible for booking appointments, with whom and when.

Most women – and some of their partners – experienced no complications that they associated with their weight during pregnancy, but nevertheless followed a complex care pathway, requiring them to attend both local clinics and the city hospital, undergoing invasive surveillance, perceiving and experiencing stigmatising treatment. When they believed no complications or adverse outcomes had occurred within their pregnancies, they questioned the usefulness of the care package and further criticised the treatment they had experienced. This will be explored within the next chapter.

Chapter Six

Postnatal

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6.6	**Postnatal care and deferring plans for behaviour change**
6.7	**Chapter summary**

6.1. Introduction

In chapters four and five, I explored themes within the study data regarding how women, and their partners, understood concepts around health, weight and risk in the context of their everyday lives and then, more specifically, in pregnancy. I argued that, for all women, to differing degrees, pregnancy in the context of obesity was an experience characterised by 'stigmatised risk' and that their beliefs and perceptions were shaped by this and the moral work that they undertook in response to it, to resist responsibility for imposing risk. As such, most participants attempted to present themselves as 'normal'', as far as possible, employing various tactics to reinforce this. Experiences of 'high-risk' care, relationships with health professionals and engagement with formal health messages were shaped by the experience of stigmatised risk, and this extended to the accounts of several partners, who experienced and resisted stigma on behalf of their pregnant partner.

In this chapter, I explore first the views of the women and participating partners when interviewed during pregnancy, as they contemplated future parenthood. I then explore the women's perceptions and beliefs after their babies had been born. In addition I explore their experiences of maternity care as they looked back at their pregnancy and childbirth experiences. I consider any changes that may have occurred in their understandings and beliefs about the impact of weight on health in pregnancy, and how these related to their perceptions of health and their everyday lives more broadly as they moved into parenthood. Finally, I consider their beliefs and plans for future health, and the information and support they received during the first weeks following birth.

6.2. Planning for future health

The previous chapter explored the ways in which the women discussed their experiences during their pregnancies, including how they experienced stigma, and their understandings of the concept of weight-related risk.In addition, all pregnant participants and several partners who described themselves as 'overweight' talked about their future health, and specifically expressed intentions to improve their health after the births of their babies.

6.2.1. Focussing on future fitness

In describing their historical efforts to lose weight, most women talked about experiencing stigma throughout much of their lives, seeking to lose weight in order to conform to the cultural slim ideal (explored in chapter four); by contrast, when considering health and weight loss after the births of their babies, participants, in particular those who were pregnant with a first child, focussed instead on improving their health and fitness. This was strongly associated with the ability to meet both the perceived physical demands of being a parent and, in addition, engagement with the moral agenda of being a 'fit' parent, a good role model who displays positive personal characteristics.

Several women, like Ruth, talked about intending to become fitter and healthier in order to play actively with their children. Ruth referred to her current embodied experience of being unfit and pregnant:

Ruth: "I'd like to be able to, like, run about with him and play and stuff, instead of being… sitting in one of the chairs, like, 'Oh my God!'… knackered all the time. I want to be healthy, ken, because, like, when I was younger, I used to always go out running and playing football and stuff with boys and everything. Can't do that. I can't even jog. Or walk fast. Tried power walking at work the other day and I got halfway down the corridor and I was like, 'Oh my God. I need a motorised scooter'"

[Ruth 27, 1st baby, 1st interview, gestation 22+6]

Ruth repeatedly used humour in this way during her interviews, perhaps as a tactic to avoid talking openly about her experience of poor fitness, at least in part the embodied consequence of her increased weight. Other participants, such as Martha and Anne made jokes about their size and fitness also, in similar ways, possibly to deflect anticipated stigma.

Ruth went on to describe her anticipation that the change in lifestyle that parenthood would bring would lead to weight loss without the need for active dieting, or reducing her intake:

Ruth: "But, like, I do think that after I obviously have him… I think the weight will probably come off. Which, I mean, I would be happy if it did, but even if it didn't come off straight away, I'll still have this end result, so I'll not be as, like, kind of, focussed and like, 'Oh my God'"

[Ruth 27, 1st baby, 1st interview, gestation 22+6]

Here, also in common with others, Ruth, who had spoken about her focus on losing weight pre-pregnancy, now subtly used the ideal of fitness for parenting to demonstrate her shift from achieving slimness to improving fitness. To do so, she invoked the baby as both a reason to be fit, but also as a reason to not aim specifically for weight loss.

Ruth's partner Graham expressed a similar view regarding the new role of parenting leading to weight loss:

Graham: "My lifestyle will probably never change cos of my work. Ruth's will, because of the baby. So I think Ruth wants to lose weight….. But I think that will happen naturally"
Alice: Because of the…?
Graham: "Change of lifestyle"

[Graham 32, Ruth's partner, 1st baby, gestation 25+2]

Amy, who had lost some weight prior to becoming pregnant, separated concepts of health and fitness. She talked about her plans for improving her fitness after her baby was born:

> *Amy: "I definitely want to continue losing weight… once the baby's here. Cos like, it's just like… I start to worry about stupid things like… going to the park and… trying to run around and me getting out of breath and… being, like, an active mum…"*
> Alice: Mmm?
> *Amy: "...and I know that that might be difficult the way I am. For as much as I might be healthy, I'm not fit. So… ermm, so that's definitely gonna be my number one thing, is sort of… get fit… just fitter. And I know, like, having a baby, running around, it'll probably do it itself. But it's just… I definitely don't want to be one of these mums that has to sit everything out. I won't change what I was doing before. I'll continue what I was doing. Just hopefully… things will fall into place"*
> [Amy 26, 1st baby, 1st interview, gestation 16+3]

Like Ruth, and Graham, Amy referred to her desire to lose weight, but framed it as an inevitable consequence of improved fitness, itself a consequence of increased activity due to being a parent. Amy claimed she was healthy, but could not claim she was fit, thus separated the notions of fitness and health. Indeed, at points during their interviews, most women described themselves as 'healthy', however only two, Anne and Carrie, who had routinely undertaken physical activity prior to pregnancy, described themselves at any point as 'fit'. None described themselves as slim. The focus on becoming 'fitter' drew on the notion of a state of good health as not necessarily related to fitness, and also drew away from the notion that they needed necessarily to be slim in order to be either healthy or fit.

In addition, in discussing their future plans, several women explicitly ruled out wanting to become 'too slim'post-pregnancy, which they referred to as being 'skinny', a negative term for a slim body, with connotations of under-weight and ill-health. Amy said:

> *Amy: "I don't ever want to be skinny. That's not my intentions. I want to get fitter, that's for definite. Errm... I don't ever want to be like a size 10, because I haven't been for so long, and it's just… I'm quite happy being bigger. Because as long as I'm fit enough to do stuff with my kid, then I'm happy"*
> [Amy 26, 1st baby, gestation 16+3]

Carrie, who had strongly expressed her view that she was healthy throughout her interviews, expressed a similar intention with regard to physical fitness:

> *Carrie "I mean, I definitely would like to lose weight to be able to run about with him more. But not… not drastic. I'd be happy just to lose a couple of stone. Getting back into the… healthier… I say healthier, just not the morbidly obese range [laughs]*
>
> [Carrie 38, 1st baby, 1st interview, gestation 18+5]

Anne was another participant who referred to her desire to achieve physical fitness once her baby was born, whilst rejecting the 'ultra-slim' ideal. She said:

> *Anne: "I'd still like to look nicer. I'm not wanting to be skinny-skinny though, I'd be quite happy to be a 14 or a 16, but a nice toned 14 or 16"*
>
> [Anne 32, 1st baby, 1st interview, gestation 17+1]

Thus, several participants referred to, and resisted the dominant discourses which link low body weight, physical fitness and good health. Participants mostly perceived and presented themselves as 'healthy' and in planning for future health, they focused on fitness, as they anticipated the physical requirements of daily life becoming more demanding due to parenting responsibilities. However, under the continuing shadow of stigma, they resisted the idea that this would require drastic weight loss. By using the derogatory term 'skinny', several attempted both to deflect stigma and to lend legitimacy to their future ideal of being larger, but nevertheless fit, and healthy.

6.2.2. 'Family obesity' and fitness: a good role model

In addition to fulfilling the role of an active parent, able to carry out the requisite physical tasks and play with their children, several participants were concerned about being a good role model to their children. Anne's husband Ian referred to his observation of patterns of overweight within families, which accords with biomedical and public health discourses regarding the association between parental and offspring obesity:

> *Ian: "I don't want our kids to be overweight, and you… you tend to see that. You see that if you've got parents who are overweight, their children tend to be overweight as well".*

Alice: So do you worry about that?
Ian: "Yeah, I don't want them to, sort of, have those same issues that I've got"
[Ian 32, Anne's husband, 1st baby, gestation 18+0]

His wife Anne did not refer to this, but rather to her fear of the future stigma that her children might experience due to her, and her husband's, weight:

Anne: "I don't want to have them having a fat mum that picks them up from school. I don't want them to get slagged that their mum and dad are fat"
[Anne 32, 1st baby, 1st interview, gestation 17+1]

Although Anne was pregnant with her first child during the study, her reference to 'them' and 'they' demonstrates her thoughts and fears for the future, when she and Ian had more than one child. She worried about future stigma impacting the whole family.

Martha also discussed her plans to be a good role model to her daughter:

Martha: "I didn't learn to swim until I was in my 20s, and I think that I don't want her to have the same issues as I've had with weight. If she gets the good practices in now, it'll not be like forcing her. Get her used to exercise and being out and playing and all the rest of it, because I was a lazy child. Give me a colouring book and I was happy, whereas my brothers were up the hills all the time and playing for hours. I don't want her having the same issues that I've had growing up, so I would like to be more sensible. I don't want her to have a fat mum that won't do anything with her because she can't."
[Martha 41, 1st baby, 2nd interview, gestation 35+0]

The prospect of new baby clearly triggered a mix of emotions and planning for all participants. Some reflected on their own childhoods, relating sedentary habits which became entrenched in adulthood. A very strong focus emerged on the benefits of physical activity, for individual fitness and health, but also in order to be a morally 'fit' parent and role model for a child.

6.2.3. Second and subsequent children: renewed intentions to improve health

Four women who participated in the study had an existing child or children, and they expressed similar intentions to those having their first baby in terms of increasing physical fitness, losing weight and improving future health. When interviewed late in pregnancy,

Rachel said of her first child, who was three years old at the time of her participation in the study:

> *Rachel: "There is stuff that I kind of… not kind of… knew… It's stuff that I guess I had… kind of… already admitted to myself, like I can't… you know, I can't run around after [1st child] the way that another mum would. That obviously pre-dates pregnancy, but being pregnant really, really brings that home to you… of like, you know, what actually the implications on [1st child] are. Not just about, you know, what he sees as normal and what his future is if he has an obese mother, in terms of his own eating habits, just that I don't want to compromise his childhood because I'm too unfit. I don't know how I'm going to do it, but I just know that all the excuses I've used between [1st child] arriving and now, I've got to find a way around those because I've got to… I've got to lose weight"*
>
> [Rachel 38, 2nd baby, 2nd interview, gestation 36+1]

Having experienced caring for a first baby and having not lost weight 'naturally', through parenting, in the way that the first-time parents like Ruth, Graham and Amy anticipated, Rachel now expressed a resolve more strongly than other participants to achieve better fitness following the birth of her second baby. She described her understanding of the embodied reality of being unable to 'keep up' with and play with a small child, the reality that those participants expecting a first baby were anticipating. Her use of the word 'obese', resisted and not used by most women, demonstrated an engagement with the health discourse regarding her weight. She referred to the reasons, or 'excuses', that she had used when she had not lost weight previously, concluding she needed to overcome them in order to be a good parent.

Thus, all participants, late in pregnancy, expressed a resolve to become fitter once their babies were born. This was the case for both first time mothers and those who already had children. The latter group also made reference to their previous experiences of intending to lose weight, but not doing so after pregnancy, and beginning their index pregnancy at a higher weight. It was clear from numerous references made by participants to fitness and participation in physical activities with children that being an 'active' parent, one who was mobile and taking an active role in their child's life, was an important signifier of an ability to fulfil the moral responsibility to be a 'good parent'.

6.2.4. Future thinking: deferring behaviour change

, Although all participants in this study cited improved physical fitness as a motivator and a goal, only some specifically identified weight loss as a goal for improved health. In addition, none described firm plans for behaviour change. Those participants having a first child used vague language, expressing a belief that the lifestyle changes brought about by becoming a parent would inevitably lead to improved fitness and consequently weight loss, without the need for behaviour and lifestyle changes("Just hopefully… things will fall into place": Amy). The accounts of those having a subsequent child demonstrated that this inevitable improvement in health and fitness had not followed the birth of a previous baby, and they expressed renewed intentions to improve health, lose weight and/or improve fitness; however, the language they used demonstrated plans for behaviour change were vague and deferred to the future (Rachel: "I don't know how I'm going to do it").

6.3. Interlude: pregnancy & birth complications/interventions

Below I present a summary of the complications/interventions experienced by participants in this study, before moving on to explore their experiences of pregnancy and birth, and plans for future health, once their babies were born, during postnatal interviews. All participants except Amy took part in a postnatal interviews, and these were conducted when participants' babies were between four and eight weeks of age.

Eva: prolonged pregnancy; elective caesarean (Eva had had two previous emergency caesarean births).

Rachel: early induction of labour; at 38 weeks' gestation; vaginal birth; Down's Syndrome diagnosed shortly following birth.

Martha: pre-existing diabetes requiring treatment with insulin; early induction of labour; emergency caesarean section.

Mary: severe anxiety and depression during pregnancy; elective caesarean section.

Amy: early induction of labour, forceps delivery.

Anne: augmentation of labour; emergency caesarean section.

Carrie: breech presentation; elective caesarean section.

Babs: symphysis pubis dysfunction; spontaneous labour; vaginal birth.

Louise: diagnosed with OCD during pregnancy; early induction of labour, emergency caesarean section.

Rebecca: spontaneous onset of labour; emergency caesarean section.

Ruth: spontaneous onset of labour; emergency caesarean section.

6.4. After the birth

In postnatal interviews, women reflected on their pregnancy and birth experiences. Several women perceived that they did not experience any complications during pregnancy. Some of those that did implicated the medicalised management they had experienced, thereby resisting personal responsibility for their weight and associated problems.

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6.4.1. Questioning medicalised management

Several women were critical of the medicalised management of pregnancy that they had experienced. Some referred to the serial ultrasound scans they had undergone, which were intended primarily to monitor the growth of their babies, and as a result of scans, several women had their labours induced as the result of a concern about their babies being large. Some referred to the inaccuracy of the monitoring of fetal weight in utero that was achieved via these serial ultrasound scans. There is evidence that the accurate assessment of fetal size is made more difficult by maternal obesity (Best, Tenant, Bell & Rankin 2012). The excerpt below is typical example of the uncertainty and anxiety that resulted from serial scans for several participants. Babs described how she felt she had had a ‘near miss’ in terms of induction of labour after a series of scans which were inaccurate and distressing for her:

> *Babs: “I went to the 32 week one, he was measuring really big. Errmm… his stomach in particular... was measuring something like 38 weeks or something, at 32… which was really strange… in comparison to a couple of weeks before. And then I went in at 36 weeks, and he was measuring normal again. Cos they had said to me at 32 weeks, ‘If he continues on that line, then we might have induce you early, because it could be a sign, well… it’s the only sign we’ve got that he could be a big baby’. I was like, ‘Oh dear, I dinnae want that’ and they were like, ‘So we wouldnae let you go past your due date and we’d probably deliver you a wee bit early, just to… prevent intervention’ they said, but that didnae work out. And then when I went to my next scan, it was fine, but the midwife said, ‘Well*

the problem is if we take out that scan that you had four weeks ago, it looks like he's following a perfect line. If we put that [subsequent] scan in, it looks like he's taken a drop in growth…'
Alice: OK?
Babs: "Uh-huh. Also with the signs… because I was showing signs of pre-eclampsia, so … because poor growth can be a sign of pre-eclampsia. And then he was born and he was 5 pound 13. So… I don't know. He wasn't big"
Alice: Did they think that was small?
Babs: "Yes, they thought he was a bit small, because they thought he was over 6 pounds at his scan a week earlier, and obviously they're not that accurate. But they were talking like he was gonna be a big… a big baby, like over the 8 pound mark. So errr… I just think they coulda delivered me early for nothing…"
[Babs 27, 2nd baby, 2nd interview, baby 4 weeks old]

In most cases, the complications experienced by the women in the study were those which are more likely to occur in the context of maternal obesity. An awareness of risks of complications such as high blood pressure, pre-eclampsia, gestational diabetes and the risk of having a baby that was 'large-for-dates' was expressed by most participants. However, although some had been aware in pregnancy that they were more likely to be recommended to have an induction of labour (which indeed four women underwent), with associated risks, including fetal distress and an increased likelihood of caesarean delivery, induction of labour and caesarean delivery were not identified by participants as obesity-related 'complications'.

Some women explicitly questioned the nature of the risks that their weight had posed in pregnancy. Carrie, for example, described her ideas about her sugar consumption and the risks of developing diabetes, referring to and questioning the information regarding epidemiological risk that she had accessed during her extensive online searching:

Carrie: "So I was eating so many of those [sweets]… that I was convinced… not that I think it's got anything to do with how much sugar you take I suppose… but I was convinced that they were gonna be like, 'Oh my god'"
Alice: You think the amount of sugar isn't..?
Carrie: "Well I don't know like… You have to have a decent diet, do you know what I mean? But I suppose there's more to it than just having ate a lot of sugar. There's more factors of getting raised blood sugars in pregnancy than just your diet. I know that once you've got raised blood sugars you can manage it wi' your diet. Like I know my friend's having to monitor hers four times a day…. bless her… but what I mean is it's not just that alone"
Alice: Because some people get it and some people don't?

Carrie: "Uh-huh. Me just having a load of fizzy juice and tangy Haribo [sweets] for some people would be enough to push them over into diabetes, but for me, I was lucky and it didn't. But I was convinced it was gonna, and then when I phoned to get my results and they were like 'they were 5.5 and they need to be below 8', or whatever, and I was like, 'Wow! Check me!"'

[Carrie 38, 1st baby, 2nd interview, baby 6 weeks old]

Later, she spoke of her frustration at not having accurate information regarding risk available to her. She described during both of her interviews spending considerable time searching for information on the internet, but not understanding – and thus questioning – the risks associated with obesity in pregnancy. To make sense of it, she drew on examples from her social network:

Carrie: "I'd love to… and I'm sure I said this to you at the time, and I've said it to a million people… I'd love to know like… what the heightened risk of… like women of normal weight, what percentage get gestational diabetes, and then women of BMI of over 35, whatever… how many get gestational diabetes. What… you know, when they say you've got a 50% higher risk, do they actually mean of the 2% that get it, or…? I'd just like to know what the actual stats are because… I do think the fear of god is kinda put into you, and you're almost anticipating all these things to go wrong. And in reality, it was a textbook pregnancy, and my other friend who went to the clinic had a textbook pregnancy, and my… I've got friends who… are of average weight who… got gestational diab[etes]… and who got pre-ecl[ampsia]... and who got rushed into hospital and got kept in… d,you know, all these things that… it can go wrong for anybody. It's probably just… genetics and the luck of the draw. There's probably… you're much less likely I guess, but again I'd like to just know how less likely you are. Obviously it's not good to have a high BMI. You should have a weight that's not going to put you at a higher risk of complications, but I just would like to know what the higher risks are"

[Carrie 38, 1st baby, 2nd interview, baby 6 weeks old]

Carrie questioned the risks that had been presented to her and highlighted the complexities surrounding the representation of risk and the difficulties inherent in navigating information sources online. She interweaved biomedical information, notions of epidemiological and clinical risk, personal experience and anecdotal evidence from the experiences of her many friends, in order to ultimately suggest that the risks are exaggerated by health professionals. Speaking during Eva's pregnancy, Eric questioned the risk discourse around obesity, with referring to his perception of it as stigmatising, and relating it to his wife Eva's experiences:

Eric: No, well they make her feel… obviously... fat, because they… when they went in… obviously they go, 'Well, you're going to need to go through to [bigger hospital] to do thing' and it's pretty obvious why, you know? Because… she looked it up online [laughs] to see that it's basically just for bigger women or whatever to… uh… check on them. But she's been through three births now and she never had a problem"

[Eric 30, Eva's husband, 3rd baby, gestation 18+6]

During her pregnancy, Anne said she didn't anticipate or experience any problems related to her weight. She talked about her weight, her pregnancy and her high-risk care:

Anne: "I was never really overly concerned about it before, and I probably wasn't during the pregnancy. When they were like, 'You've put on this', I'd never put on a lot so I was always like, 'It's only a pound'. I don't think they were concerned that I'd put on any… maybe if you were putting on loads because you were eating they'd say, 'What are you eating? What are you doing and are you exercising?'"

[Anne 32, 1st baby, 2nd interview, baby 4 weeks old]

Anne spoke several times about 'being bright' or 'knowing what is going on' during her interviews, appealing to, and resisting the demonised stereotype of an ignorant, lazy 'fat' individual by emphasising her healthy state and good level of health-related knowledge.

Louise also speculated that her weight had not caused her to experience complications:

Louise: "You know, my weight didn't seem to affect my pregnancy at all"
Alice: Mm-hm?
Louise: "Um… I had really good blood pressure the whole time… my blood sugar was really good."
Alice: Oh yes, they do those diabetes tests don't they?
Louise: "Yeah, they do the gestational diabetes, but they also just do your blood sugars all the time. You know, all of my test results and... my heart rate and everything were all really normal and... and similar to someone… who's not obese. So, I don't feel that my weight really impacted my pregnancy at all."

[Louise 32, 1st baby, 2nd interview, baby 5 weeks old]

Later she spoke of her plans to have another baby soon, referring to her awareness of the recommendation to lose weight prior to conception, but also her plans to go ahead anyway:

Louise: "Yeah, I would like to…. think about getting pregnant about this time next year, and you know, having them quite close together, and I don't think that I would be in a normal BMI by that point. I would have to lose a lot of weight get into a normal BMI range. I don't think I'll be able to do that and I think I'd be required to go to that clinic"

[Louise 32, 1st baby, 2nd interview, baby 5 weeks old]

Here, the complexities of Louise's perception of risk related to her weight and pregnancy are demonstrated. Louise was very anxious about her baby's health and development during pregnancy and found the extra surveillance reassuring, particularly the ultrasound scans. During this postnatal interview she talked about having been assessed by a psychiatrist and being diagnosed with OCD late in the pregnancy. Like other women, she described herself as healthy, a description that she illustrated with details of her healthy diet. Looking back on her pregnancy, she believed her weight had not caused any problems. The broad social and cultural acceptance of biomedical representations of pregnancy as inherently risky, added to her anxiety about her pregnancy and symptoms of OCD, may account for her emphasis in her narrative being diverted from her weight. The lack of complications that she perceived reinforced her account of herself as physically healthy, eating a healthy diet, and that her weight had not caused complications. In addition to resisting the associated stigma, Louise did not engage with the biomedical discourse pertaining to obesity and pregnancy. Thus, planning another pregnancy without first losing weight was to her a sensible idea, particularly as the clinic would be available to exclude problems and reassure her.

Their perceived lack of complications reinforced their accounts of themselves as 'healthy' despite their weight. The strong theme of good food as health-giving, unrelated to body weight, was referred to repeatedly by participants, thereby further resisting the 'layering of stigma' associated with 'cheap', or ready-made foods, perceived to be of low nutritional value.

6.5. The responsibility of mothering

As discussed above, several women represented motherhood as having led to a shift in their attitude to their bodies, no longer feeling a pressure to lose weight due in order to change

their physical shape and appearance. For women having their first child, accounts drew attention to the new role of mothering, with the primary focus on providing for the needs of the child.

6.5.1. A resistance to 'dieting'

The role of mother meant a renewed emphasis on buying and preparing food which was home cooked and regarded, therefore, as being healthy. Most women described their diets as already consisting of healthy foods, so for most this constituted an affirmation of their good behaviour and fitness for motherhood, rather than requiring a major shift in health or dietary habits. In particular, for those who were breastfeeding, emphasis was placed upon the need to nourish the maternal body in order to ensure that it produced nourishing milk. Several women described having had problems early on in establishing breastfeeding, and described their commitment to prioritising breastfeeding and consuming 'good food', not restricting intake, in order to maximise successful breastfeeding.

Louise described breastfeeding her new baby as a time when she would not seek to lose weight:

> *Louise: "What I'm really conscious of doing is not…. not… trying to go on any kind of calorie-controlled diet, because I don't want to mess with my milk supply. But just to eat heathy, nutritious food for her"*
>
> [Louise 32, 1st baby, 2nd interview, baby 5 weeks old]

She described her mother visiting for several weeks just after she gave birth. She said:

> *Louise: "Well my mum was here for the first 7 weeks... which was amazing. And she was cooking really…. good, healthy, wholesome food"*
>
> [Louise 32, 1st baby, 2nd interview, baby 5 weeks old]

Louise presented not dieting, not losing weight, as a matter of self-sacrifice, part of being a good mother and thus prioritising her baby's needs. She went on to describe her attitude to health, weight and fitness in the context of her new role as a mother. I probed her about her views regarding health being necessarily dependent upon weight, specifically a 'healthy' weight:

Alice: So you said in the pregnancy, you didn't think weight affected it. So, do you think, getting older, weight can become an issue?
Louise: "No, but I am very conscious that I am really overweight and to be able to be an active and healthy mum to her I need to lose it, so that I can do the things that she wants to do as she gets bigger. That's why the exercise thing is really important to me. You know, getting a level of fitness, cos I didn't do anything during my pregnancy. I had exercised a lot more in the year before the pregnancy but it had all dropped off, so it's just getting my fitness back to be able to do stuff. I no longer care if I'm in size 16, size 18 clothes for the rest of my life. It doesn't bother me like it used to, but I want to know that I'm healthy, I'm eating right and that I'm… active. And if I lose weight, great. And if I don't then, as long as I know that what I'm putting in my body is nutritious and healthy and good for her and I know that we're out and moving and exercising then… that's the main thing. I think that's healthier than obsessing over whether or not I'm losing weight"

[Louise 32, 1st baby, 2nd interview, baby 5 weeks old]

In common with other participants, Louise referred to, and rejected as 'unhealthy', the notion of 'dieting' to achieve weight loss. 'Dieting' behaviour was presented negatively by several women, who represented the term to mean a highly restricted nutritional intake, depriving the body of what it needed. This was presented by several as particularly undesirable and selfish when breastfeeding. In addition, several women made reference to their belief that focussing on dieting was focussing on them*selves*; something that was presented as selfish in the context of being a good mother.

During her first interview, at 20 weeks' gestation, Louise had criticised her mother's attitudes and beliefs about food and health, saying she was 'always buying into the latest fad', and was negative about Louise's weight, encouraging her to diet. In contrast, after the birth of her baby, Louise talked about how her mother had helped her to find out about nutrition in relation to breastfeeding. Louise was also meeting friends who had new babies several times a week:

Louise: "Yeah… and you know there are some things that are really, really way out there, but actually, she [Louise's mum] helped me discover a lot about... the types of foods to eat to make your milk come in and... you know… the types of things to eat to help the baby thrive. I mean I'm eating cake still… because... that seems to be what you do when you're a new mum. You see people and you have

cake and coffee [laughs], but I'm a lot more conscious about, you know, getting enough protein… getting enough vitamins…"

[Louise 32, 1st baby, 2nd interview, baby 5 weeks old]

In her role as a mother, Louise's own mother was supporting her, and had become an ally in her views on nutrition and breastfeeding. Louise's account focussed on presenting mothering and breastfeeding as an embodied project, and one which weight loss could imperil. She also referred to participating in the very common practice of middle-class mothers with new babies meeting socially in cafes and consuming calorie-rich food and drinks, referring specifically to its social sanctioning.

Mary also talked about being conscious about what she ate while breastfeeding:

Mary: "But now I am breastfeeding, I have to eat in order to have healthy milk, you know like… because sometime if... I did not breastfeed, sometimes I would only eat once a day, you know, whatever rubbish I can find. When I'm forcing myself to eat three, four times a day, to eat more fruit and vegetables, not necessarily for weight, but to be healthy for the baby, you know? I am conscious of the fact that, being a big person, it increases the risks of a lot of things, and I won't be healthy for a long time. My baby needs me now. I don't want her to lose me before she is an adult. So I have to consider how to keep myself healthy… and that means losing weight. I think the advice of the dietitian at the hospital was …and from my understanding she is the director of the weight loss programme, so… She said I should not consider any kind of diet, apart from a healthy diet in general until at least six months. The baby should be six months, especially if I breastfeed. So considering the fact that I am taking vitamins, breastfeeding vitamins, and I am still taking the iron, and I lost a lot of blood… and I am probably losing a lot of things through breastfeeding, it will not be a good choice to start dieting at this time. I have days when I feel a little bit… not dizzy, but weak. When I am quite tired…"

[Mary 38, 1st baby, 3rd interview, baby 5 weeks old]

Thus Mary too presented herself as being a 'good mother', prioritising her baby now and in the longer term. This meant not attempting to lose weight immediately, but deferring it to the longer term, in order to put her baby's immediate nutritional needs first. She talked about the demands on her body, about 'losing a lot of things', physically giving up things to prioritise her baby, concluding that dieting would be too demanding for her and not appropriate in terms of her priorities for early motherhood.

Two women did describe having enacted healthy behaviour changes and experiencing embodied benefits as a result, including weight loss, since becoming parents. Anne said she and her husband Ian had lost weight following the birth of their baby. During her postnatal interview, Anne, who had lost weight early in pregnancy due to extreme nausea and vomiting, described how they had achieved this:

Anne: "I never put on any of my own weight, so since I've had [the baby] I tried a dress on the other day and it fits me and it never fitted me before. I was like, 'Yes!' I think that's probably helped by the fact that I definitely don't eat nearly as much, or pick as much, because I've got him and I'm busy. I take him out a walk, I could be out for two hours, and then I've not eaten"

[Anne 32, 1st baby, 2nd interview, baby 4 weeks old]

Later she spoke more about how busy being a mother made her life. She said:

Anne: "I'm not sitting in front of the telly eating, snacking. Ian and I aren't going out for meals. We're not going out for any cocktails and I'm not making any cocktails, so I think we'll probably lose weight anyway. Then you're lifting prams, so that's a kind of exercise, isn't it?"

[Anne 32 1st baby, 2nd interview, baby 4 weeks old]

Martha was another participant who commented on the impact of her change in habits since her baby's birth:

Martha: "I'm not snacking as much. It's quite surprising. Because I'm having to do online shopping to get delivered, I'm not buying rubbish. I don't know what my weight is, I haven't weighed myself since giving birth, but I'm back in the same size of clothes. I had to buy an outfit for Saturday night and I'm back to the size I was when I got pregnant. That's surprising, I thought I would have been a wee bit heavier, wider. That surprised me, I was like, 'That's a bit odd!' I wasn't very happy with the size I was before I got pregnant, but at least I've not ended up going up two or three dress sizes, which can happen."

[Martha 41, 1st baby, 3rd interview, baby 4 weeks old]

Despite expressed beliefs during pregnancy about the inevitability of gestational weight gain, Anne and Martha perceived that they had not gained excessive weight during pregnancy. The embodied evidence of this – trying on pre-pregnancy clothes for example - was experienced very positively.

In contrast to others, who were deferring weight loss efforts, Anne and Martha described enacting behaviour changes which had led to health benefits. Anne went out walking with

her baby in his pram frequently. Martha had switched to online shopping which led to her making healthier food choices.

6.5.2. The responsibility for health improvement

Once their babies were born, two women discussed specific health concerns which informed their intention to lose weight. Martha was diabetic and a lone parent:

> *Martha: "Yeah, well... I want to lose weight. And if anything I've got a focus now that I never had before. You know if I was losing weight, there was always like, 'Ach well, life's too short' and all the rest of it. Whereas now it's, no, no, no, I want to lose weight so that we can… because it is just me and her, so she's not… you know so I can get down and play with her. You know, we'll just see what happens. I'm optimistic… that I've got a rea… you know, I've got a reason for doing it sensible now, rather than just vanity or… you know? She's not gonna have… a lot, so I have to be there for her and I don't want to leave her too early because I've not looked after myself and I've given myself a heart attack by the time I'm in my fifties. That's not fair on her"*
>
> [Martha 41, 1st baby, 3rd interview, baby 4 weeks old]

Martha re-framed weight loss as no longer selfish, or vain, but as a moral imperative, to be a good mother and live a long life.

Another woman, Rachel, described herself as having been overweight for most of her adult life, occasionally embarking on diets and losing some weight, but regaining it again during times of stress or unhappiness, when she 'comfort ate'. When Rachel's baby was diagnosed with Downs Syndrome shortly after birth, she said in her interview several weeks later:

> *Rachel: "So on one level… my instinct was, 'I have to get well now, I have to get... fitter,' you know? Because I need to be around for longer. Because there's somebody who needs me more."*
>
> [Rachel 38, 2nd baby, 3rd interview, baby 5 weeks old]

She continued:

> *Rachel: "…And on the other level, I'm expressing every two hours and so it sort of feels like all bets are off and I can eat whatever I want."*
>
> [Rachel 38. 2nd baby, 3rd interview, baby 5 weeks old]

Later she said:

Rachel: "I'm being naughty at the moment, but I'm aware of it. But there's also a part of me that's saying, 'Be kind to yourself', but not kind to yourself like 'Let yourself eat chocolate', but saying 'Don't…' you know, 'Don't stress yourself out'. But you know, it's toast… It's toast and things. When there are biscuits around ... and people buy you things as well, and now I have the lactation cookies as well"

[Rachel 38. 2nd baby, 3rd interview, baby 5 weeks old]

Thus Rachel alluded to a tension between addressing the long term health risks she identified as associated with her weight, and living her life in the present, with her baby's unexpected diagnosis, disrupted sleep patterns and chaotic domestic arrangements, which had led to a return to the 'comfort eating' she had referred to in recounting previous challenging times during her lifelong complex relationship with food.

Due to their experiences of their responsibility as parents – Martha as solely responsible for parenting and Rachel as the mother of a disabled child – these two women referred specifically to their mortality, the potential for their weight to shorten their lives, in their discussion of the future and their plans to lose weight. In most other women's accounts, there was a strong motivation to improve fitness and general health; however, the initial postnatal period was characterised by a focus on the baby and on a continuation of the approach to food taken by most participants during pregnancy – that of eating 'good' food, viewed as nutritious and, for some, now supporting the production of 'nutritious' breast milk, whilst also eating 'treats' such as chocolate, cakes etc. The return to weight loss efforts was associated with stress, difficulty, misery, discipline and indeed was cited by some as not compatible with 'good' mothering, particularly in relation to breastfeeding.

In addition, all participants described plans for improving health and fitness and weight loss; however none had firm plans to enact lifestyle changes. All described feeling optimistic about future success in their health-seeking endeavours, but their expressions were vague ('if I lose weight, great, if I don't then…': Louise). Despite their lifelong struggles with weight and consequent awareness of the difficulties inherent in losing weight, they expressed optimism and determination, however whilst simultaneously deferring health improving behaviours.

6.6. Postnatal care and deferring plans for behaviour change

Following the detailed accounts given by all women about their interactions with health professionals during pregnancy, and the surveillance and examinations they experienced at the specialist clinic, there was a striking lack of discussion in most women's accounts regarding their postnatal care. Eight of the ten participants who took part in a postnatal interview had had a caesarean section and had stayed in hospital for more than one night, but all were discharged home following a routine post-operative stay of three days or fewer, and experienced no post-operative complications.

Specifically, there was an absence of discussion about any health and weight loss advice or information provided by health professionals, despite questions being posed by me about this. In addition, although several participants recalled being told about postnatal weight loss services while they were still pregnant, they were not then provided with any relevant information, either during their postnatal hospital stay or during visits at home from a community midwife.

Although several women stated their intention to return to, or join commercial slimming clubs, they and others referred to an understanding that they should delay weight loss efforts, quoting varying lengths of time, ranging from six weeks to six months. Some spoke of waiting for life to 'settle down' (Rebecca), referring to the lack of routine, broken sleep and focus on baby care which typically characterises the early postnatal weeks.

Some women had been informed that follow-up would be available via the high-risk clinic, but none had received an appointment or information. Participants described receiving no formal weight loss advice or offer of referral to weight loss services from their community midwives or health visitors. When asked if she had spoken to her midwives or any other health professional about losing weight, Babs said:

> *Babs: "I know what it takes to lose weight, it's just the getting the… motivation to…cos the sleepless nights make you very tired and very hungry [laughs] and actually it's not just that you're hungry, it's more that you need a quick fix just to… keep you going because you're tired. So…"*
> Alice: And do you have an idea about what you're going to do?

Babs: "I will be going back to Slimming World, because it was working for me, I was losing weight and I can make a meal for everybody".

[Babs 27, 2nd baby, 2nd interview, baby 4 weeks old]

Martha talked about her pregnancy weight gain and her future plans for weight loss:

Martha: "Most people say, 'I put on three stone when I got pregnant', and things like that. I don't know what I put on weight-wise. I think I looked at it and it was about two stone, two and a half stone, at one stage, which was less than I thought I would put on. I didn't really pay attention. It wasn't that I was deliberately eating rubbish but I just kind of relaxed and didn't freak out if I wanted a treat. We'll see what happens. I spoke to them at the slimming club when I was there and they were like, 'Because you're not breastfeeding you can come back once the baby's four weeks'. I was like, 'Four weeks?' I kind of want to enjoy baby a bit first, so that's what I'm going to do… There's a part of me that's like, 'Just relax and enjoy it for a bit before you get your head back into it'"

[Martha 41, 1st baby, 3rd interview, baby 4 weeks old]

Martha had gained much more weight than the specialist clinic she attended recommended in pregnancy. However, she quoted the example of others gaining three stone, elsewhere referring to a friend gaining four stone, using these examples to 'other', in order to present her own gain as relatively low or 'normal'. Her comments drew upon cultural expectations of postnatal weight loss, 'getting one's figure back' and an acknowledgement of her experience of it as hard work, involving planning and restricted calorific intake. As a lone new parent, Martha was tired and busy meeting the demands of a new baby. She wanted to delay embarking on the difficulties she associated with dieting, instead 'enjoying' her baby for a while.

Some women described community health professionals offering reassurance and advice about their weight. Ruth described her efforts to increase her activity and improve her fitness and her community midwife's response:

Ruth: "She even caught me outside trying to jog, and she was like, 'What are you doing?' And I'm like, 'I'm trying to be healthier' and she was like, 'You're not allowed to do any of that until after 12 weeks!' I was like 'I know but…' She was like, 'No buts, get back to your house now!' and she drove me up here and she came in for a tea or a coffee and she was like, 'You need to get a chill pill, Mrs'"

[Ruth 27, 1st baby, 2nd interview, baby 7 weeks old]

The accounts of participants' experiences of postnatal care focussed on midwives and health visitors providing standard, low-risk follow-up care, discouraging an early return to, or commencement of, physical activity, and delivering or reinforcing messages regarding delaying weight loss behaviours to a later, unspecified date.

Interviewed 6 weeks after the birth of her baby, Eva tried to remember the conversation she had had with a dietitian during pregnancy, referring to her friend who had been offered a free pass to exercise classes:

> *Eva: "And I can't remember if the lady said that they would refer me to that, or if it was something else, but it was… but basically she said I couldn't go to it until I was six weeks postnatal anyway, especially cos I had a section. So I'm just waiting to see if anybody mails me or..."*
> AK: Would you like to do that?
> *Eva: "Probably yeah. Cos like… I'm trying to lose weight. It's the big thing in my life, eh?"*
>
> [Eva 28, 3rd baby, 3rd interview, baby 4 weeks old]

Eva's comment, that trying to lose weight was the 'big thing in her life' sums up the feelings expressed by most participants in the study. The professed motivation for this had shifted from improving 'the look' of the body to conform to the slim ideal, to making health improvements and fulfilling the role of the 'fit' parent. There was a strong sense conveyed by several women that weight loss, bodily and health improvements were a *project*, a long-term combination of efforts which pre-occupied them, led to a series of successes and failures, and was characterised by 'yo-yo' dieting, and cyclical losses and gains.

6.7. Chapter summary

In this chapter I have explored the accounts of participants, during pregnancy, anticipating the future and planning to improve health, and then following birth, contemplating their experiences of 'high-risk' pregnancy and continuing to plan for better health, fitness and, in some cases, weight loss. I have shown that all participants, without exception, stated they wished for better health, thus acknowledging the detrimental effects of obesity on health, and intended during pregnancy to later enact healthy behaviours, such as exercising, in

order to achieve this. A belief was expressed by some participants during pregnancy that the lifestyle changes brought about by becoming a parent would lead to weight loss without the need for dieting, for example through being busy and more physically active while 'keeping up' with a child.

Following birth, improved fitness continued to be a focus for most participants, with most women explicitly stating they wished to lose weight. However, although the women talked about plans to lose some weight, several stated that they did not wish to be in a 'normal' BMI range (described by many as 'skinny'), emphasising their intention to lose a small amount of weight alongside enacting other positive health behaviours, such as increasing physical activity.

To support their resistance to the focus on weight loss as necessary in order to achieve health benefits, participants drew on cultural norms such as that of the 'good, unselfish mother' to portray dieting and weight loss as activities which were not compatible with prioritising a baby. Health behaviours which promoted weight loss were termed 'dieting', an activity which was presented as unhealthy, whereas 'healthy eating', consuming home-cooked, health-giving foods was presented as compatible with 'good mothering', and with a desire to nourish the breastfeeding body, in turn to nourish the baby.

It may be that, as their large bodies signalled their past failures to lose weight, they drew on the context of their emerging role of being a mother and the perceived need to be physically active to divert focus from weight loss, a project which they knew from experience to be difficult, and one which drew associated pressure and stigma. In the context of an interview concerning their weight and health, participants may have been reluctant to state they intended to lose significant amounts of weight, as this would draw attention to their bodies as signifying past failures. To state such a hope or intention would involve a specific acknowledgment of their bodies as a problem.

For three women, specific circumstances – what is termed 'super morbid obesity' (an extremely raised BMI) for Mary, lone parenting and diabetes for Martha, and a child with a disability for Rachel - had caused them to consider the possible consequences of obesity for

their morbidity and mortality. These women explicitly spoke about their need for weight loss in order to live longer. However, in common with other participants, these women were planning but delaying weight loss efforts, describing only vague plans, and had little or no formal advice or support from health professionals. For almost all participants, there was a perception, reinforced by health professionals in some cases, that there was a necessary formal time period within which attempts at weight loss and undertaking exercise was not recommended, or indeed was unsafe. This was particularly the case for those women who had undergone a caesarean delivery. However, the perceived length of this time period varied in different women's accounts, and confusion was expressed, particularly in the context of breastfeeding.

It was clear from the majority of women's accounts – including the previous experiences of unsuccessful weight loss attempts by those with existing children - that beliefs about weight loss following the birth of a baby were complex. However, many of the women shared factors in common, such as: a lack of knowledge or willingness to acknowledge the extent of the risks posed by their weight and the complications they experienced; an intention to become fitter and healthier, alongside a desire to shift the focus away from weight loss and questioning health messages around dieting. The focus on improving fitness and resistance of weight loss as a necessary goal represented yet more 'moral work', and further demonstrated the stigma associated with their size. As such it was necessary to reject the implication that, at that size, they could not be 'healthy'.

In addition, it is clear that, in view of the strong, commonly expressed desire to enact health behaviour changes, by both women and their partners, in the context of becoming a parent, this early parenthood period represented an opportunity to engage these women and their partners in initiatives which could have informed and supported them to achieve health benefits. The missed opportunities for engagement, support and information-giving in this postnatal period, as well as throughout pregnancy will be considered within the final chapter.

Chapter Seven

Discussion

Stigmatised risk and the desire to be 'normal'

7.1. Introduction

In this chapter I summarise the findings of my study, contextualising these in relation to the existing literature. I discuss the implications of the findings, and the ways in which these confirm or extend what was known prior to this research. I then outline the limitations of the study and make some reflexive observations about the research process. Finally, I evaluate the contribution of the research to the field of study, before making suggestions as to how this might inform policy and practice, and future research.

The rationale for this study was that, despite convincing evidence of the risks associated with maternal obesity and especially very severe maternal obesity, little is known about 'what works' in terms of providing maternity care for very severely obese women. An increasing number of pregnancy interventions designed to mitigate the risks associated with maternal obesity have been trialled in the UK and elsewhere in recent years, but these have experienced limited uptake (Atkinson et al. 2011; Heslehurst, 2011) and poor compliance (Poston et al., 2013), indicating that such programmes may not be acceptable or accessible to many women. Recently, it has been recommended that ecological approaches may be more effective in addressing maternal obesity, and that robust evidence regarding women's perceptions and lived experiences of obesity in maternity is required to inform these approaches (Hanson et al., 2016).

This qualitative serial interview study was undertaken with eleven pregnant participants, who were interviewed either twice or three times, and with seven of their partners who were interviewed once. Through semi-structured interviews, the experiences of women and partners were explored with regard to their everyday lives, their beliefs and experiences regarding health, weight and pregnancy. Prior to this research being undertaken, a number of studies had explored the maternity experiences of women with obesity (BMI >30kg/m^2)

(see Appendix I). However, these had in the main focused on experiences of healthcare delivery and interactions with health professionals. In this thesis, I sought to broaden the focus in order to contextualise these experiences and, where possible, draw upon the views and experiences of their partners. Consideration of the accounts of *both* members of the couples interviewed, in combination, generate many of the more novel findings of the thesis, such as the ways in which both members of a couple might perceive and experience stigma, and use neutralisation strategies, such as attempts to 'other'and normalise weight, in order to reassure themselves regarding the woman's health, moral agency and 'fitness' for motherhood.

In addition, with one exception - a study that explored specifically attitudes to exercise in pregnancy in women with a BMI >40kg/m^2 (Denison et al. 2016) - previous research has not considered the experiences of women with incremental categories of obesity, but have included all women with a BMI >30kg/m^2. Thus, to my knowledge, this is the first study to have explored in depth the pregnancy experiences of exclusively 'very severely obese' women (BMI >40kg/m^2) with regard to their constructions of pregnancy, health and weight. This has enabled me to offer insights into the experiences of this most stigmatised and 'at-risk' category of obese pregnant women.

Referring to existing literature, I argue below that, for most women in this study, the experience of pregnancy was one of negotiating *stigmatised risk*. Women wanted to experience pregnancy as a positive embodied experience and as a 'pause' from the pressure to lose weight and the shadow of stigma. In short, they wished to be viewed as 'normal' (Goffman, 1963). To this end, they wished to be perceived within both healthcare settings and everyday life as primarily 'pregnant' rather than 'obese'. Their attendance at a high-risk clinic and experiences of pregnancy care, however, constantly reinforced 'obesity' as their primary health state, perpetuating feelings of stigma in some, and heightening anxieties about pregnancy, due to an expectation of complications embedded within the structure of their healthcare. To resist this 'risk manifested in stigma' (Stengel, 2014), women drew reassurances from their social worlds, including their partners. They found ways to reinforce, justify, and act upon deeply-ingrained lay beliefs, many of them at odds with formal pregnancy advice.

A desire was expressed by all participants, including partners, to enact health behaviour change once their babies were born. However, strong lay beliefs, the continuing impact of stigma, and a lack of support and information from formal healthcare sources, meant that, at 4-6 weeks following birth, few participants had implemented change or were even contemplating change in the near future. I argue further that the lack of information and support from formal healthcare sources, aimed at engaging women and partners in the context of their strong motivation to enact behaviour changes, represents a missed opportunity for healthcare providers to foster partnerships with women and families. Pregnancy and the immediate postnatal period could thus represent a crucial 'moment to engage', as part of developing a novel approach to service provision, rather than as Phelan's 'teachable moment' (2010, p.135.e1), referred to by several authors, and which I suggest is potentially stigmatising.

7.2. Lay beliefs, coupled relationships and gestational weight gain

As has been observed elsewhere, within a lifetime of misery associated with high body weight, and the negative feelings and stigma, such as those recounted and discussed within chapter four, the impact of establishing a long-term coupled relationship was significant for participants in my study. This was in terms of their experiences of, and ideas about obesity, and the impact upon their domestic circumstances, including the food that they consumed. A coupled relationship was reported by several as coinciding with a relaxation in the pressure to conform to a slim ideal. As noted by Delormier, Frohlich & Potvin (2009, p.217), patterns of eating are 'embedded in the flow of day-to-day life, formed in relation to other people, alongside everyday activities that take place in family groups, work and school'; as such, '[e]ating does involve isolated choice, but it is choice conditioned by the context in which it occurs'. Previous studies that explored weight and dieting behaviours within couples, unrelated to pregnancy, have found that people on average gain weight in married and cohabitating relationships (Averett, Sikora and Argys, 2008), and that there is a tendency for couples' BMIs to correlate (Di Castelnuovo, *Quacquaruccio, Donati, de Gaetano and Iacoviello,* 2009; Jacobson, *Torgerson, Sjostrom and Bouchard,* 2007;). However, to my knowledge the impact of pregnancy on these collaborative dieting behaviours, or indeed broader shared lifestyle behaviours, has not previously been

explored. Several individual members of couples recalled pre-pregnancy life together as characterised by intermittent collaborative dieting behaviour, leading to cycles of weight gains and losses. However, all participants in this study who had previously dieted together gave accounts of also ceasing weight loss efforts together, with both partners gaining weight during pregnancy. Pregnancy represented a 'pause' for both members within couples, when, for the woman, 'being pregnant' represented their primary health state (Sui et al. 2013b), and lay beliefs were very much drawn upon to inform and justify eating behaviours.

In their accounts of eating decisions and behaviours, participants referred to a range of influences, including lay beliefs regarding pregnancy diet. In their paper, Kraschnewski & Chuang (2014) observe that women have come to regard pregnancy as a time when they can eat and gain weight freely, which they summarise as 'eating for two', with the authors pointing to social norms as responsible for perpetuating this belief. Participants in my study demonstrated a more nuanced approach to eating in pregnancy, depicting themselves as resisting this social sanctioning to some extent, demonstrating an awareness of the benefits of exercising restraint. Indeed the term 'eating for two' was specifically referred to and rejected by several pregnant participants in describing their behaviours (and even Babs who talked about having a 'free pass' to eat said, 'I know I shouldn'ae', indicating her awareness that this was not clinically recommended). Having established this, participants did report increasing intake of certain foods that they believed to be recommended, but also clearly perceived a greater social sanctioning of the consumption of 'treat' foods. The rejection of 'eating for two' thus allowed them to demonstrate appropriate knowledge whilst consuming with less restraint - resisting negative stereotyping whilst 'enjoying' pregnancy (through not dieting).

A continuing challenge for healthcare provision is the lack of evidence regarding healthy and appropriate weight gain in pregnancy (NICE, 2010), and the lack of agreement internationally regarding recommended weight management before, during and after pregnancy (Scott et al., 2014). A recent review of interventions concluded that 'there remains no evidence-based approach for any specific dietary regimen to improve pregnancy outcome in overweight and obese women' (Flynn et al., 2016, p.326). Thus, policy makers

and health professionals are not equipped with the evidence with which to formulate clear health messages. The accounts here demonstrated deeply ingrained beliefs among pregnant participants and their partners, reflecting strong social norms regarding the benefits of following cravings, the need to increase intake of certain foods and the inevitability of weight gain, and these were at odds with both formal healthy eating advice, and the advice provided to them at the high-risk clinic they attended. Thus, while Kraschnewski & Chuang (2014, e.257) observe that 'pregnancy is a time when science and society diverge on the topic of weight', I suggest that the invoking of lay beliefs in discussing eating behaviours may be, in part, due to the lack of strong evidence and unambiguous health advice regarding gestational weight gain, which cannot at this stage provide sufficiently clear guidance to challenge deeply embedded social and cultural beliefs.

The presence of, and resistance to, stigma, in addition to a perceived lack of information, also informed participants' questioning of dietary advice. In terms of healthy eating, Phelan (2010, p.135.e3) identifies pregnancy as a 'teachable moment' - a naturally occurring life transition or health event that is thought to motivate individuals to spontaneously adopt risk-reducing health behaviours. However, although my participants spoke of an intention to enact behaviour change *after* pregnancy (see also Khazaedezadeh et al, 2011; Lavender and Smith, 2016), they referred to not restricting their intake or attempting weight loss during pregnancy. This was one reason why dietetics consultations were associated with feelings of stigma and/or frustration. Implicit in the offer of dietetic counselling was a message that their eating was problematic (McNaughton, 2011); however, as there is no evidence base which could inform specialist advice for this group of women (CMACE, 2010), the only advice available is in the form of education and information about 'healthy' eating in pregnancy in general (see also Heslehurst et al, 2015). Several of the women in my study rejected the suggestion that they needed to be 'taught' about healthy eating, with some alluding to the fact that the reasons underlying their weight gain and retention were complex (Cataldo, 1985), and that to suggest that those reasons could be reduced to a need for education regarding healthy eating was insulting and patronising. By contrast, those interactions with health professionals within which they felt acknowledged as individuals, or which helped them to normalise their pregnancies, were experienced positively, suggesting

pregnancy may be a time to *engage* women and partners through first acknowledging and neutralising stigma, rather than solely to *teach*, regarding health interventions.

7.3. The experience of stigmatised risk

'…to claim that the war on obesity can be neatly divorced from stigma against people deemed fat is a Cartesian inspired myth…'

(Monaghan, 2006, p.132)

The findings of my study demonstrate that the presence of stigma pervaded and informed women's experiences and understandings of pregnancy and health at multiple levels. It has been argued that the media and public health representations of maternal and resultant offspring obesity constitute a 'moral panic' (Bell et al. 2009), a phrase coined by Cohen (1972) to define instances where 'the identifiable, usually marginalised behaviour (or group) comes to stand as a signifier of a generalised social crisis and is represented by hegemonic institutions as threatening or antagonistic to the morals, values or interests of society as a whole' (Bell et al. 2009, p.157). Thus, obesity is a highly stigmatised physical condition, at a societal, community and a personal level (Brewis, 2014; Puhl and Brownell, 2006), and rising rates globally are characterised by a 'profound global diffusion of negative ideas about obesity' (Brewis et al. 2011, p.269e) leading obesity to be viewed as 'epidemic, crisis and individual responsibility' (Throsby, 2007, p.562). In this regard, obesity differs from many other risk factors in pregnancy, and for most participants, risk in pregnancy became overlaid with stigma. Obese women's beliefs that they are stigmatised in healthcare is well-documented (Drury, Aramburu and Louis, 2002; Puhl and Heuer, 2010) and in previous studies, obese pregnant women have reported perceiving their care as stigmatising (Furness et al., 2011; Heslehurst et al., 2013; Mills et al. 2013; Mulherin, Miller, Barlow, Diedrichs and Thompson, 2013; Nyman et al. 2010*)*. Mulherin et al's (2013) quantitative study of obese women's experiences of stigma in maternity care found that having a higher BMI in pregnancy was significantly associated with a tendency to perceive more negative treatment during pregnancy and less positive treatment following birth than normal weight women. The more subtle or perceived forms of stigma had a profound impact, but were difficult sometimes for participants to define and were thus impossible to respond to. Many

negative opinions and attitudes towards obese individuals may be so subtle and deeply ingrained that they may be hard to pinpoint (Lewis et al 2011) and, resulting from many years of experiencing such stigma, it may be anticipated or perceived, regardless of the attitude of the individual health professional.

The accounts provided by the women in my study demonstrate that the impact of this stigma, and the ways in which it can be experienced through the life course, may be nuanced and shifting. These complexities have previously been under considered in the pregnancy literature. Scambler (2009) refers to *felt* stigma to describe a sense of shame and anticipation of encountering discrimination or *enacted* stigma. Concurring with findings from meta-syntheses (Heslehurst et al., 2015; Smith and Lavender, 2011), the women in my study reported only a few instances of directly stigmatising care, or *enacted* stigma, during maternity care interactions. However for some of my participants, *felt* stigma, a more pervasive and widely felt form of stigma, seemed ever-present, in the context of a long history of feeling stigmatised due to their weight. Several participants recalled negative or traumatising experiences, such as bullying in childhood and adolescence linked to their obesity (see also Jarvie, 2013; McCabe, Miller, Laugesen, Antony and Young, 2010). Concurring with the accounts given by women in other studies (Furber and McGowan, 2010; Heslehurst, 2013), my participants were highly sensitive regarding any past negative treatment from health professionals, or in some cases the treatment of family members or friends, suggesting these encounters can have a deep and lasting impact.

Link & Phelan (2006, p.528) warn that a fear of acquiring a stigmatising label often leads 'individuals to delay or avoid seeking treatment altogether, while those already labelled may decide to distance themselves from the label, forgoing treatment or becoming noncompliant' . This was not the case for the women in my study, who accepted a referral for high-risk care, and attended serial appointments, often experiencing long waiting times, and in some cases making long journeys and incurring financial costs. However, most women simultaneously resisted the 'high-risk' label, presenting themselves as relatively 'low-risk', with their choice to attend represented as adopting a 'just in case' approach, being cautious, a 'good mother'. As such, they resisted obesity-related risk, instead drawing upon notions of pregnancy itself as inherently risky, as risk is a lens through which all

women, regardless of weight, must view childbearing in the context of the medicalisation of pregnancy and birth (Coxon, Sandall and Fulop, 2014; Hallgrimsdottir and Benner, 2014). In this way, participants presented themselves as 'normal', rational and responsible mothers-to-be.

As Petersen and Lupton (1997) have noted, the positioning of women as producing ill-health in their children has long been a central element of public health initiatives – and also biomedicine itself. Lupton (2012) observes that all pregnant women are now expected to adopt a multitude of risk aversive behaviours in order to protect their unborn child. Salmon (2011) identifies this individualisation as 'reproductive citizenship', which connotes pregnant women as having a 'duty' to self-regulate their *risky* bodies , with particular attention paid to those risks which have potential to negatively impact upon the fetus. This concept of 'reproductive citizenship' invokes socially constructed gender norms and expectations of the archetypal 'good mother', aimed at utilising women's agency to make decisions about risk founded on their own understandings of their body and their needs as autonomous individuals. My participants' bodies visibly demonstrated their failure to conform to this, and most employed strategies to resist this within their accounts, specifically to resist the suggestion that they had 'failed morally', that they were not 'good mothers'. As such, they sought to provide evidence that risks did not apply to them personally, claiming 'normality' as far as they could.

Previous studies of obese pregnant women (BMI >30kg/m^2) have noted their resistance to the term 'obese' (Jarvie, 2013; Khazaezadeh et al. 2011). 'Obesity' as a description of a physical condition has been interpreted by 'overweight' and 'obese' research participants elsewhere as an extreme *otherness* (Jarvie, 2013; Monaghan, 2006), giving rise to stigmatising descriptions of those 'others', who require 'reinforced beds' (Jarvie, 2013, p.212) or experience physical disability, such as the inability to walk. Several women in my study, all of whom were 'very severely obese', invoked a 'fat continuum' (Cordell and Ronai, 1999), placing themselves far from the upper end of this in an attempt to 'other' as part of their narrative resistance to being labelled 'obese' (Eva and Eric for example described her mother, who was physically disabled due to her weight as 'obese', whilst Eva – clinically 'very severely obese', described herself as 'overweight'). Interestingly, this and other

examples echoed accounts of 'mildly obese' participants in Lewis et al's (2010) qualitative study, who also stigmatised others bigger than themselves, whereas 'very severely obese' participants in Lewis et al's study acknowledged their size as problematic. Their 'moral work' was instead undertaken in presenting themselves as 'at war' with these 'problematised' bodies, thus resisting responsibility for their size. This sentiment was echoed by some of the women in my study who appeared to have the very highest BMIs, who also presented themselves as 'at war' with, their 'different' bodies (Mary and Eva). Such an incremental shifting of the thresholds at which different strategies might be employed by stigmatised individuals suggests two possible and connected explanations: first, that the increasing prevalence of obesity means that cultural understandings of 'normal' and 'obese' have shifted (Johnson, 2008; Mills, Schmied and Dahlen 2013; Singleton & Furber 2013), thus 'obesity' as it may be clinically defined has little resonance within social and cultural discourse; second, that there is no objective cut-off at which 'obesity' as a label will be accepted without question, but rather that within different social and clinical settings, different strategies to resist stigma and uphold moral worth may be employed.

In Goffman's essay, the author defined stigma as an 'attribute that is deeply discrediting', reducing the bearer from 'a whole and usual person to a tainted, discounted one' (Goffman 1963, p3). Green (2009) suggests that the ways in which stigma and shame are experienced have shifted in recent decades, as those with chronic conditions no longer necessarily accept these as stigmatising. However, the accounts of participants in my study concur most closely with those of drug users that the author studied, in that 'moral work' is still undertaken in order to present oneself as a 'good' person, to resist the taint of enduring stigma. In fact, very severe obesity continues to fit Goffman's (1963, p.4) category of 'abominations of the body', those whose appearance violates culturally accepted norms of ideals of beauty. Since Goffman's seminal work was published, many social scientists have elaborated and conceptually refined ideas of stigma. Pertinent to the findings of my study is the definition put forward by Jones et al. (1984), who use Goffman's (1963, p.4) observation that stigma can be seen as a relationship between an "attribute and a stereotype" to produce a definition of stigma as a "mark" (attribute) that links a person to undesirable characteristics (stereotypes). For my participants, the "mark", their very severe obesity, was constantly visible, and the 'moral work' they undertook during interviews was done in order

to distance themselves from the undesirable characteristics of gluttony, stupidity, laziness and ill-health, and being identified as of low SES (Vartanian & Silverstein 2013).

This 'moral work' was done using various strategies within participants' weight-related accounts, which fit Monaghan's (2006) categories of *excuses, justifications, contrition* and *repudiation*, (see Table 2) which the author adapted from Scott & Lyman's (1968) exploration of the accounting that individuals engage in to 'explain untoward behaviour and bridge the gap between actions and expectations' (ibid: p.46). While Monaghan's study explored the accounts of overweight and obese men, I found the categories pertinent in considering the accounts of the pregnant women I interviewed. Their descriptions of the historical reasons for their high weight could be categorised in the main as: *excuse* accounts, 'where people accept the pejorative status of bodyweight or fat, and perhaps ways of living assumed to cause unwanted weight, but mitigate individual responsibility' (Monaghan, 2008, p.37), for example when some participants invoked a health problem, or something 'different' about them, as responsible for their size: *justifications*, 'responsibility is accepted but the pejorative status is denied partially or totally' (Monaghan 2006 p144), for example when participants questioned the validity of the BMI measurement or talked about themselves when slimmer or other slim individuals as 'skinny' or 'anorexic': *repudiations*, when individuals 'challenge disapproval by denying the relevance of personal responsibility… [r]epudiation differs from excuses regarding the negativity of fat embodiment' (ibid.: p.155), for example when participants emphasised their absence of health problems and distanced themselves from pregnancy risk: *contrition*, an acceptance of responsibility for excess weight or weight gain…' and '...the undesirability of weight or adiposity is accepted' (ibid: p.151), for example by those women who acknowledged the detrimental health effects of very severe obesity and expressed a determination to lose weight following birth.

	Accept pejorative status	Deny pejorative status
Accept responsibility	Contrition	Justifications
Deny responsibility	Excuses	Repudiation

Table 4: An expanded accounts framework (Source: Monaghan, 2008, p.133)

Interestingly, the partners I interviewed also used *excuse* accounts in describing their understanding of the causes of a partner's weight prior to pregnancy, emphasising their consumption of a 'healthy' diet; or *repudiations,* in emphasising their pregnant partner's lack of weight-associated health problems, in addition to employing strategies to highlight the deviance, or more extreme obesity, of others. This was the case for both partners who described themselves as overweight, and those who did not. As Monaghan states (2006) the accounts framework helps us to make sense of weight-related words within an idiom of responsibility and culpability. Attendance at the high-risk clinic represented an acceptance on one level of the presence of risk caused by maternal obesity. As a result, participants were compelled to make a defence of their size, or of them*selves*, as socially fit individuals.

Most women's and their partners' accounts of pregnancy matters also concurred, in terms of maintaining a distancing, or 'denial of injury' (Monaghan, 2006, p.134) to both maternal and fetal health, and a resistance of the stigmatised risk associated with maternal obesity. This included portrayals of being 'on the threshold' of eligibility for referral for high-risk care (with an implication of being thus on the threshold of 'normal' in terms of clinical BMI categorisation, although this was not the case), the emphasising of another, health factor, for which they could not be held blameworthy, as a reason for being referred (e.g. Ruth's PCOS, Babs' previous pre-term birth), 'othering' via highlighting larger pregnant women and/or other deviant, blame-inducing behaviours, such as drinking alcohol or smoking (none of which any participant in this study reported they undertook in pregnancy). These strategies have been observed elsewhere among pregnant women with co-existing obesity and diabetes (Jarvie 2013): however, my study confirms that these strategies can also be employed by women who are *very severely* obese, and in addition that, in view of the fact that, without exception, their accounts were supported by their partners, in terms of the strategies they employed to resist stigma, risk and/or responsibility, that partners clearly discuss, and may be highly influential in terms of beliefs and behaviours regarding weight in pregnancy.

Once their babies were born, some women's accounts were characterised by *contrition* – (evident for example in Rachel's comment 'I have to get well now'), while *repudiation* was

expressed by several others (evident in Louise's comment 'my weight didn't seem to affect my pregnancy at all'). I discuss this further in section 7.6.

7.4. Social class, stigma and 'moral accounting'

Participants in my study were from a range of socio-economic backgrounds. I found that those who were from lower socio-economic backgrounds were more preoccupied with accounting for their size by undertaking 'moral work' than those from middle class backgrounds, and that this was in order to distance themselves from the stigmatised *other* that is associated with a social underclass, and the 'layering of stigma' (Jarvie, 2016, p.27) associated with being 'fat, female and poor' (Carpenter and Bartley, 1994, p.1715). However, regardless of social class, participants appealed to ideals of a 'wholesome' obesity, of the consumption of 'healthy' (home-cooked) food as both morally and nutritionally superior, meaning their bodies were healthy despite their weight, and partners concurred with these constructions. Additionally, they presented mothering as necessarily subverting one's own needs, prioritising those of their child or children. This resonates with the accounts of Australian overweight and obese mothers in Warin et al's (2008) study. Here, middle class participants drew on ideals of 'good mothering' as being selfless, providing nurture and love through food, whilst representing dieting as 'selfish', and 'unhealthy', and framing the taking of regular exercise and cultivating a slim body as 'obsessing'. In similar ways, several women in my study indicated that, for them, becoming a mother allowed them to demonstrate a shift in focus from the *body* to the *baby,* employing repudiatory tactics to justify a focus on 'healthy food' and physical fitness rather than weight loss.

Although my study sample included women from working class backgrounds, and some women and their partners discussed financial concerns during interviews, none discussed these constraints impacting upon their food choices, or preventing them from eating healthily. This contrasts with the accounts of obese and diabetic pregnant participants in Jarvie's study (2013), several of whom cited material deprivation as restricting their choices and preventing them from being able to follow healthy eating advice. It should be noted with regard to this that, as my study sample was drawn from women who chose to attend a hospital-based, high-risk clinic, which serves a large Scottish city and surrounding regions with a broad demographic mix, and which only around 50% of eligible women choose to

attend annually, it may be that women of higher SES are more likely to attend this clinic, and that my sample was not representative of women who do not attend in respect to their material circumstances.

7.5. The clinic: mixed experiences of stigma and risk

All of the women in this study talked about their experiences of attending a specialist antenatal clinic which provides care to women with a BMI >40kg/m^2 at the start of pregnancy. Some women's accounts suggested that elements of the stigma they experienced were embedded within the system of care, both more broadly, and within the structure and delivery of care within the specialist clinic they attended. This led to further 'moral work' and resistance, which impacted upon their experiences of care, their relationships with health professionals and their engagement with formal health messages regarding risk.

Risk discourse is central to the contemporary governance of pregnancy and is pervasive and powerful; as Lupton (1999) suggests, it would be difficult for women not to be drawn into the discourses of risk that surround my study. For the women in my study, and their partners, engaging with risk meant engaging with the notion of the 'problematised' body. They accepted a referral to a high-risk clinic, but undertook 'accountancy talk' (Jarvie, 2013, p.22; Keenan and Stapleton, 2009) in order to distance themselves from risk, shift focus, resist stigma and build a morally legitimate maternal identity.

I have discussed the ways in which participants attempted to present and experience their pregnancies as 'normal'; however, attendance at the clinic repeatedly reinforced to them that they were not regarded as such. Women in other studies have described feeling upset that their weight was frequently referred to by caregivers (Furber and McGowan, 2010; Jarvie, 2013). For women in my study, risk was a constant focus, indeed the very reason for the service, and the expectation of complications was embedded, and their choices for labour and birth controlled and restricted. Thus, there was a tension within narratives between acknowledging risk, wishing to protect their health and that of their unborn babies, whilst feeling upset and stigmatised by the label (see also Heslehurst et al., 2013) and a strong resistance to both the notion of risk and their responsibility to mitigate it.

7.5.1. Maternal obesity: 'liminality' or 'high-risk'

The experiences of my participants with regard to their care appeared to differ according to whether or not they had co-existing morbidities or complex obstetric histories. As I outlined in the introductory chapter, obesity is defined as a chronic disease within biomedical and public health discourse (Allison et al., 2008; Jutel, 2006; 2009; Kerrigan and Kingdon, 2010), however, participants in this study did not recognise their 'obesity' as a health condition. In a context which privileges the biomedical construct of clinical risk (Rothman, 2014), participants for whom 'obesity' was their sole risk factor, distanced themselves from these risks, which they felt were applied in an arbitrary, depersonalised way. Thus a 'high-risk' status for several led to an experience of pregnancy as a 'liminal' state. Pregnancy itself has been described elsewhere as a state of 'liminality', of being 'betwixt and between' (Turner, 1969, p.95) due to uncertainties surrounding its outcomes. Several of my participants experienced a liminal state, between 'low risk' and 'high risk': experiencing no perceived problems, but nevertheless regarded clinically as 'at risk' and thus closely monitored. The acquisition of a 'high risk' label in pregnancy may adversely affect a woman's psychological state, and her own and her family's sense of well-being (see Hatmaker and Kemp, 1998; Lyerly et al., 2007). Some participants in my study were distressed by the emphasis placed upon risk, the expectation of complications and the use of interventions. A growing body of work suggests that obesity stigma can impact negatively upon health in a number of ways, including promoting poor coping mechanisms, mental health issues, co-morbidities of obesity, avoidance of healthcare, and negative interactions with health care providers (Puhl and Heuer, 2010). In line with this, it has been suggested that stress related to obesity stigma may exacerbate metabolic dysfunction, and in addition, that obesity stigma may contribute to increased intervention rates and associated poorer outcomes for mothers and babies (Bernecki DeJoy and Bittner, 2015). In light of this, I suggest that the impact of high-risk care and obesity stigma on women's decision-making and on outcomes warrants further quantitative and qualitative enquiry.

However, negative experiences of care which focused on risk and anticipated complications were by no means universal among participants, as some women acknowledged their high-risk status and reported positive experiences of pregnancy care. These participants experienced complications which they acknowledged were related to their weight, or had

co-existing risk factors or medical problems. This led to them experiencing care more positively for two important and connected reasons. Firstly, the additional risk factor, whether related to their obesity or not, provided a diversionary focus for their accounts, therefore not focussing on obesity and alleviating stigma. Additionally, their accounts demonstrated that these women experienced greater continuity and perceived that they received respectful treatment as a result of their higher risk status.

Related to this, the positive experiences with community midwives which participants discussed focussed on a distancing from the issue of weight, and this corroborates the evidence from other studies of obese pregnant women and confirms that this can also occur in interactions with very severely obese women (Jarvie, 2013; Nyman et al. 2010). It is well documented that, due to associated stigma and lack of evidence-based guidance, health professionals find it difficult to discuss weight-related issues with pregnant women (Knight and Wyatt, 2010; Schmied et al. 2011); however this down-playing of the issue of weight on the part of community midwives may also have been in an attempt to promote normality and optimise the potential for normal birth (Kerrigan, Kingdon and Cheyne, 2015). This focus on the positive aspects of pregnancy, affirming women's feeling of 'normality' in pregnancy, and leading to positive experiences and relationships (Gardner et al., 2012; Hildingsson and Thomas, 2012), suggests further that women wish to be treated as 'normal', with health care systems and individual health professionals focusing primarily on them as individuals, and their pregnancies, rather than their weight.

7.6. Postnatal support: a missed opportunity

Current UK NICE public health guidance (2010) for supporting obese women after childbirth recommends that health professionals use the 6–8 week postnatal check, or a follow-up appointment within the next 6 months, as an opportunity to discuss a woman's weight and offer support and up-to-date advice about how to lose weight safely after childbirth. It recommends further that women with a BMI >30kg/m² should be made aware of the increased risks that being obese poses and be encouraged to lose weight via a structured weight-loss programme. Bearing these current guidelines in mind, there was a striking lack of support and information available to participants in this study once their babies had been born, which is brought into sharper focus when contrasted with the high level of scrutiny

and surveillance they had experienced during their 'high-risk' pregnancies. This corroborates the evidence from studies elsewhere of obese women (Dinsdale et al., 2016; Jarvie, 2016), indicating that women at the greatest risk – those who are 'very severely obese' – may not be offered the recommended level of help and support.

In the immediate postnatal period, several participants foregrounded the responsibility for feeding their babies (breastfeeding), with several invoking the baby in this way as their primary reason to delay weight loss efforts. In addition, the wide range of opinions regarding the optimum time to begin to weight loss efforts and undertaking exercise demonstrates participant's lack of knowledge in this regard. In addition, although all had emphasised an intention to improve fitness, for some, within this context, the need to necessarily lose weight in order to improve health was denied, echoing the repudiatory accounts of some participants in Monaghan's (2006) study of overweight and obese men. They reported receiving little information or support regarding this, with the majority of comments reporting midwives and health professionals discouraging early weight loss attempts and encouraging rest, particularly in women who had given birth by caesarean section.

7.7. A conceptual framework for maternal 'very severe obesity' in pregnancy as an experience of stigmatised risk

The model displayed in Fig. 1 provides a conceptual framework by which 'very severe obesity' in pregnancy may be understood to be an experience of 'stigmatised risk'. As such, it illustrates the impact that stigma may have upon women and partner's understandings and perceptions regarding obesity and risk in pregnancy and beyond. For the women in this study, who may have experienced many years of weight cycling and weight stigma due to the 'moral taint' of excess body weight, conception led to the additional burden of an awareness of pregnancy-associated risk. Formal information regarding this risk was delivered in the context of a depersonalised, fragmented high-risk maternity care. To resist this stigmatised risk, women and their partners used a combination of strategies to reassure themselves regarding weight, pregnancy and risk, and to protect moral identity. These included drawing upon lay beliefs regarding for example the inevitability of gestational

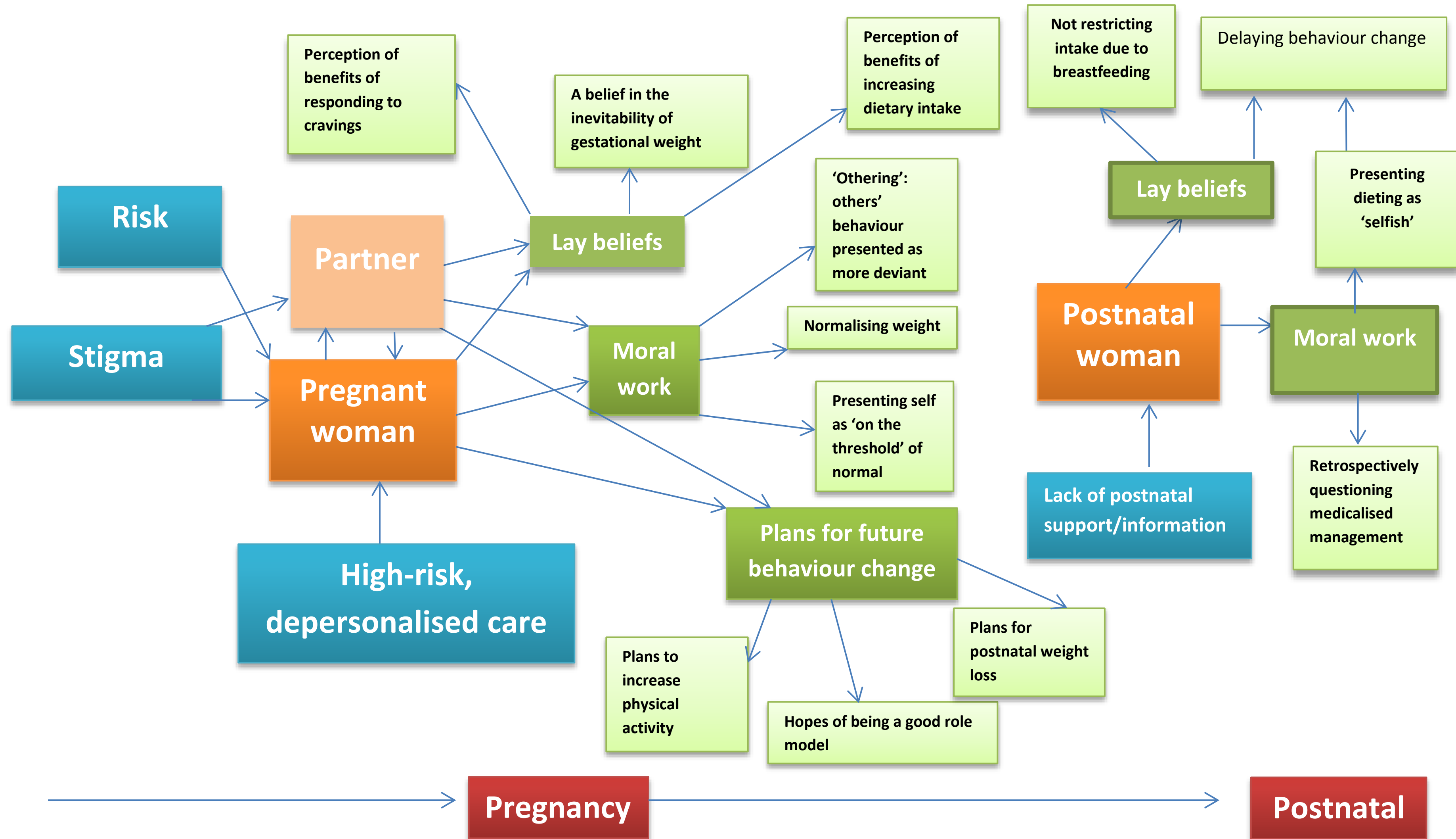
weight gain, the benefits both of responding to cravings – giving the baby 'what it needs' – and of increasing nutritional intake. In addition, women undertook moral work in order to present themselves as morally 'fit' for parenting. This included normalising their own weight, both by presenting it as on the threshold of 'normal', and by comparing themselves to others who they considered to be 'bigger', or to be engaging in behaviours they considered to be morally deviant - or 'more deviant' - than their own. The model further illustrates women's high levels of motivation during pregnancy to enact changes once their babies were born, to lose weight, became more active, improve health, increase longevity and be a positive role model to their children; however, this altered following birth for most women, who then delayed weight loss efforts and lifestyle change, again drawing upon lay beliefs, such as the need to increase intake when breastfeeding, and undertaking moral work, for example by presenting themselves as prioritising their babies by not seeking to lose weight. This change occurred alongside - and perhaps in part as a consequence of - a withdrawal of formal support and information regarding weight loss and lifestyle change in the postnatal period.

New: This liminality is characterised by uncertainty and it is important that health professionals understand and communicate the uncertainties regarding maternal weight and risk in pregnancy

Eradication of fat not the only goal – emotional well being, acknowledgement and neutralisation of stigma and building of relationships good for pregnancy outcomes?

Clinical approaches to maternal 'obesity' means grasping this nettle and tackling both, finding a way through this intersection. Means speaking to moralism whilst also discussing risk openly and being open to relationship building, which can enhance pregnancy experiences and physical, emotional and mental well-being.

Fig. 1 A conceptual framework for maternal 'very severe obesity' in pregnancy as an experience of stigmatised risk



The lack of postnatal input that women reported highlights the focus of biomedicine in the context of pregnancy on the monitoring and protection the health of the fetus (McNaughton, 2011; Petersen, 1997, Petersen and Lupton, 1997), as once pregnancy is over, health care input and interest ceases. For some participants who believed they had not experienced weight-related complications, this led to a retrospective repudiatory response to their care management. Some believed they had had their choices restricted and described fragmented care, which may not have been needed in their view, as the additional surveillance had been 'just in case'. This may be in part due to a normalising of caesarean section delivery, due to high rates among all pregnant women, such that it may no longer be viewed as an 'intervention'. Some participants appeared unaware of the potential contribution of their weight to the complications they did experience; thus, they presented themselves as having been 'low-risk' and also felt stigmatised by the fact that they had been treated as 'high-risk' and had experienced depersonalised, disruptive care, and had had their choices for birth restricted (regarding the use of water for pain relief for example). Therefore, I would argue that this lack of support and information in the postnatal period strengthened the repudiatory dismissal by some participants of the potential health benefits associated with losing weight prior to conceiving again.

7.8. Summary

Through an exploration of the serial accounts of pregnant women who are very severely obese, together with those of several of their partners, I have demonstrated the complex 'in-between' path (Zinn, 2008, p.439) which many negotiated through pregnancy, simultaneously accepting and resisting their high-risk status. I have explored the ways in which individual members of couples provided concurring accounts of lay beliefs regarding the embodied experience of pregnancy, and how stigma played a key role in the ways in which women, and their partners, related to concepts of risk and the experience of a 'high-risk' pregnancy. Although most participants reported no instances of *enacted* stigma during the index pregnancy, many accounts revealed *felt* stigma which impacted upon their experiences of healthcare interactions, and their interpretations and understandings of formal healthcare advice.

Protection from stigma was afforded by a shifting of 'high-risk' status to another clinical factor, and the better continuity of care associated with this. Social class also appeared to be a protective factor in this for women of higher SES, who did not experience, or resist, stigma within their accounts as extensively as those of higher SES. However, I believe I have demonstrated that *all* women, and most of their partners, undertook 'moral work' to account for themselves as good mothers-to-be, and that this necessitated a subversion of biomedical discourse regarding the causes and consequences of maternal very severe obesity.

7.9. Contribution to knowledge

Through qualitative semi-structured interviews, this study has explored the experiences of women, and their partners, regarding their everyday lives, beliefs and experiences pertaining to health, weight and pregnancy. To my knowledge this is the first study to specifically consider the socially-embedded experiences of women with a BMI >40kg/m^2 (categorised clinically as very severely obese), alongside those of their partners/husbands. Qualitative work in this field has focussed on interactions and experiences within the healthcare setting, and has focussed in the vast majority of studies on women with a BMI >30kg/m^2 (categorised as obese).

The serial interview approach allowed me to follow women through pregnancy, capturing their experiences on two or three occasions, facilitating a consideration of change within the context of everyday experiences, how the women related to their social and cultural worlds, experienced their bodies in pregnancy and their roles as mothers, and how this impacted upon their interactions with health professionals and their experiences of stigma and understandings of risk.

Interviewing pregnant participants more than once, during and after pregnancy, was important in terms of my ability to establish rapport and to collect rich data regarding the psychosocial aspects of their lives. This led to disclosure of richer data than one interview alone would have done. I believe this has enabled me to consider, through close scrutiny of the women's accounts of their experiences of accessing high-risk multi-disciplinary care, the relevance and acceptability of maternity policy and practice to women's lives.

I have demonstrated that, for many, the presence of stigma, embedded within the existence of a high-risk clinic, which focussed on the women's bodies, framing them as problematic, was detrimental to their experiences of pregnancy and to their engagement with health messages. This occurred largely in the absence of enacted stigma within individual interactions, but which nevertheless led, for some, to negative experiences and a resistance to health messages. The extent of resistance and repudiation was further entrenched by the lack of continuity and postnatal follow-up, and limited provision of information about risk.

My study is the first to explore partners' experiences and beliefs regarding weight in pregnancy, and I have demonstrated that partners can experience stigma on behalf of a pregnant partner in some instances, in particular when the couple was of lower SES, and/or expecting a second or subsequent baby and therefore had previous experiences of pregnancy and pregnancy care. It has been noted here and in other studies of pregnant obese women that women may continue to feel angry about historic weight-related stigmatising encounters with health professionals (Heslehurst et al., 2013; Jarvie, 2013), in some cases long after the event. Some male partners in my study expressed similar anger and feelings of stigma related to treatment experienced in a previous pregnancy.

There has been an identified need for research which adds to understandings of how lay people understand their bodies and their health (Lupton, 2003; Willig, 2000) and, in light of the health risks associated with maternal obesity the need is pressing in this case. It has recently been suggested that ecological approaches to tackling obesity in pregnancy are required (Hanson et al., 2016). I believe that my study offers insights which can inform the development of such approaches in the future.

Social support is considered to be a key influence on, and motivator for, lifestyle change/physical activity, particularly for women (Dencker et al., 2016; Furness et al., 2011;). Similarly, Smith, Taylor and Lavender's (2015) qualitative study of postnatal women one year after birth identified that social and familial support were key to implementing and maintaining health change. My study has demonstrated that: pregnancy beliefs can be jointly held and reinforced within couples; and that dieting is stopped together and planned

changes are experienced together. This new knowledge can be harnessed by policy makers and clinicians in exploring ways to engage and support couples together towards changes in beliefs and behaviours.

7.10. Limitations of the study

As discussed in section 7.4., my study sample was drawn from women who chose to attend a hospital-based high-risk clinic, which serves a large Scottish city and surrounding regions, which is home to a broad demographic mix with regard to social class. Obesity follows a social gradient (Robertson et al. 2007), and my sample included women with higher SES than expected. Therefore, as only around 50% of eligible women choose to attend the clinic, it may be that women of higher SES are more likely to attend, and that my sample was not representative of women who do not attend in respect to their material circumstances. This warrants further investigation, as materially deprived women from lowest SES groups who are very severely obese may be subject to a layering of adverse circumstances which are particularly detrimental to health.

In addition, the oldest participants in my study were 26 (pregnant participant) and 28 (partner), thus my sample does not necessarily represent the views and experiences of younger childbearing women who are very severely obese, and their partners. As above, and connected to material circumstances, it may be that younger women are less likely to attend a centralised, hospital-based clinic.

Lastly, although the local population from which my sample was drawn is diverse in socioeconomic terms, it is largely white Scottish in its ethnic mix. It would therefore have been difficult for me to purposively sample women from minority ethnic groups within the study timescale. My sample included one pregnant participant from a middle income country and one partner participant from a low to middle income country. Nevertheless, my findings cannot be considered representative of women and partners from minority ethnic groups. An exploration of socially- and culturally specific beliefs and experiences within a range of ethnic groups might form the basis of future research.

7.11. Conclusion: implications for policy, practice and future research

This PhD thesis has demonstrated the complex ways in which very severely obese women may simultaneously engage with, but also seek to resist, formal messages around weight and health in pregnancy. Health professionals experience difficulties in caring for, and communicating with women who are very severely obese (Foster & Hirst, 2014; Heslehurt et al., 2015; Olander, Atkinson, Edmunds & French, 2011). They have a delicate task to perform in providing sufficient information and safe care within the context of stigmatised risk, maintaining respectful treatment, support and encouragement to women who may be highly sensitised to negative treatment. However, stigma and risk may be experienced and related to in very different ways by very severely obese women, due to a number of factors, such as social class, social support, and parity. It is therefore important to consider women as individuals, resisting a 'one size fits all' approach, in developing care pathways which engage and support women and their partners.

Most women and all partners in this study shared common beliefs regarding diet and weight in pregnancy, such as the benefits of unrestricted intake, following cravings and gestational weight gain. However, it should be noted that although the accounts were largely consistent across partners and within couples, my sample was small. This issue warrants further enquiry, to inform approaches to engage women and partners in pre-conceptual, pregnancy *and* postnatal care initiatives, providing support and education in order to change lay beliefs regarding pregnancy nutrition and health. Partners' views have been observed to be highly influential with regard to smoking cessation (Flemming et al. 2014) and breastfeeding (Renfrew et al. 2012). I suggest this is an area where further research would inform the design of interventions designed to impact upon family approaches to lifestyle and health.

The universally negative experience of dietetic advice reported by women in my study suggests that evidence is required to ascertain the most effective and acceptable ways in which to deliver healthy eating support and information in pregnancy. With regard to this, consideration should be given to the fact that the majority of participants had previously attended a slimming club at some time during adulthood, with almost half attending when they discovered they were pregnant. Most were attending Slimming World, which offers a modified plan for pregnant women to follow, which is supported by the Royal College of

Midwives. However, all participants in this study stopped attending during pregnancy. Their accounts of attending these groups indicated they were experienced positively, and that they did not find them a stigmatising forum in which to discuss weight and diet, and seek support. Future research could explore both the aspects of the design, delivery and acceptability of these services, before, during and after pregnancy to inform dietetic support in pregnancy,

The experience of most of the participants in this study was that care was fragmented, indicating that the model of care was not clearly defined. This impacted upon the experiences of women. There is a dearth of evidence to support optimal multi-disciplinary team (MDT) structure and working practices, and indeed little research has been undertaken regarding MDT working within the context of high-risk pregnancy (Bick et al., 2014). I would suggest that future research into the optimal timing and structure of MDT working in relation to maternity care for very severely obese women may help to inform the streamlining of service provision.

In light of the fragmented care most women reported, and the repudiatory accounts regarding the risks associated with obesity expressed by some women once their babies had been born, future research could explore the effectiveness of engaging women and families in supportive relationships during pregnancy, when motivation to enact healthy behaviour change is high but is deferred until after the birth. Such research could explore relationship-centredness in the context of supporting very severely obese women through birth and into the postnatal period, to inform ways to engage women and families with risk discourse, exploring ways to acknowledge and neutralise stigma and to initiate behaviour change. The relationship-centred care model has been developed and used elsewhere in healthcare (Nolan, Brown, Davies, Nolan, and Keady, 2006; Nolan, Davies, and Grant, 2001; Nolan, Lundh, Grant, and Keady, 2003) and is based upon an acknowledgement that relationships are critical to the care provided by nearly all practitioners and a sense of satisfaction and positive outcomes for patients and practitioners (Tresolini and The Pew-Fetzer Task Force, 1994). The design of future research and intervention studies thus would include the input of very severely obese women, their partners, and health professionals.

Summary: key recommendations for policy and practice

1. Future research might explore innovative multi-disciplinary care pathway design, which considers relationship-centred approaches, in order to frame discussion regarding weight and health in ways which acknowledge and neutralise stigma. Key stakeholders, including health professionals, women and partners should be involved from the conception and design of such an intervention.

2. Engage women and partners in the design and development of future interventions in pregnancy, in order to avoid the implementation of a patronising, 'one-size-fits all' approach.

3. Explore the ways in which women and partners can be provided with information which challenges lay beliefs around eating and weight gain in pregnancy, without causing further stigmatisation and, ultimately, disengagement. Within this an exploration of aspects of successful commercial weight loss organisations might be useful.

4. Explore ways in which women and their families, highly motivated during pregnancy to enact future behaviour changes, might be better supported in the postnatal period in order to lose weight and improve health.

5. In relation to the above, explore the barriers and facilitators which midwives perceive to offering support and advice regarding lifestyle change to women in the postnatal period.

6 In the light of the interesting but limited findings of this study regarding the beliefs and experiences of women's friends in relation to pregnancy, weight and risk, explore further through future research the potential role and impact of the views of significant individuals other than partners.

7.12. Final reflections

This thesis has shown that maternal very severe obesity is not understood and experienced by pregnant women as a 'health condition' or a value-free 'risk factor', but rather is

experienced and negotiated in complex and nuanced ways, and is strongly characterised by stigma. As I stated in chapter three, I withheld my background as a midwife from research participants to avoid being seen as associated with a stigmatising system of care, or with previous stigmatising encounters with health professionals. However, I have reflected throughout the undertaking of this study that, in the very act of asking participants to discuss their views and experiences, I was necessarily asking them to account for their size and, to some extent, acknowledge it as a problem. This has troubled me, as I wished to avoid adding to any feelings of stigma that participants may have experienced. However, I observed that, although several expressed anger or frustration due to their high-risk status and their associated restricted care options, few had challenged health professionals face to face (and in particular those expecting a first child). It has been observed that 'obese people passively agree with the major construction of obesity as their own fault, because that is how they have been inculcated socially, rarely publicly challenging the social construction that weight is the result of personal weakness' (Rogge, Greenwald & Golden, 2004. p312);. I believe my study gave them the opportunity to make that challenge, to express their views about pregnancy, health and ultimately to inform debate and further research which will improve their care.

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Appendix I

Qualitative studies exploring the pregnancy experiences of women with overweight or obesity in pregnancy included within the literature review chapter

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Appendix II: Characteristics of included studies following quality appraisal						
Author and country	Method of investigation	Aims/objectives	Sample size	Recruitment strategy	Study setting	Key findings
Anderson et al. (2015) USA	Qualitative, semi-structured focus group	To explore barriers and facilitators to health eating and beliefs about GWG	29 womenwith a BMI >30 kg/m^2 in three focus groups	Recruited at a community-based perinatal centre	Community	Multi-level opportunities to promote healthy GWG. Better communication needed.
Atkinson et al. (2016) England, UK	Qualitative, cross-sectional interviewing	To investigate why women decline or disengage from specialist services	18 women with BMI >30 kg/m^2	Women approached by project lead at weight management service	Not stated	Importance of first contact. Missed opportunities for support. No need for help. Service not meeting needs.
Claesson et al. (2008)	Interviews	To investigate women's satisfaction with a weight intervention programme	56 women with a BMi >30 kg/m^2	Recruited via hospital-based antenatal clinic	Not stated	Women must be instrumental in setting own goals. Women must receive continuous support to be successful.
Dencker et al . (2016)	Qualitative semi-structured telephone interviews	To explore women's experiences of a lifestyle intervention	17 women who had participated in a pregnancy lifestyle intervention	Recruited as part of a three-year follow-up of lifestyle intervention	Telephone	The child as motivator for change. The need for self-efficacy. The need for support .
Denison et al. (2015) Scotland, UK	Qualitative semi-structured interviews	To explore barriers and facilitators to undertaking exercise in pregnancy	13 women with a BMi >40kg/m^2	Recruited via a specialist clinic	Not stated	Complex barriers to lifestyle change. The need for personalised support to make lifestyle changes.
Dinsdale et al. (2016)	Qualitative, semi-	To explore experiences	24 women with a BMI	Via consultant	Participants' homes	Communication. Sensitivity

England, UK	structured interviews	of weight management support in pregnancy	>35 kg/m^2	midwife gatekeepers: postal recruitment	(*n=20*) and via telephone (*n=4*)	and respect. Accessible services
Furber & McGowan (2010) England, UK	Qualitative, longitudinal design, face-to-face semi-structured interviews	To explore the childbearing experienceso f women with a BMI >35 kg/m^2	19 women with a BMI >35 kg/m^2	Recruitment via midwife approach at specialist clinic	Maternity setting	Humiliating experiences. The medicalisation of obesity.
Furness et al. (2011) England, UK	Qualitative, semi-structured focus groups	Perceptions and experiences of women and healthcare providers regarding care provision	Not clear – 6 women with a BMI 30kg/m^2	Recruitment via a midwife at a specialist clinic	Community setting	Service provision. Weight management. Communication.
Heslehurst et al. (2013) England, UK	Low-structured depth interviews	To explore women's views and experiences of obesity in pregnancy and views regarding services	15 women with a BMI >30 kg/m^2	Postal recruitment	Participants' homes, maternity, unit, Sure Start centres	The role of family, women's experiences and pregnancy experiencesin shaping beliefs.
Heslehurst et al. (2015) England, UK	Qualitative, one –to-one in-depth interviews	To explore obese women's experiences of pregnancy, to inform service development.	15 women with a BMI >30 kg/m^2	Recruitment in person and via post through specialist midwife	Maternity and community setting	Experiences of weight, negative experiences, views regarding ideal service provision
Jarvie (2015)	Qualitative, longitudinal design; semi-structured interviews	To explore the discourses and lived experiences of women with maternal obesity and GDM	30 women with a BMI >30 kg/m^2 and co-existing GDM	Recruitment from two NHS hospital clinics, approached by midwives	Not stated	Women rhetorically defended themselves. Those of lower SES at greater risk of experiencing stigma.
Keely et al.	Qualitative,	To explore	8 women	Recruitme	Participant	Perceptions

(2011) Scotland, UK	semi-structured interviews	women's experiences and perceptions regarding risk.	with a BMI >40 kg/m^2	nt at a specialist clinic via a midwife	s' homes	of health and risk. Experiences of care.
Keenan & Stapleton (2010) England, UK	Qualitative , longitudinal design; semi-structured interviews	To explore women's experiences of becoming mothers	60 women interviewe d. Not all were obese (unclear which)	Purposively selected via snowballin g	Participant s' homes	Not perceiving weight as problematic. Negative treatment from health professionals
Khazaezad eh et al (2011) England, UK	Qualitative, focus groups and individual interviews	To explore women's views regarding maternity service provision for maternal obesity	6 obese pregnant women and 3 obese women trying to conceive	Recruited from hospital clinics. Purposively sampled to be ethnically diverse	Private hospital consultati on rooms	The importance for advice to be culturally sensitive and for traditional foods to be considered
Lavender & Smith (2016)	Qualitative methodolo gy, focus groups and semi-structured interviews	To gain insight into the experiences of pregnant women with a BMI >30 kg/m2	34 women participate d	Women who were attending a lifestyle programm e in pregnancy were invited to take part in either a focus group or interview	Not stated	Informational expectations not met. Some health professionals appeared uninterested, insensitive or unconfident.
Lindhardt et al. (2013) Denmark	Qualitative, face-to-face, in-depth interviews	To explore women's experiences of maternity health care	16 women with a pre-pregnant BMI of 30 kg/m^2 of more	Recruitme nt at a specialist clinic via a midwife. Randomly selected	Participant s' homes	An accusatorial response from health care providers. Lack of advice.
Mills et al. (2011) Australia	Qualitative, face-to-face interviews	To explore women's experiences of attending two	14 women with a BM>30 kg/m^2	Recruitme nt through a midwife at a specialist	Participant s' homes and maternity setting	Being overweight and pregnant. Being on a change

		maternity units in Australia		clinic		continuum. 'Get alongside us': support.
Nyman et al (2010) Sweden	Qualitative face-to-face interviews	To explore women's experiences of encounters with midwives and physicians during pregnancy	10 women with a BMI >30 kg/m^2	Recruitment via a specialist clinic via a midwife	Participants' homes	Pregnancy led to feeling scrutinised. Negative experiences heightened this; supportive encounters countered this.
Petrov Fieril et al. (2017) Sweden	Qualitative interviews	To describe women's experiences of participating in a lifestyle intervention	11 women with a BMi >30 kg/m^2	Women participating in a lifestyle intervention in pregnancy	Healthcare facilities, telephone or participants' homes.	Implementing new habits requires support and non-judgmental attitudes. Small changes can bring unexpected success.
Smith, Taylor & Lavender (2015) England, UK	Qualitative, semi-structured face-to-face interviews	To explore the postnatal experiences of women who are obese in relation to implementing behaviour change	18 women with a BMI of .>30 kg/m^2 at the start of pregnancy	Women who had participated in a lifestyle intervention RCT during pregnancy were interviewed 1 year after giving birth	Participants' homes	Women require support to implement behaviour change in the postnatal period
Stengel et al. (2012)	Qualitative, semi-structured telephone interviews	To ascertain women's experiences with GWG	24 overweight and obese women	Women participating in a related study were screened	Telephone	Women valued advice but were advised poorly regarding

				for eligibility and invited to participate		GWG. Health care providers were perceived as unconcerned.
Sui et al. (2013)	Qualitative interviews	To explore barriers and facilitators to healthy behaviour changes in pregnancy	28 overweight and obese women	Women who were participating in a RCT (LIMIT) were interviewed at 28 weeks of pregnancy	Private room in hospital	More barriers than enablers were identified. Interventions should be individually planned and implemented
Thornton et al. (2006)	Qualitative, semi-structured interviews	To explore the influence of social support on the beliefs and behaviours of recently immigrated pregnant Latina women	10 pregnant women and 10 people who influenced them	Women were recruited via flyers or via health professionals at a health centre	Where participants felt most comfortable (own homes, restaurants etc.)	Absence of support and advice from female relatives were prominent barriers to maintaining healthy practices during and after pregnancy
Vallianatos et al. (2008) Canada	Qualitative, semi-structured interviews	To explore the beliefs and pregnancy experiences of Cree women	Pregnant Cree women and Cree elders			In pregnancy, lay belief can be favoured over medical advice, due to complex barriers
Wiles (1994) England, UK	Qualitative, longitudinal design, face-to-face interviews	To explore the beliefs about gestational weight gain of women of above average weight	37 women of above average weight	Identified via hospital notes. Contacted and recruited via GPs	Participants' homes	Not perceiving GWG as problematic. Wishing to be perceived as 'pregnant', not 'fat'.

Appendix III: Consent forms

AN EXPLORATION OF THE PREGNANCY EXPERIENCES OF WOMEN WITH A BODY MASS INDEX (BMI) OF MORE THAN 40

VOLUNTEER CONSENT FORM

Researcher: Alice Keely

Study ID Number: …………

I have read and understood the information sheet and this consent form. I have had an opportunity to ask questions about my participation.
I understand that I am under no obligation to take part in this study and that my care will not be affected either way.
I understand that I have the right to withdraw from this study at any stage without giving any reason.
I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from Edinburgh Napier University, from regulatory authorities or from NHS Lothian, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.

I understand that my interviews will be audio recorded and typed up, and that sections of what I say may be quoted in study reports and publications, but that my name, or any other information which might reveal my identity, will not be used.
I agree to participate in this study.

Name of participant: ____

Signature of participant: ____

Signature of researcher: ____

Date: __________________

Name of researcher: Alice Keely
Rm 3B.41
Sighthill Court
Edinburgh
EH11 4BN

Email / Telephone: 40136837@live.napier.ac.uk / 07947 306 480

AN EXPLORATION OF THE PREGNANCY EXPERIENCES OF WOMEN WITH A BODY MASS INDEX (BMI) OF MORE THAN 40

VOLUNTEER CONSENT FORM

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I understand that my interviews will be audio recorded and typed up, and that sections of what I say may be quoted in study reports and publications, but that my name, or any other information which might reveal my identity, will not be used.
I agree to participate in this study.

Name of participant: ______________________________________

Signature of participant: ______________________________________

Signature of researcher: ______________________________________

Date: _________________

Name of researcher: Alice Keely
Rm 3B.41
Sighthill Court
Edinburgh
EH11 4BN
Email / Telephone: 40136837@live.napier.ac.uk / 07947 306 480

Appendix IV: Information sheet: pregnant women

TITLE OF PROJECT:
AN EXPLORATION OF THE PREGNANCY EXPERIENCES OF WOMEN WITH A BODY MASS INDEX (BMI) OF 40 OR MORE.

Name of Researcher:
Miss Alice Keely

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?
In the UK, the number of women who are overweight when they have a baby is rising. In the past few years, health researchers have been investigating the best way to help women, in terms of weight management during pregnancy and to improve the health of themselves and their babies. However, little is known about women's experiences of being overweight during pregnancy. This study will explore what women think and feel about their pregnancy and health more generally, and about the advice they are given, where that advice comes from, and about the care they receive.

Why have I been chosen?
You have been chosen because you are pregnant and when you booked in for antenatal care with your midwife your body mass index (BMI) was 40 or more. BMI is a simple calculation that is done using your height and your weight.

Do I have to take part?
No. It is up to you to decide whether or not you wish to take part. You don't have to give a reason for not taking part and this will not affect your care in any way.

What will happen to me if I take part?
The study will involve taking part in up to three interviews with the researcher (Alice Keely). This study will be part of Miss Keely's PhD studies. If you are interested in taking part, she will arrange to see you, go through this information sheet, and answer any questions you have about the study. She will then ask you to sign a consent form (Version 1.0) to show you have agreed to take part in three interviews. Two of these would take place during your pregnancy and one after the baby is born. These will be arranged at a time and place to suit you. The first interview could be at the same time as completing the consent form if this is suitable for you. Each interview will last for about one hour. With your permission it will be tape recorded. This is so the researcher can listen to the interview later and write down what you have said in detail. She can also give you her full attention during the interview. Any information which you give will be anonymised, which means that reports will not mention your name or personal details, or the names of your family members or friends, or any other information which could identify you, or them, to others. The recording will be erased once the data from the study has been summarised in reports. In the interviews, the researcher will ask about your experiences and feelings in relation to your everyday life and your pregnancy. She will also ask you some questions about your weight and your pregnancy care. You do not have to answer any questions you are not completely happy with.

Following the first interview, the researcher may ask you to identify one or two significant individuals, either someone who you live with, or spend a lot of time with, or someone whose views are important to you. This may be your husband or partner, or another family member or friend. The reason for this is that the researcher may want to ask them to take part in a similar interview that relates to their experiences and feelings in relation to your pregnancy. The researcher will ask you to pass an information sheet to this individual, and ask if they would be willing to be contacted with a view to taking part in the research. You are not obliged to identify anyone to be approached if you do not wish to. If you do identify anyone, these individuals will not be obliged to take part in the study and this does not affect your participation.

What are the possible disadvantages and risks of taking part?
Some of the issues to be explored in the interviews, such as body weight, can be sensitive, and some women find talking about these issues can be distressing. If this happens, you will be offered a break in the interview, or you can stop the interview at any time. You will also be offered a list of contacts for further advice and support.

What are the possible benefits of taking part?
You will not benefit directly from this research but it may improve our understanding about women's experiences of pregnancy and pregnancy care. Some women may find it helpful to talk in confidence to a researcher about their views and experiences. We also hope that the information we gather about your own experiences may be helpful for planning services for women in the future.

Will I receive expenses and payment for taking part?
Yes. You will receive a £10 gift voucher following your first and third interviews, as a thank you for taking part. Any expenses you incur will be refunded to you.

What will happen if I don't want to carry on with the study?
You do not have to take part in this study, and **you may withdraw from it at any time** without giving a reason. If you withdraw from the study, we will destroy all your data if that is what you want. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care that you receive. This includes leaving out questions you do not want to answer during the interview.
Should you experience any complications in your pregnancy, I will contact you to discuss whether or not you wish to continue to participate in the study.

What if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak with the researcher who will do her best to answer your questions. If you remain unhappy and wish to complain formally, you can do by contacting the Independent Advisor who has been appointed to this study, but who is not involved with the study (contact details can be found at the bottom of this information sheet).

What will happen at the end of the study?
After you finish your interviews, your participation in the study will end. We will write a up a report of our findings and can send you a copy if you wish

Will my taking part in this study be kept confidential?
Yes. All information which is collected about you during the course of the research will be kept strictly confidential. Records of your personal information will be kept in a locked filing cabinet and on the researcher's password-protected computer for one year. Transcripts of your data will not identify your name or other personal information once they are transcribed. These will be stored for five years before being destroyed. You will be referred to by a number or pseudonym in any study report. Names of individuals and places you discuss will also be changed or removed in order to protect anonymity.

If you disclose during an interview that you intend to cause harm either to yourself or others, the researcher is obliged to break confidentiality and to inform the individual, and if appropriate your GP and any other relevant professionals.

What will happen to the results of the study?
The results of the study will be written up in a report and will be published in academic journals and websites. The researcher will also present the findings of the study at conferences. We may use quotations from your interviews but your identity will be protected.

Once again, many thanks.

Contact Details:

Researcher:

Alice Keely
Edinburgh Napier University
Room 3B.45
Sighthill Court
EH11 4BN

Independent Advisor:

Dr Barbara Neades
Senior Lecturer
Edinburgh Napier University
Room 3B.41
Sighthill Court
EH11 4BN

Appendix IV: Information sheet: Partners

TITLE OF PROJECT:

AN EXPLORATION OF THE PREGNANCY EXPERIENCES OF WOMEN WITH A BODY MASS INDEX (BMI) OF 40 OR MORE

Name of Researcher:
Miss Alice Keely

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?
In the UK, the number of women who are overweight when they have a baby is rising. In the past few years, health researchers have been investigating the best way to help women, in terms of weight management during pregnancy and to improve the health of themselves and their babies. However, little is known about women's experiences of being overweight during pregnancy. This study will explore what women think and feel about their pregnancies and health more generally, and will also explore the views of family members and friends.

Why have I been chosen?
You have been chosen because your close family member or friend is pregnant and when she booked in for antenatal care her body mass index (BMI) was 40 or more. BMI is a simple calculation that is done using height and weight.

Do I have to take part?
No. It is up to you to decide whether or not you wish to take part. You don't have to give a reason for not taking part and this will not affect your care in any way.

What will happen to me if I take part?
The study will involve taking part in one interview with the researcher (Alice Keely). This study will be part of Miss Keely's PhD studies. If you are interested in taking part, she will arrange to see you, go through this information sheet, and answer any questions you have about the study. She will then ask you to sign a consent form (Version 1.0) to show you have agreed to take part in the interview. This will be arranged at a time and place to suit you. The interview could be at the same time as completing the consent form if this is suitable for you. The interview will last for about one hour and will involve only you and the researcher. With your permission it will be tape recorded. This is so the researcher can listen to the interview later and write down what you have said in detail. She can also give you her full attention during the interview. Any information which you give will be anonymised, which means that reports will not mention your name or personal details, or the names of your family members or friends, or any other information which could identify you, or them, to others. The recording will be erased once the data from the study has been summarised in reports. In the interview, the researcher will ask about your experiences and views about your family member or friend's pregnancy and health. You do not have to answer any questions you are not completely happy with.

What are the possible disadvantages and risks of taking part?
Some of the issues to be explored in the interviews, such as body weight, can be sensitive, and some people find talking about these issues can be distressing. If this happens, you will be offered a break in the interview, or you can stop the interview at any time. You will also be offered a list of contacts for further advice and support.

What are the possible benefits of taking part?
You will not benefit directly from this research but it may improve our understanding about women's experiences of pregnancy and pregnancy care. Some people may find it helpful to talk in confidence to a researcher about their views and experiences. We also hope that the information we gather about your own experiences may be helpful for planning services for women in the future.

Will I receive expenses and payment for taking part?
Yes. You will receive a £10 gift voucher following your interview, as a thank you for taking part. Any expenses you incur will be refunded to you.

What will happen if I don't want to carry on with the study?
You do not have to take part in this study, and **you may withdraw from it at any time** without giving a reason. If you withdraw from the study, we will destroy all your data if that is what you want. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care that you receive. This includes leaving out questions you do not want to answer during the interview.

What if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak with the researcher who will do her best to answer your questions. If you remain unhappy and wish to complain formally, you can do by contacting the Independent Advisor who has been appointed to this study, but who is not involved with the study (contact details can be found at the bottom of this information sheet).

What will happen at the end of the study?
After you finish your interview, your participation in the study will end. We will write up a report of our findings and can send you a copy if you wish.

Will my taking part in this study be kept confidential?
Yes. Information which is collected about you during the course of the research will be kept strictly confidential. Records of your personal information will be kept in a locked filing cabinet and on the researcher's password-protected computer for one year. Transcripts of your data will not identify your name or other personal information once they are transcribed. These will be stored for five years before being destroyed. You will be referred to by a number or pseudonym in any study report. Names of individuals and places you discuss will also be changed or removed in order to protect anonymity.

If you disclose during an interview that you intend to cause harm either to yourself or others, the researcher is obliged to break confidentiality and to inform he individual and, if appropriate, your GP and any other relevant professionals.

What will happen to the results of the study?
The results of the study will be written up in a report and will be published in academic journals and websites. The researcher will also present the findings of the study at conferences. We may use quotations from your interview but your identity will be protected.

Once again, many thanks.
Contact Details:

Researcher:

Alice Keely
Edinburgh Napier University
Room 3B.45
Sighthill Court
EH11 4BN

Independent Advisor:

Dr Barbara Neades
Senior Lecturer
Edinburgh Napier University
Room 3B.41
Sighthill Court
EH11 4BN

APPENDIX VI: TOPIC GUIDES

AN EXPLORATION OF THE PREGNANCY EXPERIENCES OF WOMEN WITH A BODY MASS INDEX (BMI) OF 40 OR MORE

RESEARCHER: ALICE KEELY

TOPIC GUIDE: PREGNANT WOMEN

Aim 1

To explore the experiences, attitudes and health-related behaviours of women with a BMI >40kg/m^2 during pregnancy; and to identify the factors and considerations which shape their beliefs, experiences and behaviours, and how these may change during and after pregnancy.

a. What are the lived experiences and perceptions of women with a BMI >40kg/m^2 during pregnancy and following the birth of their babies? How and why do these change over time? What contextual factors shape and influence these experiences and perceptions?
b. What are the perceptions and attitudes towards their bodies of women with a BMI >40kg/m^2 during pregnancy? How does this differ to perceptions and attitudes prior to pregnancy? How and why do these perceptions and attitudes change during pregnancy and following childbirth?
c. What factors and considerations influence and inform women's food and eating practices? How, if at all, have food, eating and other lifestyle habits changed during pregnancy?

Can you tell me about yourself? (Prompts – where are you from originally? have you always lived here? what family do you have? (living here with you and nearby), what do you do for a job?

Probes – living circumstances, housing, family members, friends, daily routines, work and other commitments, leisure time, structure of typical day.

Can you tell me about your pregnancy? (Prompts – Is this your first pregnancy? how have you been? How are you feeling now?)

Probes –

feelings since becoming pregnant,

perceptions of health, whether these differ before and during pregnancy

lead into….

Can you tell me about how you feel about your body? (Prompts: Can you tell me about the history of your weight? How do you feel about your weight?)

Probes – before/during/after pregnancy – changes over time, diet and exercise, changes during pregnancy, beliefs about pregnancy, weight and health more generally.

Aim 2

To gain an understanding of women's perceptions and experiences of maternity health care and the impact, if any, of their interactions with maternity health care providers on their beliefs and practices in relation to obesity and pregnancy.

a. What are the principle resources and sources of advice (both formal and lay sources) that women draw upon during pregnancy, to inform their beliefs and health-related behaviours? What is the nature of the information that women have been given by health professionals, as well as information gained from other sources? How do women process and understand this information, and how do they relate it to their bodies and pregnancies?

Can you tell me about the pregnancy care you've received so far?

relationship/interaction with midwife and other healthcare staff

information or advice given by healthcare staff and how feelings/views about it

any diet or lifestyle advice and views about it

weight in pregnancy, perceptions of implications for health and health of the baby.

Feelings about the birth

Aim 3

To determine the impact, if any, of the beliefs and attitudes of significant members of the women's families and social networks upon the women's experiences, attitudes and health-related behaviours in relation to obesity and pregnancy.

a. What is the nature of the information that women have been given by family and friends, as well as information gained from other sources? How do women process and understand this information, and how do they relate it to their bodies and pregnancies?

b. What, if any, kinds of discourses are women drawing upon during pregnancy? How do they engage with these discourses and how do they relate it to their bodies and pregnancies?

Can you tell me a bit more about your family? (Prompts – do you have many friends? Do you have family close by? Do many of them have children?)

Probes: - partner, family and friends, social activities, beliefs about pregnancy, diet and health more generally, friends and family, advice and views about health, pregnancy, diet.

AN EXPLORATION OF THE PREGNANCY EXPERIENCES OF WOMEN WITH A BODY MASS INDEX (BMI) OF 40 OR MORE

RESEARCHER: ALICE KEELY

TOPIC GUIDE: PARTNERS

Aim 3

To determine the impact, if any, of the beliefs and attitudes of significant members of the women's families and social networks upon the women's experiences, attitudes and health-related behaviours in relation to obesity and pregnancy.

a. What is the nature of the information that women have been given by family and friends, as well as information gained from other sources?

b. How do significant individuals within the index women's families and social group perceive the index women's health and body weight? How, if at all, do these understandings and perceptions differ and change during the women's pregnancies?

c. What, if any, kinds of discourses are family members and friends drawing upon to inform their views about obesity in pregnancy?

Can you tell me about yourself? (Prompts – where are you from originally? have you always lived here? what family do you have? (living here with you and nearby), what do you do for a job?

Probes – living circumstances, housing, family members, friends, daily routines, work and other commitments, leisure time, structure of typical day.

Can you tell me a bit more about your family?

Probes: - partner, family and friends, social activities, lifestyle, work and other commitments, diet and health more generally, views about pregnancy, weight and health, own pregnancies/children

Can you tell me about your relationship/friendship with [index woman]? Nature of relationship, how long, prompt re. pregnancy views about about pregnancy & birth, health, weight, diet, lifestyle.

Can you tell me about your own life/health? – inc. pregnancies & more generally, views about body weight and health, feelings about their own body & health, any issues discussed with index woman.

Appendix VII: Extract from research diary

11/03/15 – Following my first pilot interview with Eva.

Working class estate in (area).
Partner brought kids back with sweets. She joked that it looked bad.
A lot of the time, I was wondering ‘where should I steer this? What am I aksing? What do I want to know?’
She was friendly, open, but also detached, didn’t make much eye contact during the interview (we sat at the dining table and she looked out of the window).
She was making a representation of herself. I need to unpick what she was trying to say.
Critical of others – family/in-laws/medical profession. Husband and friend not so much.
Next time – more about the body, embodiment.

When she described following a diet or following medical advice, she used a da-de-da-de-da, list-reeling, bored tone. Did this mean, ‘so I followed the advice but I knew it wouldn’t work/knew better, and I was right’?

Mentions sugar addiction.
Next interview – weight gain? Maintain? Did she follow advice at antenatal clinic?
Wanted a ‘real’ plan – ‘personal’ plan – individualised care. Tangible advice.

Tracing what food has meant in her life. Now feeding kids and husband.

Appendix VIII: Related published work (published in Midwifery Journal, In Press, available online 26th September 2016)

"If she wants to eat…and eat and eat…fine! It's gonna feed the baby": pregnant women and partners' perceptions and experiences of pregnancy with a BMI >40kg/m^2

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Abstract

Introduction: Women with a raised BMI are more likely to gain excessive weight in pregnancy compared to women with a BMI in the normal range. Recent behaviour change interventions have had moderate to no influence on GWG, and no effect on other perinatal outcomes. Evidence is required regarding the social and cultural contexts of weight and pregnancy. No studies to date have included the views of partners

Aims: 1. To explore the experiences, attitudes and health-related behaviours of pregnant women with a BMI >40kg/m^2; and to identify the factors and considerations which shape their beliefs, experiences and behaviours, and how these may change during and after pregnancy. 2. To determine the impact, if any, of the beliefs and attitudes of significant members of the women's families and social networks upon the women's experiences, attitudes and health-related behaviours in relation to weight and pregnancy.

Methods: This was a prospective serial interview study. Semi-structured interviews were conducted with 11 pregnant women with a BMI >40kg/m^2, during pregnancy and after birth, and once with 7 partners (all male) of women. Interview questions were designed to be appropriately but flexibly framed, in order to explore and gather data on participants' everyday life, lifestyles, views, experiences, relationships and behaviours, focussing more specifically on beliefs about health, pregnancy, weight and diet. Thematic content analysis was used to formally analyse and unearth patterns in the data

Findings: The findings can be grouped into six interrelated themes: the complexities of weight histories and relationships with food; resisting risk together; resisting stigma together; pregnancy as a 'pause'; receiving dietary advice; postnatal intentions. These

themes are inter-related due to the ‘spoiled identity’ (Goffman 1963) that the large body represents in western culture and related stigma.

Conclusion and implications: This study provides evidence that there exist deeply ingrained social and cultural beliefs among women and in particular their partners, regarding pregnancy diet and weight gain. Further, it appears that partners may resist stigmatised risk on behalf of a pregnant wife or partner in pregnancy. All women (and several men) expressed an intention to adopt healthy behaviours and lose weight once their baby was born. Further evidence is required regarding the means by which women who experience stigmatised risk during pregnancy, and their partners, might be engaged and receptive to health advice. Models which draw on ideals of relationship-centred care, and self-efficacy via open discussion with women and families, engaging women and partners by providing them with an opportunity to talk about their beliefs and concerns, could be explored to inform future research and practice.

Key words: pregnancy; obesity; BMI; stigma; risk; partners; couples

Introduction

Women with a BMI >30kg/m^2 (defined as clinically obese) are more likely to gain excessive weight in pregnancy compared to women with a BMI in the normal range (Restall *et al* 2014), leading to increased risks of high birthweight, and maternal postpartum weight retention with associated risks (Siega-Riz *et al* 2009). In women with a BMI >40kg/m^2 (very severely obese), for whom pregnancy risks are incrementally greater (CMACE/RCOG 2010), limiting gestational weight gain may reduce the risk of adverse pregnancy outcomes (Crane *et al* 2009). A number of randomised-controlled trials have sought to examine the efficacy of pregnancy intervention approaches such as diet and exercise programmes, cognitive behavioural therapy (CBT), and social (cognitive) learning theory, on maternal weight gain and fetal growth (Smith & Lavender 2011; Dodd *et al* 2010; Oteng-Ntim *et al* 2011; Thangaratinam *et al* 2012). However, recent RCTs of behaviour change interventions have experienced low uptake (Dodd *et al* 2014; Poston *et al* 2015), indicating poor acceptability. Multiple systematic reviews (Campbell *et al* 2011; Dodd *et al* 2010) and meta-analyses (Oteng-Ntim *et al* 2012; Agha *et al* 2014) have concluded that behaviour change interventions to date which have focused on limiting GWG via a combination of dietary counselling, weight monitoring, and exercise programmes for all categories of women with a BMI >30kg/m^2 have had moderate to no influence on GWG, and no effect on other perinatal outcomes.

It has been argued that, in common with biomedical approaches to weight loss in the general population, antenatal interventions trialled to date have engaged with maternal obesity as primarily a nutritional phenomenon and that, by employing behaviouralist approaches to lifestyle

modification, theoretical underpinnings are based on analyses that regard 'food, bodies and eating as disembodied and disengaged from the social contexts in which people live their lives' (Warin *et al* 2008 p98). The authors of the landmark Foresight Report argue that a broader societal approach is needed to tackling obesity, requiring change at personal, family, community and national levels (Robertson *et al* 2007). However, current and recent approaches do not adequately acknowledge pregnancy and increased weight as highly embodied and constantly lived experiences, occurring within, and shaped by, their families and communities (Throsby 2007; Schmied & Lupton 2001).

Recent evidence has identified health behaviours and values shared between partners as a greater contributor to increased weight than other factors, such as the influence of parents and upbringing (Xia *et al* 2016) Studies of the general population have found that weight is a common conversation topic for many couples (Bove & Sobal, 2011). In addition, increased weight in fathers has been shown to be associated with increased risks of offspring increased weight (Fleten *et al* 2012; Patel *et al* 2011). Pregnant women with a BMI >30kg/m^2 in one small qualitative study described partners as either supportive or unsupportive in their efforts to eat healthily in pregnancy (Heslehurst *et al* 2013a) and participants in a study which explored the attitudes of women with a history of gestational diabetes to engaging in physical activity also reported that lack of partner support was a barrier to perceived healthy behaviour change (Graco *et al* 2009). However, to the authors' knowledge there are no studies that explore the views of pregnant women's partners regarding pregnancy diet, GWG and associated risks. Evidence of the views of partners regarding pregnancy risk, diet, lifestyle and GWG would broaden understanding of the complexities surrounding the social meaning of weight and diet in pregnancy, including its impact on engagement with formal sources of health information and health interventions (Kraschnewski 2014).

This paper reports findings from a qualitative study which explored understandings of diet, weight and health among pregnant women with a BMI >40kg/m^2, and their partners. The women attended a specialist antenatal clinic for women with a BMI >40kg/m^2 during pregnancy in a Scottish city. Focusing on beliefs and experiences regarding diet and weight gain in pregnancy, we explored the embodied experiences of pregnant women, situated within their day-to-day lives and relationships. By drawing on the perspectives of their partners alongside the pregnant women, we aimed to explore how ideas regarding weight and diet are constructed by individuals and within couple relationships during pregnancy, and the consequences for women's engagement with specialist services and formal health messages such as advice regarding GWG.

Aims

1. To explore the experiences, attitudes and health-related behaviours of pregnant women with a BMI >40kg/m^2; and to identify the factors and considerations which shape their beliefs, experiences and behaviours, and how these may change during and after pregnancy.
2. To determine the impact, if any, of the beliefs and attitudes of significant members of the women's families and social networks upon the women's experiences, attitudes and health-related behaviours in relation to weight and pregnancy.

Methods

Design

This was a prospective serial interview study: 11 pregnant women with a BMI >40kg/m^2 who were interviewed either once or twice during pregnancy, and once following birth. Pregnancy can be a time of transition, both physically and emotionally, thus a longitudinal approach afforded the opportunity to explore the extent to which pregnancy and birth experiences brought change in participants' views and beliefs. In addition, partners of 7 pregnant participants were interviewed once during the index woman's pregnancy. Data collection and analysis took place concurrently, in order to explore emergent themes (Mason 2002). The study thus progressed iteratively, enabling interview questions and sampling to be guided by the experiences of participants. Semi-structured interviews afforded the flexibility required to gain an in-depth understanding of participants' views and experiences (Brett-Davies 2007). One-to-one interviews were chosen to encourage individuals to discuss sensitive issues, including those they may not feel able to discuss in the presence of a partner.

Ethical approval was granted by NRES committee northwest on 18th December 2014 (REC reference no: 14/NW/1413).

Recruitment and sampling

Eligible women were identified and approached during their attendance at a specialist antenatal clinic in a Scottish hospital, which provides care for pregnant women with a BMI >40kg/m^2. Participants were selected purposively in order to achieve a sample that broadly reflected childbearing women in Scotland in terms of age, ethnicity and social class. Recruitment to the project began in April 2015, and interviews began in May 2015 and were completed in February 2016. Following initial interviews, each index woman was asked to nominate individuals from her family and/or social network to be approached to take part in the study and to provide them with a recruitment pack. Formal verbal and written consent was obtained in person immediately prior to initial interviews taking place.

In total 53 women were approached to participate in the study and 52 accepted a study information pack. 14 women responded to a follow-up telephone call and 12 women agreed to participate. However, one woman miscarried prior to her interview taking place. Therefore, 11 women took part in an initial antenatal interview. The study protocol originally included two antenatal interviews and one postnatal interview. Five women took part in a second antenatal interview, when it was decided that, as second interviews were not providing richness and depth in terms of new data compared with first interviews, and due to the limited timescale of the study, these would not be conducted with the remaining six women. Of the 11 women, eight nominated their partner or husband to participate in interviews (two women did not have a partner, and one woman did not wish to approach her partner to participate). Of those approached, seven partners (all male) agreed to be interviewed and one declined.

Table of Demographics here

The Interviews

Using a broad topic guide, interview questions were designed to be appropriately but flexibly framed, in order to explore, and gather data on, pregnant participants' everyday lives, views, experiences, relationships and behaviours. Specifically, they focussed on weight history and general health, diet and eating, and pregnancy, as well as experiences of pregnancy care. Follow-up interviews explored whether their views had changed during pregnancy. The third interview, which took place in the postnatal period, included questions designed to explore experiences of birth and views on maternity care as well as their perceptions and feelings following birth. Interviews with partners and husbands included questions designed to explore their views and perceptions about health, weight, diet and exercise, as well as their perceptions of their partner's BMI, diet and general health status during pregnancy. Earlier interviews were reviewed prior to follow-up interviews and the topic guide was tailored accordingly. Interviews were digitally audio recorded with consent and transcribed verbatim.

Data Analysis

Thematic content analysis was used to formally analyse and unearth patterns in the data. Using an interpretive approach, themes were developed in an iterative and inductive way, involving the breaking down and reassembling of data following a thematic analysis framework developed by Braun and Clarke (2006). This involved multiple hearings of the audio recording and readings of the

transcripts in order to become immersed in the data, with concurrent generation of initial codes via note-taking. This was followed by a re-focusing of the initial analysis by arranging early codes into the broader level of themes, using NVivo10 software. Themes were then reviewed and refined, enabling a move beyond initial, more descriptive analysis, to identify participants' ideas and conceptualisations regarding key themes such as stigma and risk. This was followed the development of a more structured framework, enabling further identification of recurrent themes across and within participants' accounts (Braun & Clarke; 2006). Pseudonyms were chosen by participants.

Findings

The findings can be grouped into six interrelated themes: the complexities of weight histories and relationships with food; resisting risk together; pregnancy as a 'pause'; receiving dietary advice; postnatal intentions. These themes are inter-related due to the 'spoiled identity' (Goffman 1963) that the large body represents in western culture. As such, although the women in this study voluntarily attended for high-risk care, thereby acknowledging the 'problem' of their increased weight in pregnancy, both members of several couples individually performed 'identity work' (Faircloth 2010) to simultaneously acknowledge - and resist- the negative associated characteristics of increased weight. In so doing, they negotiated a complex 'in-between' path (Zinn 2008 p439) through pregnancy, navigating the shadow of stigma, biomedical representations of risk, dietary and lifestyle advice, and referring to reassuring messages, lay beliefs and norms regarding pregnancy, food and weight, which they experienced within their everyday lives.

Weight histories: Eating and Dieting

Most pregnant participants gave detailed life histories during interviews, including accounts of their weight. Some women linked their early years and past events to adult behaviours, recounting a troubled relationship with food and eating. Some had experienced emotional distress in childhood or teenage years and/or depression in adulthood, and this was characterised for several by what was described as 'emotional' or 'comfort' eating at times of psychological distress. Eva described a difficult childhood, gaining a lot of weight in her early teens, which led to struggles with her weight throughout adulthood:

"…I started my period when I was like…thirteen, fourteen…and it was like…like when I was a kid I was like…tiny. I was a tiny wee kid. And then I started my period and, you know, you start getting boobs and a butt and then everything else just kept going….ha!...basically [*tearful*] … And then…I don't know, you just slowly get…fatter and fatter…"

[Eva 28, 3rd baby]

Her husband Eric described the emotional impact he observed her weight had on Eva. However, his comment also demonstrates the complexities of the interplay within their relationship. Asked if Eva's weight and serial dieting was an issue which caused tension, Eric said:

"It doesn't cause tension. She gets pretty sad… I try to be helpful. I just try to be supportive, but there's not much you can do. You can't force someone to do something. You can say to them, 'Oh, are you gonna do that? But if you're only gonna do it for a month or something, what's the point?' I only step in occasionally, if she's gone on some stupid diet that annoys me, and then err… I'm just like, 'Look, that's enough'. [laughs] 'Here's a bit of cake…"

[Eric 30, Eva's husband, 3rd baby]

However, other women were keen to emphasise that it was not a traumatic history or mental health problems which accounted for their increased weight, but rather an enjoyment of their lives and of what they described as 'good' food. Jane said:

"Ian and I are fat because we both love cooking. It's not that we don't eat healthy. We love to cook and we love to make big lovely dinners and treats. 'Let's have some potato dauphinoise', and…. we love cheese…. and we have nice tasting food. We don't just eat crap, but we probably eat too much bad stuff. We like to go out and we like cocktails. We like nice stuff. When we want to lose weight we can, but I think we're quite happy really anyway."

[Jane 32, 1st baby]

These women had partners who they also identified as overweight and they described dieting together, deriving mutual support, as well as colluding in 'breaking' their diets. Jane's husband Ian talked about this:

"And I think what we tend to do when we're on a diet is… one gives permission for the other one to sort of… break their diet. So if you're on your own, you're less likely to do it, less likely to go off your diet... but maybe I say, 'I could really fancy… this tonight', and maybe Jane, sometimes she'll be like, 'No, you can't have that, stick to your diet', and other times it'll be, 'Let's have that', and vice versa, so…"

[Ian 32, Jane's husband, 1st baby]

Resisting Stigma Together: 'they presume that everybody stuffs their face with cake all day'

Regardless of how they accounted for their weight, all participants resisted stigmatising explanations for their size, and both members of several couples concurred in this, contributing together to the 'identity work' (Faircloth 2010) that each woman undertook to preserve her moral integrity and resist the blame for her size. One couple, Mary and Adrian, described their food choices, stressing how Mary ate healthy food, and was not greedy:

“I’m not an over-eater. I don’t have sweets in the house. I don’t eat every single day chocolates and…I don’t have that. Like, if I eat an ice cream, I eat an ice cream, like a cone or…[some]thing. I don’t eat a whole tub of ice cream, you know? And that was… most of my life, because I’m not a big eater of take-aways or McDonalds or... because I’ve been born and raised in a family, in a country where we... we eat from scratch. We eat quite natural ingredients as I said, and cook in quite a… healthy way”

[Mary 38, 1st baby]

“She eats healthy, like. Since we’ve been together, she eats the healthy food, because I like healthy food, and then like…Whenever we go for shopping like, you see our basket is like…veg, fruit, more veg [and] fruit than any other thing.”

[Adrian 28, Mary’s husband, 1st baby, gestation 17+6]

Others, like Eva and Eric, both angrily rejected the assumptions they believed health professionals made about Eva’s eating habits and lifestyle. Eva said:

“I think the thing as well…they think you’re just sitting here stuffing pints of Ben & Jerry’s, like… that’s not what my life is like…” [tearful]

[Eva, 28, 3rd baby]

Using similar language to his wife, Eric expressed the same view:

“Cos they just go… they presume [Eric’s emphasis] that everybody’s stuffs their face wi’ cake all day, cos you… if you look online, it’s like… a person who’s lost like 10 stone and they’re like, ‘I used to sit and I used to eat crisps all day’, and I’m like you’re full of cr…[isps]? Who even does that?”

[Eric 30, Eva’s husband, 3rd baby]

Resisting Risk Together: ‘there are women who are much more at risk’

Almost all of the pregnant participants described themselves as ‘healthy’, despite their weight. Some attempted to normalise their weight in order to relieve anxiety regarding pregnancy risk. Several women and their partners or just above at pregnancy booking compared themselves favourably to others in terms of weight and associated risk, with some of those who had a BMI of 40 kg/m^2 referring to the fact that this meant they were only just eligible for referral for high risk care. One woman, Rachel, said:

“When I saw Dr [consultant]… a number of times she made it pretty clear that I’d only just made it into their clinic. That I was one of the smallest ladies that she treats…The last time I saw her in the clinic, she made it pretty clear that she didn’t expect to ever see me again. She gave me my plan of care: ‘Go and have a nice delivery’”

[Rachel 38, 2nd baby]

Rachel’s husband Ben commented on this also:

"…Rachel is barely within the clinic that we're in at the moment in terms of risk factor. There are women who are at much more risk"

[Ben 40, Rachel's husband 2nd baby]

Other participants, both pregnant women and partners, drew on ecological fallacies in order to negotiate the notion of weight-related pregnancy risk. These included: highlighting other health behaviours, such as drinking or smoking in pregnancy, as more risky than having a high BMI; emphasising pregnancy as by its nature risky, and the experience of complications as randomly occurring among the pregnant population; highlighting the positive pregnancy experiences of family, friends or those accessed online who also had a raised BMI in pregnancy.

Pregnancy as a Pause: '…it feels like it gives you a free pass'

The accounts of many of the women and their partners demonstrated that they both perceived and experienced pregnancy as a time of change in terms of food and diet, and this manifested in different ways. Some women perceived a relaxation of cultural and social pressure to attempt to control their weight once they were pregnant. Five women had been members of commercial slimming clubs immediately prior to becoming pregnant, but stopped attending once they discovered they were pregnant despite four being advised by their club that they could attend during pregnancy. Advice from clinical staff to stop attending, as well as pregnancy symptoms such as nausea were described as reasons for leaving, however, the perceived relaxation from the pressure to lose weight was also an important factor. One woman who stopped going was Babs. She said:

"I think it goes to extremes in pregnancy, and I think a lot of folk change their diets totally because they think 'I need to eat healthy for the baby' and I'm not saying that I didn't eat healthy meals as well, I just did eat…crisps and chocolate as well…so…"

She explained why she increased her intake of junk foods in pregnancy:

"Oh, I think it feels like it gives you a free pass. Mmm…yeah, I do. And I shouldn'ae feel that but I do. Mm-hmm. You just think, 'Oh, I can deal wi' it after'… I just think, 'Well, I'm gonna..'. this is likely to be my last baby, I can lose the weight once I'm done"

[Babs 27, 2nd baby]

Babs' 'free pass' was one which enabled her to eat as she pleased. Her comments indicate her expectation that she would gain excessive weight, and was planning to return to the slimming club following birth, thus intended enjoy the freedom she felt in pregnancy to enjoy foods she deprived herself of when dieting. At the high-risk clinic they attended, all participants were advised to limit

pregnancy weight gain, and aim for weight maintenance. Babs' husband Jim Bob rejected this advice, indicating instead his belief that Babs should follow her cravings and that weight gain in pregnancy was inevitable:

"At the minute… she's eating Fray Bentos pies [laughs] and pork pies for her lunch and that because that's what she's wanting and that's <u>her craving</u> [Jim Bob's emphasis]. Is it bad? Is it good? It's not having any ill-effects on her, from what I can see and that…She's going to put weight on cos she's pregnant, there's no denying that. After her pregnancy she'll be like, 'Oh, look how heavy I am!'"

He went on to outline his view that Babs shouldn't restrict her intake of food:

"If she wants to eat…and eat and eat…fine! It's gonna feed the baby. OK, there might be a McDonalds and a…a load of crap going in as well, I'm not saying it's all good food and nutrition, but…the baby will take what it needs out of that, so…"

[Jim Bob 30, Babs' husband, 2nd baby]

Other partners expressed similar views, regarding cravings, unrestricted intake and pregnancy weight gain as inevitable, indeed desirable, as it would bring nourishment to the baby. Several women as well as their partners expressed a belief in the benefits of following cravings; that this was their bodies' and their babies' way of 'telling them' what they should eat. Although several women specifically referred to their belief that the need to 'eat for two' was untrue, this was interpreted as allowing oneself unrestricted intake, associated with stigmatised gluttonous wanton consumption. Most women described consciously increasing their intake of certain food groups, such as calcium-rich foods, fruit and vegetables, citing this as recommended by pregnancy health professionals. Many women also described 'allowing' themselves more unhealthy foods or 'treats' during pregnancy. Below, Ruth and Graham's descriptions illustrate this overlap of increasing intake of perceived 'recommended' foods, alongside consuming more unhealthy, 'treat' foods, common to several participants' accounts. Referring to common cultural beliefs about pregnancy cravings, Ruth said:

"Because, I mean, I have been eating healthily. I've been eating a lot more fruit and things, because I keep on getting craving for certain fruits…[] Because they say whatever baby fancies is what you're neglecting, or what you're missing in your diet. And I was like, 'Right, OK'"

[Ruth 27, 1st baby]

Ruth's partner described the changes in her diet:

"[Ruth]'s changed, she's eating loads of fruits and grapes and... [pause] She's eating a lot of shite as well to be fair… rubbish. Takeaway crap"

[Graham 32, Ruth's partner, 1st baby, gestation 25+2]

Dietary Advice: 'I'm bright and I know what's good'

All participants were offered a dietetics consultation as part of the high-risk service and though some participants described their experience of this as reassuring, the information regarding healthy eating was described by all women as not new or useful to them. Several women, like Jane, felt stigmatised by the offer of a dietary consultation, offended by the suggestion that she needed advice. In common with others, she simultaneously acknowledged and reproduced the cultural stereotypes she perceived to be associated with excess weight, while resisting the application of them to herself and her husband. She said:

"We're not miserable old fat people or anything, and we do go out and walk and stuff. I don't think the clinic's going to tell me, 'This is what you should be eating and this is what's good for your baby', because I'm bright and I know what's good"

[Jane 32, 1st baby]

Eva described in detail during her interviews her years-long struggle with her weight. In common with Jane and several other participants, she described feeling frustrated and stigmatised by the advice she was given at the specialist antenatal clinic:

"You know, and I understand it's like, you know, they're just doing it because they're trying to help and… But you're like, well, what's the point in telling me… that, 'You're pregnant, so you can't diet… but you're fat, so you're just kinda like…[*tearful, whispering*]… *really bad*', you know what I mean? […] Like, I can't do anything about it, so you're making a person feel - you know what I mean? - bad about something they've already got an issue with."

Later, she said:

"I mean, I know all this… I mean I've studied this so much… like… I could be a dietitian probably! I just can't implement it, for whatever reason, like… know what I mean?"

[Eva 28, 3rd baby]

While acknowledging that dietary advice was well-intentioned, Eva rejected the notion that simple information-giving alone would be useful for her, alluding in this later comment to the complex reasons underlying her size. She considered herself an expert in food and dieting, and was frustrated by judgments which she perceived as underpinning the advice she received. During her three interviews she described how clinical consultations were emotionally and psychologically difficult for her. Her husband Eric recalled how upset Eva had been on several occasions following her antenatal clinic appointments. In common with other participants, Eva and Eric both described their shared perception that the advice to maintain weight in pregnancy would in practice, result in loss of body

fat, due to the increasing weight of the fetus. Eric was scathing about this, suggesting that following such advice could be harmful to the baby. He said:

"How do you lose weight when you're pregnant? It's not gonna happen is it? No-one ever went on a diet when they were pregnant. It's the most ridiculous thing I've ever heard of. I mean, after the baby, fair enough. But I mean…during the birth? Do you want to put the baby at risk? No. So…yeah, it's ridiculous [laughs]. People generally tend to gain weight during pregnancy. I mean, why would you want to lose it? Nah, I don't agree wi' it. So they can… [laughs] … I tried not to swear, but I was saying they can shove it, you know? Their stupid advice."

[Eric 30, Eva's husband]

<u>Postnatal Plans: 'I don't want them to have those same issues that I've got'</u>

All of the women and their partners expressed a desire to have a healthier lifestyle and lose weight once their babies were born. In this context, they acknowledged having health concerns related to their weight, in particular about their fitness and their ability to have an active role in their child's life and to fulfil their perceived cultural ideal of a 'fit' parent. In addition to their intention to be good role models, several participants cited their fear that their children may experience stigma due to their parent's size as an incentive to lose weight. Jane said:

"I don't want to have them having a fat mum that picks them up from school. I don't want them to get slagged that their mum and dad are fat."

[Jane 32, 1st baby]

Her husband Ian worried about the connection between parental and offspring size:

"I don't want our kids to be overweight, and…you…you tend to see that. You see that if you've got parents who are overweight, their children tend to be overweight as well… I don't want them to, sort of, have those same issues that I've got".

[Ian 32, Jane's husband]

In addition, a desire to enhance longevity was cited by some participants. One of these women was Rachel, who described herself as having been overweight for most of her adult life, occasionally embarking on diets and losing some weight, but regaining it again during times of stress or unhappiness, when she 'comfort ate'. Whilst she was a participant in the study, Rachel's baby was diagnosed with Down's Syndrome, shortly after birth. In her interview several weeks later, she said:

"So on one level…my instinct was, 'I have to get well now, I have to get...fitter' you know? Because I need to be around for longer. Because there's somebody who needs me more."

[Rachel 38, 2nd baby]

She continued:

"…And on the other level, I'm expressing every two hours and so it sort of feels like all bets are off and I can eat whatever I want."

[Rachel 38. 2nd baby]

For most participants, like Rachel, early motherhood led to disrupted sleep patterns due to frequent infant feeding, extreme tiredness and domestic disorganisation, with most partners returning to work following limited paternity leave provision. In addition, when interviewed in the postnatal period, several women were unsure as to the ideal time to re-start weight loss efforts, with some citing caesarean section or breastfeeding as a possible reason for delay. Most women were unsure about where to seek advice, having been discharged from the high-risk clinic. They reported having had no discussion with their community midwives about postnatal weight loss and available support services.

Discussion

Focussing on diet, GWG, and the formal care and advice provided by NHS health professionals within a high-risk hospital-based antenatal clinic, this paper has explored the perceptions and experiences of women with a BMI >40kg/m^2, and their partners. The views and experiences of pregnant women with a raised BMI regarding health and weight have been explored in previous studies (Furber & McGowan 2010; Heslehurst *et al* 2013a; Mills *et al* 2011; Smith & Lavender 2011; Stengel *et al* 2012); however, the views of couples have not previously been explored. Using qualitative methods, the complex histories and accounts that women provide for their weight have been accessed, including how individuals within a couple may experience and resist weight stigma together, or on behalf of a partner. Participants wished to experience a relaxation of the pressure to lose weight, with both individuals within couples drawing on commonly held cultural beliefs, as well as ecological fallacies, regarding pregnancy risk, diet, weight gain and the embodied experience of pregnancy.

Couples in this study expressed concurring views regarding issues of diet and weight in pregnancy, and these were sometimes at odds with formal healthy eating advice. Pregnancy is 'a time when science and society diverge on the topic of weight' (Kraschnewski 2014 e257) and, as the accounts here demonstrate, there exist deeply ingrained beliefs regarding food and nutrition in pregnancy, such as the benefits of following cravings, the need to increase intake of certain foods and the inevitability of weight gain. It has been observed that people on average gain weight in married and cohabitating relationships (Averett, Sikora, & Argys, 2008), and that there is a tendency for couples' BMIs to correlate (Jacobson *et al* 2007; Di Castelnuovo et al 2009). There are currently no UK guidelines regarding healthy weight gain in pregnancy (NICE 2010), and a recent review of interventions concluded that 'there remains no evidence-based approach for any specific dietary

regimen to improve pregnancy outcome in overweight and obese women' (Flynn *et al* 2016 p326). The findings from this study provide further evidence to support the view that it may be more appropriate and effective to focus on healthy eating and exercise in pregnancy, rather than on GWG (Smith *et al* 2015). It has been demonstrated elsewhere that partners can help one another manage their weight (Dailey *et al* 2011), and this could be investigated in the context of providing support for healthy eating in pregnancy.

However, the dietary advice participants in this study received in pregnancy addressed only 'the simple physics of energy input and output' (Throsby 2007 p.1563), and was experienced as stigmatising and patronising. Several women rejected the notion that they required information and education abut healthy eating, with some discussing emotional or psychological problems relating to their weight, demonstrating the complex interweaving reasons which may cause and maintain increased weight. Blaxter theorises that although most people understand healthy lifestyle messages, few succeed in enacting these changes in their own lives (2004). In addition, for large women, although pregnancy is a time when health is a concern, the focus tends to be upon future health, with plans to make changes being made for after pregnancy (Smith *et al* 2016). The accounts of partners in this study demonstrate that they too view pregnancy as a 'pause' from efforts to lose weight and from associated health concerns. Partners as well as pregnant women were engaged with health messages and risk discourses for the future, in particular with regard to avoiding increased weight in their children, via personal weight loss, being active, being a good role model and a 'fit' parent.

Obesity is highly visible and is highly stigmatised in western society (Puhl & Brownell 2006; Brewis 2014). In his seminal work on stigma, Goffman argues that, although the stigmatised individual feels a deep sense that (s)he is a 'normal person', (s)he nevertheless simultaneously holds the same beliefs about identity as others, and will perceive that those others will not 'accept' him or her on 'equal grounds' (1963 p17-18). Thus, it can be understood how, as Rich observes, 'fighting fat… can be experienced as highly oppressive in everyday life' (2011 p7). Within their accounts, women and partners defended dietary habits and attempted to normalise body size, employing similiar 'rhetorical neutralisation strategies' (2016; p20) to those used by participants in Jarvie's study of pregnant women with diabetes and with a raised BMI. It can be argued, therefore, that current biomedical approaches to maternal weight management, which primarily locate the 'problem' of obesity with the individual (Unnithan-Kumar & Tremayne 2011) serve to heighten anxiety and increase feelings of stigma (Aphramor & Gingras 2011; McNaughton 2011). Therefore it is essential

to engage women and partners in non-stigmatising relationships in order to discuss these issues and deliver health messages in a timely and sensitive way. This may be achieved through the development of a relationship-centred approach to pregnancy care, which engages couples in a non-stigmatising way, by focussing on individual needs and concerns (Scottish Government 2010a). In addition, as midwives and other health professionals feel ill-equipped to communicate with and care for women effectively (Heslehurst *et al* 2013b: Oteng-Ntim 2011; MacLeod *et al* 2013; Davis *et al* 2012; Olander *et al* 2010), a framework that considers the needs of all individuals within a relationship, may be considered.

Limitations of the study

The study sample was accessed from one specialist clinic in Scotland. Annually, approximately 50% of eligible women decline referral to this service, and an exploration of views of these women would provide further evidence in this area, although they may represent a hard to reach group. In addition, the study sample was relatively small and as the youngest pregnant and partner participants were 26 and 28 respectively, it is may not be representative of the views and experiences of younger couples, who are typically more socially deprived (Robertson *et al* 2007; Scottish Government 2010b). Further, although the sample was broadly representative of the population of the Scottish city from which it was derived (predominantly white British), the views of women and partners from a range of ethnic backgrounds have not been explored here.

Conclusion and Implications for Practice

Increased weight in pregnancy has garnered increased attention in recent years from the public health community and mainstream media, which identify large women as being to blame for producing larger, ‘obesity-prone’ babies (Keenan & Stapleton 2011; Jarvie 2016). Findings from this study suggest that the ‘stigmatised pregnancy’ which is experienced by many women with increased weight may also be experienced by their partners on their behalf. Women may feel better supported by a partner than by formal health care provision, and may be alienated by formal health messages, drawing instead from informal health messages and anecdotal support and advice from their partners, families and broader social worlds.

Women with a BMI >40kg/m^2 are not a homogenous group, and increased weight can occur for many complex reasons (Jebb 1997). However, all participants in this study shared both an engagement with, and resistance of, the shadow of stigma, as well as an intention to achieve postnatal weight loss, and were focussed on their future health and that of their children. Evidence is required regarding the content and timing of efforts to engage women and partners in health

education programmes, but also the ways in which women who experience stigmatised risk during pregnancy, and their partners, might be engaged and receptive to advice. Approaches which draw on ideals of relationship-centred care, and self-efficacy via open discussion with women and families, engaging women and partners by providing them with an opportunity to talk about their beliefs and concerns, could be explored in future practice and research. This would enable sensitive discussion of risk and encourage healthy behaviours in pregnancy and beyond, and may contribute to a social and cultural shift in attitudes regarding issues around food and health behaviours in pregnancy. Future research may investigate the development of a programme which lasts from pregnancy to the postnatal period, which indeed for many women will precede the pre-conceptual period for a subsequent pregnancy.

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