Multiple dimensions of self

A longitudinal grounded theory study exploring women's experiences of maternity care when they present in pregnancy with a BMI of 35 or above

By

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ABSTRACT

Over 20% of women embarking on a pregnancy are 'obese' by Body Mass Index (BMI) definition in the United Kingdom (UK). The subsequent maternal and fetal complications arising from this has led to the implementation of maternity policy and practice to manage these women to ensure a good outcome.

This thesis aims to answer the question of: What are women's experiences of their maternity care when they present in pregnancy with a BMI of 35 kg/m² or above? This question arises in the context of practices that exist within maternity services which medically manage women who present in pregnancy with a high BMI and how this management is received and perceived. While medical studies abound, these women's experiences in relation to choice, consent and control in terms of how their pregnancies are managed are little researched. This is despite choice and control being an integral aspect of maternity policy in the UK, with informed consent a legal and ethical requirement. This thesis seeks to fill this gap.

The first part of this thesis, a meta-narrative review, considers how maternal 'obesity' discourses have evolved over time and across disciplines. A historical timeline was captured considering the reviewed literature in relation to evolving maternity policy and practice. Over time the management of 'obesity' has shifted from a focus on weight gain and diet in pregnancy, to increasing medicalisation, to a renewed focus on management using a public health approach. Four themes: 'women's beliefs and experiences of weight'; 'social determinants'; 'being risked-managed'; and 'attitudes of caregivers' were also identified. Increased medicalisation of maternal obesity, which includes defining and managing weight as pathological was found to limit women's choice and control over their maternity care, although this was not explicitly explored within the literature. Lack of consideration of choice, consent and

control was evident. It is imperative therefore that this gap in the literature is fully explored, of which this thesis aims to address.

The second part of the thesis presents the findings of a constructivist grounded theory study underpinned by poststructuralist feminist epistemology. A longitudinal study was undertaken across the pregnancy continuum, with interviews undertaken at four time points. Eleven women were recruited to the study and 30 interviews conducted between January 2018 and April 2020.

The findings suggest that there are multiple factors that influence women's perceptions of weight and care which impact on choice, consent and control, namely: social and cultural factors, maternity practices, maternity service provision and maternity policy. From this, emergent theorising of; 'the conditioned body'; 'the (in)visible body'; and 'the contesting body' evolved. In order to develop a deeper theoretical interpretation of the findings, the works of three prominent 20th Century theorists - Simone De Beauvoir (1906-1986), Michel Foucault (1926-1984), and Erving Goffman (1922-1982) were explored. Further theorising from the findings that appear to impact on choice, consent and control was then constructed; 'disciplined self'; 'surrendering self'; 'embodied self'; 'marginalised self'; 'resisting self'; and 'self- agency'. Collectively these make up the substantive grounded theory of; 'multiple dimensions of self'.

This study offers unique interpretations, with 'multiple dimensions of self' appearing to affect women's abilities to exercise choice, give consent and feel in control. Reconsideration of maternity policy, practice and risk processes are needed to avoid a reductionist approach to body size, providing individualised, compassionate care which is woman/person centred. Development of enhanced communication skills and knowledge of public health strategies for health professionals will promote positive relationships, avoiding a paternalistic

approach to care. It is imperative that the psychology of self is further understood by health professionals through education strategies in order to support women who present in pregnancy as ‘obese’. Further research examining ‘dimensions of self’ and how self impacts on perceptions of weight and maternity care is needed to understand the complexities for those living with ‘obese’ who access these services.

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For Eliza Jane, and all the strong women who have made an impact on my life.

1912-1984

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ACRONYMS AND SYMBOLS

BMI: Body mass index

CEMACH: Confidential enquiry into maternal and child health

CMACE: Centre for Maternal and Child Enquiries

C/S: Caesarean section

CTG: Cardiotocograph

DVT: Deep veined thrombosis

GTT: Glucose tolerance test

Kg/m²: Kilogram- metre squared

N/A: Not applicable

NMC: Nursing and Midwifery Council

NHS: National Health Service

PICO: Negative pressure wound dressing used to reduce infection and improve blood flow

PPH: Post-partum haemorrhage

RCOG: Royal college of Obstetricians and Gynaecologists

VBAC: Vaginal birth after caesarean section

VE: vaginal examination

VTE: Venous thromboembolism

WHO: World Health Organisation

≥: equal to or more than

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GLOSSERY OF TERMS

Anaesthetist: A doctor who specialises in administering anaesthesia.

Antenatal: Pertains to pregnancy and the period before birth.

Anti-D: An immunoglobulin used to neutralise any rhesus positive cells that may have entered the blood stream of a rhesus negative woman during pregnancy or birth (also see rhesus negative).

Antithrombotic: a drug that reduces the formation of blood clots. Often used as a precaution for prevention of clots.

Assisted delivery: The use of instruments (ventouse or forceps) to aid the birth of the baby.

Bariatric bed: A heavy duty extra - wide bed with increased weight capacity to accommodate patients with a high BMI.

Booking appointment: A woman's first antenatal appointment, usually undertaken by a midwife.

Caesarean section: The use of surgery to deliver a baby. Can be elective (pre-planned) or performed in an emergency.

Cannula: A sterile tube inserted usually into a vein to either remove blood or give fluids and/or drugs.

Cardiotocograph: A machine used to record the fetal heart rate and uterine contractions.

Continuity of carer: Where women are cared for by the same small team of midwives and other health professionals throughout the pregnancy continuum.

Deep veined thrombosis: A blood clot that develops in the body, usually found in a deep leg vein.

Epidural: Administration of an anaesthetic via the epidural space around the spinal cord. This is a local anaesthetic enabling the woman to remain awake during a procedure.

Forceps: Instrument used in an assisted birth.

General anaesthetic: Medication which renders an individual in a state of unconsciousness.

Gestation: The period of development of the fetus from conception to birth. Usually lasts 40 weeks.

Gestational diabetes: A type of diabetes that can develop during pregnancy.

Glucose tolerance test: A screening test usually carried out between 24-28 weeks of pregnancy to test for gestational diabetes.

Hyperstimulation: Can be a complication of induction of labour. Defined as uterine contractions lasting longer than two minutes or having more than five contractions in a ten-minute period.

Induced: To have labour artificially commenced.

Induction of labour: Artificial means to commence labour.

Instrumental birth: See assisted delivery.

Large for gestational age: A baby who has an estimated weight on ultrasound scan or is born with a weight which exceeds the usual weight expected for the baby's gestation.

Macrosomia: A new-born baby who weighs significantly more than the average.

Obstetrician: A doctor specialising in pregnancy and childbirth.

Perineal haematoma: Localised bleeding between the anus and vagina on the perineum that causes swelling and pain.

Pessary: Medication inserted into the vagina to induce labour.

Polycystic ovaries: A hormone imbalance resulting in irregular periods, weight gain, unwanted hair growth and acne.

Postnatal: The period after childbirth.

Post-partum haemorrhage: Excessive bleeding post birth of 500mls or more or any blood loss detrimental to the health of the woman.

Rhesus negative: Rhesus factor is an inherited protein found on the surface of red blood cells. When absent this protein is known as rhesus negative. Rhesus

disease can occur if a fetus is rhesus positive and the mother is rhesus negative. Prophylactic anti-D is offered in pregnancy to avoid this (also see anti-D).

Sepsis: A condition caused by the body's response to an infection.

Small for gestational age: A baby who has an estimated weight on ultrasound scan or is born with a weight which falls below the usual weight expected for the baby's gestation.

Staples: Metal surgical staples used to close surgical incisions.

Sweep: Pertaining to membrane sweep. A procedure where a finger is placed into the cervix and using a circular motion the membranes are separated from the cervix. Used to induce labour.

Syntocinon: A drug belonging to a group of drugs known as oxytocic drugs. It makes the muscles of the uterus contract and is used to induce and augment labour, to aid the birth of the placenta and to treat post-partum haemorrhage.

Thromboembolism: A blood clot that breaks away from one site within the body and travels to another part of the body, blocking a blood vessel.

Transverse (lie): the fetus is lying in a sideways position.

Ultrasound scan: A medical assessment of the fetus using high frequency sound ways.

Vaginal examination: An internal examination to assess the cervix and to assess the dilatation of the cervix.

Venous thromboembolism: A blood clot which has travelled via the circulation to the lungs.

Ventouse: A medical intervention to extract a baby from the birth canal by use of a vacuum.

Waterbirth: The birth of a baby in water.

CHAPTER 1

INTRODUCTION TO THE THESIS

1.0 Introduction

This thesis presents the findings of a longitudinal constructivist grounded theory study, underpinned by poststructuralist feminist epistemology. The central question of this thesis is: What are women's experiences of their maternity care when they present in pregnancy with a BMI of 35 kg/m² or above? The question arises in the context of practices that exist within maternity services and concerns whether women are active participants in, and are able to make informed decisions about, the care they receive. Central to this study therefore is choice, consent, and control.

This introductory chapter presents the aims of the study followed by the theoretical and methodological positioning. Following this choice, consent, and control and how this is positioned within the study will be presented. The historical origins of 'obesity'[1], 'obesity' as an embodied concept and maternal 'obesity' will then be introduced. How the thesis is situated, and the structure of the thesis will conclude this chapter.

1.1 Aims of the study

The aims of this study are concerned with understanding women's experiences of their management and care when they book with a BMI of 35 or above and how these experiences impact on choice, consent, and control. It will achieve this by:

[1] Throughout the thesis 'obesity' and 'obese' will be written in inverted comas to indicate the dilemma I have with using the word 'obesity' which comes from a biomedical stance. This is discussed later in this chapter.

- Collectively considering women's experiences of their management and care throughout the pregnancy continuum[2] when they book in pregnancy with a BMI of 35 or above

- Exploring women's experiences of choice, consent, and control throughout the pregnancy continuum when they book with a BMI of 35 kg/m² or above.

To address these aims, three original research components are presented. First, a meta-narrative review was undertaken, which shows how maternal 'obesity' discourses have evolved over time within and between disciplines in relation to choice, consent and control. Second, an empirical component using a longitudinal constructivist grounded theory approach underpinned by poststructural feminist epistemology was carried out. This study reports the experiences of eleven women who presented in pregnancy with a BMI of 35kg/m² or above[3] in relation to following a medical management plan of care. Third, a theoretical interpretation of the women's accounts, drawing on the work of three prominent 20th Century theorists, Simone De Beauvoir (1906-1986), Michel Foucault (1926-1984), and Erving Goffman (1922-1982), was undertaken, aiding development of a novel substantive grounded theory of 'multiple dimensions of self'. By fostering a deeper understanding of women's experiences throughout the pregnancy continuum, this thesis aims to contribute to midwifery, maternity, and feminist thought.

[2] for the purpose of this thesis pregnancy continuum refers to pregnancy, birth, and the early postnatal period.

[3] From here on in kg/m² will be omitted following BMI.

1.2 Theoretical and methodological positioning

The empirical element of this thesis is positioned through a poststructural feminist lens. Central to this is the concept of 'situated knowledges' coined by Donna Haraway (1988). She proposed that science is biased, its objective-realism coming from a 'view from above, from nowhere' (p.589), its universal position being aligned with white, heterosexual male privilege. Terming this 'the god trick', she suggests that it invalidates the position of others, denying them a voice and making assumptions that all opinions are equally weighted, arguing that knowledge production is viewed 'better from below' (p.583). By acknowledging individuals' situated knowledges, a better understanding of their world view can be obtained, providing more objectivity on difference and the challenges that may bring.

An alternative theory on knowledge production, coming from a political ontological rather than epistemological perspective, is subjugated knowledges (Foucault, 1980) and relates to situated knowledges. Foucault also valued 'the view from below' as opposed to above, arguing like Haraway (1988), against 'the god-trick'. Unlike Haraway however, Foucault does not consider gender in his approach. Foucault was not concerned as Haraway was with the methods adopted by scientific discourses within society, but rather the political power which controls and manipulates scientific discourse. He takes a historical approach to mapping the course of political discourses and the impact from below. Added to this, he proposed that subjugated knowledges are knowledges that are disregarded, and unworthy of consideration, citing that of the psychiatric patient as an example (Foucault, 1965). Both Haraway and Foucault theories draw attention to the views of minority, marginalised and oppressed groups.

In consideration of Haraway and Foucault, this study positions women as embodied and located knowers. By undertaking empirical research viewing the world of women who present in pregnancy with a BMI of 35 or above, the women's views are captured from below, providing an understanding of their perceptions of management and care.

A constructivist grounded theory approach following grounded theory principles proposed by Charmaz (2014) has been adopted for the empirical study within this thesis as it aligns with my own ontological and epistemological position of relativism and interpretivism. As an alternative to a positivist stance:

> *A constructivist approach places priority on the studied phenomenon and sees both data and analysis as created from shared experiences and relationships with participants and other sources of data*
> (Charmaz, 2014, p.239)

Using a longitudinal constructivist grounded theory approach the women's situated knowledge was gathered and analysed from early pregnancy to the early postnatal period in an attempt to understand their experiences in relation to choice, consent and control, generating new theory from the findings. Choice, consent, and control are defined below and situated in the context of this thesis.

1.3 What is meant by choice?

Promoting choice for women and their families has been high on the UK maternity agenda since the publication of Changing Childbirth (DoH,1993, p.6) which advocated choice and control as essential components of good quality care:

> *The woman should feel secure in the knowledge that she can make her choice after full discussion of all the issues with the professionals*

> *involved in her care. She should also feel confident that these professionals will respect her right to choose her care and ensure that the services provided are of the best possible quality.*

The notion of choice was revisited with the publication of Maternity Matters (DoH, 2007) which introduced four choice guarantees for women. These were: choice of access to maternity care; choice of type of antenatal care; choice of place of birth; and choice of postnatal care. The focus was on meeting individual needs, particularly for disadvantaged or vulnerable women, in order to improve equity of outcome and prevent avoidable deaths. More recently the *National Maternity Review, Better Births* (NHS England, 2016) has proposed that care throughout the pregnancy continuum should be woman-centred, with choice, consent and control being paramount. Drivers for change are on-going with Maternity Choice and Personalisation Pioneers being supported to develop ways of improving choice for women through personalised maternity care and the implementation of continuity of carer (CoC) for all women by 2023. At the time of writing, however, it is evident that the role out of continuity of carer has stalled due to the COVID- 19 pandemic, shortages of midwives, and safety concerns.

The *National Maternity Review, Better Births* (NHS England, 2016, p.32) found through engagement with women in England that:

> *Women want to be able to choose the care that is right for them, their families and their circumstances, and they want the care to wrap around them… women do not always feel like the choice is theirs and that too often they felt pressurised by their midwives and obstetricians to make choices that fitted their services.*

In response to this, recommendations made suggested that:

> *Women should be able to make decisions about their care during pregnancy, during birth and after the baby's birth…. They should feel supported to make well informed decisions….and their choices should be acted upon.*
> (NHS England, 2016, p.43)

Better Births stresses that choice 'is not a tick box exercise' but an ongoing process beginning at first contact and negotiated through evidence-based discussions throughout the pregnancy continuum. (NHS England, 2016, p.44). It is envisaged that continuity of carer should be promoted to help achieve this, with women building a meaningful relationship with health professionals, fostering a safer service with the woman at the centre of the care process.

As well as maternity specific publications, *Equity and Excellence: Liberating the NHS: No decision about me, without me* (DoH, 2010) set out the Government's vision of a health service putting patients first. Consultations were undertaken with the public on what choices they would like regarding health care and what support they wanted in order to make informed choices. Proposals were established with *Liberating the NHS: No decision about me, without me* becoming the vision for an inclusive health service (DoH, 2012). From this, *The NHS Choice Framework: What choices are available to me in the NHS?* (DoHSS, 2016) was published, setting out some of the choices available to health service users including choice about maternity services.

In implementing choice within maternity care, it is imperative that practitioners have the knowledge to educate and support women to enable them to make true informed choices in all aspects of their care. This is iterated in the documents discussed above and underpinned by the General Medical Council (GMC) (2013, 2020) guidance on consenting patients and decision making, as well as the Nursing and Midwifery Council (NMC), *The code* (NMC, 2018, p.6) which states:

> *Listen to people and respond to their preferences and concerns…. encourage and empower people to share in decisions about their treatment and care.*

It would appear given the clear guidance available for health professionals that there should be no issues in advocating choice for women. The reality however is more complex, influenced by the social and cultural context of both women's lives and maternity service provision (McAra-Couper, Jones and Smythe, 2011). It could be argued that choice in maternity care has been intrinsic to maternity policy now for over 25 years, therefore should be embedded in maternity practice and culture, yet it appears that consumer choice although evident in pursuing change, is at odds with the NHS in England which is under resourced and over stretched (House of Commons Committee of Public Accounts, 2014), making it difficult to envisage how the service women wish for can be realistically supported.

In terms of the social and cultural context of women's lives, women who have complex social needs and co-morbidities are more likely to have poor perinatal outcomes (knight et al., 2018, 2019). These women are more likely to be from disadvantaged backgrounds and often have less choice in maternity care due to reduced health literacy and access to resources (Cardwell and Wainwright, 2019; Carolan and Hodnett, 2007; Ebert et al., 2014,). McLeish and Redshaw (2019) suggest that disadvantaged women are less likely to engage in the decision-making process due to lack of confidence and low self-esteem, with Stapleton et al. (2004) suggesting that women are positioned socially by health professionals who dictate care based on social group as opposed to individualised need. This is particularly relevant to those women who present in pregnancy living with 'obesity'. It is well documented that low socio-economic status is associated with 'obesity' (Booth et al., 2017; Hoebel et al., 2019; Mayor, 2017), as well as maternal 'obesity' being associated with increased

mortality and morbidity both for their mother and her baby (Lee et al., 2015; Huo et al., 2021).

Ellis (2004) argues that inappropriate care is more likely if women are not involved in the decision making as health professionals' own beliefs are imposed, with Thompson and Miller (2014), suggesting that professionals exert control by limiting choices for women anyway, withholding information to fit in with the service as opposed to women's individual needs and requests. It needs to be acknowledged however that for some women, handing over responsibility for their care to professional 'experts' is preferable (Edwards, 2008).

The ability to practise choice is also affected by maternity policy and practice and the belief that pregnancy and childbirth is 'risky' (Martin, 2007). In the pursuit of reducing risk, increased intervention and regulation further reduces choice for women (Jomeen, 2007; Walsh, 2009a). A culture that regulates pregnancy and birth also restricts choice through fear and women doubting their ability to birth (Martin, 2007). This is problematic for women who live with 'obesity' as the mere fact they have a high BMI deems them to be at risk of complications during pregnancy and birth (Denison et al., 2018). Dominant discourses exist, women encouraged to comply with increased surveillance and intervention in the interests of a safe outcome for both them and their baby (Jomeen, 2010). To go against medical advice risks mother blaming, and as Snowden et al. (2011, p.8) suggest, women are 'explicitly bound by the consequences of making the wrong choices' as the life of their baby is at stake.

In contrast to this, medicalisation is often seen as the 'norm' within Western maternity care systems (Downe, McCormick and Lawrence Beech, 2001) with some women not opposed to interventions that have been normalised over

time. An example of this is presented by Widlund et al. (2009), who state that most women accept that scanning in pregnancy is acceptable and an opportunity to see their baby. The authors argue that the clinical purpose of the scan as a screening tool has been lost with 90% of women in their study already knowing they would have the scan before any information was given and were happy with the choice they made. They suggest that this is an example of how choice and consent has been shaped by multiple influences including medical and social constructs.

1.4 What is meant by consent?

Informed consent is the process of health professionals and patients making decisions around treatment and care based on a shared understanding (DoH, 2009). This includes ensuring that the patient fully understands the treatment and care being offered so they are fully informed (General Medical Council, 2020). Obtaining informed consent is a fundamental principle in English law (Smith, 2018). Anyone over 18 years of age, who is deemed to have mental capacity by definition of the Mental Capacity Act 2005 is afforded this right and is free to make autonomous decisions about their care, including consent to or refusal of treatment. In Scottish law this principle applies from the age of 16 (Age of Legal Capacity (Scotland) Act, 1991). Article 8 of the Human Rights Act 1998 upholds the right to a private and family life, with a more recent test case Montgomery v Lanarkshire Health Board [2015] UKSC 11 (involving a pregnant woman who was deemed to have been withheld information which would have altered her birth choices and outcome if known) being influential in changing how health professionals gain consent. The Royal College of Obstetricians and Gynaecologists (2015) Clinical Governance Advice on gaining consent states:

> *Before seeking a woman's consent for a test, treatment, intervention, or operation, you should ensure that she is fully informed, understands*

> *the risks of receiving no treatment, as well as any reasonable or accepted alternative treatments.*
> (RCOG, 2015, p.2)

The Nursing and Midwifery Council (2018, p.7) are clear in reiterating this and supporting the importance of nurses, midwives and nursing associates gaining informed consent: 'Make sure that you get properly informed consent and document it before carrying out any action.'

Conversations for consent to clinical interventions in maternity care are often framed in a way which exaggerates risk, failing to acknowledge the opinions of women (Nicholls, et al., 2021). Routines of maternity care coupled with time constraints on health professionals and the fear of risk and litigation may impact on the information given to women, affecting their ability to give true informed consent, thus violating their human rights (Golden, 2018). Maternal 'obesity' which is deemed to be 'risky' is usually managed using a standardised approach within the UK (Denison et al., 2018), which may result in women being coerced to give consent, or consent to care of which they do not fully understand (Nicholls, et al., 2019).

1.5 What is meant by control?

Control during pregnancy and childbirth is multifaceted. Women's perceptions of control are constructed through their beliefs around pregnancy and childbirth and are often tied up in the belief that hospital is the safest place for birth (Barber, Rogers, and Marsh, 2007; Budin, 2013). Women who have felt in control of the birthing process speak of being empowered and report increased satisfaction in terms of birthing experience and quality of maternity care, with women who have had no control over their birthing experience feeling disempowered, reporting dissatisfaction and a negative birthing experience (Martin and Jomeen, 2004). Coercion and control exerted by health

professionals may also erode control for women, with evidence to suggest that how health professionals perceive birth, through either a medical or social model of care, has a direct impact on the options made available to women as well as hospital protocols and policies restricting options (Cook and Loomis, 2012).

Other aspects of control relate to women having control over their bodies. It is well documented in the literature that pregnancy and childbirth is a time where women's bodies are seen to be uncontrollable (Davis-Floyd, 1994; Lupton and Schmied; 2013). Pregnant and birthing women's bodies leak, are emotional and are at risk of outward, public displays of breaking down, thus rendering them as out of control (Longhurst, 2000). Added to this, woman who live with 'obesity' are deemed to be unable to conform to societal expectations of what constitutes an acceptable body size and therefore their bodies are also viewed as being out of control (Lupton, 2013a).

It is evident that choice, consent, and control during the pregnancy continuum is situated in a social, cultural and medical context. Choice is limited through maternity policies, procedures, available resources, and the medicalisation of childbirth. It has been extensively debated in the literature, particularly in relation to choice of place of birth (Coxon et al., 2012; Hinton et al., 2018; Hollowell et al., 2015), mode of birth (Loke, Davies and Mak, 2019), and birth practices such as induction of labour (Harkness et al., 2021; Jay, Thomas and Brooks, 2018) and pain relief (Hughes, 2016; Lally et al., 2014). It appears, however, that there are no studies examining exclusively these phenomena in relation to maternal 'obesity' (see Chapter 3, Meta-narrative review, p.49). With the increase in the prevalence of maternal 'obesity' and associated complications and a risk managed approach to care, it is important that women's experiences in relation to choice, consent and control are explored in

order to inform current maternity care practices, providing justification for this study.

In order to add further context to the study, consideration of how 'obesity' as a concept is discussed below. How 'obesity' and maternal 'obesity' have evolved over time and become a condition to be managed is presented with further justification for this study.

1.6 'Obesity' as a historical, culturally contingent, and embodied concept

The World Health Organisation (WHO) (2019) defines 'obesity' as a medical condition where an excess of adipose tissue (fat) accumulates in the body that increases the risk of ill-health. Adipose exists in all human bodies. Classification of adipose in excess is historically and culturally contingent, and widely contested (Evans, 2004). Seen as a modern day 'pandemic', dominant knowledges at a political level have medicalised 'obesity', through the introduction of policy and practice to 'treat' the 'condition', with 'obesity' discourses making a value judgment based on body size (Evans, 2006).

From a historical perspective, 'obesity' has been depicted through art since early civilisation, with the 35,000 - 40,000-year-old female statuette 'The Venus of Hohle Fels' being recognised as one of the earliest examples of figurine sculpture (Haslam, 2015). Multiple Venus figurines have since been uncovered, particularly throughout Europe. Although it is not known what their significance was, they are thought to be ritualistic, linked to celebrating and worshipping fertility and childbearing. Over time however, 'obesity' has become a form to be damned. Early Christian references in The Bible for example, although not directly calling out 'obesity', denounces overindulgence, with greed and gluttony being two of the deadly sins (Buchwald, 2018).

The construct of the 'obese' body has been both desired and vilified. Multiple examples reflect this, from the paintings of the Flemish painter Ruben who depicted the 'obese' female body as a thing of beauty (Sweet, 2014) to 'obesity' being viewed as a sign of wealth when famine was commonplace (Ferris and Crowther, 2011). These are all positive traits associated with being 'obese'. In contrast, Shakespeare's Falstaff, seen as lazy, frail and a 'glutton' who was a 'harbinger of diseases' suggests that 'obesity' is also associated with negativity, with certain personality traits attributed to the 'obese' body (Buchwald and Knatterud, 2000, p.403-404): 'Thou seest I have more flesh than another man, and therefore more frailty'. (Wells and Taylor, 1987, Henry the IV Part I, 3.3.167-169). Falstaff's traits are still projected onto individuals who are deemed to be 'obese' today, with societal influences perpetuating the falsehood that all individuals living with 'obesity' are lazy, weak, lack willpower and are a drain on society (Karsay and Schmuck, 2017).

The word 'obesity' can be traced back to the seventeenth century, originating from the Latin *obēsus*, literally translating as 'to eat away' (Barnett, 2017). Historically, 'obesity' was a derogatory term. It is interesting to note that it was regarded as a medical problem as far back as 400 B.C. by the ancient Greeks, with Hippocrates himself linking food consumption to energy expenditure (Haslam, 2007; Haslam and Rigby, 2010) and 'obesity' to premature and sudden death (Chadwick and Mann, 1950). Hippocrates suggested that diet and exercise was conducive to good health:

> … if we could give every individual the right amount of nourishment and exercise, not too little, and not too much, we would have found the safest way to health.
> (Cited by Michels, 2003, p.486).

The word 'obesity' was adopted by medicine in the twentieth century and is now a word which is commonplace describing individuals with an excessive

accumulation of body fat which may or may not have a detrimental effect on health and well-being (Krishnamoorthy et al., 2006; WHO, 2019).

Modern day social representations of the 'obese' body are associated with lack of motivation, lack of self-control, laziness and shame and blame (LeBesco, 2001; Bordo, 2003; Lupton, 2013a). Bordo (2003) suggests that the 'obese' body has through social constructs become a representation of morality (or immorality) and ill-health, with 'obese' bodies being regulated and pushed to conform to social ideals. From a medical perspective 'obesity' is generally said to occur if there is an excess of energy intake in relation to energy expenditure, which follows a Cartesian mind/body dualism approach which views the mind as separate from the body (Thibaut, 2018). In taking this scientific objective approach there is a failure to acknowledge how 'obese' bodies experience the world around them, or the lived experience that leads to excess weight gain in the first place (Ueland et al., 2019). Added to this the 'obese' female body is also subjected to female embodiment whereby cultural, societal, and political concepts are projected on them which are gendered, subjecting them to subordination and objectification (Chrisler and Johnston-Robledo, 2018). The maternal 'obese' body is viewed as problematic with research and subsequent policy predominantly obstetric focused, striving to reduce risk (Chu et al., 2007; Denison et al., 2018; Kristensen, 2005; Norman, 2011; O'Brian et al., 2003; Sebire et al., 2001). Consideration of the biopsychosocial health model that moves beyond the physical and the 'eat less, move more', risk-reducing mantra popularised through medical discourses is lacking, with 'obesity' remaining a culturally contingent and embodied concept.

1.7 Classification of 'obesity'

In determining 'obesity' the body mass index (BMI) is commonly used (Townsend and Scriven, 2014) and is recommended for use in maternity care in

the United Kingdom (UK), with BMI measurements being undertaken on first contact (usually the 'booking' appointment) with pregnant women (National Institute for Health and Care Excellence (NICE), 2010). BMI is calculated as weight (Kilograms) divided by the square of the height (metres) and is classified using the World Health Organisation (WHO) BMI classifications that are based on the relationship between BMI and mortality (WHO, 2004). Table 1 highlights the principal cut off points of the international classification of adult weight using BMI.

Table 1. Principal cut off points of the international classification of adult weight using BMI (adapted from WHO, 2004). At: http://www.euro.who.int/en/health-topics/disease-prevention/nutrition/a-healthy-lifestyle/body-mass-index-bmi [Accessed 18 August 2021]

Definition	BMI range (kg/m²)
Underweight	Under 18.5
Normal	18.5-leass than 25
Overweight	25 to less than 30
Obese (class 1)	30 to less 35
Obesity (class 2)	35 to less than 40
Obesity (class 3)	40 or over

1.8 'Obesity' as disease

It has been stated by the World Obesity Federation that 'obesity' is a chronic disease, following an epidemiological model with food being the pathological factor (Bray, Kim and Wilding, 2017). 'Obesity' as pathological is widely debated (Kyle, Dhurandhar and Allison, 2016), with 'obesity' being classified as a complex health condition with multiple factors contributing to it which is often outside of an individual's control (Vandenbroeck, Goossens and Clemens, 2007). It is accepted that 'obesity' predisposes people to multiple conditions including cancer, diabetes, and circulatory problems (Schrecker and Bambra,

2015; Townsend and Scriven, 2014; World Health Organization, 2019). Controversially, however, it has been argued that not all people living with 'obesity' develop ill health and have no other associated risk factors (Wildman et al., 2008). Although research suggests that half may develop 'obesity' associated conditions over their lifetime (Kramer, Zinman and Retnakaran, 2013). This is reflected in maternity care, where although there is a wealth of evidence to suggest 'obesity' is associated with maternal and fetal complications there are some studies that dispute this (Rowe, Knight and Kurinczuk, 2018; Hollowell et al., 2014). Some women have no risk factors other than being 'obese' and for these women care is not individualised, subjecting them to increased surveillance and medical intervention (Rowe, 2018). Cheek (2008) considers this as the 'what if approach to health' as opposed to 'what is' (cited by Tischer, 2013, p.6). Rendering 'obesity' as a disease suggests that to be 'fat' is to be unhealthy and therefore to be 'thin' is desirable and an indicator of wellness (which is not necessarily the case), with 'obesity' a problem to be treated and cured through self-regulation (Tischer, 2013). This suggests that physical health can only be achieved if you are thin and fit into the defined medical parameters of BMI (Lawrence and Kopelman, 2004).

1.9 Maternal 'obesity': The growing medical problem

'Obesity' (BMI of 30 or above) is described throughout the literature as a global 'epidemic' which raises significant concerns in relation to the health and wellbeing of populations as well as subsequent health care provision (Royal College of Physicians, 2013; Brewer, 2017). 'Obesity' is cited as a major risk to health throughout the pregnancy continuum (Edwards and Wright, 2020; Kerrigan and Kingdon, 2010, 2015; Wuntakal and Hollingworth, 2009).

Evidence suggests that 'obese' pregnant women are at an increased risk of pregnancy and birth complications than those of 'normal'[4] weight (Denison et al., 2018). Increased morbidity and mortality of both mother and infant is well documented, with 34% (n=71) of maternal deaths between 2015-2017 in the UK and Ireland being women with a BMI of 30 or above (Knight et al., 2019). From a maternal perspective, women with a higher BMI are at an increased risk of post-partum haemorrhage, wound infection (Myles, Gooch and Santolaya, 2002; Tipton, Cohen and Chelmov, 2011) and venous thrombolytic embolism (Morgan et al., 2012), with conditions such as gestational diabetes, pre-eclampsia and eclampsia also more prevalent (O'Brian et al., 2003; Sebrie et al., 2001), affecting both the woman and her baby. Risk of miscarriage, pre-term birth and stillbirth have also been reported to be increased, with stillbirth cited as being twice as likely for women who are 'obese' (Denison et al., 2018). An increased risk of neural tube defects in the fetus (Shaw, Velie, Schaffer, 1996), and abnormal fetal growth (Leddy, Power and Schulkin, 2008) is also associated with maternal 'obesity', with the long-term health of babies found to be compromised. This notably includes an increased risk of heart disease and type 2 diabetes, as well as being more likely to be 'obese', increasing the risk of associated conditions across the life course (Hong and Chung, 2018; Leddy, Power and Schulkin, 2008). In the light of this women who present as 'obese' in pregnancy are considered at 'high risk'[5] of complications and are managed accordingly.

1.10 Maternal 'obesity': A medical problem needing to be managed

With increasing research considering mortality and morbidity impact on

[4]The word normal is inserted in inverted commas throughout the thesis to indicate that normal is derived from the medical definition of what it is to be identified as 'normal'.

[5] For the purpose of this thesis 'high risk' is defined as a pregnancy deemed to put the mother and the fetus/baby at risk of increased morbidity or mortality. I propose that 'high risk' is a contentious term which seeks to discipline and 'normalise' members of society through increased surveillance. It assumes a high BMI equates to poor health which may not be the case for all women. It is therefore written throughout this thesis in inverted commas.

maternal ‘obesity’, management care pathways have been developed to manage the risks in the UK (Denison et al., 2018). Women who present in pregnancy with a BMI of 30 or above are considered to have maternal ‘obesity’ and are managed based on the CMACE/RCOG *Management of Women with Obesity in Pregnancy* (2010) joint guideline and RCOG Green-top Guideline 72*: Care of Women with Obesity in Pregnancy* (Denison et al., 2018). Management varies according to BMI range with women with a higher BMI receiving extra screening intervention and pregnancy care. On top of this local trust guidelines vary in their management with cut off BMI ranges for certain aspects of care such as labouring and birthing in water and homebirth. These guidelines promote the medical management of maternal ‘obesity’, with BMI remaining the standard classification for identification of maternal ‘obesity’ despite its identified flaws and questionability regarding validity (Albers et al., 2006; Depres, Lemieux and Prud’homme, 2001). Added to this there are no agreed definitions of what constitutes weight related risk in pregnancy in the UK, with no defined BMI categories for pregnancy which are evidenced based (Heslehurst, 2011). It is also argued that BMI alone is not a good predictor of risk. BMI, parity and gestational weight gain collectively have been found to provide a better indication of risk (Magann et al., 2011; Yang et al., 2017), with high gestational weight gain being associated with the highest risk of complications (Santos, et al., 2019). Excessive weight gain in pregnancy may therefore be more prevalent as an indicator of risk than pre-pregnancy weight (Durie, Thornburg and Glantz, 2011; Knight- Argawel et al., 2016b; Ramachenderan et al., 2008). There also appears to be some indication that maternal ‘obesity’, as a sole risk factor may not negatively influence the pregnancy continuum nor is risk the same for all women living with ‘obesity’ (Hollowell et al., 2014 2015).

In spite of this, maternal BMI recorded at the booking appointment[6] is still used as the main predictor for risk. This negates to account for women who book with a 'normal' BMI and subsequently have excessive weight gain in pregnancy. These guidelines also limit choice for women and assumes all women with a BMI over 30 at booking are at a higher risk of pregnancy complications. This blanket approach to care fails to consider the variations in the health status of women living with 'obesity' taking a one-size-fits-all medical approach.

Not all women who present in pregnancy as 'obese' will go on to develop complications, with evidence to suggest that multiparous women for example, whose only risk factor is a high BMI, may have a lower intrapartum risk than previous research suggests (Hollowell et al., 2014). It also could be argued that women with a high BMI are more likely to have complications throughout the pregnancy continuum by virtue of being medically manged (Cudd, 2006; Davis, 2013; Goer, 1995; 'O Dwyer et al., 2012). It is difficult to establish however if maternal 'obesity' which predisposes women to complications is the cause of increased medical intervention or if increased medical intervention by virtue of being 'obese' leads to a cascade of further interventions.

It is argued that the technocratic approach to maternity care (Davis- Floyd, 1992; 1994; 2001), which is concerned with outcomes in relation to mortality and morbidity rates only, has generated a culture which is fetus-centric (Rothman, 2001). Edmunds (2005) argues how a medical approach to maternal 'obesity' fails to consider the social and political constructs that exist or the experiences of women who are 'labelled' as 'obese'. It needs to be acknowledged that 'fatness' is embedded in social, cultural and political discourses and cannot be considered in isolation (Tischner and Malson, 2011).

[6] Booking appointment refers to the first appointment women have with maternity services, ideally undertaken before 10 weeks of pregnancy.

However, it is equally important to emphasise that some women desire a medical approach to care and that such care practices (for 'high risk' women) can lead to improvements in morbidity and mortality (Christiaens and Bracke, 2009; Green and Baston, 2007). This view highlights how medicalisation both shapes and conflicts with women's experiences of pregnancy and childbirth (Christiaens, Nieuwenhuijze and De Vires, 2013). This is particularly relevant for women living with 'obesity' who are by virtue of their weight, and the risks associated with weight and pregnancy subjected to increased medicalisation (Denison et al., 2018).

Early theorists have much to say about the rise of medicalisation, which first appeared as a concept in the 1970s (Conrad, 1975; Illich, 1975; Zola, 1972). Defined as something that has been made medical, it has come to be associated with the move to define human behaviour as a problem or condition that needs to be treated by the medical profession, with previously non-medical issues being medically defined (Conrad, 1975). This has led to medicine having social control and power over the masses. This control is defined by Foucault (1973, 1977) as the 'medical gaze', giving medicine legitimacy to intervene, treat and scrutinise, which Conrad (1992) asserts has been most notable within childbirth and the rise of obstetrics. Medicalisation and more recently biomedicalisation are therefore important concepts to consider when examining maternal 'obesity' and these are further conceptualised in Chapter 2.

As a society, reducing risk has become the 'norm', within all areas of life. With advancements in health care and the rise of medicalisation, reducing risk to improve and maintain optimum health has become paramount (Conrad, 1992). Women living with 'obesity' who present in pregnancy are deemed 'high risk' and therefore need to be managed through risk assessment (Denison et al.,

2018). However, it could be argued that actual risk is rarely discussed, and therefore informed choice is lacking (Hull et al., 2011). This erodes women's autonomy, with health professionals controlling care and offering limited choice (Jomeen, 2010). In order to provide appropriate care that meets the needs of these women during the pregnancy continuum, it is imperative that women's experiences are therefore examined, of which this study aims to explore.

1.11 Why do the experiences of women living with 'obesity' matter?

There is a plethora of research related to clinical complications and outcomes for women who are 'obese' and their babies, yet research into women's experiences is lacking (Heslehurst et al., 2015). Listening to women's stories is invaluable for maternity service development, with UK government policy promoting user involvement in all aspects of care (NHS England, 2014; NHS England, 2016). The care women receive during pregnancy and childbirth influences future interactions with health providers for themselves and their family as well as the mother/child relationship (Hopopainen et al., 2020; Mannava et al., 2015). It is therefore vital that women's voices are heard to inform maternity care provision. This thesis therefore aims to consider women's experiences in order to add to the body of knowledge that currently exists.

1.12 Maternal 'obesity': the embodiment of a burgeoning feminist issue

There is a substantial body of feminist theorising on the medicalisation of pregnancy and childbirth, reproductive technologies, fertility and reproductive freedom (Bartky, 1990; Bryson, 1999; Davis- Floyd, 1994; Donnison, 1988; Gilligan, 1982; LeBesco, 2004; Oakley, 1979, 1980, 1984, 2016; Rothman, 1989), as well as the nature of women's embodiment and fat studies (Lupton, 2013a; Orbach, 2006; Pausé, 2020; Tischer, 2013). There is less feminist literature in

relation to maternal 'obesity', although it appears to be gaining momentum in line with the rise in 'obesity' globally (Lee, 2020; Parker, 2014; 2017; Parker and Pausé, 2018) (see also Chapter 3, Meta-narrative review, p.49). There have also been recent attempts to engage health professionals in understanding women's experiences (Smith, Cooke and Lavender, 2012; Ward and McPhail, 2019). What is lacking in the feminist literature on women's experiences of maternal 'obesity' is a thorough understanding of how choice, consent, and control impacts on experience.

It is well documented that the medicalisation of childbirth offers an illusion of choice, with only endorsed options of choice available (Crossley, 2007; Jomeen, 2012; Yuill et al., 2020). Choice is also a double-edged sword for feminists; there are those who advocate the 'natural' childbirth discourse, rejecting gendered medical dominance (Brubaker and Dillaway, 2009; Kitzinger, 2005; Oakley, 1984, 1986; Tew, 1998) and others who have highlighted the benefits of technological advancements, arguing these have freed women from the pain and suffering of childbirth as well as offering choice in reproduction (Annandale and Clark, 1996; Beckett, 2005; Tong, 1998). Informed consent can only be granted if choice is advocated, yet information giving is often more focused on clinical risk, injecting fear, and subsequent cohesion (Nicholls et al., 2021), with health professionals maintaining control and power over pregnancy and birth (Newnham, 2014). This is despite maternity policy advocating choice (see 1.3 above). How choice, consent and control intersect with maternal 'obesity' management and care and the impact on women's experiences is therefore worthy of exploration.

1.13 What's in a word?

In situating this thesis, I felt it was important to explore the language used when discussing 'obesity'. Puhl, Peterson and Luedicke (2013) in considering

the public perceptions of the language used by health professionals in relation to weight found that words such as 'weight' or 'unhealthy weight' were more acceptable than 'obese', 'morbidly obese' and 'fat' (p. 615). This was regardless of the demographics of those asked. Other research supports this, with the words 'obese' and 'fat' being the least acceptable (Auckburally, Davies and Logue, 2021; Dutton et al., 2010; Glenister et al., 2018; Lydecker et al., 2016; Sonneville et al., 2019; Volger et al., 2012). The National Institute for Health and Care Excellence (NICE) (2016) advise that health professionals should use language which is sensitive yet use the word 'obese' in their own guidelines (NICE, 2010). It could be argued therefore, that NICE have neglected to recognise the psychological ramifications of the 'obesity' label that the word provokes (Lozano-Sufrateui, Sparkes and McKenna, 2016). Added to this, organisations that advocate for sensitive use of language such as the World Obesity Federation and Obesity Action Coalition, continue to use 'obesity' in their titles. They accept, however, that the word 'obesity' is contentious and is often used in a derogatory way to shame and stigmatise, arguing that the word should be reclaimed and recognised as the complex disease it is.

Vartanian (2010) proposes that the word 'fat' is a more acceptable term, with fat activists suggesting that 'fat' is a neutral word which many have reclaimed (Saguy and Ward, 2011). Yet the word 'fat' is not judgment free either (Auckburally, Davies and Logue, 2021; Dutton et al., 2010; Glenister et al., 2018; Lydecker et al., 2016; Meadows and Daníelsdóttir, 2016; Puhl, Peterson and Luedicke, 2013; Sonneville et al., 2019, Volger, 2012). In fact, Dutton et al (2010) and Volger et al., (2012) found the word 'fat' to be the least acceptable. This poses a dilemma for those concerned with weight in what is acceptable language to use as it could be argued that all weight related language is valued ladened through social construction (Meadows and Daníelsdóttir, 2016).

Personally, I prefer the word ‘fat’, as ‘fat’ means excess adipose tissue of which I have plenty. Although considered overweight with a BMI of 28 at the beginning of my PhD journey and ‘obese’ by the end (my PhD being directly linked to my now BMI of 30) I identify as being a ‘fat lass’, having embarked on years of dieting and subsequent weight gain. I concur with Lupton (2013a) and Saguy and Ward (2011) who suggest that ‘fat’ is a descriptive word as opposed to ‘obese’ which has medical connotations, suggesting that to be ‘fat’ is to be diseased. I may be ‘fat’, but I do not consider myself diseased, so for me the word ‘obese’ is derogatory. I acknowledge this is not the only view and this has left me with a dilemma of what term to use throughout this thesis. When applying for ethics approval to undertake the empirical study for this thesis I used the word ‘fat’ in my application and as a condition for approval from the NHS Ethics Committee I was asked to remove the word as they felt it was a derogatory term. In response to this, I asked my larger friends and family how they perceived themselves, and interestingly most identified as ‘fat’. They talked of going to ‘fat club’ and ‘fat class’ in the pursuit of weight loss but did not consider themselves as being diseased or their weight as a medical condition. In hindsight, it would have been appropriate to gain further public opinion through engaging with women’s groups such as Maternity Voices Partnerships as well as pregnant women. At the time, however, I was early in my PhD journey and had not sought ethics approval to support this line of enquiry.

In further consideration of the language used throughout this thesis the World Obesity Federation (no date), advocates caution when writing about people with ‘obesity’, highlighting the importance of using first-person language. This is supported by the Obesity Action Coalition (2022) who state that although now widely used to describe other chronic diseases, e.g., a person with diabetes as opposed to a diabetic person, the language used in referring to

people living with ‘obesity’ continues to stigmatise, e.g., continued use of an ‘obese’ person as opposed to a person living with ‘obesity’. Obesity UK, in their report: *Language Matters: Obesity* (2020) reiterate this, calling on health professionals to consider the language they use when caring for people living with ‘obesity’, providing guidance to avoid stigmatisation (Albury et al, 2020). It is argued, however, that the use of first-person language may increase stigmatisation (Meadows and Daníelsdóttir, 2016, p.1):

> *…the apparent need to separate a person from the characteristic in question implies an inherent adverse judgment…. the idea that we are all people but some of us are “burdened” with this millstone around our neck both denotes that only by fixing or removing this blight can we become like “everyone else,” and precludes that we can ever be “normal” in our current form.*

A dichotomy exists, therefore in the language to use throughout this thesis.

After further consideration of this and with the intent not to offend I have used the term ‘obesity’ and ‘obese’ throughout this thesis. As these words are used in maternity care settings and are the framework for BMI, I feel they are appropriate to use. These words, however, are concerned with the medicalisation of ‘fat’ and the biomedical discourses that exist for women during pregnancy and birth and do not sit comfortably with my feminist values and beliefs. Therefore (as stated earlier on page 1 of this chapter), I have written the words in inverted commas throughout to highlight this. I have also used first-person language throughout. I acknowledge, however, that whatever language I use I risk offending some readers and I apologise for this. Is it not my intention to offend and I have been mindful throughout of the language contained within this thesis.

1.14 Situating self

For the duration of the study, I kept a reflective journal to situate myself throughout, documenting my own lived experiences both from a position of being a PhD student, my experiences of working as a midwife and my own struggles with weight. I have shared some of the stories that have resonated with me on my PhD journey, and they are positioned throughout the work. Ongoing reflexivity has allowed me to consider my own prejudices and preconceived assumptions, helping to minimise my pre-understandings as I collected, analysed, and presented the data. The drive for undertaking this study was two-fold: experience of caring for women during the pregnancy continuum who clinically identified as being 'obese', and feminist values that stem from the strong matriarchal influences within my family.

In 2010, the Centre for Maternal and Child Health Enquiries (CMACE) and the Royal College of Obstetricians and Gynaecologists (RCOG) published *Management of Women with Obesity in Pregnancy*, acting on concerns highlighted in the 2004 and 2007 *Confidential Enquiry into Maternal and Child Health (CEMACH) Saving Mother's Lives* report (Lewis, 2004, 2007). At the time of the publication, I was working as a community midwife with seconded hours to move forward maternity services, following the Department of Health's (DoH) publication of *Maternity Matters* (DoH, 2007), which advocated woman focused, woman-centred care based on choice, access, and continuity of carer. I was asked as part of this role to lead on the development of trust guidelines for the management and care of maternal 'obesity'. Working with these guidelines saw me managing maternal 'obesity' in a prescriptive way, thinking that I was doing the best for women. Over time it became apparent that by treating all women living with 'obesity' the same I was not advocating choice, was unsure whether women truly understood the care offered, and began to question the imbalance of power in the woman-midwife relationship. Providing

care in this way continues despite UK Government policy promoting the notion of choice in childbirth for all women. (DoH, 1993; DoH, 2007; NHS England: Better Births, 2016). The importance of informed consent, with women being in control of their pregnancy and birth working in partnership with care providers is at the forefront of these policies, allegedly embedded throughout maternity services. I would argue that a dichotomy exists between policy and reality.

I grew up in a matriarchically household and was greatly influenced by my maternal grandmother and her two sisters. My mother was one of two daughters and having four female siblings our home was filled with strong, invincible women. Now having two daughters of my own my desire to ensure women's voices are heard is engrained in my being.

1.15 Situating the thesis

Following consideration of the context surrounding maternal 'obesity' and the drive to undertake this study from a personal and professional perspective, a longitudinal study using constructivist grounded theory methodology was designed, through a poststructural feminist lens. This enabled the exploration of the spoken, unspoken and actions of the women recruited who presented in pregnancy with a booking BMI of 35 or above. From this, a deeper understanding of how 'obesity' affects women's pregnancy and childbirth experiences was fostered.

1.16 Structure of the thesis

This thesis comprises of eleven chapters. An overview of each chapter is presented below:

Chapter 2 presents feminist thought, medicalisation, biomedicalisation and the embodiment of self during pregnancy and childbirth in relation to choice,

consent and control. It provides a historical examination of how medicine has evolved and how this intersects with feminist thinking and embodiment across time.

Chapter 3 presents the first component of the thesis, examining the existing literature using meta-narrative review. It examines how different research traditions over time have studied maternal 'obesity' in relation to choice, control and consent. This chapter forms the framework for the study to inform the empirical work.

Chapter 4 presents the theoretical and philosophical underpinnings of the study. Constructivist grounded theory methodology is presented with a justification for its selection. The methods used for undertaking the empirical work are discussed in Chapter 5. This chapter describes the study design, how the study was undertaken, detailing how participants were recruited, methods of data collection and ethical considerations. Further justification for the methodology is also presented.

The introduction to the participants of the study is presented in Chapter 6. Chapter 7 presents the findings of the study. The following two chapters, 8 and 9, present and build on the findings to offer a theoretical interpretation of the data in relation to women's experiences. Chapter 9 also presents my substantive constructed grounded theory of 'multiple dimensions of self' as well as a discussion of the wider literature.

Chapter 10 presents an evaluation of the study using Charmaz's (2014) criteria of credibility, originality, resonance, and usefulness. A narrative of the study's original contribution is also presented to support this. The strengths and limitations of the study are discussed and recommendations for policy, practice

and education is presented with recommendations for further research. Chapter 11 concludes the thesis with a reflexive account of my own positioning and my PhD journey.

1.17 Conclusion

Chapter 1 has presented an overview of the content of the thesis, considering the aims of the study and the theoretical and methodological positioning has been introduced. Choice, Consent and Control have been introduced with definitions and consideration of how these impact on pregnancy and childbirth discussed, supporting the justification for the thesis. The historical context of 'obesity' is given, and prevalence discussed. How 'obesity' has evolved into a disease to be medically managed has been explored. Chapter 2 provides an overview of the feminist theoretical landscape of which my study is positioned. Feminist concepts of choice, consent, and control as well as feminist thought on medicalisation, embodiment and self are presented.

CHAPTER 2

FEMINIST THOUGHT, MEDICALISATION, BIOMEDICALISATION AND THE EMBODIMENT OF SELF DURING PREGNANCY AND CHILDBIRTH

> *The medicalisation of childbirth has changed the subjective experience of reproduction altogether, making dependence on others instead of dependence on self a condition of the achievement of motherhood.*
>
> Oakley, *Women Confined* (1980, p.98)

2.0 Introduction

The previous chapter introduced the thesis and offered a background. Choice, consent, and control as key elements underpinning UK maternity care policy for over 30 years were presented. The purpose of this chapter is to introduce feminist engagement with the concepts of choice, consent, and control. It draws on feminist conceptualisations of medicalisation, biomedicalisation, embodiment and self to provide an overview of the contemporary feminist theoretical landscape into which my thesis and empirical investigation is positioned.

2.1 Background

Medical dominance and the medicalisation of pregnancy and childbirth has been exacerbated with the move from home birth to hospital birth. In the twentieth century medicine began to standardise 'normal' labour and birth in line with other medical practices. This resulted in childbirth becoming increasingly managed and interventions instigated when progress fell out of the standardised 'norms' (Donnison, 1988). In the UK, with the birth of the National Health Service in 1948 giving free access to health care, increasing medical beliefs around risk and safety and the prospect of being cared for in a new state of the art hospital setting paved the way for the move to birthing in hospital (Davis, 2013). In 1959 the Cranbrook Report (Ministry of Health, 1959)

recommended that there should be enough beds for 70% of births to take place in hospital, with the Peel Report (Department of Health and Social Services, 1970) offering beds for all births regardless of health risk, setting the agenda for the development of maternity care in the UK. Some authors argue that this resulted in a subsequent move from a social model of care to a pathogenic, medical model of care[7] (Macintyre, 1977; Oakley, 2016). The move to birthing in hospital allowed medical professionals to argue that the safest place to birth is in a hospital setting, with an increase in medical interventions becoming routine practice (Cahill, 2000; Oakley, 1984).

Parallel to this, the feminist landscape was divided, with medicalisation being both a concern for feminists[8] but also liberating. Second wave feminists argue that the medicalisation of childbirth has led to women losing control over their birthing experience, with women's bodies reduced to machines and birth being deemed 'risky' (Reissman, 1983). They suggest birth is a natural phenomenon with medicalisation increasing harm and persuading women that childbirth is a pathological process needing medical intervention (Vasquez, 2012). In contrast to this, third wave feminists oppose 'natural' childbirth, suggesting more harm occurs when women are unable to meet the birthing ideal (Annandale and Clark, 1996). They propose this adds pressure on women defining them by their 'reproductive capability' (Vasquez, 2012, p.8).

[7] Two differing models of maternity care exist. The medical model views pregnancy and childbirth as being a 'risky' event that needs medically managed and controlled to ensure safety. The social model views pregnancy and childbirth as a normal pathological event (Teijlingen, 2005).

[8] First wave feminism- Modern feminism from the 19th century onwards began (in Western society at least) with what is now termed first wave feminism and was interested with women's rights and equality.
Second wave feminism- Following the right to vote, women took up the struggle of women in relation to economics, sexuality, and reproduction with the rise of second wave feminism emerging following World War Two.
Third wave feminism- Concerned with individualism and diversity. Emerging in the 1990's, third wave feminism has been informed by a new generation of women, embracing womanhood, and taking back control of their bodies and celebrating difference through transversal politics (Snyder,2008)

A notable example of feminism's opposing views on childbirth is access to pain relief during labour. From the early twentieth century first wave feminists fought to control their birthing experience through medical intervention for a pain free birth (Skowronski, 2015). By the 1960's, however, second wave feminists were rejecting access to pain relief, campaigning for a return to 'natural' childbirth, suggesting women had become disengaged from the birthing process through the increased use of pharmacological analgesics (Unmansky, 1996). More recently third wave feminists have called for women to be able to choose a birth free from pain, embracing technoscience and rejecting the 'natural' birth stance as compounding the traditional stereotypical discourses associated with what it means to be female (Beckett, 2005). They seek to centre women's choice as a feminist issue, viewing the medicalisation of childbirth and pain relief in particular as both having positive and negative attributes (Skowronski, 2015).

Changing Childbirth (1993) centred choice, consent, and control as central tenets in women's birth experience was a combination of government sponsored research by the National Perinatal Epidemiology Unit (NPEU) and the lobbying of (mainly) women, namely the National Childbirth Trust (NCT), Royal College of Midwives (RCM) and the Association for Improvements in Maternity Services (AIMS). *Changing Childbirth* was the first-time choice, consent and control for women was given consideration with regards to maternity policy and practice. More recent policy responses, *Maternity Matters* (2007) and *Better Births* (2016), have continued to promote choice, with the latter suggesting that continuity of carer is fundamental in reducing risk and empowering women, keeping choice, consent, and control firmly in the minds of policy makers (NHS England and NHS Improvement, 2021).

A consequence of policies to promote choice for women, however, has led to an increase in risk assessment criteria that control who is suitable. Following the implementation of *Changing Childbirth*, Campbell and Porter (1997, p.351) argued that patriarchal medical models of care still dominate, with women continuing to birth under the influence of obstetric control:

> *One practical consequence of this* [Changing Childbirth] *has been the drawing up of long, detailed lists of selection or risk assessment criteria. The application of these ensures that birth outside a consultant obstetric unit is restricted to those women deemed to be very unlikely to develop complications during pregnancy or labour (even though there appears to be little scientific evidence that these criteria actually predict this accurately), and women who are prepared to exert choice, in spite of an adverse risk assessment (Campbell, unpublished paper). Thus, a policy designed to increase women's autonomy, which did not find favour with the medical establishment (British Medical Association 1993, Royal College of Obstetricians and Gynaecologists 1993), has been substantially diluted when implemented locally.*

Henderson and Redshaw (2017) to some extent concur, arguing continuing rates of intervention and medicalisation of childbirth have actually reduced choice for women. They suggest however that since *Changing Childbirth* many more women are presenting in pregnancy with more complex social and medical needs, with the social structure within the UK becoming more diverse adding to this. Maternal 'obesity' is viewed as 'risky' therefore managing risk to reduce mortality and morbidity is paramount (Denison et al., 2018). This raises the question, however, of whether women are afforded true autonomy or if the obstetrician as the 'expert' reinforces the control medicine has over the masses and an expectation for women to conform (Dahlen, 2017). It is argued that choice remains an illusion with women limited in the choices they can make regarding their maternity care due to how those choices are presented by health professionals (Jomeen, 2012; Mobbs, Williams and Weeks, 2018; Yuill et

al., 2020), who gain control through exaggerating risk (DeVries, 1992). Lothian (2012, p.46) concurs stating:

> *Where there is limited risk, it can be "created" by redefining ordinary life events as risky and emphasizing whatever risk exists. The medical model of birth encourages women to see birth as inherently risky for mother and baby.*

The medical model of care therefore controls the birth experience by presenting birth as 'risky' when in fact many women would birth with minimal intervention (Einion, 2018).

In considering maternal 'obesity' and risk, follow on studies from the Birthplace National Cohort Study (Birthplace in England Collaborative Group, 2011) compared 17,230 women and how their BMI impacted on interventions and complications during labour (Hollowell et al., 2014, 2015). The findings suggested that although 'obesity' is associated with increased risks to both the mother and her baby, the risks were not the same for all women living with 'obesity'. Women whose only risk factor was their 'obesity' who had had a previous baby were found to have a lower risk of complications than previously thought. Other studies also suggest that maternal 'obesity' is not necessarily an independent risk factor for maternal or fetal complications, including large for dates babies and preeclampsia complications (Hirshberg et al., 2017; Ott et al., 2018). This raises the question of why a blanket approach to maternal 'obesity' management and care is prevalent within the UK (Mills, Schmied and Dahlen, 2013), with 'obesity' medicalised and medical interventions routine. In answering this, consideration of how pregnancy and childbirth has become medicalised warrants further discussion and is therefore presented below.

2.2 Medicalisation

Medicalisation theories abound (Zola, 1972; Illich, 1975; Conrad, 2005) but of particular relevance to this thesis is that proposed by Clarke et al., (2010, p.47). They define medicalisation as: 'the process through which aspects of life previously outside the jurisdiction of medicine come to be construed as medical problems', with the women's health movement and social scientists widely contributing to the discussion on the over medicalisation of women (Clarke et al., 2010). Ehrenreich and English (1972) considered medicine as marginalising the role of women as healers yet recognised that medicine had a positive role to play in liberating women through the use of reproductive technology. They also recognised the importance of medical advancements in improving morbidity and mortality for women through improved contraception, safe abortion, and safer childbirth (Ehrenreich and English, 1973). Following this in 1979, however, they published *For Her Own Good* in which they criticised medicine in controlling motherhood, with doctors as experts adding to the oppression of women. Around the same time Ruzek (1978) considered gender and the overmedicalisation of women, with Oakley (1984) exploring the history of medical care during pregnancy and childbirth and the rise in gendered surveillance and control, particularly in the surveillance of the fetus. In relation to this thesis, management and care of the maternal woman living with 'obesity' absolutely reduces maternal and fetal mortality and morbidity but its focus on fetal outcome negates women's agency over their own bodies.

Women's bodies in relation to childbirth have been scrutinised in the feminist literature, highlighting how medicalisation can reduce women's choice, consent, and control during this time (Davis-Floyd, 1992; Martin, 2001; Oakley, 1980; 1984). In consideration of medicalisation and embodiment, Martin (2001, p.57) in *The Woman in the Body: A Cultural Analysis of Reproduction* suggests that childbirth is seen as the production of a product (baby), the uterus being a

machine and the woman producing the baby. The woman goes into labour, which is work. The labour is monitored, a set time placed on it, the doctor the 'foreman'. Technology is used to speed up labour and intervene, ensuring the product is produced in a timely manner, controlling women. Martin argues that using production metaphors to describe reproduction objectifies women, reducing them to their bodies. Women's bodies are seen as separate from self, as objects, with women becoming detached from the process. This analogy is further exacerbated for birthing women who live with 'obesity' due to their bodies being 'risky', under the gaze of the 'foreman' at all times.

Reproductive technology has also allowed women's bodies to be controlled through either delaying motherhood or enabling motherhood (or not), with increased surveillance such as ultrasound scanning making the fetus visible to medical eyes perpetuating this (Singer, 1989). In fact, the rise of ultrasound scanning of the fetus is particularly illuminating in demonstrating how the medicalisation of childbirth has come to include biomedicalisation (Clarke et al., 2010) which is considered below.

2.2.1 From medicalisation to biomedicalisation

From the mid 1980's there was a shift in medicalisation theorising to biomedicalisation, a term coined by Clarke et al. (2010) to explain the complexity of medicalisation in society today. They suggest that medicine has become more complex and multidimensional with advances in technoscience contributing to this shift, and argue that political, economic, scientific, and cultural influences have contributed to the corporate rise and privatisation of health, with the focus on promoting health and reducing risk through increased surveillance. This 'Medical-Industrial complex'[9] (Clark et al., 2020, Ehrenreich

[9] Term introduced by Ehrenreich and Ehrenreich (1971) in The *American Health Empire.* The term refers to the health industry as a business and its concern with profit.

and Ehrenreich, 1971, Relman, 1980) moves beyond medicalisation with advances in science supporting the development of technology transforming health into a commodity for the good of the consumer:

> *In the biomedicalization era, the visual 'ideal of transparency' extended clinically by the endoscope during the medicalization era is further extended by video, digitalization, and robotics* (Clarke et al., 2010, p. 132).

Studies exploring advances in biomedicine extend from cradle to grave, manipulating nature. From human cloning (Prainsack, 2006), and infertility (Friese, Wänke and Plessner, 2006), through to defying death through seeking to prolong life (Shim, Russ and Kaufman, 2006). All of which are actively pursued in a world where consumerism is king (Clarke et al., 2010). Ultrasound scanning of the fetus is particularly notable as a technology embraced by women and their families:

> *A major intersection of consumption and clinical medical imaging is the use of ultrasound to produce the ''visible fetus''…Instead of waiting until birth to pass out cigars, today American dads-to-be are passing around ultrasound images…Embodied quickening has been replaced with a kind of 'technological quickening', a family media event.* (Clarke, et al., 2010, p.137).

Ultrasound scanning has become a routine part of antenatal care, yet NICE (2010) suggests it is not associated with improved outcome. Scanning the fetus is a screening tool which assesses risk, which in turn may lead to increased medical intervention. Roberts et al. (2015) argue that scanning the fetus leads to an increased awareness of risk, which in turn reduces choice for women through fear and lack of understanding of what constitutes risk. From a feminist perspective, ultrasound scanning is deemed to be an example of how pregnancy and childbirth have been taken over by technology and has been criticised for becoming a means of social control with biomedical and

technological processes eroding women's choices (Conrad, 1992; Levy, 1992; Shumaker and Smith, 1994). Frost (2020, p.54) concurs, proposing that: '…the desire to become pregnant or to be reassured about a fetus's health is a powerful motivator for women to consent to – and even request – imaging'. An example of how medicalisation has moved into the realms of biomedicalisation, ultrasound scanning has rendered women to become consumers of medicine through actively seeking visualisation of their baby.

Advances in fetal medicine, however, have resulted in increased focus on the health of the fetus, increasing the medical and social scrutiny on the pregnant body and justifying a medical model of care (Oaks, 2000). Research into the potential risks to the fetus of a woman living with 'obesity' renders maternal 'obesity' a threat (Parker, 2012, 2014). This in turn has led to further scrutiny, surveillance and intervention for women who present in pregnancy as 'obese' (Parker, 2014). Added to this is the long-term effects on the child, with research suggesting that future 'obesity' and predisposition to certain diseases are programmed in utero, therefore apportioning blame on the 'obese' mother (Freeman, 2010; Heslehurst et al., 2011). Pregnant women living with 'obesity' are constructed as being irresponsible, bad mothers and in need of increased surveillance (McNaughton, 2011).

2.2.2 The biomedicalisation of 'obesity'

It is within the biomedicalisation period that concern for 'obesity' has arisen. The early 2000's saw a rise in concern around the increase in 'obesity' rates (Herrick, 2009; Parker, 2014), with Lupton (2013a) suggesting this was around the time 'obesity' became a pathogenic condition to be managed. Also, around this time the World Health Organisation labelled 'obesity' a 'chronic disease', developing a global strategy to address the issue (WHO, 2004). Constructing 'obesity' as an 'epidemic' has been enabled by the plethora of scientific

research around prevalence and its links to ill-health and chronic illnesses such as diabetes, heart disease and stroke (Lupton, 2013a; Schrecker and Bambra, 2015). Although these claims are true, 'obesity' has been problematised through research following scientific paradigms which marginalise, stigmatise and subject often vulnerable individuals to medical subordination (Syed, 2019). Parker (2017, p.23) suggests that:

> *…obesity science represents an overly mechanistic and reductionist version of body weight and health that is highly inflected with moral and economic valuations of fat bodies as deviant, lazy, greedy, unproductive, and in need of expert control.*

With the growing emphasis of 'obesity' as a medical issue it has become standard practice that all those who are deemed 'obese' by BMI definition are subjected to increased scrutiny and medicalisation regardless of their health status (Blackburn, 2011). Biomedicalisation is evident in how 'obesity' is treated, with medicalisation and moralism combining to promote the desire to be thin and healthy, most notably through surgical intervention, drugs, diet, and exercise regimes (Clarke et al., 2010). This has created a new market for specialist goods and services to support and uphold the perfect body, further fuelling the biomedicalisation shift. Unfortunately, however, interventions to 'treat' the individual living with 'obesity' often fail. Syed (2019, p.5) states:

> *Imposing lifestyle changes, behaviour modification, diets, and promoting physical activity in order to tackle the health problems related to obesity is a recipe for failure, and furthermore, they are not very effective for managing diseases that have apparently plagued obese bodies because the underlying issues of income inequality, social exclusion, sexism, and racism need to be addressed.*

Failure to address the underlying issues associated with 'obesity' suggests that biomedical discourses are socially, politically and financially driven (Crossley, 2004; Evans, Crookes and Coaffee, 2012; Guthman, 2011)

In relation to maternal 'obesity', biomedical discourses govern and regulate (Rich, 2005; Syed, 2019). Parker (2014, p.111) suggests that the pregnant woman living with 'obesity' is seen to be a major risk to the health and well-being of the fetus, her own health, and the health of her family:

> *Combined with the increasing surveillance and regulation of the pregnant body, the persistent hype and revile about obesity as a health crisis, and presiding neoliberal politics with their emphasis on individual self-governance leading to maternal responsibilization, situating women's reproductive bodies as the harbinger of the 'obesity crisis' provides the 'perfect storm' for an intensification of individual blame on women for obesity and population health, particularly those women already marginalized by intersecting oppressions.*

Concurring with Parker (2014), Ward and McPhail (2019) explore the concept of 'fat' shaming in relation to reproductive health. They suggest that women living with 'obesity' are deemed responsible for the health of their children which has been fuelled by the recent explosion in fetal medicine and epigenetics linking maternal 'obesity' to lifelong health issues in children. Friedman (2015) argues this 'policing' is centred around medical 'truths' that claim 'obesity' is unhealthy and reversible, further fuelling the shame rhetoric. Women living with 'obesity' and more notable mothers who live with 'obesity' are seen to be responsible for the ''obesity' epidemic', diverting attention from the social, political and economic inequalities that lead to 'obesity' in the first place (Bordo, 2003).

In the context of this thesis, women presenting in pregnancy with a BMI of 35 or above appear to be subjected to management and care which follows a biomedical framework. This is well documented in the literature (Furber and McGowan, 2010; Heslehurst et al., 2013; Smith and Lavender, 2011), with increased medical intervention concerning. This study therefore seeks to move forward the maternal 'obesity' discourse discussion to consider how the

biomedicalisation of 'obesity' affects choice, consent, and control across the pregnancy continuum.

2.3 Embodiment

This thesis is concerned with reproduction and embodiment in relation to women living as 'obese'. Socially constructed, embodiment is how the body presents itself, with its interactions being seen as a reflection of self (Turner, 2004; Waskul and Vannini, 2006). The term was coined by Merleau-Ponty (1945 [1962]) who suggested that how we view and understand the world is done through our bodies, the lived body. Foucault (1977), echoes this, considering the body as a visual representation, seen, and interpreted by others, impacting on the sense of self. Foucault's 'docile body' has been particularly useful in understanding the construction of the body which is regulated and disciplined in order to conform (see Chapter 8, 8.4). Although concerned with all bodies, Foucault has paved the way for feminist thinking on the female body and how it is lived (Bartky, 1988; Bordo, 2003). Women's bodies are particularly scrutinised, constantly interpreted and with assumptions made. Chrisler and Jonston-Robledo (2018, p.9), for example, state that:

> *Women's bodies are perceived by many as sex objects or as objects of beauty and are subject to constant evaluation and judgment. These judgments are considered normative and need not be hidden or kept private (e.g., street harassment, slut bashing, the fashion police). Most girls and women are aware that they are constantly subject to evaluation, which makes it difficult for them to attain a comfortable embodiment.*

It should be acknowledged however that early feminist thought on the body predated the work of Merleau-Ponty and Foucault, with Simone de Beauvoir in her publication of *The Second Sex* (1949 [1997], p.39) suggesting that to be 'present in the world' was to exist within a body, with the body being corporeal yet not separate from the self. She argued that women were imprisoned by

their physiology particularly around reproduction making them different from men, masculine ideology being superior, creating inequality. She suggests that women are seen only by their biological body which society perpetuates through patriarchal constructs. Grosz (1994) concurs, suggesting that historically the female body has been seen as biological, associated with nature and reproduction.

2.3.1 The natural body

It was during the period of enlightenment[10] that scientific discourses rendered the body to an object, with medicine establishing the workings of bodily functions during this time. Previous thought of the body as metaphysical moved to that of the body as mechanical (Kierans and Bell, 2016). Prior to this there was a general assumption that men and women were of the same sex. Medicine, proving otherwise paved the way for the concept of gender (Outram, 2013), with, (until recently) the male anatomy being defined as the 'norm' (Walsh, 2009b). These 'norms' rendered women as less rational and inferior to the male body which was and still is seen in opposition. For women, the body being associated with menstruation, fertility, pregnancy, and birth regardless of whether they directly experience these events has kept them grounded within biology (Chrisler and Johnston-Robledo, 2018). Simone de Beauvoir argues that distinction between women as biological and men as cultural forced women into domestic subservience, with man regulating and dominating society as well as controlling the family (1949 [1997]).

In relation to pregnancy, the female body has been perceived as being unpredictable due the gendered belief that it is fundamentally flawed (Martin, 2001). During the enlightenment, Descartes (1596-1650) in his *Meditations on*

[10] A period of significant intellectual and scientific progress, which included the natural and social sciences. Its origins date from the 16th and 17th Centuries.

First Philosophy (1641 [1998]) suggested that the body and mind were separate entities, each being able to exist on their own. Martin (amongst others) argues how it was this Cartesian dualism that effectively reduced women's bodies to machines, needing to be controlled.

2.3.2 The lived body

Historical discourses that have constructed women as biological and men as cultural have shaped how women perceive and live within their bodies. Beauvoir (1949 [1997]) suggests that women's bodies are lived differently throughout the life course, from childhood to puberty, menstruation, and motherhood, lived as objects through others gaze. Her work on the body has been influential in feminist thinking, with later feminists such as Young (1980) taking up the mantle.

In her seminal work *Throwing Like a Girl: A Phenomenology of Feminine Body Comportment Motility and Spatiality,* Young (1980), discusses the differences in a boy and a girl throwing a ball proposing that women have been conditioned to think differently about their bodies. She suggests how they function, move and the space they occupy are gendered. This ultimately impacts on their self-confidence, causing them to doubt their bodies' abilities, with women being conditioned into thinking they are weak and feeble through objectification:

> *…the fact that the woman lives her body as object as well as subject. The source of this is that patriarchal society defines woman as object, as a mere body, and that in sexist society women are in fact frequently regarded by others as objects and mere bodies. An essential part of the situation of being a woman is that of living the ever-present possibility that one will be gazed upon as a mere body, as shape and flesh that presents itself as the potential object of another subject's intentions and manipulations, rather than as a living manifestation of action and intention. The source of this objectified bodily existence is in the attitude of others regarding her,*

> *but the woman herself often actively takes up her body as a mere thing*. (p.155).

The lived body is viewed by both Beauvoir and Young as a consequence of the space women occupy in modern society and how their situation negatively impacts on their position in the world and how they engage with the world (Lennon, 2019). All actions appear therefore to be a consequence of socialisation and learned behaviour (Kierans and Bell, 2016). This gender socialisation expects women to conform to societies expectations of what constitutes womanhood, with women's bodies gendered.

Women's bodies are lived bodies in ways men's are not and childbirth is one of the most cited examples of this (Bartky, 1990; Bordo, 2003; Davis-Floyd, 1994; Lupton, 1998; Martin, 2001; Oakley, 1980, 1984). Widely debated in the feminist literature, the pregnant childbearing body is viewed as undisciplined, unruly, and erratic (Carter, 2010). In spite of this women are expected to take responsibility for their unborn baby, with their lived body surrendered to the gaze of the medical profession who through medicalisation seek to control.

> *…they [women] are confronted with the lack of control that humans ultimately have over their bodies and at the same time are subject to increased public scrutiny mandating control over their bodies and are held personally accountable for the outcome.* (Carter, 2010, p.995)

This is acutely apparent for pregnant women living with 'obesity' who through medical discourses are subjected to increased medicalisation by virtue of their weight.

2.3.3 The trained body

Kierans and Bell (2016, p.149-150) propose that the lived body through 'individual bodily practices are turned into shared social facts, as individuals are 'trained' and learn how to do (and how to feel and think) as others do.' Foucault's (1977) theorising offers an explanation to support this. In *Discipline and Punish,* Foucault argues that from the public execution of prisoners in the 1700's where the body was subjected to horrific torture culminating in death, to the evolvement of the prison system and incarceration, the body has moved from being out with of the realms of society to being governed and controlled by society (Kierans and Bell, 2016). Dominant systems have over time through exerting control rendered individuals to 'docile bodies' that can be manipulated and trained. Those in a position of power have extended this governance to control other aspects of life, with institutions, in particular the medical establishment welding power over the masses through its clinical 'gaze' (Foucault,1973) (also see Chapter 8, 8.4).

From a feminist perspective the trained body has been born out of a desire to conform to societal expectations of what constitutes the female form. Mary Douglas (1970, p.12) suggests the female body is a system of 'natural symbols' that needs to be controlled or 'policed' depending on the social occasion. Bartky (1988), who concurs with Foucault and the 'docile' body, supports Douglas's view. She suggests that the desire by women to conform to feminine ideals in relation to fashion and beauty is an example of how bodily practices have become ritualised and a form of feminine discipline.

This has extended to the pursuit of the perfect body through fitness regimes controlling and regulating the body. This healthism suggests personal accountability for one's own health, with 'obesity' being subject to the medical gaze (Gard and Wright, 2005). Diet and fitness regimes, however, change and evolve, remaining elusive and often unachievable. This populous discourse that still strives for the perfect body can now be achieved through biomedicalisation under the guise of 'obesity' as disease which can be treated under the surgeon's knife (Clarke, et al., 2010).

2.3.4 The 'obese' body

Feminist perspectives in relation to embodiment of the 'obese' body in Western society have historically focused on Western ideals of femininity and the idea that 'thinness' equates to happiness, success, and beauty (Donaghue and Clemitshaw, 2012). It became an area for feminist discussion in the 1970's with the infamous work of Susie Orbach (1978) *Fat is a Feminist Issue,* who considered compulsive eating by women as a way of coping with the impact of the gender inequalities that effect all women's lives with being 'fat' an 'adaption to the oppression of women' (Orbach, 1978, p.22). Moving on from this, Thompson and Moore-Groarke (1994) in *When Food Becomes Your Enemy: Anorexia, Bulimia and Compulsive Overeating*, suggest that overeating is an attempt to cope with the cultural and social issues associated with race, poverty, and sexist attitudes, demonstrating through case studies the devastating impact this has on women's lives. It has been argued that 'obesity' cuts across both genders, yet in reality women bear the load (Davis, 2010; Fikkan and Rothblum, 2012) with historical patriarchal oppression subjecting women to increased scrutinisation in regard to their body size (Bordo, 2003). This is particularly apparent in media intense messages aimed primarily at women, suggesting 'fat' as being undesirable and unwanted, leading to self-

loathing and psychological distress in trying to conform (Ponterotto, 2016). LeBesco, (2004) argues that the social construct of 'obesity' and the damnation of individuals who are deemed to eat too much and exercise to little is misleading as many women who are living with 'obesity' are fit and active, nor do they overeat. Bordo (2003, p.189) concurs, attacking Western culture and its focus on thinness suggesting that 'fat' has become the enemy, that has spiralled to epidemic proportions, a war that needs 'attacked' and 'destroyed' at all costs.

In support of society's fixation with body size, Foucault (1977) argues that neoliberal governance[11] 'normalises' specific body types. In order to achieve this 'norm', individuals are tasked with conforming to an acceptable standard within society through obeying the parameters set. 'Normalisation' is used to coerce people into meeting these 'norms', making them compliant through constantly reminding them of their 'abnormal' bodies (Foucault and Rabinow, 1984). To be 'obese' suggests that individuals are not working hard enough to fit their society's 'norms' and are deemed deviant. By medicalising 'obesity' this deviance is further vilified through continued surveillance and intervention (LeBesco, 2004, 2011).

From a poststructuralist feminist viewpoint, Davis (2010) argues that feminist thinking on 'obesity' has been too preoccupied with social and cultural discourses on what constitutes the ideal body form, eating disorders and rejection of the medicalisation of 'obesity'. With the evolving 'fat' acceptance feminism movement going someway to address the variations of 'normal', she suggests that 'fat' feminism has not gone far enough, advocating for

[11] Neoliberalism is a set of political economic rules that can advance human wellbeing through supporting a free market. The role of the government is to uphold an institutional framework to support this. In relation to 'obesity' management neoliberal ideology puts responsibility on the individual to adopt healthy 'lifestyles', therefore creating a market for healthism.

consideration of those whose access to food and exercise is compromised as well as recognition of the actual medical problems that women living with 'obesity' attain by virtue of their 'obesity'. Ultimately, she proposes that feminist thinking on 'obesity' has rejected those who are further marginalised through colour or low socioeconomic status. She calls for a rethink of feminist enquiry taking into consideration gender, race and socioeconomic status and the constraints that keep people 'obese', as well as consideration of the wider social and cultural constructs of 'obesity' outside of the Western world.

2.4 Self

> *Without a body, there is no self. In the most basic sense, a living body provides a home for the self, and the brain creates the mind, which produces the sense of self* (Chrisler and Johnston-Robledo, 2018, p. 4).

Numerous theories on self are evident within the literature (Cooley 1902; Freud, 1923; Mead, 1934; Goffman, 1963). Some theorists suggest the concept of self begins as an unconscious drive which is biological in order to meet basic needs e.g., Freud's 'the id'[12], with others arguing that self is a product of the world that is occupied, influenced by external factors, for example Cooley (1902), who proposes that self is perceived through how others see us. Self is therefore constructed through language and meaning:

> *Knowledges of the self form a multiverse of meanings which are created through one's experiences in relation to others and through social contexts. Through these self-knowledges we punctuate and construct our views and experiences of ourselves and others*. (Hart, 1986, p.44)

[12] The id is conceptualised by Sigmund Freud (1856- 1939) in his psychoanalytic theory of personality as an element of personality that is unconscious and functions to ensure basic human needs are met e.g., food, comfort, desire. Other personality elements develop with age, the ego, to moderate the id, and the superego which guides morals and ideals.

As others see us through our bodies, the body and self cannot be separate. In relation to this thesis, the 'obese' body becomes a visual representation of self, with socially constructed narratives in relation to 'obesity' projected through the body onto the self. The body as a visual representation of self, is therefore a central component of self-image and subsequent self-worth (Leary and Tangney, 2012). Dissatisfaction of the body has long been associated with women in particular (Quittkat et al., 2019; Polivey and Herman, 2007; Weinberger et al., 2016). So much so, it is often referred to as 'normative discontent' (Runfola et al., 2013). This may be problematic in terms of the psychological impact this may have for women across the life course. It is well recognised that low self-esteem impedes health and wellbeing and subsequently decision making (Jomeen and Martin, 2008; Mann et al., 2004; Wray and Stone, 2005) which is of particular concern for this thesis and the impact of 'obesity' on choice, consent and control.[13]

2.5 Conclusion

This chapter is integral to this thesis which is concerned with the 'obese' body as it considers the landscape in which this thesis is situated. It has considered how choice, consent and control have been highlighted as a priority in maternity service provision through government policy and practice. In discussing the rise of medicalisation, biomedicalisation and how this intersects with feminist thought however, a dichotomy is apparent with medicine seeking to control reducing choice, consent and control. In exploring embodiment and the female body, further concerns have been highlighted in how the female body has been manipulated and controlled through gendered discourses over

[13] Further theorising of self is offered in Chapter 8. In undertaking a constructivist grounded approach to the empirical study within this thesis, the generated theory uncovered in relation to self draws on theories of self to illuminate.

time. An overview of self has also been offered as it is central to the theory generated from the empirical study contained within this thesis[14].

The following chapter introduces and critically engages with the cross-disciplinary research base using a meta-narrative approach to review the literature. Literature exploring the experiences of women who live with 'obesity' in relation to their management and care during the pregnancy continuum is reviewed with particular consideration of choice, consent, and control.

[14] As 13 above

CHAPTER 3

META-NARRATIVE REVIEW

3.0 Introduction

The previous chapter discussed the wider positioning that has helped to both inform this thesis and deepen my own understanding of the wider issues in relation to medicine, bio/medicalisation and embodiment and how these discourses interject with choice, consent and control. Feminist perspectives were explored in relation to the female body, 'obesity' and maternal 'obesity'. The chapter concluded with consideration of self.

This chapter introduces and critically engages with the cross-disciplinary research base using a meta-narrative approach to review the literature. The purpose of the review was to explore women's experiences of management and care during the pregnancy continuum and how this may influence choice, consent, and control when they present in pregnancy with a high BMI. Cross-disciplinary research ultimately shapes policy and care management across maternity care, therefore examining historically how the literature has evolved and its impact on women's lives was deemed appropriate. A meta-narrative review approach was considered the most relevant to use in the context of this work and is presented below. First, however, why the literature review was undertaken before the empirical study (in keeping with grounded theory) is discussed below.

3.1 To do or not to do? The literature review

Traditionally, when undertaking research, it is normal practice to undertake a literature review to inform the research design, deepen understanding and identify gaps in the existing literature (Hart, 1998; Gibbs, 2008). When undertaking grounded theory research, however, when to do the literature

review is widely contested (Dunne, 2010; Glaser, 1992; Glaser and Strauss, 1967). Classic grounded theory advises delaying the literature review until after data collection in order to keep the mind clear, avoid bias and allow the researcher to develop new ideas (Glaser and Strauss, 1967). Strauss acknowledged in later work, however, that it was difficult for researchers not to bring previous knowledge and experience to their research and relaxed his view of delaying the literature review (Strauss and Corbin, 1990). Glaser on the other hand has always maintained that grounded theory researchers remain uncontaminated by what has gone before (Glaser, 1978, 1992, 1998, 2001), and that they should adopt a purely objective approach to the research in question. Not engaging with previous research, however, runs the risk of existing theory being rehashed (Charmaz, 2014). In challenging this approach, Charmaz recognises the reality of researchers needing to assess the existing research base to ensure the project's originality which requires knowledge of what has gone before. In view of this she advocates scoping the literature to avoid knowledge gained influencing the grounded theory study and theory generated (Deering and Williams, 2020).

Charmaz (2014, p 307) suggests that regardless of when the literature review is undertaken it should 'fit the specific purpose and argument of his or her research report'. This concurs with Thornberg (2012) who advocates that grounded theory should be informed, the study being grounded within the data but being informed by existing literature. He suggests that this approach fits with a constructivist grounded theory study of being pragmatic and abductive. Thornberg (2012) also suggests that it is unrealistic to expect a researcher with expertise in a certain field to be blind to existing knowledge.

I undertook the meta-narrative review prior to the empirical research being undertaken. The reason for this was that I needed to have completed a

literature review prior to seeking ethical approval therefore could not avoid engaging with the literature prior to my data collection. As ethical approval was sort early in my studies I had not firmly decided on my methodological approach at this time. If, in keeping with classic grounded theory (Glaser and Strauss, 1967) had I delayed my literature review until after data collection and analysis I may have avoided any pre-conceived ideas being re-constructed within my own study. However, my background affords me considerable knowledge on the management and care of maternal 'obesity' and my experiences have brought me into contact with women living with 'obesity' over many years, so it could be argued I may have pre-conceived ideas anyway. Added to this the gaps identified in the literature review cemented the use of constructivist grounded theory as an appropriate methodological approach to adopt for my empirical work.

3.2 Meta-narrative review

Meta-narrative review methods were developed by Greenhalgh et al. (2004, 2005) using a historical and philosophical perspective to understand the available literature, drawing on Thomas Kuhn's work: *The Structure of Scientific Revolutions*. Chapter 5, *The Priority of Paradigms* (1962, p.43-51) suggests that science is generally managed following predetermined rules which have shaped the course of 'normal science' over time. Researchers from different traditions view these rules according to their discipline, working with what already exists and producing research following the same set of rules.

This is the first meta-narrative review to consider maternal 'obesity' and women's experiences of care. The objective of this review was to 'make sense' of the experiences of these women who access maternity care. It examined the differing research paradigms across the disciplines and over time and considered women's experiences of management and care, focusing on choice,

consent, and control. Consideration was also given to how women's experiences have been conceptualised over time, mapped against how policy and practice has shaped the management of maternal 'obesity'.

A meta-narrative review was deemed appropriate in engaging with the literature as it crosses interdisciplinary boundaries. Women who present in pregnancy living with 'obesity' are often cared for and signposted to professionals across disciplines, so it was imperative that interdisciplinary research was captured in order to understand women's experiences. By being able to map women's experiences across time, a timeline could be established of how the literature intersects with the introduction of policy and practices to manage maternal 'obesity'. By understanding this, further insights into women's experiences over time could be gained.

This review follows RAMESES publication standards for meta-narrative review which are adhered to throughout (Wong et al., 2013). The six guiding principles on which meta-narrative reviews are based have been followed explicitly and used in data collection, analysis, and synthesis. These principles have been identified by Greenhalgh and Wong (2013) as being paramount in ensuring that the review is philosophically clear, adding to the knowledge base of the topic considered. These are:

Pragmatism: Pragmatism was adopted across the review from scoping the literature to analysing the chosen literature. The included literature was chosen based on how the aims of the review could be met with regards to the development of a historical timeline and corresponding narrative.

Pluralism: Greenhalgh and Wong (2013, p.6) state that in ensuring pluralism it is important to:

> *…develop an account of the topic area that is illuminated from multiple angles and perspectives. A meta-narrative review must analyse more than one paradigm and produce a recognisable set of distinct meta-narratives together with a higher-order synthesis of these results.*

Multiple research paradigms across disciplines were identified and included in the review. These were then compared and contrasted.

Historicity: These concerns how research traditions have developed over time. Key events that have shaped the tradition are included in this review, meeting this meta-narrative review principle.

Contestation: How research from different research traditions was compared and contrasted to examine how maternal 'obesity' is framed across the traditions and the differences explored.

Reflexivity and peer review: All findings were reviewed by myself as the researcher and my PhD supervisors. The findings were also presented to an external audience of whose feedback was used to further reflect and analyse. This helped to ensure quality and reduce bias aided by continuous reflexivity throughout the review process.

3.3 Search strategy

The literature search consisted of two phases. Phase 1 was undertaken in early 2017. Phase 2 was undertaken in March 2017 and subsequently updated in September 2019, March 2020, and May 2021 to capture any newer published data of significance to be included in the review.

3.3.1 Phase 1

The first phase involved scoping the literature to identify the range of research in relation to the subject area. This included examining grey literature, informal

sources, and networking to identify research traditions. From this information, subsequent databases aligned to these traditions were identified to be searched (Phase 1).

Phase 1 of the review was conducted adopting search strategies proposed by Bates (1998). This involved using a 'berry picking' model which mirrors researchers' normal search behaviour as opposed to the more traditional approach of information retrieval, where a query is asked by the researcher which is matched to the contents of a database with a single set of outputs. The flexible nature of this approach allowed the exploration of new ideas from the information gathered. Flexibility also aligns to the principles identified by Greenhalgh and Wong (2013) in ensuring that the search was varied and broad to allow comprehensive mapping of the subject area (Phase 1) (Figure 2.1).

3.3.2 Phase 2

Phase 2 (Figure 3.1) comprised undertaking a systematic approach, to identify primary research for inclusion from the databases identified in phase 1. Qualitative, quantitative, and mixed method approaches were considered. Seven databases were identified from Phase 1, which aligned to the differing research traditions identified: CINHL Complete, MEDLINE, MIDIRS, PsycINFO, Scopus, SocINDEX, and SPORTDiscuss

3.3.3 Search terms

Search terms were identified and grouped according to the PEO model and Boolean operators were used (Bettany-Saltikov, 2012; Khan et al., 2003) (Table 2).

Table 2. Search Terms

Population	Exposure	Outcomes
Wom?n, maternal, mother*, obese, pregnant	Antenatal, intrapartum, postnatal, postpartum, childbirth, birth, lab?r, delivery, maternal nutrition, pregnan*, obesity, feminis*	Experiences, autonomy, consent, control, choice, management, weight, BMI, policy, theories, concepts

3.3.4 Inclusion and exclusion criteria

The following inclusion and exclusion criteria were developed in relation to the subject aims (Table 3).

Table 3. Inclusion and Exclusion Criteria

	Inclusion Criteria	Exclusion Criteria
Population	Women who are pregnant and are identified or identify as being 'obese' Women who were 'obese' during pregnancy	Women's partners or family/friends. Women who are pregnant and are/or identify as being of 'normal' weight or overweight. Non-pregnant women who are overweight or 'obese' Infant/child/offspring Lactation/Infant feeding
Exposure	Makes use of qualitative or quantitative and/or mixed method tools including interviews, narrative accounts, and/or observations to assess women's experiences of management and care during the pregnancy continuum who live with 'obesity'	Studies that do not consider women's experiences. Studies considering pre-pregnancy/pre-conception care
Outcome	Women's experiences of being pregnant, maternity services including satisfaction	Maternal, labour and childbirth outcomes and infant outcomes. Infant feeding/lactation Infant/child/offspring

	with management and care, ability to make informed choices, feelings in relation to being in control and giving consent with regards to management and care given.	
Type of study	Qualitative studies, quantitative studies including mixed methodologies. Published and unpublished work.	None
Language	Studies written and/or published in English.	Other languages
Time period	All	No exclusions

3.4 Selection of studies

From the original systematic search conducted in March 2017 from the seven databases identified in Phase 1 of the literature search (Fig. 1), 244 papers were retrieved. Through hand searching a further nine papers were deemed suitable for consideration and one book chapter. From these 211 papers were rejected at title and abstract stage, with a further 22 studies rejected at full read and following discussion with my supervisors. One paper was rejected at second full read, leaving a total of 19 papers and one book chapter for inclusion in the review. Subsequent searches in September 2019 and March 2020 yielded no further literature, with one paper being identified in May 2021 which was included in the final review. A total of 20 papers and 1 book chapter was included in the final synthesis (see figure 2.1).

3.5 Quality appraisal

Quality appraisal was undertaken using tools which aligned with the research traditions identified in the review and as specified by the *Quality standards for*

meta-narrative reviews (The RAMESES Project, 2014). Qualitative studies (n=18) were appraised using a tool developed by Walsh and Downe (2006) that ranks studies using a checklist, grading A-D (Appendix A). This framework for quality assessment of qualitative studies is a synthesis of multiple appraisal tools, being grounded in subjective epistemology which I felt was relevant to use within this review. The studies were graded independently by myself and one of my supervisors. All A graded studies were included automatically. Discussions were undertaken with one of my supervisors regarding inclusion of those graded B or C. Quantitative studies (n=2) were appraised using the Effective Public Health Practice Project (EPHPP) quality assessment tool for quantitative studies (2009) (Appendix B), which again were graded by myself and a supervisor. The EPHPP assessment tool was used as it has been developed specifically for quantitative study appraisal and was user-friendly. The mixed method study (n=1) retrieved was appraised using both of the quality appraisal tools. As all 21 of the studies met the quality appraisal tool criteria they were included in the review (see Table 4, quality rating).

3.6 Data extraction and synthesis

Data extraction and syntheses was undertaken in keeping with the review aims, with particular regard to how women's experiences of maternal 'obesity' have been conceptualised over time with reference to the historical context and how policy has influenced the research traditions. Discussions were undertaken between myself and my supervisors and different concepts between the traditions were identified for further discussion.

Findings from the studies were manually mapped using colour coding, with themes identified. Critique was undertaken following the meta-narrative principles (Wong et al.,2013), pragmatism, pluralism, historicity, contestation, reflexivity, and peer review as discussed in 3.2 above.

3.7 Results

A total of 21 studies were included in the final review (Fig. 3.1). Of these, two were quantitative, one mixed method and 18 qualitative in their methodological approach. The disciplines most represented were Midwifery (n=7), followed by Interdisciplinary (n=5), Health Sciences and Health and Medical Sciences (n=5), Social Sciences (n=2), Psychology (n=1), and Public Health (n=1). The studies were undertaken in high income countries: America, Australia, Canada, Denmark, England, Ireland, Norway, Scotland, Sweden, and the UK. The studies were published between 1993 and 2020. Studies included are shown in Table 3, with key research traditions and women's experiences conceptualised in Table 4. Three areas for consideration were identified: narratives from research traditions; historicity; and cross cutting narratives. Emerging themes from the latter in relation to choice, consent and control were constructed: 'being managed'; 'attitudes of care-givers'; 'social determinants'; and 'women's beliefs and experiences of weight'.

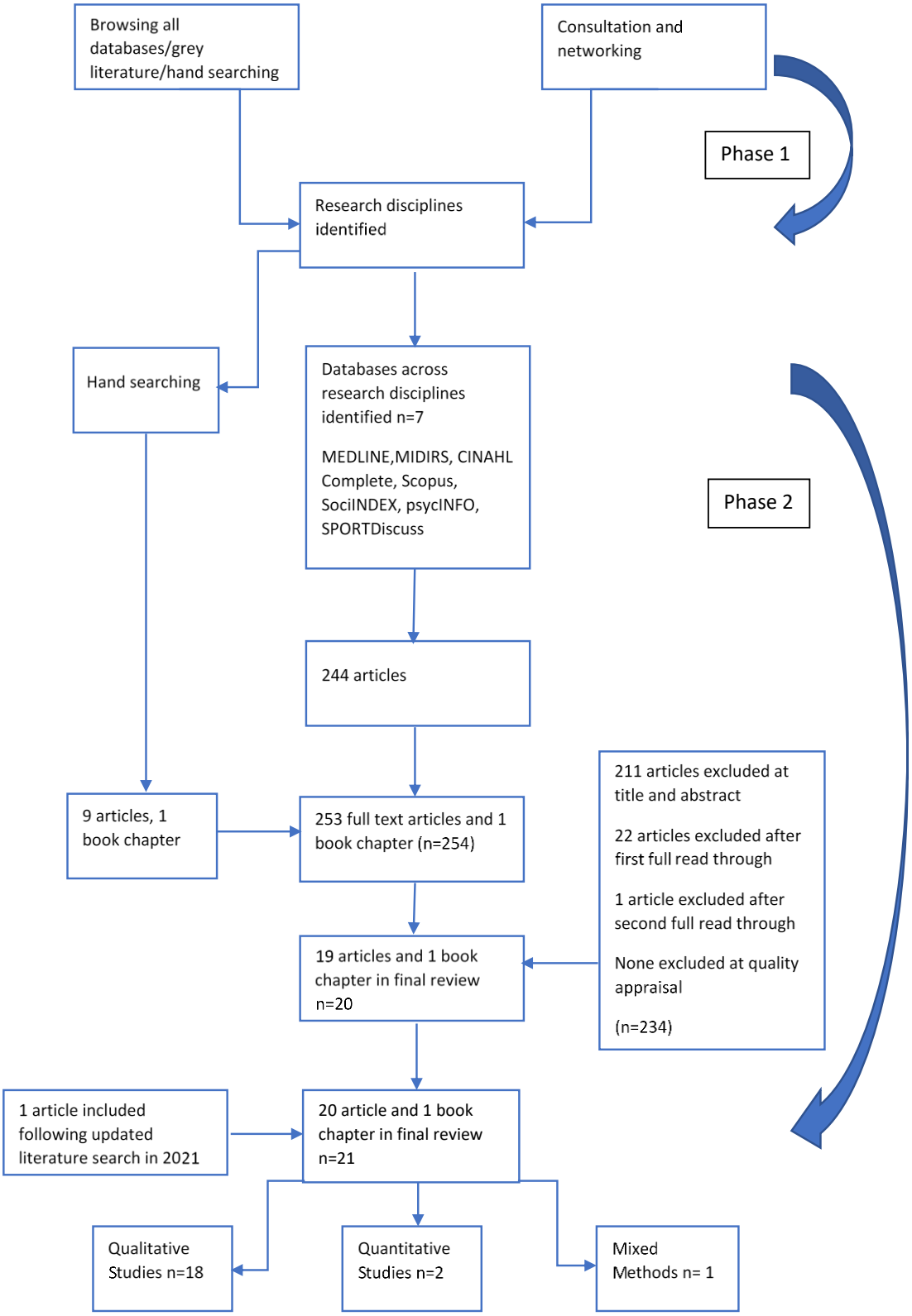

Fig. 3.1: Search and selection flow chart. Adapted from Greenhalgh et al. (2004)

3.8 Characteristics and quality grading of the included studies

The characteristics of each study are recorded in Table 3. Of the two quantitative studies, Hildingsson and Thomas (2012) collected data through questionnaires and antenatal records mid-pregnancy, and through questionnaires two months following birth. In comparison Mulherin et al. (2013) used a self-reporting survey to collect information from women who had given birth in 2009. Heslehurst et al. (2015) used semi-structured interviews, postal surveys (staff) and case note audit in their mixed methods study, using a triangulation convergence-coding matrix to integrate the themes across the qualitative and quantitative data collected. Women were interviewed once during the antenatal period and case notes were audited to access compliance of 'obesity' management offered.

Of the 18 qualitative studies, 17 collected data using semi-structured and/or in-depth interviews. Five studies involved women being interviewed post birth. Lavender and Smith (2015) collected data through inviting participants to a focus group 4-6 weeks after birth. Nyman, Prebensen and Flensner (2010) interviewed postnatal women, undertaking one interview 4-6 weeks following birth; Dinsdale et al. (2016) interviewed women 3-9 months following birth and Atkinson and McNamara (2017) interviewed women at 6-10 weeks postnatal. Thorbjörnsdottir et al. (2020) undertook a single interview with participants who had birthed in the previous five years and had a BMI above 30 at the onset of pregnancy. Atkinson, Olander and French (2013) and Mills, Schmied and Dahlen (2013) interviewed women either in pregnancy or in the early postnatal period with Bombak, McPhail and Ward (2016) interviewing women on their experiences of being 'obese' and accessing fertility treatment as well as recruiting pregnant women and women who had given birth. Eight studies undertook one interview at various stages of the antenatal period (Adolfsson, Anderson and Edgren, 2013; Heslehurst et al., 2013; Jette and Rail, 2014; Keely,

Gunning and Denison, 2011, 2011; Knight-Agarwel et al., 2016a; Lindhardt et al., 2013; Wiles, 1994; Wiles, 1998). Only one study (Furber and McGowen, 2011) undertook more than one interview with women, which examined women's experiences of 'obesity' management. Women were interviewed in the third trimester and 3-6 weeks after birth, to explore their experiences of 'obesity' management across the antenatal, birth and early postnatal periods. Only one study (Furness et al., 2011) collected data through a focus group, with women during pregnancy invited to attend with the aim of understanding women's perspectives of maternal 'obesity' support services.

While most studies recruited women with a booking/pre-pregnancy BMI of 30 or above, Wiles (1994, 1998) used actual weight as an indicator for recruitment, women who had reached a weight of 90Kgs by the 30th week of pregnancy. This strategy may have been indicative of the time the study was undertaken. Bombak, McPhail and Ward (2016) and Mulherin et al. (2013) recruited women who self-identified as being 'obese', with Hildingsson and Thomas (2012) comparing perinatal outcomes and women's satisfaction of care in women with a BMI of 30 or above against women of 'normal' weight. Only one study focused exclusively on women with a BMI of 40 or above (Keely, Gunning and Denison, 2011).

The majority of studies (n=14) used thematic analysis in their data analysis, with Lindhardt et al. (2013) and Thorbjörnsdottir et al. (2020) utilising Giorgi's (1985) phenomenological method of analysis, Nyman, Prebensen and Flensner (2010) adopting Karlsson's (1995) phenomenological five stepped approach and Atkinson and McNamara (2017) using a six stepped interpretative phenomenological analysis. Adolfsson, Andresen and Edgren (2013) favoured Graneheim and Lundham's (2004) qualitative content analysis.

All the studies were undertaken in Western high-income countries giving a limited analysis of the cultural impact globally of maternal 'obesity' and women's experiences. This may be due to literature written in languages other than English being excluded from the review and therefore needs to be recognised as a limitation. With the rise of 'obesity' in Western society, an increase in research around this phenomenon may also be a reason why only research undertaken in Western high-income countries was identified.

Table 4. Summary of included studies

Author	Year/ country	Title	Study design	Sample size	Quality rating
Adolfsson, Andresen and Edgren	2013 Sweden	Why obese women feel better about their "big" condition when they are pregnant: A qualitative study performed in Sweden	Interview study	15	C
Atkinson, Olander and French	2013 UK	Why don't many obese pregnant and post-natal women engage with a weight management service?	Cross sectional interview study. Semi-structured interviews	18	B
Atkinson and McNamara	2017 Ireland	Unconscious collusion: An interpretive phenomenological analysis of the maternity care experiences of women with obesity (BMI≥ 30kg/m²)	Semi-structured interviews	15	B
Bombak, McPhail and Ward	2016 Canada	Reproducing stigma: Interpreting "overweight" and "obese" women's experiences of weight-based discrimination in reproductive healthcare	Semi- structured interviews	24	B
Dinsdale et al.	2016 UK	"As soon as you've had the baby that's it…" a qualitative study of 24 postnatal women on their experience of maternal obesity care pathways	Semi-structured interviews	24	B
Furber and McGoven	2011 UK	A qualitative study of the experiences of women who are obese and pregnant in the UK	Semi-structured interviews	19	B
Furness et al.	2011 UK	Maternal 'obesity' support services: a qualitative study of the perspectives of women and midwives	Semi-structured focus groups	7 women, 7 midwives	B

Author	Year/ country	Title	Study design	Sample size	Quality rating
Heslehurst et al.	2013 UK	Women's perspectives are required to inform the development of maternal obesity services: a qualitative study of obese pregnant women's experiences	In-depth interviews with discussion prompts	15	B
Heslehurst et al.	2015 UK	An Evaluation of the Implementation of Maternal 'obesity' Pathways of Care: A Mixed Methods Study with Data Integration	Semi structured interviews, postal survey and case note audit.	Study 1: 17 2, Study 2; 166 Study 3: 59 case notes	Mod/B
Hildingsson and Thomas	2012 Sweden	Perinatal Outcomes and Satisfaction with Care in Women with High Body Mass Index	Case control study. Questionnaires. Data retrieval from medical records	919	Mod
Jette and Rail	2014 Canada	Resisting, reproducing, resigned? Low-income pregnant women's discursive constructions and experiences of health and weight gain	Semi-structured interviews	34	B
Keely, Gunning and Denison	2011 UK	Maternal obesity in pregnancy: Women's understanding of risks	Semi-structured interviews	8	C
Knight-Agarwel et al.	2016 Australia	The perspectives of obese women receiving antenatal care: A qualitative study of women's experiences	Semi-structured interviews	16	B
Lavender and Smith	2015 UK	Seeing it through their eyes: a qualitative study of the pregnancy experiences of women with a body mass index of 30 or more	Focus groups and semi structured interviews	34	B

Author	Year/ country	Title	Study design	Sample size	Quality rating
Lindhardt et al.	2013 Denmark	The experience of pregnant women with a body mass index ≥ 30 kg/m² of their encounters with healthcare professionals	In-depth semi- structured interviews.	16	B
Mills, Schmied and Dahlen	2013 Australia	Get alongside us', women's experiences of being overweight and pregnant in Sydney, Australia	Interviews.	14	B
Mulherin et al.	2013 Australia	Weight stigma in maternity care: women's experiences and care providers' attitudes	Study 1; Retrospective cross sectional designed survey completed on paper, online or by telephone. Study 2; Online Survey.	Study 1; 627, Study 2; 215 and 33	Mod
Nyman, Prebensen and Flensner	2010 Sweden	Obese women's experiences of encounters with midwives and physicians during pregnancy and childbirth	Interview study	10	A
Thorbjörnsdottir et al.	2020 Norway	"Talk to me, not at me": obese women's experiences of birth and their encounter with birth attendants—a qualitative study	Semi-structured interview	10	A
Wiles	1994 UK	'I'm not fat, I'm pregnant': the impact of pregnancy on fat women's body image	Semi-structured interviews	37	C
Wiles	1998 UK	The views of women of above average weight about appropriate weight gain in pregnancy.	Semi-structured interviews	37	B

Table 5: Summary of results of the Meta-narrative review

Academic discipline	**Research tradition**	**Definition and scope**	**Women's experiences conceptionalised in relation to control, consent, and choice**	Key authors
Midwifery	Midwifery Studies/Evidenced-based Medicine	Studies of maternity practices and strategies to improve the care of women and babies.	Humiliation, stigmatisation, feeling exposed and scrutinised. Keeping silent, fear and anxiety. Lack of communication, collusion to avoid challenging discussions. Health professionals seen as authoritative, gate keepers of care. Positive and negative encounters with health professionals. Maternal body seen as a vessel. Mother blaming, labelling, ignored.	Nyman, Prebensen and Flensner (2010) Furber and McGoven (2011) Keely, Gunning and Denison (2011) Hildingsson and Thomas (2012) Mills, Schmied and Dahlen (2013) Lavender and Smith (2015) Atkinson and McNamara (2017)
Interdisciplinary (medicine, sociology, health, midwifery, nutrition and dietetics,	Health Studies	Study of health practices and strategies to improve and manage diseases/conditions	Pregnancy was a reason to overeat. Lack of motivation to lose weight. Lack of social support seen to have a negative impact on diet. Stigmatised, vulnerable, and embarrassed about weight. Reluctance of health professionals to discuss weight.	Furness et al. (2011) Heslehurst et al. (2013) Heslehurst et al. (2015)

Academic discipline	**Research tradition**	**Definition and scope**	**Women's experiences conceptionalised in relation to control, consent, and choice**	Key authors
psychology, nursing, technology, and communication)		within the population	Lack of continuity of care that prevented women from discussing weight. Inconsistent advice given. Positive experiences noted in relation to attending a targeted clinic. There was a clear difference in the support women received across differing management pathways, with those with a BMI≥40kg/m² receiving more support. These women reported better communication from health professionals and had a better understanding and awareness of the risks associated with 'obesity'. Women with BMI≥30kg/m² and BMI≥35kg/m² were unaware of being on a care pathway, felt ill-informed, thought associated clinical assessments were routine for all pregnant women and were not aware of 'obesity' associated risks. The words, 'obese', 'clinical obese' and 'morbidly obese' were perceived negatively. Women who are 'obese' have historical weight issues. Information giving can be confusing, contradictory and a judgmental approach by health professionals is adopted. Expectation that women will 'comply' with care.	Dinsdale et al. (2016) Knight-Agarwel et al. (2016a)
Health Sciences and Health and Medical Sciences	Health Studies/Evidence - based Medicine	Studies to improve health through scientific research	Initial contact with service providers and information given counts. Some women 'offended' by being invited to attend a clinic for raised BMI Opportunities missed with women identifying needs that were not met.	Adolfsson, Andresen and Edgren (2013) Atkinson, Olander, and French (2013)

Academic discipline	**Research tradition**	**Definition and scope**	**Women's experiences conceptionalised in relation to control, consent, and choice**	Key authors
			Some women did not want support with others preferring group-based weight loss services or dissatisfied with support offered. Health professionals as 'gate keepers'. Evidence of imbalance of power and lack of choice. Impersonal care. Stigmatisation, shame, use of insensitive language, refusing to treat, fetal risk discourse, fear. Women living with 'obesity' may not identify as being 'obese' although they felt they did not conform to societal concepts on the female body, feeling a failure because of this. Pregnancy was a time when it was acceptable to be 'big' and this improved self-esteem as these women felt they 'fitted in'. Competence and experience of their midwife was a priority. They generally understood the increased risks of being 'obese' but wanted midwives to treat them as other pregnant women and not keep highlighting the risks. Contact with midwives was a positive experience. Health professionals implied blame or criticism. Women experienced heightened vulnerability. Unaware of being referred for specialist care. Lack of advice and information, inconsistency of information and conflicting advice	Bombak, McPhail and Ward (2016) Lindhardt et al. (2013) Thorbjörnsdottir et al. (2020)
Public Health	Health Promotion	Studies to improve the health and well-being of the population.	Managing behaviour to ensure the health of the baby is evident. Socioeconomic factors have a bearing on weight gain and health related activity.	Jette and Rail (2014)

Academic discipline	**Research tradition**	**Definition and scope**	**Women's experiences conceptionalised in relation to control, consent, and choice**	Key authors
Women's Studies	Feminist Sociology	Study of how society views women at an interactional and political level.	Humiliated by health professionals. Being 'fat' more socially accepted when pregnant. Lack of professional support or advice. Conflicting advice. Self-controlling. Pregnant Comments made by medical staff were deemed to be 'derogatory' and 'insulting'.	Wiles (1998) Wiles (1994)
Psychology	Behavioural studies	Study of the behaviour of the population.	High BMI negatively impacts on the care women receive. Weight stigmatising attitudes of caregivers apparent.	Mulherin et al. (2013)

3.9 What is a paradigm, tradition, discipline, or approach?

While undertaking this meta-narrative review it became apparent that research traditions, paradigms and approaches are sometimes used interchangeably with no consensus on definition. The concept of a research discipline is also not straightforward, with 'discipline' having multiple meanings (Becher and Trowler, 2001). Table 6 conceptualises the apparent differences (and similarities), which was compiled to aid my own understanding when comparing the literature and compiling the results and subsequent analysis. This allowed be to align my results to Kuhn's (1962) work around research paradigms and RAMESES Meta-narrative review publication standards (Wong et al., 2013).

Table 6: Definitions

	Definition
Research discipline	A branch of knowledge with a particular object of research which is specialised to a particular group (Krishnan, 2009)
Research tradition	Well established methods used when undertaking research by a research discipline (Jacob, 1987)
Research paradigm	An established model/philosophy shared by a research/scientific discipline (Kuhn, 1962)
Research approach	A way of doing research • Qualitative/quantitative • Inductive/deductive

Qualitative research accounted for most of the literature considered in this study (n=18). It was evident that in keeping within the qualitative research paradigm

these studies were interpretive. The quantitative studies (n=2) used positivist ontology, which aligns with a traditional 'natural science' research paradigm associated with quantitative methodology. One study used a mixed methods approach, often referred to as the third research paradigm (Johnson, Onwuegbuzie and Turner, 2007); this type of study uses two or more methods to collect and analyse both quantitative and qualitative data (Teddlie and Tashakkori, 2009).

In considering the literature reviewed, each discipline was critiqued to establish the paradigm pathway followed. A paradigm is a viewpoint, a collection of theories which guide particular disciplines, with each discipline following a set of rules and methodological research methods that align with these theories (Kuhn, 1962). Medicine, for example, historically takes a pathogenic approach, with psychology taking a behaviourist approach. In the literature reviewed there was evidence of the paradigm followed that aligned to a particular discipline, however there was also evidence of a paradigm shift from a pathological approach to research to a health- orientated approach. Heikkinen (2000) suggests that this paradigm shift is reflective of how society has evolved over time with recognition that susceptibility to illness is often grounded in the social and economic environment. He argues that health is 'not merely the absence of disease' as conceptualised by the World Health Organisation (WHO) (1948), but also includes social and psychological wellbeing. Therefore, it has been inevitable that medical and health research and care has shifted from being concerned with treating disease to reducing the risk of ill-health for the populous through health promotion and disease prevention (Department of Health and Social Care, 2018; WHO, 2013). The narratives from the disciplines reviewed are presented below.

3.10 Narratives from midwifery

The midwifery profession is defined as 'being with woman', literally translating from the middle English 'mid' (with) and 'wife' (woman) (Wickham, 2018). The role of the midwife being to work with women providing care and support throughout pregnancy, birth and in the postnatal period (International Confederation of Midwives, 2018). Midwifery specific research abounds (Hutton, 2017), however in

relation to maternal 'obesity' and women's experiences it appears research is lacking. Seven studies were found to be relevant to this review that aligned with the midwifery research tradition. Of these six focused on women's experiences of the care given (Atkinson and McNamara, 2017; Furber and McGowen, 2011; Hildingsson and Thomas, 2012; Keely, Gunning and Denison, 2011; Lavender and Smith, 2015; Mills, Schmied and Dahlen, 2013), with one considering women's experiences of the attitudes of health professionals and other caregivers (Nyman, Prebensen and Flensner, 2010). Six studies undertook their research using qualitative research methods (Atkinson and McNamara, 2017; Furber and McGowen, 2011; Keely, Gunning and Denison, 2011; Lavender and Smith, 2015l Mills, Schmied and Dahlen, 2013). Hildingsson and Thomas (2012), however, used quantitative research methods to explore experiences of women throughout pregnancy and birth with a BMI of 30 or above, as well as maternal characteristics and birth outcomes. Questionnaires were used to collect data with a positivist epistemological and objective ontological approach being adopted. Characteristic of the midwifery tradition which unites medical and nursing traditions, this study was more aligned to medicine in seeking answers to questions to establish the truth about maternal 'obesity' experiences, outcome and how this correlates with maternal characteristics. This is also evident in the study of Keely, Gunning and Denison (2011) who used an interpretive qualitative approach, exploring morbidly 'obese' (BMI of 40 or above) pregnant women's experiences in relation to their understanding of 'obesity' risk. The women interviewed 'normalised' their 'obesity', which was subsequently explored using evidence constructing 'obesity' as a condition and a disease to be managed, reflecting a medical research tradition. The other studies were more woman-centred, encompassing midwifery's core principle of 'with women'.

3.10.1 Midwifery with a twist – with woman or with medicine?

Historically, male perspectives have taken precedence over females in defining ways of knowing (Guiver, 2009) and this appears to be reflected in Hildingsson and Thomas (2012) and Keely, Gunning and Denison (2011) as discussed above. Midwifery traditionally is about being 'with woman' and 'ways of knowing' that

come from a female intuitive perspective, yet the studies would indicate that midwifery research tradition sits with obstetrics, which is male dominated, drawing on logic and rational thought. This was evident across several of the disciplines, with women's experiences focused on the medical management of maternal 'obesity' as a 'condition', with research seeking to improve medical care for this group using a medical model of care (Atkinson, Olander and French, 2013; Furness et al., 2011).

3.11 Narratives from the Interdisciplinary Studies, Health, Public Health and Medical Sciences

These studies (n=6) were difficult to differentiate between due to being undertaken by a variety of health disciplines whose research approach was similar. They have therefore been considered collectively; with subtleties conceptualised below.

The six studies reviewed aligned to health, public health and health and medical sciences (Adolfsson, Andresen and Edgren, 2013; Atkinson, Olander and French, 2013; Bombak, McPhail and Ward, 2016; Jette and Rail, 2014; Lindhardt et al., 2013; Thorbjörnsdottir et al., 2020). Concepts from a public health perspective considered external factors affecting maternal 'obesity', namely the social determinants of health as having a bearing on weight gain and health related activity (Jette and Rail, 2014). This is reflective of the public health paradigm which considers the socioeconomic context of individuals' lives and their reality within that context (Khanal, 2012). Bombak, McPhail and Ward (2016) considered reproductive care and women who were overweight or 'obese' and their experiences of discrimination. The study adopted a sociological approach and via use of interviews actively considered the negative impact of reproductive services on women's experiences. Coming from a health science perspective traditionally concerned with disease this research demonstrates a paradigm shift from the study of pathology to a more holistic approach to research. This was also reflected in the work of Lindhardt et al. (2013) and Thorbjörnsdottir et al. (2020). Coming from a medical and health science paradigm respectively, both considered women's experiences of care and attitude of caregivers as opposed to following the traditional pathological

focused approach usually adopted by health and medicine.

Adolfsson, Andresen and Edgren (2013) focused on the relationship between 'obese' pregnant women and their midwife and care received. In contrast to this, Atkinson, Olander and French (2013) examined the experiences of 'obese' pregnant and post-natal women who had declined or disengaged from a weight management service. Both studies highlighted that women were shocked to be referred for care in relation to their weight and either did not consider themselves 'obese' or had not been informed of referral.

Of the five interdisciplinary studies (n=5) all examined women's experiences of care (Dinsdale et al., 2016; Furness et al., 2011; Hestlehurst et al., 2013; Heslehurst et al., 2015; Knight- Argawel et al., 2016a), with three focusing on women's experience of following prescribed management plans (or disengagement from) in line with current policy and practice within the UK (Dinsdale et al., 2016; Furness et al., 2011; Heslehurst et al., 2015). All the studies were undertaken during a time of increased interest in maternal 'obesity' management and reflect the increasing medicalisation of maternal 'obesity' at that time, following a medical paradigm in their approach concerned with reducing risk.

Of note, Heslehurst et al. (2015) conducted a mixed methods study evaluating the implementation of a maternal 'obesity' care pathway, interviewing women, sending questionaries to health professionals, and undertaking a clinical audit to access compliance with care. By using a mixed methods approach both the depth from qualitative data and breadth of quantitative audit data (from women's medical records) enabled a thorough interpretation of maternal 'obesity' management. By using objective epistemology in data collection and considering women's experiences using an interpretive approach, as well as considering health professionals views, the synergy created strengthens the recommendations made.

3.12 Narratives from Women's Studies

This tradition provides the earliest storyline and includes two studies (Wiles 1994,

1998). The distinctiveness of this tradition lies in its unification of feminist theory with empirical research centring the everyday lives of women. Women's feelings and beliefs around weight were explored in two studies by the same author (Wiles 1994, 1998). Both studies considered women's experiences during and after pregnancy from a sociological perspective using feminist phenomenology and an interpretive approach based on grounded theory, considering how external forces, which influence behaviour, govern women's weight. These studies used actual weight as an indicator for recruitment, with women approached for inclusion who had reached a weight of 90Kgs by the 30th week of pregnancy. This strategy is likely indicative of a time when weighing pregnant women was not routine practice in the UK, as well as being undertaken before BMI as an international standard for weight measurement changed its parameters (Lupton, 2013a). These studies found comments made by health professionals were perceived by women as derogatory and insulting. At the same time women perceived being 'fat' as being more socially acceptable when pregnant. These studies suggest contradictory messages about women, fatness and pregnancy in everyday culture when compared to women's experiences of maternity care.

3.13 Narratives from Psychology

Mulherin et al. (2013) used a quantitative approach to examine weight stigma in maternity care and considered 'obesity' from a behaviourist perspective. By viewing women living with 'obesity' as being controlled by their environment and considering how environment affects behaviour, the authors' research tradition was consistent with its psychological roots.

Interestingly, most of the studies do not consider what women want or expect from their care. Most of the included studies appear to blur the boundaries in relation to the research tradition normally aligned to their profession, adopting medical research tradition traits in interpreting the data. It could be argued that generally the research reviewed is interested not in the women themselves but their care and management.

3.14 Historical context: Evolving policy

Mapped across time, the literature reviewed reflects evolving policy in relation to managing 'obesity' risk across the countries studied (Table 7). This is significant, as prior to 2004 and before the publication of *The Confidential Enquiry into Maternal and Child Health (CEMACH) Saving Mother's Lives*, (Lewis, 2004, 2007) which reported an increase in maternal deaths of women with a BMI of 30 or above in the UK between 2000-2002 and 2003-2005 respectively, maternal 'obesity' research appears to be limited to medical research examining the complications associated with maternal 'obesity'. Women's experiences prior to Wiles' work (1994, 1998) were sketchy, yet maternal 'obesity' risk had been recognised within obstetrics since the early 1900s (Lim, 2015). Research in this area became more prevalent following the publication of the CEMACH report in 2004, with the publication of findings of a national obesity project in the UK (CMACE/RCOG, 2010) and best practice guidelines (CMACE/RCOG, 2010; NICE, 2010) fostering a plethora of research examining mortality and morbidity outcomes. With the implementation of these guidelines and others throughout the Western world, research has latterly begun to consider women's experiences of the care received.

Table 7. The evolvement of the management and care of maternal 'obesity' in relation to women's experiences: A historical perspective.

Year	Authors	Historical context in relation to key maternal 'obesity' policy and practices.	Development of the management and care of maternal 'obesity' conceptualised through time in relation to women's experiences.	Women's experiences conceptualised in relation to control, consent and choice
1994	Wiles		Focus on weight gain in pregnancy and diet	Humiliation from health perspective. Being 'fat' more socially accepted when pregnant.
1998	Wiles	National Institute of Health (USA) reduced overweight threshold of BMI from 27.3 kg/m² to 25kg/m² and reclassified 'obesity' as a BMI of 30 kg/m² or above.	Focus on weight gain in pregnancy and diet	Lack of professional support and advice. Conflicting advice. Self- controlling
2004		UK: - Confidential Enquiries into Maternal and Child Health (CEMACH) (CEMACH,2004) reported an increase in maternal deaths between 2000-2002 of women living with 'obesity'		
2007		UK: - CEMACH (2007) reported an increase from the previous report of maternal deaths in women living with 'obesity' (2003-2005). UK: - Royal College of Obstetricians and Gynaecologists (RCOG) published consensus views on 'obesity' and reproductive health. Specific recommendations made regarding the management of women living with 'obesity' during pregnancy.		

Year	Authors	Historical context in relation to key maternal 'obesity' policy and practices.	Development of the management and care of maternal 'obesity' conceptualised through time in relation to women's experiences.	Women's experiences conceptualised in relation to control, consent and choice
2009		USA: - weight gain guidelines update published (Rasmussen and Yaktine,2009) US		
2010	Nyan et al.	UK: Publication of findings of a national obesity project - Confidential Enquiries into Maternal and Child Health (CMACE)(CMACE, (2010) UK: - Publication of best practice guidelines with an estimation that 1in 5 pregnant women in the UK 'obese' (CMACE/RCOG, 2010). UK: - Publication of The National Institute for Health and Care Excellence (NICE) guidance, Weight management before, during and after pregnancy. Canada: - Publication of clinical practice guidelines, Society of Obstetricians and Gynaecologists of Canada (Davis, 2010) Australia: - Publication of maternity and neonatal guidelines (Queensland Health, 2010)	Focus on risk. Fetus-centric care.	Humiliation. Feeling 'exposed' and scrutinised. Keeping 'silent'. Fear and anxiety. Health professional's as authoritative, gatekeepers of care. Positive and negative encounters with health professionals. Maternal body as a vessel.
2011	Furness et al. Furber and Gowen Keely, Gunning and Denison	UK: - CMACE (2011), slight decrease in maternal deaths of women living with 'obesity' between 2006-2008 Ireland: - Publication of clinical practice guidelines- Institute of Obstetricians and Gynaecologists in Ireland (IOG), (Health Service Executive, 2011) Australia: - Publication of clinical guidelines for the state of Victoria (Maternity and Newborn Clinical Network, 2011)	Increased focus on medicalisation of care and reducing risk. Fetus-centric care.	Humiliation and stigmatisation. Feeling 'ignored', conflicting advice, lack of communication, no explanations of care given, mother blaming, labelling.
2012	Hildingson and Thomas		Focus on increased likelihood of pregnancy	Fear, lack of continuity, generally satisfaction with care.

Increase in medicalisation of maternal 'obesity'

Year	Authors	Historical context in relation to key maternal 'obesity' policy and practices.	Development of the management and care of maternal 'obesity' conceptualised through time in relation to women's experiences.	Women's experiences conceptualised in relation to control, consent and choice
			related complications for women with a high BMI.	
2013	Adolfsson, Andresen and Edgren Atkinson and McNamara Heslehurst et al. Lindardt et al. Mills, Schmied and Dahlen Mulherin et al.	USA: - Publication of clinical guidelines in relation to weight gain during pregnancy (American College of obstetricians and Gynecologists (ACOG),2013a) and 'obesity' in pregnancy (ACOG,2013b)	Evidence of increased medicalisation and adherence to best practice guidelines and how managing 'obesity' is high on the public health agenda.	High BMI negatively impacts on care received. Care perceived as 'prescriptive'. Impact of policy affecting women's views. Being treated differently put in a 'bucket', being 'put into boxes'. No explanations of care given, conflicting advice. Feeling 'exposed'. Lack of appropriate equipment, negative attitudes of care givers and effect on quality of care. Mother-blaming.
2014	Jette and Rail		Focus on weight gain in pregnancy and diet	Conflicting advice, experts exerting control, women wanting to control their bodies.
2015	Heslehurst et al. Lavender and Smith	NHS Maternity Services Data Set (2015) begins collecting data on BMI at antenatal booking appointment.	Move to engage women in 'lifestyle' programmes and care being streamed into 'pathways, depending on BMI, with increased medicalisation of care the higher the BMI. Increasing evidence of 'obesity' as a public health issue.	Expectation that women will 'comply' with care offered. Lack of understanding, conflicting advice and lack of information giving. Fear and anxiety. Lack of training of health professionals impacting on care. Acceptance of being 'fat' and pregnant.
2016	Bombak, McPhail and Ward		Focus on healthy diet and activity with undertones of	Health professionals as gatekeepers. Imbalance of power. Stigmatisation and vulnerability. Refusal to

Increase in medicalisation of maternal 'obesity'

Year	Authors	Historical context in relation to key maternal 'obesity' policy and practices.	Development of the management and care of maternal 'obesity' conceptualised through time in relation to women's experiences.	Women's experiences conceptualised in relation to control, consent and choice
	Dinsdale et al. Knight-Agarwel et al.		increased medicalisation of maternal 'obesity'. Implementation of maternity 'obesity' 'pathways' for monitoring throughout the pregnancy continuum. Main focus on BMI above 40kg/m²	treat. Fetal risk discourse. Fear and anxiety. Felling 'exposed'. Mother blaming. '
2017	Atkinson and McNamera	RCOG guidelines in the UK 'Care of Women with Obesity in Pregnancy', updated in 2018	Focus on the importance of effective communication to promote health promotion and provide maternity care.	Problems communicating with unconscious collaboration between health professionals and women
2020	Thorbjörnsdottir et al.		The birth process is negatively impacted by risk processes	Loss of autonomy Lack of communication Shame and blame

3.14.1 Historical context: Focus shift

In addition to the different approaches to research in line with evolving policy, evidence emerged suggesting that over time the management of 'obesity' has moved from a focus on weight gain and diet through increased medicalisation, to renewed focus on improving diet and physical activity through public health (Fig. 3.2). This focus shift may be reflective of the increase in cost for health service providers in managing maternal 'obesity' (Allen-Walker et al., 2016; Morgan, 2014; Soltani, 2009,) as well as the notion of individuals being empowered to take responsibility for their own health. It may also be reflective of a research paradigm shift, moving from the focus on risk and medicalisation of maternal 'obesity' to addressing maternal 'obesity' through the public health agenda.

Reflecting on the historical context of maternal 'obesity' takes me back to my early career. I qualified as a midwife in December 1991 and cannot remember weighing women routinely. In fact routine weighing of women stopped in the early 1990s as there was no clinical evidence at that time that it had an inpact on outcome (Allen-Walker et al., 2016) and no guidelines exisited on management and care for women living with 'obesity' at this time. This correlates to the literature reviewed, with Wiles' (1994, 1998) research reflecting the focus on weight gain and diet from an asethetic perspective and the stigmatisation associated with that, as opposed to concerns for maternal and fetal outcome. With the increase in maternal 'obesity' and subsequent research concerned with maternal and neonatal mortality and morbidity from the late 20th, early 21st century, it was inevitable that the focus would shift to increased medicalisation to improve outcomes. Subsequently, a further shift focusing on risk epidemiology, with diet and physical activity interventions reducing risk has emerged.

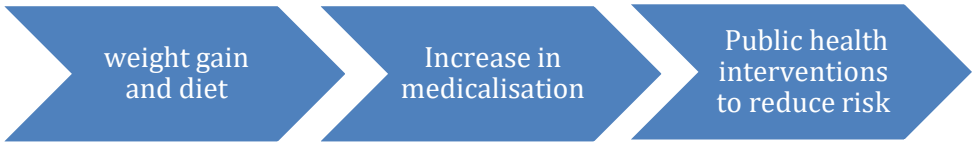

Figure 3.2 Historical context of 'obesity' management and care conceptualised through women's experiences

3.15 The impact of women's experiences on choice, consent, and control

The main aim of this meta-narrative review was to identify how the experiences of women living with 'obesity' impact on their choice, consent, and control and how this has evolved over time. In relation to women's experiences emerging patterns across the literature were identified. Four themes in relation to these were constructed. These were 'being managed'; 'attitudes of care-givers'; 'social determinants'; 'women's beliefs'; and 'experiences of weight' (Table 8).

Table 8: Emerging patterns across the literature in relation to the reviews aims of conceptualizing women's experiences of choice, consent, and control throughout the pregnancy continuum.

	Theme	**Study**
Experiences of choice, consent, and control throughout the pregnancy continuum of women living with 'obesity'	Attitudes of caregivers	Wiles (1994) Wiles (1998) Nyman, Prebensen and Flensner (2010) Furber and McGowen (2011) Furness et al. (2011) Keely, Gunning and Denison (2011) Mills, Schmied and Dahlen (2013) Hildingsson and Thomas (2012) Adolfsson, Andresen and Edgren (2013) Atkinson, Olander and French (2013) Heslehurst et al. (2013) Lindhardt (2013) Mulherin et al. (2013) Lavender and Smith (2015) Bombak, McPhail and Ward (2016)

Experiences of choice, consent, and control throughout the pregnancy continuum of women living with 'obesity'		Dinsdale et al. (2016) Knight-Agarwel et al. (2016a) Thorbjörnsdottir et al. (2020)
	Being 'managed'	Furber and Mcgowen (2011) Keely, Gunning and Denison (2011) Mills, Schmied and Dahlen (2013) Hildingsson and Thomas (2012) Atkinson, Olander and French (2013) Heslehurst et al. (2013) Lindhardt et al. (2013) Mulherin et al. (2013) Heslehurst et al. (2015) Lavender and Smith (2015) Bombak,, McPhail and Ward (2016) Dinsdale et al (2016) Knight-Agarwel et al. (2016a) Thorbjörnsdottir et al. (2020)
	Social determinants	Hildingsson and Thomas (2012) Mills, Schmied and Dahlen (2013) Mulherin et al. (2013) Jette and Rail (2014) Heslehurst et al. (2015)
	Women's beliefs and experiences of weight	Wiles (1998) Wiles (1994) Nyman, Prebensen and Flensner (2010) Furness et al. (2011) Mills, Schmied and Dahlen (2013) Adolfsson, Andresen and Edgren (2013) Atkinson, Olander, and French (2013) Heslehurst et al. (2013) Jette and Rail (2014) Dinsdale et al. (2016) Knight-Agarwel et al. (2016a) Thorbjörnsdottir et al. (2020)

3.15.1 Attitudes of caregivers

Attitudes of caregivers appeared to be a common theme emerging from the literature reviewed (Table 5). Humiliation, feeling stigmatised and judged were

regularly cited when women came into contact with health professionals (Bombak, McPhail and Ward, 2016; Furber and McGowan, 2011; Furness et al., 2011, Heslehurst et al., 2013; Knight-Agarwal et al., 2016a; Lindhardt et al., 2013; Mulherin et al., 2013; Thorbjörnsdottir et al., 2020; Wiles, 1998) and are well documented in 'obesity' health related literature (Haydon et al., 2008; Swift et al., 2013). These attitudes often impacted on how the women viewed their pregnancy and the care given, leading to loss of control and autonomy. How caregivers addressed women's weight also affected choice with some health professionals ignoring the woman's weight (Mills, Schmied and Dahlen, 2013), thereby either not acknowledging weight as a risk factor for pregnancy and birth outcome or managing 'obesity' risk factors without informed consent. In some cases, women were not made aware of the risks associated with 'obesity', nor were they given adequate information about being pregnant and 'obese', therefore information to support informed choice was lacking (Keely, Gunning and Denison, 2011; Lavender and Smith, 2015; Lindhardt et al., 2013).

Most women in the studies recognised that they were 'obese' and there was an expectation that this would be addressed at antenatal appointments. Information giving varied, however, with some women not being aware of the risks associated with being 'obese', reducing choice and autonomy (Dinsdale et al., 2016; Keely, Gunning and Denison, 2011; Lindhardt et al., 2013; Thorbjörnsdottir et al., 2020). Generally, women wanted caregivers to acknowledge their weight, making helpful suggestions for management and care and involving them in the decision-making process (Adolfsson, Andresen and Edgren, 2013; Furness et al., 2011; Lindhardt et al., 2013).

Where information was given in a non-judgmental, honest, and open way, women responded positively, feeling in control and able to give informed consent and empowered to make choices around their care (Heslehurst et al., 2013; Lavender and Smith, 2015; Mills, Schmied and Dahlen, 2013).

3.15.2 Being Managed

Pregnant women with a BMI of 30 or above were medically managed with increased screening and referral for specialist care (Atkinson, Olander and French, 2013; Bombak, McPhail and Ward, 2016; Dinsdale et al., 2016; Furber and McGowen, 2011; Keely, Gunning and Denison, 2011; Heslehurst et al., 2013; 2015, Knight-Agarwel et al., 2016a; Lavender and Smith, 2015; Lindhardt et al., 2013; Thorbjörnsdottir et al., 2020). It was evident in some of the studies however that many women were not aware they had been referred for specialist care. This often only became apparent when the woman attended an appointment made for them by another health professional with no explanation given of the reason for the appointment (Atkinson, Olander and French, 2013; Bombak, McPhail and Ward, 2016; Dinsdale et al., 2016; Heslehurst et al., 2015; Knight-Agarwel et al., 2016a; Lavender and Smith, 2015; Lindhardt et al., 2013). Failing to involve women in discussions and decisions in relation to care limits choice, and consent cannot be fully gained.

Language from health professionals focused on how they would 'manage' the pregnancy and birth, with women citing that they were told they 'had to have' as opposed to being offered. This often led to women complying to care of which they had little understanding (Knight-Agarwel, 2016a; Lindhardt, 2013; Thorbjörnsdottir et al., 2020). Bombak, McPhail and Ward (2016) explored this in relation to risk, identifying an inflation of weight bias with women being managed 'just in case'.

Women's perceptions of 'obesity' risk during pregnancy and birth varied between the studies, with some women being very aware of the risks (Keely, Gunning and Denison, 2011; Thorbjörnsdottir et al., 2020) and others having either little or no knowledge (Atkinson, Olander and French, 2013; Bombak, McPhail and Ward, 2016; Dinsdale et al., 2016; Furber and McGowen, 2011; Heslehurst et al., 2013, 2015; Keely, Gunning and Denison, 2011; Knight-Agarwel et al., 2016a; Lavender and Smith, 2015; Lindhardt et al., 2013). Dinsdale et al (2016) found that women with a BMI of 40 or above were much more aware of maternal 'obesity' risk and reported more positive experiences of the care given than those with a BMI above 30 and

below 40. Almost all the women in the latter group were not aware of the management pathway of care they were receiving, nor were they aware of the risks associated with their weight. Hestlehurst et al. (2015) also found that women with a lower BMI (although still classed as 'obese' by BMI classification) reported less satisfaction than those with a BMI of 40 or above. They did report, however, that acceptance of intervention was higher when women understood the risks, suggesting that lack of understanding of risk contributed to decreased satisfaction with care. In contrast, Mulherin et al. (2013) reported less satisfaction with treatment the higher the BMI, tied up with health professional's attitudes and the stigma attached to having a high BMI. Hildingsson and Thomas (2012), however, reported no difference in care satisfaction between all BMI ranges. It is difficult to ascertain why there was a notable difference between care satisfaction across the studies. It could be argued that it may be attributed to when and where the studies were carried out, depending on if best practice guidelines were in place or being followed at the time (Mulherin et al., 2013) as well as women's perceptions of care received at that time.

Furber and McGowen (2011) and Mills, Schmied and Dahlen (2013) found that care was seen by women to be focused on the wellbeing of the fetus, failing to acknowledge the mother and her baby holistically. Women cited that extra fetal screening increased anxiety and distress, as well as feelings of guilt and blame. Paradoxically, women across all the studies prioritised the health and wellbeing of their baby reflecting the dichotomy. In support of this, Bombak, McPhail and Ward (2016) suggest that discussions around pregnancy and birth complications are framed around the fetus and not the woman. It could be argued that this approach is tied up with the medicalisation of childbirth previously discussed in Chapter 2.

Mills, Schmied and Dahlen (2013) highlighted that the women in their study felt that hospital policies and practices led to loss of autonomy, with health professionals focusing on risk as opposed to offering individualised care. Complications being pre-empted and a 'one size fits all' approach appears to foster a reduction in choice for women with regard to their preferences for care. This was

also highlighted by Thorbjörnsdottir et al. (2020), with the women in their study often unable to assert their autonomy, resulting in impersonalised care, discrimination, and restricted choice.

3.15.3 Social determinants

Hildingsson and Thomas (2012) and Mulherin et al. (2013) considered education levels as a factor influencing 'obesity' and perceived care. Hildingsson and Thomas (2012) identified a correlation between increasing BMI and decreasing educational status. This could indicate that if 'obesity' is associated with lower educational levels then these women are disadvantaged with regard to care provision as they may not be able to articulate their needs or understand the implications of care offered, thereby reducing choice, and affecting the ability to make informed decisions. In contrast to this, Mulherin et al. (2013) ascertained in their study that 40% of participants were educated to degree level, with 22% having no further education after secondary schooling. The results focus on perceived care satisfaction, with no significant variance in perceived positive or negative treatment in relation to education levels. This could suggest that education is not a factor in maternal satisfaction of care received but does not indicate if BMI is associated with level of education.

Educational status was also a consideration in the work of Jette and Rail (2014), who studied pregnant women of low income and their experiences of health and weight gain. Although not identified as 'obese' by BMI classification, the majority of women identified as 'overweight'. It was apparent that many of these women (n= 9 out of 15) were educated to degree level or above. Of these, all were immigrants whose low-income status was partially due to building a new life in a new country. This suggests a link between low income and the inability to adopt a healthy 'lifestyle'[15] regardless of education level.

[15] 'lifestyle' is a word often used when referring to people living with 'obesity', suggesting that their 'lifestyle' contributes to their weight. Although widely used in the literature it is a term that can be stigmatising as it implies that people have a true choice over their circumstances. In view of this I have used 'lifestyle' in inverted commas.

Financial stress was seen as an important factor in women's dietary choices (Jette and Rail, 2014). Availability of cheap fast food due to cost, ease of access and availability was also cited as influential. Financial implications appeared to influence choice as well as diet being controlled by others e.g., when living with relatives and not being responsible for preparing meals or relying on others financially. Feelings of inadequacy were prevalent, with financial and time constraints negatively influencing how women perceived their mothering skills. Added to this, some women experienced work and childcare issues due to having to travel further to access maternity care because of their 'high risk' status (Mills, Schmied and Dahlen 2013).

Jett and Rail (2013) also considered religion in how women perceive their health and particularly that of their baby. Several women reported that the health of their baby was in the hands of Allah, therefore relinquishing control to a higher order associated with their religious beliefs. Although open to adopting healthier diet and more physical activity where possible, these women's religious beliefs factored in the choices made. Similarly, Mills, Schmied and Dahlen (2013) highlighted cultural background as a factor influencing weight perception, with one interviewee of Tongan heritage being accepting of her weight, which for her was the cultural 'norm'.

3.15.4 Women's beliefs of weight

Women's attitude to weight and weight gain during pregnancy appears to be complex, rooted within societal expectations of the feminine body and motherhood (Adolfsson, Andresen and Edgren, 2013; Bombak, McPhail and Ward, 2016; Dinsdale et al., 2016; Furness et al., 2011; Heslehurst et al., 2013; Jette and Rail, 2014; Knight-Agarwal et al., 2016;, Mills, Schmied and Dahlen, 2013; Thorbjörnsdottir et al., 2020; Wiles, 1994, 1998). The studies concur that most women were aware of their weight prior to pregnancy, with some citing historical issues with weight, including yo-yoing dieting and eating disorders (Adolfsson, Andresen and Edgren, 2013; Dinsdale et al., 2016; Furness et al., 2011; Heslehurst et al., 2013; Knight-Agarwal et al., 2016a; Mills, Schmied and Dahlen, 2013),

suggesting underlying factors influencing size other than poor diet and lack of exercise.

An awareness of the impact of 'obesity' on pregnancy and birth, particularly on the baby, was apparent and compounded feelings of inadequacy and low self-esteem (Knight-Agarwal et al., 2016a). Generally, the need to 'control' eating in order to provide the best outcome for the baby was recognised (Heslehurst et al., 2013; Jette and Rail, 2013; knight-Agarwal et al., 2016a; Wiles, 1994, 1998) with women feeling responsible for their unborn baby's health and wellbeing. In trying to follow healthy eating patterns, however, other factors impeded this, mainly determinants of health (Jette and Rail, 2014). In being unable to maintain a healthy eating plan due to cost, one woman stated that she could not financially afford to be the 'perfect mother' (Jette and Rail, 2014, p.207). This raises the issue of feeling inadequate and being unable to parent effectively.

The concept of 'obesity' being attributed to poor mothering was apparent (Atkinson et al., 2013; Bombak, McPhail and Ward, 2016; Heslehurst et al., 2013; Jette and Rail, 2014,). Atkinson, Olander and French (2013, p.250) found that referral to weight management services by health professionals was seen by some women as questioning their ability to make healthy 'lifestyle' choices, implying that they must be 'bad mothers'.

Bombak, McPhail and Ward (2016) discussed mother blaming in relation to health professionals focus on fetal risk and how this influenced women's beliefs around weight. In their study, several women of white middle class backgrounds resisted this 'labelling' by projecting distain onto other (indigenous) pregnant women, who they deemed to be of higher risk than themselves, thus increasing their own respectability. By resisting this weight stigma, these women were able to gain some control, demanding better care, however marginalising others in the process.

Women also felt responsible for weight gain in pregnancy with Jette and Rail (2014) attributing this to society's views on the feminine body as opposed to the health of

the baby or woman. This was reiterated throughout much of the literature (Adolfsson, Andresen and Edgren, 2013; Dinsdale et al., 2016; Furness et al., 2011; Heslehurst et al., 2013; Jette and Rail, 2014; Mills, Schmied and Dahlen, 2013; Nyman, Prebensen and Flensner, 2010) with reference to society's expectations to be 'slim' and the notion of 'fatness' being associated with being 'greedy' and 'lazy' (Heslehurst et al., 2013, p.974). This was perceived to decrease self-esteem, increase feelings of guilt, and was again associated with being a 'bad mother' (Heslehurst et al., 2013; Jette and Rail, 2014). In contrast to this, however, Wiles (1994) found that for some women pregnancy was the only time society accepted their weight, legitimising their 'obesity'. Nyman, Prebensen and Flensner (2010) and Adolfsson, Andresen and Edgren (2013) also concluded that being pregnant was a time where women living with 'obesity' felt their size was accepted. It could be argued that women who think this way may feel empowered, enhancing their control over the care offered and enabling choice.

Embodiment (see Chapter 2, 2.4) appeared to affect how some women perceived the care offered/given (Adolfsson, Andresen and Edgren, 2013; Dinsdale et al., 2016; Furness et al., 2011; Nyman, Prebensen and Flensner, 2010). They expected to be judged and were extremely sensitive to comments made about their weight through living with a constant 'awareness of the body' (Nyman, Prebensen and Flensner, 2010, p.426). These women perceived that there was a positive bias towards 'thin' women (Adolfsson, Andresen and Edgren, 2013). These preconceived ideas of treatment have the potential to negatively impact on the care received, affecting positive relationship building with health professionals, thereby inhibiting choice and disenabling informed consent.

3.16 How choice, consent, and control intersect with the findings

It is well established from the plethora of evidence discussed that 'obesity' during the pregnancy continuum is associated with increased risk of adverse outcomes for both women and their babies. Women living with 'obesity' are cared for in the UK by obstetricians, using a risk management approach based on a medical model of care, which limits women's choices for pregnancy and birth. Added to this is the use

of odds ratio to determine risk, which inflates the perception of risk to women as opposed to using numerical risk which would indicate risk of 'obesity' complications as being low (Hull et al., 2015). This inflation of risk causes undue worry and concern for women who may consent to intervention without knowing their actual risk, therefore impeding choice, and inhibiting informed consent. It is argued that the technocratic approach to maternity care (Davis- Floyd, 1992, 1994), which is concerned with outcomes in relation to mortality and morbidity rates only, has generated a culture which is fetus-centric (Parker, 2014; Rothman, 2001,). This is supported in the literature reviewed with risk often attributed to fetal risk, apportioning blame on the 'mother' making them feel guilty for being 'fat'. Mother blaming undermines women's self-esteem and heightens their vulnerability making them more likely to comply with treatment (Lupton, 2013a; Parker, 2014).

Standardising care for women living with 'obesity', which involves increased surveillance and investigations suggests that complications are likely for both the woman and the baby, as opposed to assessing whether intervention is needed using a holistic approach based on the woman's health and well-being (Ahluwalia, 2015). Treating all women living with 'obesity' the same may reduce choice and may assume compliance leading to loss of autonomy and an expectation to comply. This is in contrast to government policy, which promotes the notion of choice in childbirth for all women (Department of Health/Partnerships for Children, Families and Maternity: Maternity Matters, 2007; NHS England: Better Births, 2016), yet arguably removes choice through regulating health provision in order to improve safety (NHSLA, 2013; Ahluwalia, 2015). Added to this is the association of 'obesity' being undesirable and vilified in Western society (Lupton, 2013a; Tischer, 2013), leading to stigmatisation, blame and shame. These mixed messages around 'obesity' and care provision, compounded with society's assumptions may influence how care is delivered, received, and perceived and is a concern for this thesis.

3.17 Strengths and limitations of the meta-narrative review

This review meticulously followed the quality standards for meta-narrative review developed by Wong et al. (2013). It examines the experiences of women living with

'obesity' in relation to management and care throughout the pregnancy continuum, with women's experiences conceptualised in relation to choice, consent and control during this time. By using a meta-narrative approach, research across both qualitative and quantitative paradigms and across disciplines could be included and no restrictions applied. The literature was published between 1993 and 2020 which enabled a historical timeline to be mapped showing an emerging storyline (see 3.14). This allowed women's experiences to be examined in parallel with changes to policy and practice as well as consider how women's experiences have been conceptualised across the research paradigms. Mapping also established the cyclical nature of the analysed literature. The review was limited however due to the inclusion of published research only, as well as research published in the English language limiting its scope.

3.18 Gaps and rationale

Presented below is a consideration of the rationale for this study and why I undertook a meta-narrative review of the literature. It considers how undertaking the meta-narrative review has informed the study design and development.

As stated in Chapter 1 (1.4) the driver for this study was in response to working in practice following the publication of the CMACE/RCOG Joint Guideline: *Management of Women with Obesity in Pregnancy* in 2010 and its subsequent introduction into practice. Having been instrumental in developing and embedding the guideline into local policy and practice as well as evaluating 'compliance', my attention began to focus on women's experiences. My practice at this time was driven by a medical model of care which standardised care and impeded choice, reducing autonomy for women. I also began to doubt that women truly understood the care offered, informed consent lacking. There were many reasons for this, notwithstanding lack of time and resources as a community midwife. Also, research leading to this guidance was focused on obstetric risk, and maternal and fetal complications. This medical research paradigm was dominant with little consideration of women's experiences.

In relation to caring for women with a high BMI during the pregnancy continuum my previous practice continues to bother me and is the catalyst for this study. Understanding women's experiences in relation to choice, control and consent will inform maternity service provision and health professionals understanding and educational development in order to ensure women's autonomy is enhanced. In reflecting on my reasons to undertake this study it drew me to meta-narrative review. I wanted to understand how women's experiences have been captured over time, pre and post 2010 and whether the concepts of choice, consent and control were evident within the existing research in order to inform my own study. Meta-narrative review was appropriate to do this. This is the first meta-narrative review to consider maternal 'obesity' and women's experiences of care. I was aware of only one other meta-narrative review with a maternity focus published at the time of submission, considering inequalities and stillbirth (Kingdon et al., 2019). The authors identified nine research traditions from 54 sources across 70 years showing the links between poverty and risk of stillbirth, and poverty, ethnicity, and stillbirth. The review calls for further action through policy development and further research, with all research traditions coming together to address inequalities and stillbirth using a joined-up approach. With regards to this review, it has been submitted for publication under the title: *The makings of a maternal obesity epidemic: A Meta-narrative review.* At the time of submitting this thesis it was under review.

It needs to be acknowledged that when I set out to undertake this meta-narrative review, I was unclear on my choice of study design and methodology. This was due to having to apply for NHS research ethical approval early in my PhD journey. It is unusual to do an in-depth literature review when undertaking a constructivist grounded theory approach as discussed earlier in this chapter (3.1). If a literature review is undertaken a scoping review is preferable (Deering and Williams, 2020). What the meta-narrative review did establish however, was that choice, consent and control was not explicate within the literature reviewed, was not the main focus, nor was it theorised. Some of the literature was also undertaken from a medical paradigm perspective focusing on improving care for women through

increased risk processes. None of the reviewed literature provided a deeper perspective on women's lived experiences and how this impacts on choice, consent, and control. This therefore supports the need for further research in this area which this study aims to address. These gaps in the literature helped to inform my study and my study design of using a constructivist grounded theory approach underpinned by poststructural feminist methodology which is further discussed in Chapter 4.

Medical management in the United Kingdom increases significantly for women the higher their BMI (Denison,2018, Appendix C). In view of this I wanted to conduct a study which just considered women's experiences when they booked with a BMI of 35 or above, to capture experiences of increased medical care and how this intersects with choice, control, and consent. The booking BMI of the participants recruited to the reviewed studies varied, from estimated weight to a BMI of 30 or above, therefore reducing the available knowledge in relation to those with a BMI of 35 or above. Only one study reviewed explored women's experiences when they booked with a BMI of 35 or above (Furber and McGoven, 2011), with one study focusing on women with a booking BMI of 40 or above. This study aims to address this gap adding to the body of knowledge in relation to women who present in pregnancy with a booking BMI of 35 or above.

None of the studies reviewed used a longitudinal approach across the entire pregnancy continuum, from early pregnancy to post birth, with only one undertaking two interviews in the third trimester and in the early postnatal period (Furber and McGowen, 2011). Multiple interviews from early pregnancy to following birth may have captured more fully women's experiences of care given, providing in-depth narrative at the time care was being delivered as opposed to women having to recall care received after the event. My own study explores women's experiences from early pregnancy through to the postnatal period, capturing women's experiences in a timely fashion and to gain an understanding of their reality as close to the event as possible. By doing so, this supports the uniqueness of my study, adding to the body of knowledge which already exists but

also offering further insight across the pregnancy continuum.

It could be argued that in undertaking an in-depth literature review, I risked increasing any pre-conceived ideas surrounding the phenomena to be studied, which could potentially affect my findings. As stated earlier, however, (Chapter 1, 1.14) my background affords me knowledge on the subject. Added to this, a constructivist grounded theory approach acknowledges bias, and accepts that the researcher is part of the research process. It recognises the role of the researcher in generating meaning from the data collected in collaboration with the participants (Charmaz, 2014). I argue therefore that undertaking a literature review prior to the empirical study has not influenced the study outcome.

3.19 Conclusion

This chapter has explored the experiences of women who live with 'obesity' in relation to their management and care during the pregnancy continuum and how this may influence choice, consent, and control. By examining the existing literature, an understanding of the differing concepts and research methods used across disciplines was established. How research affects policy and practice (and vice versa) and the subsequent effect on women's experiences of care was highlighted. The impact of this was apparent through using a meta-narrative approach, mapping the literature across time.

This review has been pivotal in developing understanding of how cross- disciplinary research methodology as evolved over time and the impact on this for women. In undertaking this review, a deeper understanding of the impact on 'obesity' management and care throughout the pregnancy continuum for women has been gained. How evolving research impacts on this is evident. A rationale for the study and why I undertook a meta-narrative review has been explored with gaps identified.

The following chapter will present the rationale for the ontological, epistemological and methodology positioning, methods adopted and rationale for the empirical

study exploring women's experiences throughout the pregnancy continuum when they book with a BMI of 35 or above.

CHAPTER 4

PHILOSOPHICAL AND THEORECTICAL POSITIONING

4.0 Introduction

The previous chapter presented a meta-narrative review of the literature, considering women's experiences of pregnancy and birth when they present as 'obese'. How disciplines have constructed research on the phenomena over time was critiqued and presented.

In this chapter I present the rationale for the methodology used to explore women's experiences throughout the pregnancy continuum when they book with a BMI of 35 or above. It provides the background of the ontological and epistemological positioning I have adopted for this study and positions it through a feminist lens. It also considers two differing methodological approaches, phenomenology, and grounded theory with a rationale for the constructivist grounded theory approach adopted.

4.1 Ontological, epistemological, and methodological perspectives

Ontology is a philosophical approach relating to the 'study of being' (Crotty, 1998, p.10) and considers how reality is structured (Richards, 2003), or what can be known about the world (Snape and Spencer, 2003). Epistemology is concerned with knowledge and knowing in terms of 'how we know what we know' (Crotty, 1998, p.3) or how knowledge is gained and communicated to others (Cohen, Manion and Morrison, 2007). In order to gain knowledge, researchers study various lines of enquiry using methodologies applicable to either their ontological and epistemological stance or choose an approach that is best suited to their research design (Ormston et al., 2013).

Positivism and interpretivism are opposing approaches each underpinned by contrasting ontological and epistemological perspectives (Table 9). Positivism has an epistemological position of objectivity and considers that reality exists in objects

independent of human consciousness, waiting to be uncovered (Crotty, 1998). Knowledge from a positivist perspective is viewed as value-free and can be replicated and generalised (Wellington, 2000). Research methodologies adopted following this approach come from the natural science paradigm where objects can be measured and tested with the researcher being detached from the process.

Table 9: Comparison of positivist and interpretivist approaches to research. (Adapted from Crotty, 1998 and Weber, 2004)

	Positivist	**Interpretivist**
Ontology	One reality/truth (realist)	Multiple realities/truths (relativist)
Epistemology	Objective	Subjective
Methodology	Experimental, survey research	Reality is interpreted by using various methodological approaches e.g., constructivist grounded theory, phenomenology, Narrative inquiry, Ethnography
Methods	Quantitative	Qualitative
Role of the researcher	Objective and neutral	Reflexive interpreter

Traditionally, research in medicine has been patriarchal, particularly in relation to women's health (Young, Fisher and Kirkman, 2018), following a medical (scientific) paradigm and as highlighted in the meta-narrative review, even when undertaken by midwives this paradigm may still be observed. Women may be exposed to care which is paternalistic and of which midwives often collude due to ridged hospital

policies (Kotaska, 2011), which follow a medical model of care; the essence of midwifery 'with woman' being lost, leading to loss of autonomy for women (Newnham, 2014; Newnham and Kirkham, 2019). Advances in obstetric practices through research no doubt saves lives, but often women are seen but not heard. Medicine usually adopts a positivist approach, believing that the world exists beyond the knowledge individuals have (Gray, 2017; Phillips and Burbules, 2000). Reality and truth are captured through objective measurement, with data captured considered to be real or true (Crotty, 2003). This approach exists outside of social contexts and through objective replication can be further validated as truth. Within this paradigm, the researcher is also seen to be objective (Ryan, 2018). I reject this approach as it does not consider the complexities of women's lives, ignoring the social, cultural and political aspects that influence women's life worlds. Also, in suggesting that the researcher can distance themselves from the research process it fails to recognise the researcher's unconscious pre-understandings. As the researcher I felt that I could not ensure objectivity, nor do I believe this is how knowledge and reality are experienced.

In contrast to the positivist approach, an interpretivist approach recognises that knowledge is subjective, with interpretive researchers arguing that reality is socially constructed, viewed through language and consciousness (Crotty, 1998; Denzin and Lincoln, 2017; Green and Thorogood, 2014). Interpretivism argues that natural and social realities differ, rejecting the positivist view that meaning exists within the world independently of consciousness (Gray, 2017). It also acknowledges that the researcher cannot detach themselves from the research process and as such their own beliefs influence the outcomes (Charmaz, 2014). In relation to my own methodological beliefs and positioning I identify with interpretivism. I take the position that reality and truth cannot be separated from the wider social, cultural, and political landscape that we live in. Our realities change depending on how we situate ourselves within the world at any given time and each individual brings a different perspective depending on their own reality (Ritchie and Lewis, 2003). For this study I adopted a relativist ontological stance which rejects realism and one

reality, believing in multiple realities. In doing so I reject positivism, favouring an interpretive approach.

This study aims to explore women's experiences of choice, consent, and control throughout the pregnancy continuum when they book with a BMI of 35 or above and to understand their views and experiences of management and care. In exploring women's experiences an interpretivist approach is applicable as it seeks to uncover understanding and meaning while recognising the complexities of women's lives. In considering my ontological and epistemological position I then turned my attention to feminist epistemology.

4.2 Feminist epistemology

Feminist research is grounded in theoretical principles that positions gender at its centre of inquiry, seeking to address the many inequalities that exist in society that affect women's lives (Hesse-Biber, 2014). It should be undertaken for women, to understand women's lives and provide evidence women want to change the way they live (Allen and Baber, 1992). Feminist epistemology is centred around the concept of situated knowledge and how gender affects the knowing subjects or participants, what is known and how it is known and is socially situated (Ramazanoğlu and Holland, 2002). It examines how dominant epistemology positions disadvantage women and other marginalised groups through objectivity and flawed methodology. Feminist epistemology evolved in the 1970s when androcentric methodologies were being questioned by female researchers. Following the publication of Sandra Harding and Merrill Hintikka's *Discovering Reality: Feminist Perspectives on Epistemology, Metaphysics, Methodology and Philosophy* in 1983 of which they were editors, feminist epistemology became increasingly popular, particularly within the social sciences. Feminist empiricism,

feminist standpoint theory and feminist poststructuralism evolved as three distinct theories of feminist epistemology[16] (Harding, 1987, 1991, 2004, 2007), latterly intersecting (Doucet, 2019). It is feminist poststructuralism that this study is concerned with.

4.3 Feminist poststructuralism

A feminist poststructural methodological approach underpins this study and a rationale for this is presented below. Frost and Elichaoff (2014, p.43-44) state:

> *At the heart of feminist poststructuralism is the belief that there are more satisfactory ways to theorize gender than those reliant on patriarchal or essentialist claims. The exploration of women's experiences highlights their complexity and variation as women draw on cultural, historical, political and personal constructs to make sense of themselves and their relations to the world they inhabit.*

In order to understand feminist poststructuralism, consideration needs to be given to the concept of structuralism and post structuralism. Structuralism, a movement with its origins in the 20th century work of Ferdinand de Saussure (1857-1913), argues that language is a complex system using signs which follows certain rules, suggesting that all human activity is constructed as opposed to being natural. The concept of binary opposition in which related concepts are written in a hierarchical order, for example man/woman, rich/poor, suggesting a dominance which is subconsciously internalised as true is a key concept. He stated that language is fixed with an underlying structure, language creates meaning (Hughes, 2002).

Poststructuralism followed in the late 20th century, either rejecting the notion of dominance being defined by binary opposites or expanding upon it (Frost and

[16] Feminist empiricism: The use of empirical methods from a scientific paradigm underpinned by feminist values aiming to reduce the gender bias in science.
Feminist standpoint theory: Initially, standpoint theory was concerned with concepts related to slave and master and subsequently addressed the divisions of labour which is rooted in Marxism. Various feminist standpoint theories have evolved over time to highlight how gender affects women in relation to power and inequalities within society. It has been utilised in feminist research in order to empower the oppressed by valuing their experiences, giving them a voice, crossing usually separate political, social and scientific paradigms (Harding, 2004).
Feminist poststructuralism: See 4.3.

Elicaoff, 2014). Poststructuralists agree to some extent with Saussure that how knowledge is constructed derives from language, with language being the key to understanding social structures, meanings, and relationships (Doering, 1992). They do, however, argue that language is not fixed or structured but rather meaning is forever evolving and changing: 'The plurality of language and the impossibility of fixing meaning once and for all are basic principles of poststructuralism' (Weedon, 1997, p.82).

Language can never be neutral eventually becoming the 'norm' and therefore truth, which in turn becomes the reality within society, rather how language evolves can change overtime. How individuals see themselves is derived from language, both verbal and non-verbal, imposed on them by others. Meaning is therefore not constructed by the individual but by the language of others (Foucault, 1972, Goffman, 1959, 1963). Some language is deemed to be more knowledgeable than others e.g., scientific language, creating power structures. It is these power structures that ultimately impact on individuals (Foucault, 1972)

A key concept of feminist poststructuralism is how meaning through language is gendered which in turn imposes power through societal discourses which lead to the oppression of certain groups within society (Weedon, 1997). These power/knowledge discourses affect women's reality. Many feminist scholars have directed their attention on language and how individuals use language to understand the world they inhabit (Butler, 1991, 1993; Cixous, 1981, 1986; Haraway, 1988, 1991). The work of Foucault (1966 [1994], 1972) and Derrida (1976) have been influential in informing feminist poststructuralism, with Foucault's work on how lives are shaped by language and the power relations within, and Derrida's work on binary opposites and the quest to break these down.

In understanding women's experiences in relation to maternal 'obesity' feminist poststructuralism is an appropriate lens in which to frame the study. Foucault (1983) argues that knowledge is an exchange process that occurs between individuals. This knowledge is regulated by governing bodies throughout society

which controls and conditions individuals to act in a certain way. Those who claim to be experts on the subject of 'obesity' construct language that becomes the accepted 'norm' marginalising the 'obese', exerting power (Aston et al., 2011).

4.3.1 Situated knowledges

Central to feminist epistemology is situated knowledge, knowledge which reflects the perspectives of the knower. Although widely advocated across the three main feminist epistemological theories[17], it is within feminist poststructuralism that situated knowledge has further developed. Donna Haraway introduced the term 'situated knowledges' in her seminal work *Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspective* (1988). She criticised the scientific theories of the time which were concerned with 'disembodied scientific objectivity'. She suggests that scientists generate 'universal truths' from nowhere, setting themselves outside of a world which is situated, looking in:

> *The eyes have been used to signify a perverse capacity–honed to perfection in the history of science tied to militarism, capitalism, colonialism, and male supremacy–to distance the knowing subject from everybody and everything in the interests of unfettered power.* (p.581)

She argues that this scientific view is 'a god trick' (p.582, see also, Chapter 1, 1.2), rather proposing that any situation is perceived through an embodied subject whose perspective is fluid, influenced by historical, cultural, and social constructs. In arguing this she suggests that perception is always socially situated and embodied, therefore objectivity cannot exist.

In this study it is the women who are the situated knowers as they have the knowledge of living as 'obese' as well as how their pregnancy and births were managed because of their 'obesity'. As embodied subjects they are influenced by how 'obesity' is socially constructed, therefore objectivity cannot be achieved. Added to this as the researcher I am also a situated knower and as such cannot be objective. My ontological position of relativism underpinned by the poststructural

[17] Feminist Standpoint theory, Feminist empiricism, feminist poststructuralism/postmodernism

feminist epistemology of subjectivism aligns with an interpretive paradigm of which this study has been designed.

4.4 Perspectives on methodologies considered for the study

Once I had established my ontological and epistemological positioning, I went on to consider the methodological framework for the study. I spent a considerable time dwelling on an appropriate approach to my study which saw me apply for ethics approval while still debating a way forward. In hindsight I should have ensured I had a methodological approach prior to applying for ethics approval as initially I found myself trying to shoehorn a fit, which I now recognise as a limitation. Also, my limited knowledge of research methodologies as a novice researcher meant I struggled immensely. With this in mind and trying to remain open to a method conducive to my study aims, I began to explore methodologies that aligned. As this study is situated through a poststructural feminist lens I considered two methodological approaches, phenomenology, and grounded theory, of which a feminist approach can be applied due to the qualitative methods used to collect data. Added to this, having undertaken the literature review it was clear that grounded theory methodology had not been utilised as a research methodology previously with regards to the phenomena being studied. This was therefore a further reason to explore its use for my study. How feminist methodology interjects with qualitative research is illuminated below.

4.4.1 Feminist methodology

During the latter part of the twentieth century, feminist researchers denounced traditional research methodology as male biased. They sought to address this through undertaking research that involved women, for women's voices to be heard (Hesse-Biber, 2014). Positivism and objectivity were challenged as the social context of women's lives cannot be ignored, with knowledge being situated and inseparable from the lived experiences of women (Haraway, 1988).

It is suggested that there are no distinct feminist methodologies for undertaking research, rather the methodology used has features that feminist identify with

(Harding, 1987). Reinharz (1992) supports this, seeing feminism as a perspective that traditional research methods can apply. This suggests that research which is woman-focused is pigeon-holed into male or androcentric methodologies which are hierarchical, and gender biased (Edwards, 1990). Oakley (1981) argues, however, that certain research methods such as qualitative research are consistent with feminist inquiry, suggesting that if feminist values are adopted when conducting the research, it could be considered as feminist methodology. She advocates that a nonhierarchical relationship building approach when talking to participants lessens the power imbalance that often exists between researcher and participant. She also suggests that womanhood is a common bond that binds female researchers and participants which aids the feminist research process. Cotterill (1992) and Reinharz (1992) contest this, stating that the researcher will always be in a position of power, therefore the research processes will always be hierarchical as the researcher is ultimately in control of the knowledge gained from the researched. Cotterill (1992) also contests the notion of the researcher and participants being bonded by womanhood stating that this does not consider the differences of race, class, education, or sexual orientation.

What is evident throughout the literature debating feminist methodology, however, is that feminist research should aim to undertake research which keeps the woman at the centre (De Vault, 1990, 1996; Reinharz, 1992), asserting that social and political inequalities exist and that this is the lived reality of those studied (Skeggs, 1994). Added to this, feminist research should recognise the imbalance of power that exists between the researcher and the researched (Letherby,2003). In designing the study, I wanted to be able to adopt feminist characteristics as part of my design, therefore it was imperative that my methodology was conducive to this.

4.4.2 Phenomenology

I was drawn to phenomenology as this seeks to understand the lived experiences of those being studied (Crotty, 1998). It therefore aligned with my own epistemological and ontological position. The epistemological assumptions of phenomenology in terms of revealing meaning and unearthing knowledge that

cannot be brought to the fore front by empirical-analytical style research resonated. It has also been widely and successfully used amongst feminist researchers, notably Simone de Beauvoir, Marion Young and Sandra Lee Bartky amongst others.

While there are different forms of phenomenology, it generally concerns eliciting lived accounts of a particular experience (Thomson, Dykes and Downe, 2011). Founded by Edmund Husserl (1859-1938) and developed by the work of Martin Heidegger (1889-1976) and others, in applied research, a Husserlian approach uses either a descriptive or an interpretive approach to explore the phenomena (Crotty, 1998).

Although applicable for my study, in seeking to uncover women's experiences of management and care throughout the pregnancy continuum and understand perceptions of choice, consent and control for women living with 'obesity', there were contestations. Within the Husserlian phenomenological approach, the researcher is meant to 'bracket' their own perceptions in order to reduce the risk of the researched being influenced by the researcher (Priest, 2002). LeVasseur (2003, p.413) states:

> *In what seems like something similar to Buddhist enlightenment, the logical end of Husserl's bracketing was an arrival at the "transcendental ego," the consciousness necessary for the apprehension of pure phenomenal experience devoid of any assumptions about personal history or location in space or time. Husserl thus distinguished between the "empirical ego," familiar to the natural attitude, and the transcendental ego, the purified phenomenal consciousness and the true location of the science of phenomenology.*

Essentially, Husserl's use of bracketing appears idealistic, and this aspect of his work has been heavily criticised (Paley, 2016). I felt unable to realistically 'bracket' my own knowledge and preconceived ideas, concurring with Salsberry (1989) who argues that the researcher can never be free from their own understandings or the historical context of their own lives.

In rejecting Husserl, I then turned my attention to Martin Heidegger (1889-1976), a student of Husserl. Heidegger challenged Husserl's work, moving it from an epistemological concern to an ontological one. In his work *Being and Time* (1927 [1962]) he explores the meaning of 'Being'. This interpretive approach is focused on fundamental ontology as to how we understand and interpret our life worlds, as opposed to Husserl's focus on understanding phenomenon that we encounter in our consciousness. Heidegger rejected the notion of bracketing and perceived it impossible to separate our understandings from our historical, social, and cultural contexts.

Having read an introduction to Heidegger's work and attending a conference on Heideggerian phenomenology I was drawn to this methodology. I may have continued with this approach (although more akin to being human than social interaction) but I wanted my study to be rooted in developing theory from social interactions. In designing my study my aim was not to prove a theory, rather to understand and construct theory as this offers more implicit understandings of the phenomena. Added to this, having read of Heidegger's extreme right wing views (Trawny, 2016) I found I could not separate the man and his anti-Semitic, Nazi ideology. This was therefore a further reason to reject phenomenology.

4.4.3 Grounded theory: Navigating a methodological approach

Grounded theory appeared suited to my line of inquiry in seeking to understand women's experiences of their management and care throughout the pregnancy continuum in relation to choice, consent and control when they book with a BMI of 35 or above. It appeared an appropriate methodology to consider as it allows theory to be constructed from the data collected.

Grounded theory origins are rooted in inductive qualitative methods within the field of social science. The University of Chicago (later known as the Chicago School) was significant in developing qualitative research in the first half of the twentieth century. It was at odds with the objectivity of scientific research methods

(Hammersley, 2010) and forged its own path. There was however a lack of consensus on how qualitative research was carried out during this time, with methods rarely discussed, which left it open to criticism (Charmaz, 2014). Over time grounded theory evolved beginning with what is now known as classic grounded theory, then Straussian and latterly Constructivist. Considering a grounded theory approach for my study involved understanding each of the approaches which are presented below.

4.4.4 Classic grounded theory

Initially, I considered Glasser and Strauss (1967) who advocated the notion that theory development is grounded in empirical data from the everyday social interactions of the lives researched. Sociologists Barney Glaser (1930-) and Anselm Strauss (1916-1996) helped to move qualitative methods into the mainstream and are regarded as the founding fathers of grounded theory. Their publication *The Discovery of Grounded Theory* in 1967 set out this new approach. Early grounded theory (now identified as classical grounded theory) was born out of work they undertook in hospitals in the United States of America (USA), which explored how dying patients and hospital staff dealt with death and dying. This work was a fusion of positivism advocated by Glaser, who studied quantitative research methodology at the University of Columbia, and interactionism favoured by Strauss and influenced by Herbert Blumer's work at the Chicago School of Sociology, of which Strauss was a student. They supported the notion of theory development through qualitative data collection as opposed to using deductive methods of proving or disproving current theories through testing hypotheses, which was becoming common practice in the social sciences at the time. Sociological research was at a crossroads, with qualitative methods being seen to be subordinate to positivist, objective quantitative approaches of the scientific paradigm. This was in keeping with the economic and political landscape in the USA at the time, with quantitative scholars being academically dominant and critical of the School of Chicago's qualitative work:

> *Narrowly scientific-that is, quantitative-ways of knowing held validity for mid-century positivists: they rejected other possible ways of knowing, such as through interpreting meanings or intuitive realizations. Thus, qualitative research that analyzed and interpreted research participants' meanings sparked disputes about its scientific value.*
> (Charmaz, 2014, p.6).

Glaser and Strauss's work offered practical advice for undertaking qualitative research and brought together a reliable methodology and analysis tool for others to work with, legitimising grounded theory as a credible methodology (Byrant and Charmaz, 2012), mixing both positivism and pragmatism to develop theory. They advocated that the problem to be studied should be emergent, allowing theory to be discovered within the data and that the researcher should refrain from undertaking a literature search prior to undertaking the research to ensure impartiality. The researcher should also remain independent of the research by being objective in the process. For me, this did not fit with my own beliefs on the researcher/participant relationship. My experience as a midwife caring for 'obese' pregnant women affords me prior knowledge of the subject, therefore I felt that I would struggle to be an independent researcher. Feminist thinking also argues that the researcher should be an active participant within the research process (Plummer and Young, 2010) and that to be independent suggests a hierarchy with the participant being subordinate (Mills, Bonner, and Francis, 2006). In view of this I decided that classic grounded theory was not applicable for my study.

4.4.5 Straussian grounded theory

Over time Glaser and Strauss diverged. Differences emerged and Strauss began to modify classic grounded theory to offer a more structured approach. *Basics of Qualitative Research: Grounded Theory Procedures and Techniques* (1990) written with his colleague Juliet Corbin provided a step-by-step guide to grounded theory with specific instruction on how to code the data. It moved from discovering theory from allowing the theory to emerge from the data (classic grounded theory) to creating theory corresponding to the data collected. Although widely popular with grounded theorists due to its step-by-step approach, both Glaser (1992) and Charmaz (2000) criticised its complicated coding system, with data being

manipulated through the preconceived concepts of the researcher in order to fit a theory. Charmaz went on to argue that Strauss and Corbin had made the grounded research process more complicated by moving away from a flexible approach to coding (classic grounded theory) to a structured approach that reflected positivism. In response to this Strauss and Corbin suggested that grounded theorists adopt a flexible approach depending on their studies. In fact, following Strauss's death in 1996 Corbin, although continuing to align herself to Strauss's work, moved towards acknowledging the interaction between researcher and participant and adopted a more flexible approach to data analysis.

In trying to navigate Straussian grounded theory I found that although structured, the many steps to coding as a novice grounded theorist terrifying. I could not get to grips with the excessive steps to coding and found myself bogged down in its methodical approach. I wanted something more fluid, easier to navigate and not as restricting. This led me onto the work of Kathy Charmaz, who had been under the tutelage of Strauss and had subsequently developed grounded theory further using a constructivist approach.

4.4.6 Constructivist grounded theory

Charmaz began her career as an occupational therapist, working in rehabilitation before undertaking a Master's degree in order to teach occupational therapy, subsequently moving into academia. Interested in the lives of marginalised people, her early work focused on patients with chronic illness (Charmaz, 1991). On reading Charmaz's biography I felt an affiliation, with her background being similar to my own journey into academia. She also succeeded in developing her constructivist approach in an academic era dominated by men.

Constructivist grounded theory was developed by Charmaz (2000, 2003, 2006, 2014) as an alternative to classic and Straussian grounded theory as discussed above. Charmaz first discussed her approach in Denzin and Lincoln's (2000) *The handbook of qualitative research* in Chapter 5, *Grounded theory: Objectivist and constructivist methods*. This was written during an era when grounded theory

methodology was being heavily criticised and risked being abandoned by researchers. Keeping some of the concepts devised by Glaser, Strauss, and Corbin, she moved grounded theory forward to be fit for purpose in a modern age. Rather than a prescriptive set of rules she offered a flexible alternative that could be modified and adapted. She was critical of Glaser and Strauss and their positivist approach to grounded theory methodology and how this approach did not acknowledge the subjectivity of the researcher, nor how the social interactions between researcher and participant shapes the data and eventual data analysis. She adopted the word 'constructivist' to acknowledge the interplay between the subjectivity of the researcher and how the researcher interprets and constructs theory from the data collected, as well as acknowledging the wider meaning of constructivist relating to the subjective knowledge of a single knower:

> *Constructivists study how- and sometimes why- participants construct meanings and actions in specific situations… A constructivist approach means more than looking at how individuals view their situations. It not only theorizes the interpretive work that research participants do, but also acknowledges that the resulting theory is an interpretation.* (Charmaz, 2014, p.239)

Constructivist grounded theory challenges objectivity, and recognises that multiple truths or realities exist:

> *…a constructivist approach places priority on the studied phenomenon and sees both data and analysis as created from shared experiences and relationships with participants…* (*ibid*).

This methodology is widely used within sociology and seeks to understand the social interactions and influences that affect people's lives. It has the potential to expose the issues women living as 'obese' encounter throughout the pregnancy continuum, considering the social, cultural, and political discourses as well as the gendered and hierarchical influences which affect choice, consent, and control. Plummer and Young (2010, p.308) in critiquing this approach published in an earlier edition of Charmaz's work state:

> *…(Charmaz) believes that knowledge creation is a socially constructed process, and …appreciates the intersubjective nature of the relationship between the researcher and participant. Charmaz moves fully into the interpretive paradigm with her constructivist GT.*

Charmaz adopts a relativist ontology and uses an interpretive approach to construct meaning, drawing on symbolic interactionism. Symbolic interactionism as described by Charmaz (2014, p.262):

> *…views human actions as constructing self, situation, and society. It assumes that language and symbols play a crucial role in forming and sharing our meanings and actions…This perspective recognizes that we act in response to how we view our situations. In turn, our actions and those of other people affect these situations, and subsequently we may alter our interpretation of what is, was, or will be happening.*

She adopts Blumer's (1969, p.3) three principles of symbolic interactionism. Firstly, that people will act towards something depending on what those things mean to them. Secondly, that these meanings arise out of the 'social interactions' people have with others, and thirdly, meanings are interpreted (and modified) depending on how people deal with the things they come across. Charmaz (2014, p.270) adds three further criteria extending Blumer's principles suggesting that 'meanings are interpreted through shared language and communication', 'mediation of meaning in social interaction is distinguished by a continually emerging processual nature' and 'the interpretive process becomes explicit when people's meanings and/or actions become problematic, or their situations change'.

These six principles align with this study as women who present in pregnancy with a high BMI will hold meaning in relation to their management and care and whether they feel able to exercise choice, give consent and have control. These meanings will be influenced by the social interactions they have with others as well as being engaged with people and things associated with having a high BMI. Added to this the meanings that they hold are voiced through language that constructs meaning in relation to living as 'obese' and the care afforded during the pregnancy continuum. Women's constructed meanings will impact on how

they perceive care and how they negotiate (or do not negotiate) the care afforded, ultimately impacting on autonomy.

4.4.7 Justification for constructivist grounded theory

Constructivist grounded theory aligned with my philosophical positioning of relativist interpretivism. Being flexible in its approach it allowed me to modify the methods as it is seen to be a guide as opposed to a prescriptive set of principles (see Chapter 5, 5.2.1). It also enabled me to capture data through ongoing data analysis going back to the participants to gain further understanding of particular categories of interest. It allowed me to explore the spoken, unspoken and actions of the women studied and relate this to social structures and concepts which are gendered, gaining the perspectives of women yet understanding the subjectivity of these perspectives.

Constructivist ground theory has a close affinity with feminist inquiry and therefore is aligned to the poststructural feminist theoretical landscape into which my empirical investigation is positioned. Plummer and Young (2010, p.305) propose that combining the two provides a 'greater potential to reveal issues particular to the lives and experiences of marginalized women.' Poststructural feminist inquiry seeks to give women a voice, recognising women as being legitimate knowledgeable sources, with constructivist grounded theory enabling women's voices to be heard through the researcher co-constructing theory with the women studied. Successfully combined in other studies exploring women's resistance to domestic abuse (Allen, 2011) and birth trauma (Greenfield, 2017; Greenfield, Jomeen and Glover, 2019) this seemed a fitting approach to adopt for my own study.

In relation to this study, 'obese' pregnant women are the experts in their experiences of their management and care during the pregnancy continuum and how this affects choice, consent, and control for them. Multiple realities exist for these women, and their experiences provide valid data. As no theory exists in relation to experiences of choice, consent, and control for these women as

highlighted in the meta-narrative review, constructivist grounded theory is appropriate for this study to gain new insights.

4.5 Conclusion

Having outlined my own epistemological and ontological position and how this aligns with the study aims I have considered feminist approaches to research and situated knowledges which are central to undertaking this study positioned through a poststructural feminist lens. Two methodological approaches, phenomenology and grounded theory have been discussed. My rationale for the use of constructivist grounded theory has been presented with consideration of how this aligns with feminist approaches to research. Chapter 5 describes how I designed and undertook the research for this study, with further consideration of the methods used in constructivist grounded theory and the modified version adopted.

CHAPTER 5

METHODS

5.0 Introduction

Chapter 4 presented the philosophical and theoretical positioning of this study. An overview of feminist research methods was considered and a justification for using Charmaz's constructivist grounded theory approach was provided following consideration of phenomenology and traditional grounded theory approaches. How feminist methods align with using constructivist grounded theory in relation to this study was also considered as well as a rationale for using a poststructural feminist approach.

This chapter presents a methodical account of the methods used in the empirical component of the thesis. First, the aims of the study and the relationship between my chosen methodology and the study aims will be outlined. How the study was designed and undertaken will then be presented, considering all aspects of the research process. Finally, how the data was analysed to build theory will be discussed.

5.1 Aims of the study

As introduced in Chapter 1, this study involved undertaking a prospective longitudinal study to explore the experiences of pregnant women with a BMI of 35 or above in relation to following a medical management plan of care, and how this impacts on the autonomy of this group, including issues of choice, consent, and control. The aims of the study were:

- To collectively consider women's experiences of their management and care throughout the pregnancy continuum when they book in pregnancy with a BMI of 35 or above

- To explore women's experiences of choice, consent, and control throughout the pregnancy continuum when they book with a BMI of 35 or above.

5.2 Study design

Constructivist grounded theory aligned with the study aims. As discussed in the previous chapter (4.4.7), one of its main principles is enabling participants to have a voice and to share their perceptions and experiences (Charmaz, 2014). It values personal experience and attempts to understand the social reality of experience, recognising the existence of multiple truths depending on the experience lived. This methodology is also aligned to poststructural feminist approaches as both seek to analyse existing truths, recognising that multiple truths exist through examining how behaviour is affected or influenced by societal processes (Wuest, 1995, 2001).

Constructivist grounded theory enabled me to take an inductive approach which sits with my own ontological position of relativist interpretivism, with the aim of understanding meanings and actions and how these were constructed by both the participants and myself as the researcher. A constructivist approach requires theories around the phenomenon studied to be co-constructed with participant and researcher, recognising subjectivity, and requiring the researcher to be reflexive throughout the process (Charmaz, 2014). For the purpose of this study a modified constructivist grounded theory approach was adopted which is presented below.

5.2.1 Modifying the methods used

In designing the study, it was clear that a longitudinal study was appropriate as it would ensure the study aims could be met. Longitudinal studies are useful in identifying and relating events to differing experiences and exposure (Caruana et al., 2015). There is a wealth of research supporting the use of longitudinal qualitative studies in evaluating health care (Calman, Brunton and Molassiotis,

2013; Derrington, 2019), with the approach offering an understanding of experiences over time (Saldaňa, 2003, 2011). There is also evidence of longitudinal grounded theory studies being undertaken to explore women's health. Examples of these are Campbell and Nolan's (2019) study of pregnancy yoga and self-efficacy during labour and Porter and Bhattacharya (2008), who used a modified constructivist grounded theory approach in their longitudinal study on couples accessing fertility treatment. What they do not divulge however is how they converged the two approaches. Greenfield's (2017) *Choices made by women in pregnancy, birth and the early postnatal period after a previous traumatic birth*, however, does address this. In defence of using this approach, she argues that it allows rich data to be collected in real time, with most theoretical concepts used in grounded theory, e.g., coding, memo writing and theory building (which is discussed later within this chapter), aligning with a longitudinal approach to data collection. In relation to theoretical sampling and saturation however, using a longitudinal approach can be problematic.

Theoretical sampling is defined by Charmaz (2014) as a means to collect further data relating to the emerging categories and theories that have emerged from the data (see Chapter 5, 5.11.3). It also helps to direct recruitment of participants to test initial theories with different populations/individuals. In taking a longitudinal approach, this aspect of constructivist grounded theory posed an issue. Given time frames and ethical considerations it was not possible to finish one set of interviews and then recruit other women to the study based on the theories being generated. In addressing this, theoretical sampling was achieved through intra-participant sampling based on early data collection and analysis (also see Chapter 5, 5.11.4).

Reflecting back on Greenfield (2017) who used a longitudinal approach, she does not adequately address theoretical sampling in her work, suggesting that if a new theory emerged that needed further exploration, she would have recruited further individuals. However, she does discuss the issue of saturation. Saturation occurs when no new theoretical concepts are generated from the

data. Greenfield overcame this by applying saturation to each set of interviews across the study. I considered this in relation to my study, however Charmaz (2014) does acknowledge that saturation may never be reached or that researchers may claim saturation, or stop interviewing thinking saturation has occurred, missing vital data. In view of this, my study uses the principles of 'theoretical sufficiency' proposed by Dey (1999). Dey suggests that the word saturation implies that there is no new data, and nothing can be added, proposing that having a sufficient depth and understanding of the data in order to build a theory is much more attainable.

In further defence of using a modified approach to the study Charmaz (2014, p.1) argues that: 'grounded theory methods consist of systematic, yet flexible guidelines for collecting and analysing qualitative data to construct theories from the data themselves'. The flexible approach I adopted allowed for modification while maintaining the core principles of grounded theory.

5.3 Study setting

The setting for this study was a geographical area in the North West of England with one of the highest prevalence of 'obesity' in England. The study recruited women across two boroughs within a region covered by one NHS Trust.

Maternal BMI at booking appointment between January 1st, 2018, to December 31st, 2019, is collated in Table 10. A total of 2507 women booked in pregnancy during this time with 2490 having a recorded BMI.

Table 10. BMI range of women presenting in pregnancy between January 1st, 2018, and December 31st, 2019

Definition	BMI range (kg/m²)	BMI at booking
Underweight	Under 18.5	62 (2.5%)
Normal	18.5-less than 25	1052 (42.5%)
Overweight	25 to less than 30	668 (26.8%)
Obese (class 1)	30 to less 35	409 (16.4%)
Obesity (class 2)	35 to less than 40	187 (7.5%)
Obesity (class 3)	40 or over	112 (4.5%)

5.4 Access and recruitment

The associate director of midwifery within the NHS Trust where the study was undertaken was approached and permission was obtained to apply for ethical approval. This was followed by a meeting with the consultant midwife for public health and the research midwife employed by the NHS Trust to discuss the logistics of the study. It was agreed that the consultant midwife and research midwife would act as collaborators and that participant information packs would be given to women by the community midwives. I held meetings with community midwifery teams to explain the study and research packs were given to each team containing a covering letter for the community midwives involved (Appendix D) and participant information packs. The participant information packs included a covering letter (Appendix E), participant information sheet (Appendix F), a reply slip (Appendix G) and a stamped addressed envelope for correspondence. The community midwives were asked to provide verbal communication about the study if requested, giving brief details of what the study would entail. Women were asked to return a completed reply slip if they were interested or to contact me by telephone or email. A two-week response time was given. On receiving a reply slip or contact from the woman I arranged a convenient time and place to meet. Most

interviews were held in the antenatal clinic setting either in the hospital or community clinics. A small number of interviews were conducted in the woman's home.

Recruitment commenced on 1st January 2018. The first participant was recruited in March 2018. Over time it was clear that recruitment was slow, and the study was expanded to include the antenatal clinic of the local hospital and key community clinics. This included me attending key antenatal clinics throughout the locality to aid recruitment. It became apparent that women were more receptive to join the study later in their pregnancy and this was reflected in recruitment. Four participants were recruited at 24 weeks of pregnancy while attending clinic for testing for gestational diabetes, three were recruited later between 34 and 39 weeks of pregnancy, with four contacting me following receiving an information pack via their Community Midwife. As a midwifery lecturer at the local university, I was known to the midwives within the trust and had worked with many of them previously in clinical practice. This meant that access to community midwifery clinics and hospital clinics was unproblematic, with midwives being keen to support the research study.

5.5 Sampling and selection criteria

The selection criteria for recruitment can be found in Table 11 below. This was developed to identify an initial sample of women that had the required characteristics to meet the study aims.

Table 11: Selection criteria

Inclusion Criteria	Exclusion Criteria
Pregnant with a BMI of 35 or above	Pregnant with a BMI less than 35
Participant has mental capacity to provide informed consent	Participant does not have mental capacity to provide informed consent
Viable pregnancy confirmed at dating scan (approx., 12 weeks gestation)	Non-viable pregnancy
18 years and older	Under 18 years old
45 years old or under	Over 45 years old
Participant has sufficient verbal English to participate in an interview	Participant does not speak English or insufficient English to participate in an interview

A booking BMI of 35 or above was an essential selection criterion as medical management in the United Kingdom increases significantly for these women (Denison, 2018; Appendix C) and it was important to capture women's experiences of this increased management. It was also important that participants recruited to the study were able to give informed consent to take part, therefore it was deemed appropriate to only consider participants who had mental capacity to consent. Given the study being longitudinal, recruitment following the 12-week dating scan was undertaken to ensure a viable pregnancy. In terms of age criteria, it was felt that including over 18's only avoided any issues with ethics approval involving participants under 18. The upper age limit was 45. Originally this was deemed appropriate given that pregnancy above this age would be viewed as 'high risk' and therefore establishing whether management and care was attributed to weight, or age may have proved difficult. On reflection, I would not have included an upper age limit, as problems in pregnancy can occur at any age and I did not exclude other known 'high risk' situations such as twin pregnancy, of which I recruited one participant. Added to this, the literature suggests that advanced maternal age and associated adverse outcomes is considered to be over 35 or over (Glick, Kadish and Rottenstreich, 2021, Lean et al., 2017) and therefore putting an upper age limit of 45 was arbitrary. I recognise this as a limitation and an

upper age limit should not have been included. This is further considered in Chapter 10 (see 10.2).

5.6 Ethical considerations

Ethical approval was obtained from the NHS Health Research Authority (IRAS Project ID: 223013) on 10th November 2017, after addressing amendments from their provisional opinion on 18th September 2017. A Research Passport was approved and obtained from the participating NHS Trust Research and Development Department on 4th December 2017. Approval from the Science, Technology, Engineering, Medicine and Health (STEMH) committee, University of Central Lancashire was obtained 13th December 2017 (ref no. 810). All University and NHS ethical policies and guidelines were followed throughout the research process including recruitment, consent, confidentiality and privacy, data collection, analysis, and data storage.

In examining the experiences of women who have a BMI of 35 or above, many ethical considerations were raised due to the sensitive nature of inquiry. The welfare of the participants was paramount throughout the study and the key ethical principles of beneficence, non-maleficence, autonomy, and justice were adhered to as discussed below (Beauchamp and Childress, 2013).

5.6.1 Beneficence, non-maleficence, autonomy, and justice

There are four ethical principles that are widely accepted as being the mainstay of moral life. These are beneficence, non-maleficence, autonomy, and justice (Beauchamp and Childress, 2013). Beneficence refers to the act of being kind and charitable, with non-maleficence being defined as the avoidance of needless harm. Beneficence and non-maleficence therefore require researchers to put the welfare of their participants first and avoid causing harm. Autonomy is the act of being able to make decisions, have personal views and to act based on own values and beliefs, with justice referring to the act of treating people fairly and equitably. When undertaking research all participants should be treated equally without bias and prejudice, with autonomy ensured throughout

the process for the participants to make informed choices. These four ethical principles are intrinsically linked and given the sensitive nature of this study I was mindful of my responsibility as the researcher to uphold these.

In order to support my understanding of these principles, as well as inform my knowledge of ethics in research, I attended a course facilitated by the Health Research Authority on good clinical research practice. I also developed my knowledge through UCLan's online training on good research practice and working with human subjects.

All eligible women were given a participant information pack and were invited to contact me if they were interested in taking part in the study. This allowed time for them to consider whether they wished to take part in the study, ensuring the ethical principle of autonomy was upheld through ensuring informed consent. Women interested in taking part in the study were given further information and invited to sign a consent form prior to interview (Appendix I).

Confidentiality and anonymity were maintained with interviews being held in a private clinic room or the woman's home (beneficence, non-maleficence). Informed consent was gained prior to each interview and women were able to withdraw from the study at any time with the voluntary nature of participation being emphasized. These processes further ensured autonomy was respected throughout the research process. All data was anonymised, and pseudonyms used and compliance with the Data Protection Act (2018) was adhered to throughout the study protecting anonymity, with data being stored on a secure database upholding the principle of non-maleficence.

Through balancing the desire to do good (beneficence) with doing no harm (non-maleficence), consideration was given to the possibility of participant distress as well as the possibility that a participant may disclose information of a distressing, sensitive or criminal nature e.g., domestic violence (see 5.6.2

below). By keeping the participant at the forefront when designing the study, ethical issues were systematically addressed as above, ensuring the principle of justice was maintained.

5.6.2 Psychological complexities of 'obesity'

Sensitive interviewing is an important consideration when undertaking research that may trigger distress in the participant (Dempsey et al., 2016). It was imperative therefore that consideration was given to the psychological complexities of 'obesity' and potential triggers that may cause distress during the interview process. A distress protocol was written (Appendix H) to be utilised if needed, adapted from work by Draucker, Martsolf and Poole (2009) on developing research distress protocols for sensitive subjects. The protocol provides details on recognising distress, e.g., increasing anxiety, closed body language and how to respond, e.g., stop the interview, refer with consent. An awareness of the emotional and physical effects on myself as the researcher is also an important consideration and the protocol reminded me of the support available for me if needed, e.g., making regular contact with my supervisor, keeping a reflexive journal, and using university support services.

5.7 Data collection

Data collection was obtained through undertaking in-depth interviews with participants, and demographic data to inform and conceptualise findings was also recorded. Gaps in conversation were noted and non-verbal cues were observed during the transcribing process with memoing (see 5.11.2) to capture this. I felt it was important to acknowledge non-verbal communication, concurring with Denham and Onwuegbuzie (2013, p.671) who suggest that ignoring non-verbal communication shows a lack of awareness by researchers of the 'meaningful semantics beyond speech'.

5.8 Timing of interviews

Interviews were undertaken with women at four key pivotal points throughout the pregnancy continuum, with the same women interviewed throughout. I

originally aimed to interview at 12, 24-28, 34-36 weeks of pregnancy and 6 weeks postnatal. The reason for conducting the interviews at these times was to coincide with the extra medical intervention received due to their raised BMI (Appendix C). This allowed the interviews to take place as near to the time of care to ensure experiences were captured contemporaneously. It also made it easier for women to be interviewed on the same day they were attending either the hospital or clinic for an appointment, as opposed to having to be interviewed at another time. In reality the timings of interviews did not always coincide with those intended due to issues with recruitment, timings of appointments and my availability as the interviewer and is recognised as a limitation.

5.8.1 Undertaking the interview

At the initial interview I went through the aims of my research and thanked the woman for agreeing to be interviewed. The woman was then invited to ask any questions. At this interview all participants were asked to complete a consent form if they had not already done so (Appendix I) and demographic questionnaire (Appendix J). Age, parity, BMI at first 'booking' appointment, occupation, nationality, and ethnic group were collected to aid conceptualisation of findings. Further demographics (Appendix K) were collected at the postnatal interview to capture type of birth, spontaneous or induced labour and method of infant feeding.

Traditionally when conducting research, the researcher is seen to be in a position of power with the participant as subordinate (Fontana and Frey, 2000). Constructivist grounded theory seeks to address this, advocating research driven by the participant (Charmaz, 2014). This approach fits with poststructural feminist research methods which seek: 'to provide less oppressive ways of knowing' (Varga-Dobai, 2012, p.8). In considering my research design and how I would strive to reduce the power dynamics between researcher and researcher I adopted the approach presented below.

The interviews focused on the woman's experiences of the management and care of their pregnancy up to the point in time of the interview. Interviews were held at a time and location suitable for the woman. At each interview I began by having a general conversation with the woman, enquiring about her health and well-being, and talking about the baby. I offered insights into my own life both personally and professionally, for example talking about my own children and discussing my work as a midwifery lecturer. As proposed by Oakley (1981) this enabled increase reciprocity through relationship building. Having struggled with my own weight I also shared my experiences of yo-yo dieting. I felt this commonality allowed a more open dialogue, although in doing so I had to acknowledge that my weight loss journey although similar was not the same. In acknowledging my own struggles with weight, it could be argued that I had some knowledge of the phenomena being studied. Although overweight, I am not 'obese' therefore my lived experiences differ, so I could not claim to belong to the group being studied, yet I have preunderstandings of some of the issues faced. Also, being a midwife, I had to acknowledge my position as such and the power relations surrounding this. In reflecting on this I considered whether I was an insider or outsider researcher or somewhere in between.

An insider researcher is someone who undertakes research of which they are deemed to be members, thus identifying with those they study (Corbin Dwyer and Buckle, 2009). The advantages of this is that it enables the researcher to quickly establish a relationship with their participants and often results in participants being more open in the information they share (Aldler and Aldler, 1987; Brannick and Coghlan, 2007). Tensions may arise however, as the researcher may interpret the data from their own understanding of the phenomena being studied (Corbin Dwyer and Buckle, 2009). Participants may also assume that the researcher understands their lived experiences therefore may not impart the depth of information needed in order to gain meaningful data (Berger, 2013).

In contrast to the insider, the outsider researcher is seen to be more objective in their approach as they do not have any personal understandings of the phenomena. Participants may also offer more in-depth insights into their experiences knowing the researcher has no personal experience (Corbin Dwyer and Buckle, 2009). A drawback to this, however, is that it may take time to build a relationship with participants and the power dynamics may favour the researcher (Brannick and Coghlan, 2007). My position is somewhere in-between insider/outsider. I concur with Corbin, Dwyer, and Buckle (2009) who propose that all researchers have some preunderstanding of their research topic and therefore cannot totally be an outsider, yet as researchers they are also never truly insiders due to the privileged position they hold. What was interesting in my study was that most women appeared guarded at our first meeting, and I felt they were trying to tell me what they thought I wanted to hear. They were keen to highlight positive aspects of their care in relationship to the midwife caring for them, knowing that I too was a midwife. As the interviews progressed however, and as they got to know me, they became more open and felt able to talk to me about the negative aspects of their care, contradicting some of their earlier dialogue. I propose that this may be due to me starting out my research as an outsider, however, as relationships were built, through information sharing I became an insider.

Other ways I endeavoured to address the power imbalance between researcher and researched was to ensure that the aims and intent of my research were explained to all the women before each interview took place. How the data were to be stored and disseminated was also discussed. I felt that this ensured they were always at the centre of the study and afforded them some control over the proceedings. It could be argued that there will always be a researcher/participant imbalance as ultimately the researcher has control of how participants data are analysed and interpreted (Stacey, 1988). In order to minimalize this, before each interview I recapped the previous interview and discussed with the women the data I had generated from them previously to

seek clarity. This was also instrumental in addressing methodological rigor (see 5.12, p.136).

In gaining information on the topic being studied, I started by asking an open-ended question such as 'tell me about your pregnancy care up until today' or 'tell me about the care you have had since I last met you'. This enabled a conversation to be initiated, with me often needing to do or say very little other than use my body language and give vocal reassurance such as 'mmm' and 'yes, I see' to keep the conversation flowing in an encouraging and positive manner. From the women's responses I was then able to pick out areas of interest and ask more probing questions to elicit a response, e.g. 'How did that make you feel?' On several occasions I found myself having to back away from questioning when there was potential to cause distress. This involved me being very astute in picking up on body language and altering the course of the conversation accordingly. An example of this was when interviewing Alice, who started to become upset when talking about a derogatory weight related comment made by a practice nurse. Alice lowered her head and cuddled her pregnant abdomen. I would have liked to explore her experience further but sensing she was becoming upset I pulled back, apologising that the remark had been made, and asked if she wanted to stop the interview. She declined. I then steered the conversation to talk about her baby and preparations for her baby's arrival before moving back to talk to her about her care. Carla also became visibly upset when talking about the attitude of an anaesthetist. Like Alice, her body language became closed, and I offered to stop the interview, apologising for her experience. I was mindful of implementing the distress protocol if needed (see Appendix H), and did signpost to their midwife for ongoing support, however, they did not take up the offer.

I was also mindful of the language I used myself. When asking sensitive questions about the participant's weight, I phrased the questions in a way that recognised the sensitivity e.g. 'Is it ok to ask you…?', 'Do you mind me asking', softening the questioning. As the interview progressed, I moved to shared

inquiry discussed in 5.8.3 below. The length of the interviews varied according to women's responses, lasting between 20 and 60 minutes and were conducted between March 2018 and March 2020.

5.8.2 Developing my interviewing technique

An intensive interviewing approach is advocated when conducting constructivist grounded theory (Charmaz, 2014). This involves focusing the topic but using minimal questioning, rather listening to what is being said, observing the language used as well as non-verbal cues and facilitating further discussion as needed. Intensive interviewing 'typically means a gently-guided, one-sided conversation that explores research participants' perspective on their personal experiences with the research topic' (Charmaz, 2014, p.56). From a poststructural feminist perspective there is legitimacy in the knowledge the women held, which supports Charmaz's approach (Wuest, 1995). However, I found a more integrated approach to interviewing allowed for deeper insights into women's experiences as discussed below.

5.8.3 Shared inquiry: The 'Socratic-Hermeneutic Inter-view'

My interviewing technique followed an integrated approach drawing on intensive interviewing and Sorrell Dinkins (2005) 'Socratic- Hermeneutic Inter-view' or shared inquiry. I was mindful that a one-sided dialogue could prevent deeper insights into the phenomena being uncovered and a shared inquiry approach helped to move the conversation forward, appeared to put the woman at ease and fostered a deeper understanding of the phenomena being discussed. I therefore began the interview using intensive interviewing and moved to shared inquiry as the interview progressed.

Developed by Sorrell Dinkins (2005) for use in phenomenological interviewing, the 'Socratic-Hermeneutic Inter-view' encourages the researcher and participant (co-inquirer) to have a two-way conversation around the emerging concepts from the interview itself, questioning each other in order to understand the topic more clearly. She criticises the more accepted form of

interviewing used in phenomenological interviewing, which would include Charmaz's intensive interviewing (albeit constructivist grounded theory) in which a question is asked, provoking a long narrative. She suggests this closes any discussions, preventing a deeper understanding of the phenomena. The lack of input from the researcher also inhibits exploration of their own perceptions and prejudices, affecting interpretation of the data.

The intensive interviewing approach I adopted aligns with a feminist approach to interviewing through working in partnership with women in an ethical and respectful way to ensure their voices are heard (De Vault, 1990; Harding, 2007; Oakley 1981). In using intensive interviewing, I enabled the participants to take the lead and to take the conversation in the direction they wanted to go. I had developed an interview schedule which was kept unstructured to allow this (see interview schedule, Appendix L). As the interview unfolded, I moved to shared inquiry, allowing a two-way conversation to unfold. By integrating the two approaches I found that the relationship with participants was enhanced, mutual trust was afforded, and synergistic data was collected. Examples to support this was after undertaking my first interview with one participant (Jasmine), she commented on the fact the interview 'wasn't that bad'. She had expected me to ask her a lot of questions and was nervous that she would not have the 'right answers'. Helen and Sam had expected to be interrogated by me and were originally worried about what they had agreed to. When asked if they were happy to be interviewed later in their pregnancies, they were keen to meet me again and all appeared much more relaxed at subsequent interviews.

5.9 Transcription

Initially, I planned to use a professional transcribing service to transcribe interviews, however on reflection it was decided that a more meaningful interpretation could take place if interviews were manually transcribed. I therefore transcribed all the interviews myself. Non-verbal communication was also collated such as emotive cues (laughter, sighs, pauses) to aid interpretation of the verbal. Alldred and Gillies (2012) highlight the importance of

transcription being an active process so that the subtleties of language are not misrepresented. There is also some debate over inaccurate transcription, with some transcribers having issues with accents, phrases, and sentence structure (DiCicco-Bloom and Crabtree, 2006). I did find transcribing time consuming, and I worried that nuances and communication detail, vital data in grounded theory research (Charmaz, 2014) would be missed given my lack of expertise. This was minimised through listening and relistening to the recordings in order to capture every detail. Also, by transcribing line by line the essence of what was being said was captured.

5.10 Storing the data

Interviews were digitally recorded using a small digital voice recorder. The electronic recordings were then transcribed manually as discussed above (5.8). Pseudonyms were used to ensure confidentiality and all electronic recordings deleted immediately post transcription. All data were transferred electronically via password protected/encrypted computer files and stored securely through the University of Central Lancashire (UCLan).

5.11 Data analysis

Data analysis was undertaken following constructive grounded theory methods advocated by Charmaz (2014), increasing the trustworthiness and rigor of the data analysed. This consisted of initial coding, focused coding with groups of codes becoming sub- categories eventually being collated into categories, as well as memo-writing which aided interpretation of the data. Recruitment, qualitative data collection and data analysis were undertaken concurrently in line with constructivist grounded theory methodology (Charmaz, 2014; Harvey and Land, 2017). The data was transferred into tables within a Microsoft Word document following the examples given by Charmaz (2014, p.129) and initial coding was completed manually through detailed reading. From these more focused codes were identified (see Table 12). All the data was uploaded to MAXQDA 2020 following consultation with my supervisors who suggested using data analysis software would enable me to manage my data more easily. Being

a novice at data analysis and having minimal training in using the software I found this difficult and time consuming. It led to adopting a mixture of the two. I therefore carried out initial coding manually and focused coding using MAXDQA 2020.

Initial coding yielded 1,079 codes. My initial coding was very generalised as I was worried that I had not captured all the data correctly. It soon became apparent that some of these codes, although interesting, were not relevant to the aims of the study. I focused my codes down, keeping my study aims at the forefront and narrowed down my initial coding to 772. These were then grouped by undertaking focused coding (see Table 12, 5.11.1), leading to the development of sub-categories. Relationships between them, through diagramming were identified and categories were established that impact on choice, control and consent for women living with 'obesity' during the pregnancy continuum (see Fig. 5.1).

5.11.1 Coding

The aim of initial coding is to identify the actions identified in the data rather than emerging themes. Charmaz (2014, P.117) argues that this 'curbs our tendencies to make conceptual leaps and to adopt extant theories before we have done the necessary work'. It can also identify gaps in the data needing further consideration through theoretical sampling. Being a longitudinal study there was opportunity to go back to women for clarification with emerging phenomena being explored at subsequent interviews, as well as checking findings to ensure credibility. The use of *in vivo* codes (Glaser and Strauss, 1967) was also adopted to explore how the women viewed their weight and related pregnancy care in relation to their view of reality. *In vivo* takes the actual spoken words of the participant and uses it as a code (Charmaz, 2014). Green and Thorogood (2014) suggest the use of *In vivo* codes aids categorisation of the data through examining the language used by participants when trying to make sense of the phenomena being explored.

Following this, focused coding was adopted. Focused coding considers the initial coding, picking out most frequently occurring and the most significant, allowing comparisons between the initial codes to be made and identifying similarities and differences. From these, sub- categories were developed (Charmaz, 2014). An example of the stages of coding is given below in Table 12. Table 12 demonstrates how coding was developed, showing part of a transcript from an interview with Carla (one of the participants). As codes were identified I used colour coding so I could clearly see the similarities between codes, allowing me to narrow them down into focused coding. Focused coding was also colour coded, helping me to develop my sub-categories. I repeated this with all the transcripts, linking the codes through colour coding. Once I had identified my focused coding, I was able to clarify my analysis with the participants during future interviews as well as having discussions around my analysis with my supervisors.

Table 12: Example of initial and focused coding

Extract of interview with 'Carla'	Initial codes	Focused coding
Carla: - Yeah. I haven't been offered anything. No one has said would you like to have, or we usually do this, is that ok? It has just been like…you will come in; you will be cannulated. You will have an epidural. You will lie on the bed and have a CTG. You will have your baby by whichever means we say. Erm (.)I asked about using the pool and that was a definite no. Interviewer - So, is that what was said, no? Carla: - I said (.) I asked at antenatal classes which was with one of the hospital midwives and she said they definitely wouldn't let me go in the pool, especially with me having a BMI over 40. Cos it wasn't safe in terms of the staff. If something was to happen to me there wouldn't be enough staff to get me out of the pool (laughs). interviewer: - Did you ask, or did they tell you how many women they have had to get out of the pool in an emergency or how many women have problems in the pool? Carla: - No. I thought (.)I don't necessarily want to deliver in the pool but to labour in the pool would be something I would want to do for pain relief and then get	No consideration of personal choices Being told what will happen 'Definite no' Negative encounters with health professional Not allowed in birthing pool due to high BMI Getting in the pool would be unsafe for Carla and staff Not enough midwives to evacuate pool in an emergency Wanting control over birthing experience	Lack of choice Being told Control Not allowed Negative language Not allowed Risk Risk Lack of control

Extract of interview with 'Carla'	Initial codes	Focused coding
out and deliver when I wanted to. But she said that because I was heavy there wouldn't be enough midwives in an emergency to evacuate the pool safely. But then I thought well this is a bit (.) well I go in the bath at home, so if I was to collapse in the bath at home someone would have to get me out. Well, I have never heard of anyone collapse in the pool in labour and I know people who have used the pool. So (…) They could let me and anticipate if I felt unwell or if anything started to go wrong and then get me out then. So, it was just a very definite no. If I had a homebirth my midwife said I could use my own pool, but they won't let me have a home birth because of my weight. There's a lot of like advice given, or you are told this or that has to happen, but no reason is given.	Safety Goes in bath at home Trying to make sense of the situation Considering knowledge gained from other women who have used the pool Health professionals not allowing Health professionals not allowing 'you are told this or that has to happen'	Risk Making sense of the situation- resisting Making sense of the situation- resisting Control Not allowed Being told

Once coding had been completed, comparisons were made across all the data and the focused codes were sorted into sub-categories and categories to complete the analysis (Fig. 5.1).

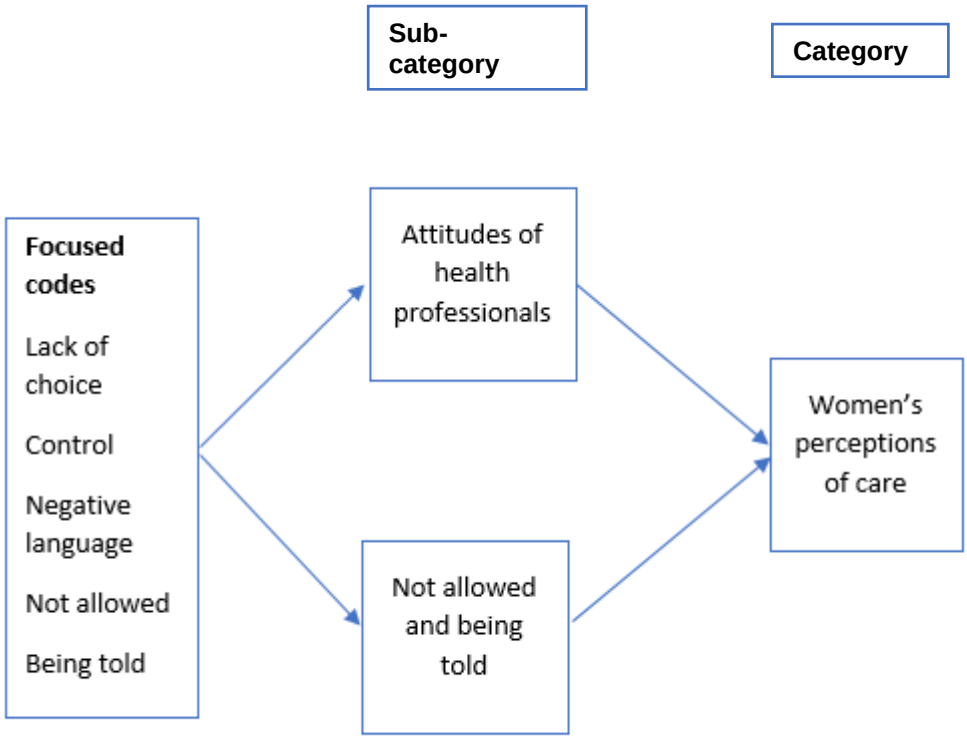

Fig. 5.1 Sorting of focused codes into sub-categories and categories (an example)

Charmaz (2014) discusses the use of axial coding that follows focused coding, which is a process of relating the emerging sub-categories and categories. Originally supported by Strauss and Corbin (1990, 1998), it has since attracted significant debate with less emphasis placed on its use (Corbin and Strauss, 2008). I considered using this method of coding to aid analysis as it appeared more systematic and is used to develop theories when there is a large amount of data. After careful consideration I felt that adding a third type of coding as a novice researcher would make the process more complex and may distract me from considering what the data is actually saying in relation to my study aims therefore did not use axial coding.

5.11.2 Memo writing

Memo writing is an analytic process which aids development of theory, through the informal recording of the researcher's thoughts and ideas, making connections between them (Charmaz, 2014). Memo writing was an integral part

of the data collection and analysis, allowing spontaneous, informal writing throughout the research process. It aided development of ideas from initial coding through to focused coding to development of sub-categories and categories. Memo writing was also used immediately post interviews to capture my feelings and initial thoughts. This enabled me to capture the essence of the interview and record nonverbal interactions which were later considered in the analysis. Charmaz (2014) suggests memo-writing is an integral element within grounded theory as it is the link between data collection and analysis, keeping you grounded and immersed in the data and subsequent analysis. It also served as a reflexive tool, capturing the research journey, and allowing preconceived ideas and presumptions to be explored and minimised. An extract of memo writing can be found below (Fig. 5.2). This is an extract of a memo I wrote immediately after my first interview with Anna.

Anna spoke about her experiences of all her three pregnancies. She was keen to talk about the negative experiences she had had with her first pregnancy and how as she began to understand the management and care of her high BMI, she was able to navigate the system and take some control over her care. I am not sure whether in this pregnancy she is making informed decisions but is ascertaining control over her pregnancy through declining certain aspects of care.

She appears to have not worked through her first pregnancy or been given the opportunity to debrief and this has affected the care perceived in her two subsequent pregnancies.

Anna is aware she has a high BMI attributing it to being fit and athletic and gaining a toehold of respectability through this. 'I am big because I am strong'. There are some interesting concepts I would like to explore more fully with Anna at her next interview particularly around informed choice and her understanding of choice.

Slimming classes feature in her interview. Again, she is aware of having a high BMI and has tried to address it. She has yo-yo dieted throughout her adult life which is interesting as it appears to influence her views around weight (I need to explore this with other participants: perceptions of weight- where does this come from? What is the impact of yo-yo dieting?).

I got the impression that Anna wanted to speak to me to off load her pregnancy experiences. She got side-tracked off her weight and I found it difficult to bringing the interview back. I need to do some work around this for future interviews and develop a strategy for steering the conversation back to my study aims.

Fig 5.2: Extract from memo written following first interview with Anna

5.11.3 Theoretical Sampling

As discussed earlier in this chapter in justifying a modified constructivist grounded theory approach to the study (5.2.1) theoretical sampling as defined by Charmaz (2014, p.193):

> *…means seeking pertinent data to develop your emerging theory. The main purpose of theoretical sampling is to elaborate and refine the categories constituting your theory. You conduct theoretical sampling by sampling to develop the properties of your categories until no new properties emerge.*

Due to this being a longitudinal study, theoretical sampling was conducted on an intra-participant basis as opposed to considering interviewing different participants. In hindsight it became apparent from the data collected that perceptions of midwives, obstetricians and anaesthetists would have added to the narratives from the women. However, ethical approval had not been sought to do this and time frames did not allow for me to seek approval and conduct interviews with these health professionals. Therefore, theoretical sampling was not utilised as effectively as it may have been and is a limitation discussed in Chapter 10 (10.2) as well as a recommendation for post-doctoral research.

In defence of this, however, as data analysis was an on-going process throughout data collection, gaps in the data around aspects of care were identified and further explored in future interviews with participants. Thus, while a longitudinal approach is not usual when undertaking a constructivist grounded theory study, an intra-participant approach to theoretical sampling helped to achieve theoretical sufficiency (see 5.2.1 above). Once I had identified some early categories which raised further questions, I was able to go back to participants to question them on aspects of the emerging data as well as check my findings with the participants to ensure 'truthfulness' (see Table 13 on methodological rigor, 5.12). Several categories were explored more fully when it became evident that similar stories were being told. It could be argued therefore that the benefits of this study centre around the rich data generated

through repeated interviews. The longitudinal approach meant there were opportunities to meaningfully test emergent categories and theorising across the pregnancy/postnatal continuum.

5.11.4 Theoretical saturation

The next step in data collection and analysis is theoretical saturation. This occurs once no new insights are being generated and is defined by Charmaz (2014, p.213) as: 'when gathering fresh data no longer sparks new theoretical insights, nor reveals new properties of these core theoretical categories'. In relation to my own study, I felt new ideas and questions were constantly being generated and this continued after I had stopped collecting data. As a PhD student with time and funding constraints I had to make a judgement on when I had achieved sufficient data to be able to generate rich and meaningful theory. As discussed in 5.2.1 above, I adopted 'theoretical sufficiency' to navigate a way around this.

5.11.5 Constructing a theory

Once data has been analysed and relationships identified which are then collated into sub-categories and categories (see example above, Fig. 5.1) theories are constructed. Charmaz (2014) suggests that a theory is the relationship between concepts identified in the data that generates further understandings and/or explanations. Theories aim to give answers to questions. My aim was to generate theories in relation to choice, consent, and control by examining women's experiences of their management and care throughout the pregnancy continuum when they present in pregnancy with a BMI of 35 or above.

I found theory construction extremely difficult. I was conscious of my own preconceived ideas in relation to my study aims and did not want my own pre-understandings to overtly affect the results. I struggled with putting forward a theory, constantly worrying 'what if I have got it wrong?' Trusting my own interpretation of the data and wanting to do the work justice for the women

who trusted me with their stories was at times overwhelming. Sommer (1994) suggests that researchers in their quest for unique insights and knowledge run the risk of dominating the research, with participants voices lost. In order to avoid this Lather (1991) highlights the need for the researcher to consider their own subjectivity through constant reflection, acknowledging their own position within the research. This was achieved by keeping a reflective journal throughout the process, going back to the women for clarification, as well as discussing my interpretation of the data with my supervisors.

I eventually realised that as I was analysing the data, I was also constructing theory, albeit tentative. I found using 'messy maps' as developed by Clarke et al. (2018) offered me a way to visualise my thinking and deepen my understanding, making links and connections between the data (see appendix M for examples of my 'messy mapping'). From this I was able to establish sub-categories, categories, and early theorising. By drawing on this early theorising, examining key theorists work to support my theorising and discussions with my supervisors, I was able to develop my eventual substantive grounded theory. Early theory construction centred around how the women appeared to be reduced to their 'bodies'. From this 'the conditioned body'; 'the (in)visible body' and 'the contesting body' were constructed. In order to develop my emerging theorising, I considered the works of three theorists, Erving Goffman, Michel Foucault, and Simone de Beauvoir to inform and offer further insights, with 'multiple dimensions of self' being constructed as my substantive grounded theory. How my theory developed is presented in Chapters 8 and 9.

5.12 Addressing methodological rigor

A criticism of using a qualitative approach to the study lies in the often-made assumption that qualitative research, being subjective as opposed to objective, falls outside the realms of science, and cannot be generalised outside the research locality (Green and Thorogood, 2014). This suggests that the study cannot be valid and reliable, language used within positivist research paradigms, which regards objectivity, precision, and generalisation as important

attributes, rejects interpretivist research paradigms as unworthy. It is unsurprising then that the methodological rigor of qualitative research has been highly debated, with arguments suggesting that rigor sits within a positivist paradigm coming from the traditional scientific quantitative research approach and therefore is not appropriate for qualitative interpretative approaches, with terms such as validity and reliability rejected by qualitative researchers because of this (Cypress, 2017). Added to this, arguments have also focused on the difficulties of using the same criteria to access rigor for differing research approaches (Davis and Dodd, 2002).

In addressing rigor within qualitative research, Lincoln and Guba's (1985) seminal work *Naturalist Inquiry* introduced criteria to support methodological rigor in qualitative research by introducing the concept of trustworthiness. Trustworthiness is concerned with the quality of the research, and the amount of trust placed on the results. To support trustworthiness, Lincoln and Guba (1985) replaced validity with credibility, generalisation with transferability, reliability with dependability and objectivity with conformability. Rigor is therefore achieved through ensuring that the findings have come directly from the participants (credibility), the research design is precise and clear (dependability), data analysis comes from the data with researcher bias reduced as much as possible through various methods such as reflexivity (confirmability), with transferability being the extent the findings can be applied to other settings.

Charmaz (2014, p. 336-337) proposes her own criteria for ensuring trustworthiness when using a constructivist grounded theory approach: Credibility, originality, resonance, and usefulness. These criteria intersect with Lincoln and Guba's work and suggest similar techniques for establishing trustworthiness, although there is some contention in relation to researcher bias. Charmaz's suggested criteria for evaluating grounded theory have been used for this study, while also reflecting on Lincoln and Guba's four criteria. As discussed earlier Charmaz recognises research bias as part of the process with

theory generated in collaboration with the participants studied. Table 13 offers an overview of how methodological rigor was achieved throughout the study, with previous consideration of the research design above and how the data was analysed, offering further evidence to support how the four criteria for assuring rigor was met (see also Chapter 10, 10.1).

Table 13. Overview of how methodological rigor was achieved

Criteria for evaluating grounded theory	How each criterion was achieved
Credibility	• Constructivist grounded theory processes from data collection through to memoing, coding, and theory building was adhered to. With systematic observations made between the categories generated from the data • Findings shaped by the participants with participants words used within the findings. • Findings checked with participants to ensure 'truthfulness' • Findings co-constructed with researcher and participants • Sufficient data was collected in order to ensure a comprehensive analysis • The personal views of the researcher were explored, and reflexivity adopted throughout. • Peer debriefing was achieved through regular supervisor meetings and discussion of my work with colleagues
Originality	• New insights were uncovered offering a differing perspective on the phenomena from that which is already known
Resonance	• Concepts were constructed offering an insight into the participants experiences of the phenomena as well as offering insights that may be applicable to others
Usefulness	• Data analysis and theory development generated new concepts to consider for maternity policy and practice as well as the wider social, cultural, and political

Criteria for evaluating grounded theory	How each criterion was achieved
	constructs that impact on the participants everyday lives • Further research was identified

5.13 Reflexivity

Reflexivity is an important aspect of qualitative research as it is impossible for a researcher to be totally objective when examining a phenomenon and is a means of recognising constructs that may negatively affect the research process and outcome (Gentles et al., 2014; Guba and Lincoln, 2005). Green and Thorogood (2014) suggest that the researcher is part of the research process and as such needs to reflect throughout, recognising and minimising their own assumptions and beliefs that could overtly influence the final interpretations generated. This process of self-awareness is important in demonstrating trustworthiness and serves to acknowledge that one's own values and beliefs may influence the findings (Kingdon, 2005).

In relation to constructivist grounded theory and this study, the findings although systematically analysed will be influenced by my own philosophical stance and experiences of the world. Charmaz (2014) suggests reflexivity is integral to the research process and cannot be separated from it. In view of this a reflexive journal was kept throughout the duration of the study as well as memo-writing being utilised as a reflexive tool throughout in line with constructivist grounded theory processes. Added to this, data were shared with my supervisors, with theory building and rationale discussed. Being able to share my work with peers through informal and formal forums also added to the reflexive process as well as discussing my data with participants.

From a poststructural feminist perspective, reflexivity is essential in reducing bias and strengthening rigor. As Haraway (1988, p.590) proposes as a researcher I am in a privileged position, and I have a 'view from somewhere'. In

undertaking this study, I had to consider not just my position as a researcher but my position as an overweight woman, wife, mother, daughter, feminist; this multiplicity being problematic given my studies focus. Throughout this thesis I strive to capture reflexivity, with Chapter 11 providing some insights to these multiple positions.

5.14 Conclusion

This chapter has outlined the details on the study design, how participants were recruited to the study, ethical issues, data collection and analysis, with consideration of methodological rigor and reflexivity. The following chapter will introduce the participants of the study leading into an introduction to the findings.

CHAPTER 6

INTRODUCING THE PARTICIPANTS

6.0 Introduction

The previous chapter presented the methods used in undertaking the research study. A comprehensive discussion on how constructivist grounded theory methods have been utilised for data collection and analysis was provided.

The purpose of this chapter is to give context to the findings presented in Chapters 7, 8 and 9. This chapter introduces the participants of the study and the demographic characteristics of the eleven women who took part. The local context is also presented to provide an understanding of how the women were situated in relation to where they lived their lives. Reflections on my interactions with the women during data collection are also presented.

6.1 Introduction to the participants of the study

Eleven women were recruited to the study between January 2018 and August 2019, all meeting the criteria discussed in Chapter 5 (5.5). The women's names have been changed and pseudonyms adopted to ensure confidentiality and participant anonymity. A total of 30 interviews were undertaken across the pregnancy continuum, 21 during pregnancy (antenatal) and nine following birth (postnatal). Of the 30 interviews, 29 were undertaken face to face and one by telephone. The final interview was undertaken in March 2020. The age range of the women was 20-38 years with BMI at booking between 35- 48. All the participants were British born and identified as White British. In relation to social status as defined by occupation (Appendix N- NS-SEC Analytic class), two participants identified as being employed in lower managerial, administrative and professional occupations, one as being employed in an intermediate occupation and one working for a small employer. Five worked in semi-routine employment, one in a routine occupation and one was a full-time student. There were a total of ten live births, with one woman unfortunately having a late miscarriage. Mode of

birth consisted of two elective caesarean sections, two emergency caesarean sections, three vaginal births and three instrumental births (one ventouse and two forceps). Participant characteristics are tabulated in Table 14 below.

Table 14: Participant Characteristics

Participant	Age	BMI at booking	Previous Births (Parity)	Number of pregnancies (Gravidity)	Social status by occupation* (Appendix N)	Ethnicity	Spontaneous/ Induced/Elective C/S	Mode of birth
Rose	28	35	0	1	2	White British	N/A	N/A
Ella	21	42	0	1	6	White British	Induced	Emergency C/S
Anna	37	48	2	3	5	White British	Elective C/S	Elective C/S
Chloe	32	39	1	3	2	White British	Elective C/S	Elective C/S
Isla	20	42	0	1	6	White British	Spontaneous	Vaginal
Carla	21	45	0	2	L15	White British	Induced	Emergency C/S
Sophie	24	43	0	2	4	White British	Induced (Twins)	Vaginal
Helen	38	41.5	3	8	6	White British	Induced	Vaginal
Sam	33	37	1	2	6	White British	Induced	Instrumental
Jasmine	20	48	0	1	7	White British	Induced	Instrumental
Alice	27	42.5	0		3	White British	Induced	Instrumental

*

Social status based on simplified National Statistics Socio-Economic Classification (NS-SEC) analytic class code. Office for National Statistics (2010) *Standard Occupational Classification. Volume 2: The Coding Index.* Basingstoke: Palgrave Macmillan. Also see Appendix N for further information on analytic class.

* Office of National Statistics (2010a) *ONS Occupational coding tool*. [online] Available at: https://onsdigital.github.io/dp-classification-tools/standard-occupational-classification/ONS_SOC_occupation_coding_tool.html?fullversion=yes [Accessed 18 August 2021]

6.1.1 The participants

Rose was 28 years old and 17 weeks with her first pregnancy when I met her for her first interview. Her BMI at her booking appointment was 35. Sadly, *Rose* had a late miscarriage at 21 weeks of pregnancy, and although I spoke to her following this to send my condolences, we did not meet face to face again. I asked her community midwife if she would like to meet to me, but Rose declined.

Ella was 21 years old when we met. This was her first pregnancy, booking with a BMI of 42. I was able to follow *Ella* throughout her pregnancy experiences, undertaking four interviews at 12, 28 and 34 weeks of pregnancy and at seven weeks postnatal. *Ella* was induced at 40 weeks of pregnancy due to her baby measuring large for dates on ultrasound scan and she had an emergency caesarean section for slow progress under a spinal anaesthetic. Her baby was found not to be large for dates and birthweight was within 'normal' parameters for gestation. In the postnatal period *Ella* developed back and leg pain as a result of the spinal anaesthetic and her recovery was impeded due to this.

Anna was 37 years old in her third pregnancy, having two young children previously by caesarean section. I did not meet her until she was 34 weeks gestation when she contacted me wishing to be part of the study. Her booking BMI was 48. I interviewed *Anna* at 34 weeks of pregnancy and then again postnatally when she was seven weeks post birth. She decided to opt for an elective caesarean section under a spinal anaesthetic to birth her baby following her previous history.

Chloe was 32 years old and in her third pregnancy, having one young child and a previous miscarriage. The first interview was held when Chloe was 20 weeks gestation. I then went on to re-interview *Chloe* at 29 and 34 weeks of pregnancy, and again at seven weeks postnatal. *Chloe* had a booking BMI of 39. She elected to have an elective caesarean section under spinal anaesthetic following a

previous caesarean section. *Chloe* had an uneventful postnatal period and remained well.

Isla, in her first pregnancy at 20 years of age, booked with a BMI of 42. I did not meet her until late in her pregnancy and her first interview was conducted at 37 weeks gestation. She had a spontaneous vaginal birth. Post birth I arranged to meet Isla for an interview, but she did not attend. I contacted her by telephone to arrange a further interview, but she was unable to schedule this.

Carla was 21 years old in her second pregnancy, having had a previous early miscarriage. Her booking BMI was 45. I recruited *Carla* late to the study and she agreed to interview at 39 weeks gestation and again at six weeks postnatal. *Carla* had her labour induced following a prolonged stay in hospital and possible infection, which resulted in an emergency caesarean section under spinal anaesthesia. In the postnatal period *Carla* remained well.

Sophie was 24 years old when we first met. This was her second pregnancy, previously having had a miscarriage. Her booking BMI was 43. I first interviewed *Sophie* at 24 weeks of pregnancy when she was attending the clinic for a Glucose Tolerance Test (GTT) (routinely offered for all women with a BMI of 35 or above due to the increased risk of gestational diabetes). She went on to develop gestational diabetes and had increased monitoring for this as well as being pregnant with twins. I interviewed her again at 32 weeks of pregnancy and when she was 12 weeks postnatal. *Sophie* had a spontaneous vaginal birth of twins following being admitted to hospital with raised blood pressure. She was scheduled to have her birth induced but went into spontaneous labour prior to induction. During the postnatal period her blood pressure returned to normal, and she remained well.

Helen was 38 years old in her eighth pregnancy when she was recruited to the study. She had two adult children and a young child aged three. She had previously had four miscarriages. Her booking BMI was 41.5. I met Helen at her

GTT appointment and interviewed her at 24 and 34 weeks of pregnancy and again at five weeks postnatal. *Helen* was induced at 39 weeks gestation due to her high BMI and the baby measuring small for gestational age on ultrasound scan. She went on to have a vaginal birth. Her baby's birthweight was within 'normal' parameters for gestational age and remained well postnatally.

Sam, a 33-year-old in her second pregnancy, booked with a BMI of 37. I interviewed her at 24 and 32 weeks of pregnancy, having met her when she attended for her GTT at 24 weeks of pregnancy. *Sam* was induced at 39 weeks of pregnancy following multiple admissions for reduced fetal movements and had an instrumental birth with Ventouse. She developed a perineal haematoma early in the postnatal period that needed treatment. She also developed postnatal depression.

Jasmine was 20 years old with her first pregnancy when I met her at her GTT appointment. She booked with a BMI of 48. I interviewed *Jasmine* on three occasions at 24 and 34 weeks of pregnancy and again at seven weeks postnatal. *Jasmine* was induced at 39 weeks of pregnancy due to her baby's static growth diagnosed on ultrasound scan. She was eventually prepared for a caesarean section for fetal distress. However, as the anaesthetist was unable to cite a spinal anaesthetic and whilst in the process of administering a general anaesthetic, her baby was birthed with forceps. *Jasmine* was readmitted to hospital in the early postnatal period with a pulmonary embolism.

Alice was the final participant recruited. *Alice* was 27 years old having her first baby when we met at her early scan appointment at 14 weeks of pregnancy. Her BMI at booking was 42.5. I interviewed Alice face to face at 14, 28, and 35 weeks of pregnancy and at 5 weeks postnatal. Her postnatal interview was conducted over the phone. *Alice* labour was induced at 39 weeks gestation due to her having gestational diabetes as well as due to her high BMI. She progressed to birth with the help of forceps following a prolonged second stage of labour. She remained well throughout the postnatal period.

6.2 Local context

Although considered in Chapter 5 (see 5.3), I felt it was important to situate the local context in line with the participant characteristics to give a deeper understanding of the reality for the women studied.

This study was undertaken in a region in the North West of England with one of the highest rates of 'obesity' in the country. Data collected from the *Health Survey for England 2019* suggests that 64.2% of the adult population in England (16 years and over) are either overweight or 'obese', compared to between 65-70% within the researched locality (Baker, 2021). The locality of the study is semi-rural with more than two-thirds of the population living rurally. There is high deprivation and unemployment with life expectancy less than the national life average. A total of 98% of the population are White with 96% being White British.

There were 2507 antenatal bookings within the locality between January 1st, 2018, to December 31st, 2019. BMIs were calculated at the initial antenatal booking appointment on 2490 pregnant women, with 17 women having no booking BMI undertaken. BMI ranged from 15 to 56. Of the women with a booking BMI undertaken, 55.2% (n= 1376) were identified as being either overweight or 'obese', with 28.4% (n= 708) presenting as 'obese' (class I) with a BMI of 30 or above and 12% (n= 299) 'obese' class II and III (BMI of 35 or above). In comparison, the most recent statistics available of the UK as a whole based on births between April 1st, 2016, and 31st March 2017, report that 50.4% of women presented as either overweight or 'obese' at booking and 20% booked with a BMI of 30 or above (National Maternity and Perinatal Audit (NMPA) Project Team, 2019). This suggests that the maternal population in the locality studied has higher rates of BMI than nationally, although comparisons must be made with caution due to differences in the years data were collected.

6.3 Reflecting on the participants

While undertaking this study, I was committed to the women participants being at its heart. Getting to know the women and following them through their pregnancy journey compounded my desire to ensure that their voices were heard. I felt very privileged to have been trusted with the information they shared and was conscious that for most of the women, discussing their lived experiences of being 'obese' was not easy, often provoking discomfort, which I observed through their body language.

Being a midwife who had previously worked in the area I was recruiting I believe helped to put the women at ease, as well as using an integrated approach to interviewing as discussed in Chapter 5 (5.8.2). Initially on first meeting I observed it was me who felt more uncomfortable. I felt uncomfortable asking questions around weight and worried about upsetting or offending. Actually, my concerns were unfounded as most of the women were very open about their weight. They all acknowledged they were 'obese' and felt that they knew what they were being asked through the information packs they had been given. All were keen to talk to me and share their experiences from the outset, with the nine women who were interviewed during the postnatal period expressing their sadness on their final interview and offering to meet for further interviews if needed.

I did have preconceived ideas about the women who might engage with the study. I didn't expect women from lower socio-economic backgrounds to participate as they did. Women including Jasmine, Ella, Helen, and Sam felt empowered by speaking to me and stated it helped them feel more involved in their actual pregnancy care. I felt that most of the women interviewed had never had the opportunity to discuss their experiences and many expressed surprise at having me take an interest in their lives. This was particularly apparent for the women who had had previous pregnancies, with them all keen to talk about their past pregnancy and births.

As discussed in Chapter 5 (5.8.1), in the main the women were very complementary of the management and care they received and were keen to reiterate this, particularly around care provided by midwives. They wanted to ensure that I was informed of the positive care they received, and all held the NHS in high esteem. As the interviews progressed, however, they appeared to feel more comfortable in discussing less positive aspects of their care, although even then they would end their account emphasising that they were not complaining. They did not want to portray health professionals in a poor light, however, some of the women's experiences suggested otherwise.

The data collected when analysed portrayed many similarities, particularly around their lived experiences of living as 'obese'. This was regardless of social status. What was evident, however, was how they were able to negotiate care, make choices around their care and articulate their understanding of the care offered which varied considerably depending on their social circumstances.

6.4 Conclusion

This chapter has introduced the participants of the study and provided contextual demographic data including the local context in which the women live their lives. It has served, along with my reflections, to ensure that the women in the study, although anonymised are at the forefront when considering the findings in Chapter 7.

The following chapter will consider the findings of the study and the early theorising that arose from the findings.

CHAPTER 7

FINDINGS

7.0 Introduction

The previous chapter introduced the eleven participants and the local context in which these women live their lives.

This chapter presents the findings for the empirical study. It begins with an introduction to category development from focused coding to the development of sub-categories and categories and provides a key to reading the findings. It then goes on to present the findings from the study in relation to the sub-categories and categories identified.

7.1 Grounded theory category development

When analysing the data, it became clear that the eleven women interviewed shared similar accounts of their experiences of management and care throughout the pregnancy continuum. How these women made sense of those experiences, however, differed depending on pre-existing perceptions of their weight. From the focused coding sub-categories were constructed then categories. Two grounded theory categories of 'women's perceptions of weight' and 'women's perceptions of care' were constructed depicting the interrelationship between the women's perceptions of weight, which were found to be associated with pre-pregnancy experiences, actions and behaviours, and perceptions of care during pregnancy, birth and the postnatal period. Early analysis suggested that women's experiences were influenced by the cultural and social context surrounding weight (macro), maternity service provision, policies and practices (meso) and the interactions women had at a micro level with health professionals. Figures 7.1 and 7.2 illustrates how this was developed.

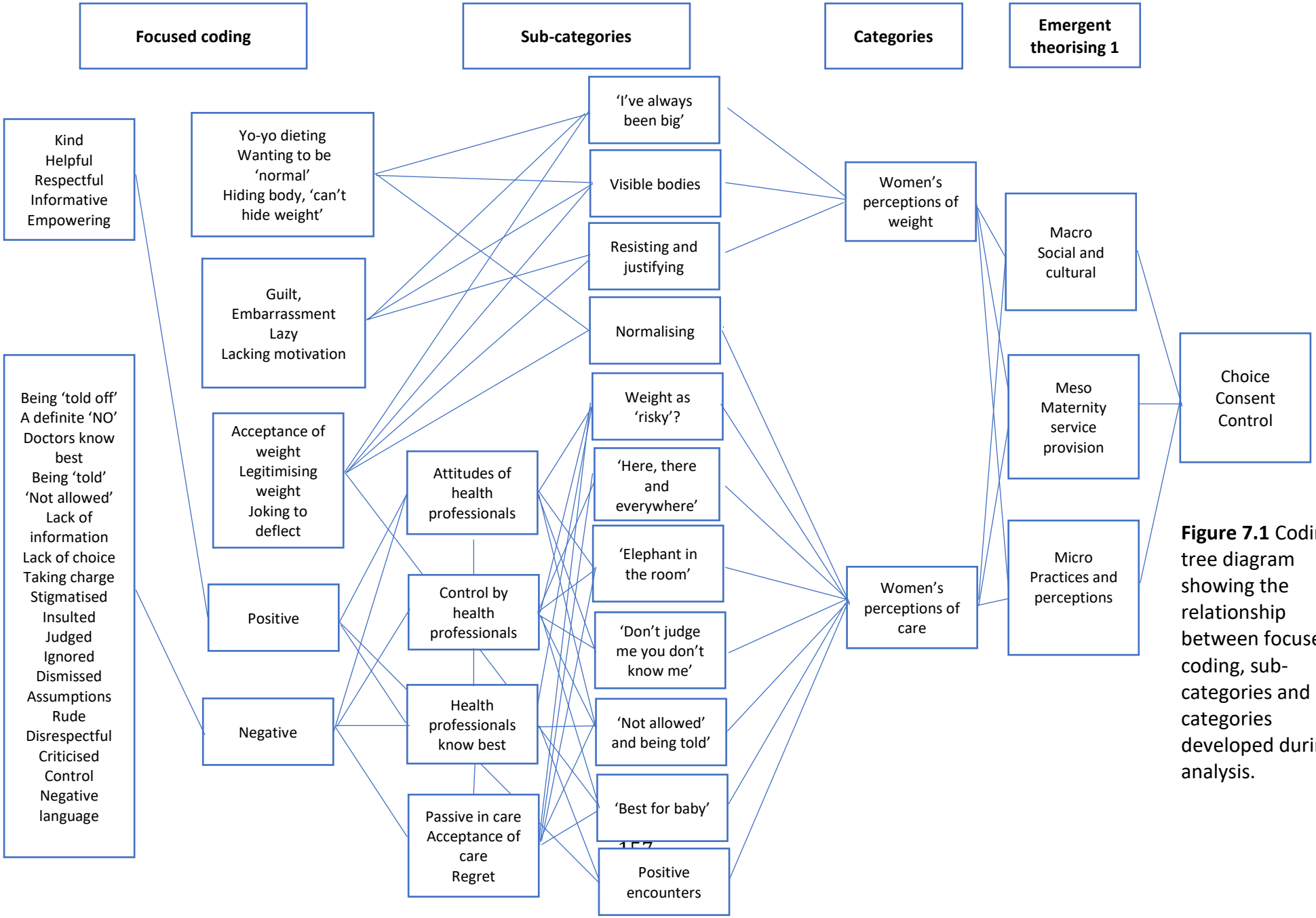

Figure 7.1 Coding tree diagram showing the relationship between focused coding, sub-categories and categories developed during analysis.

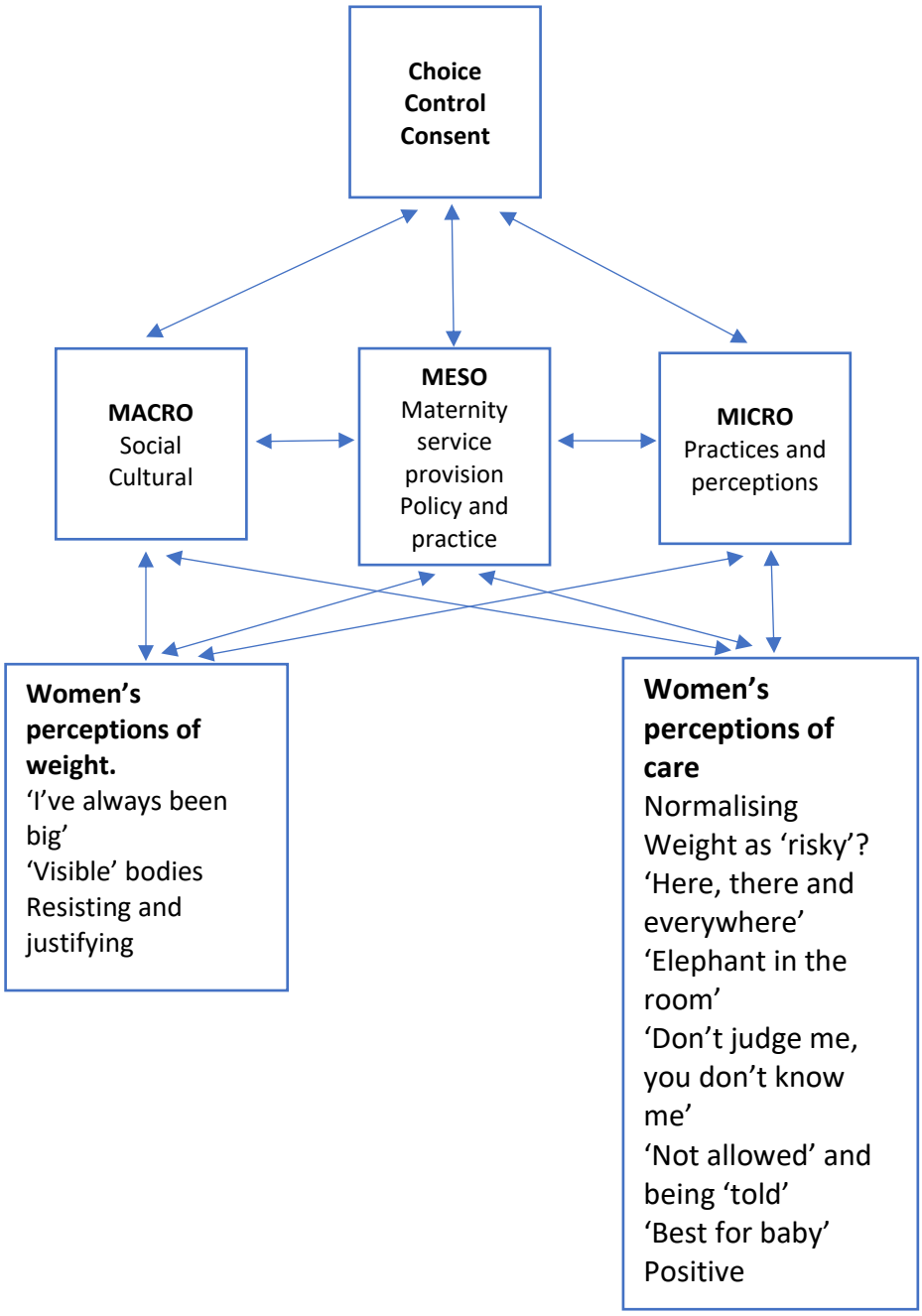

Fig. 7.2. Interacting factors impacting on women's perceptions of weight and care received affecting choice, consent and control during the pregnancy continuum

The interaction between these factors appeared to impact on women's ability to exercise choice with regards to their care, give informed consent and affected the degree of control women had over their pregnancies and births. This will be further considered in Chapter 9.

7.2 Reading the findings

The findings from the two categories, 'women's perceptions of weight' and 'women's perceptions of care' are presented below. 'Women's perceptions of weight' appear to be closely linked to their pre-pregnancy relationship with weight which in turn impacts on their perceptions of care and ability to exercise choice. The sub-categories reported in this section are: 'I've always been big', 'Visible' bodies, and 'Resisting and justifying'. Section two provides insights into 'women's perceptions of care' and is presented under the sub-categories: 'Normalising', 'Weight as 'risky'?', 'Here, there and everywhere', 'Elephant in the room', 'Don't judge me, you don't know me', 'Not allowed' and being 'told', 'Best for baby', 'Positive encounters'.

The table below provides a key to the symbols used in the presentation of the quotes in this and subsequent chapters.

Table 15: Key to symbols

Symbol	Meaning
I-1, I-2 etc.	Interview 1, 2 etc. followed by line number/s
gest.	Gestation (preceded by number of weeks)
p/n	Postnatal interview (preceded by number of weeks)
…	Part of quote removed to aid brevity and clarity
CAPITALS	Spoken loudly
underlined	Underlined word/s denotes said with emphasis
(context)	Single brackets- context added for clarity

Symbol	Meaning
((…..))	Double brackets- Non-verbal observations
(…)	Pause- each dot representing a second
(R:)	Researcher speaking
[profession]	Profession of person being referred to in square brackets

7.3 Perceptions of weight

At the first interview in the antenatal period, I asked all the women about their weight and understanding of BMI. I hoped to gain some context of their comprehension, and how this may impact on the choice, consent and control. It was clear that all the women presented in pregnancy with an understanding that their weight was contentious. As the interviews progressed their lives as 'obese' was often at the forefront and this appeared to directly impact on the choices they felt they could (or could not) make. Added to this their weight appeared to impact on their autonomy, with a general acceptance that they had to relinquish control to others as they could not control themselves. These observations are further considered below.

7.3.1 'I've always been big'

All the women's accounts suggested that they had 'struggled' with their weight for most of their adult life, with yo-yo dieting a common practice. Rose's perspective on weight highlighted this and offered an insight into the effort of managing her weight over time:

> *I have always been bigger(.)but If I really go for it like on Slimming World©, I can lose 3 stone, you know like easily. Just by(.) I think last year I lost two stone(.) and then I put it back on between then and now (..) <u>and more</u>. Erm. And I am putting it on, and I am probably at the biggest I have ever been now.* (Rose, I-1: 137-140, 17 weeks gest.)

Jasmine who identified as being 'big' her whole life described her weight gain as out of control following moving out of her parents' home and into her own house:

> *I've never ever been skinny but, it's just (.) plummeted since (..) I think it's since I've got my own house and I've (.) gone off and done my own thing and I can eat what I want and [R: yeah], I'm realising and I'm like oh god (.) so then I have tried (.) I've tried Slimming World© (.) when I did go I was 22 stone then and I feel like I've put more on.* (Jasmine, I:1, 123-130, 24 weeks gest.)

For Chloe, who also talked of yo-yo dieting in the past, there was a recognition that being 'obese' was multifaceted:

> *The thing is with weight; it isn't black and white, and women should not feel that if they have a high BMI that they need to do something about it.* (Chloe, I-1: 155-156, 20 weeks gest.)

At a subsequent interview, Chloe expanded on some of the issues that impacted on her pre-pregnancy weight, referring to emotional eating and the difficulty of trying to keep her weight under control. This further reinforced that for her, her weight was compounded by the everyday stresses of life. This was reiterated by Sam, who had a young child already, and Anna, who had had two previous children. Both talked of 'juggling' work and family life and not having time to think about what they ate. For them, they put the needs of others before their own. They were not happy with being 'bigger', however they valued their role as carer and mother, accepting to some extent their 'obesity' as a trade-off. This was also evident for Jasmine, Ella, Sophie, and Carla who, although not yet mothers, described their desire to lose weight as difficult, with their lives as women being complex. For them there was a tension between losing weight and managing their busy lives.

When asked why they felt they needed to lose weight there was a feeling of wanting to be 'normal', to 'fit in' and to 'be healthy'. There appeared to be a recognition that thinness was desirable in order to fit in to societal 'norms'. This

appeared to influence the cyclical weight loss, weight gain regime. This was apparent in how some of the woman talked about food, trying to justify their food intake both pre-pregnancy and during pregnancy. They emphasised how they try to eat healthily, and how outside forces such as reliance on others for food, family and work commitments restrict this, limiting choice. In discussing how family and work commitments impact on weight, women viewed their family as a priority, with some seeking to control their weight in order to be fit and healthy to care for their family, and others putting the needs of their family first, thereby neglecting their own needs:

> *It is very difficult to think of yourself as just you and to have time for yourself. It's me and the kids…I think this is the thing with my weight, I am bigger, but I don't have time to think about it cos I'm a mam. You don't put yourself first.* (Anna, I-2: 243-247, 7 weeks p/n)

Juggling work and family left little time to think about themselves, and being a good mother appeared to supersede their own desires

7.3.2 'Visible' bodies

Living with 'obesity' was a constant for the women interviewed and they felt they could not hide from it. The fact that their weight was always visible added to their anxieties of how society perceived them, affecting their ability to exercise choice. Rosie, a keen swimmer, talked of her embarrassment of going to the pool and her body being on show for others to see. For Sam who was a member of a gym, the visibility of her size impacted on her ability to work out without feeling exposed and the feeling of others staring:

> *…if I'm doing any cardio work, I feel like people are looking at us (slang for me) and watching us cos I'm big…whereas if I'm doing muscle, weights, it doesn't bother us because that's what I'm doing.* (Sam, I-1: 37-40, 24 weeks gest.)

She went on to talk about being conscious of her body and how this affected her exercise regime. She would avoid the gym at busy periods if wanting to do cardio

work, yet she could legitimise her weight if doing weight training, acknowledging the social and cultural constructs of what is acceptable behaviour for her body size, with weightlifting being associated with a bigger body.

As well as feeling exposed, there was evidence that their visible bodies implied to others that they were 'lazy', lacking in motivation and having 'no willpower'. Ella had internalised this, believing that she had these traits, yet worked fulltime, looked after her siblings, and supported her wider family. These perceptions were also negatively expressed by Jasmine, Rose, Helen, Sophie, and Alice. For them, social discourses that portray those who are 'obese' as lazy and lacking self-control was evident. Jasmine accepted the fact she was lazy due to her weight:

> *Look at me I'm SO lazy [makes non-verbal reference to her size], look at me, like (.). I live on a big hill, and sometimes I'll actually, I'll get off (the bus) in town and get a taxi home just so I don't have to walk up the hill. <u>So lazy.</u>* (Jasmine, I-1: 461-464, 28 weeks gest.)

Bodies being visible compounded feelings of shame and blame, with most women suggesting that somehow, they were responsible for their size. It was apparent from the first interview that most of the women perceived their weight as a moral failing, leading to low self-esteem and feelings of guilt, shame, and embarrassment. Most talked of their 'shame' at being 'bigger', with many blaming themselves for not being able to lose weight. For Sophie, her weight made her 'struggle' with her confidence, and she felt others were watching her and judging her. Helen concurred with this, suggesting 'you feel vulnerable because you are bigger' suggesting that her weight was under constant scrutiny by others.

7.3.3 Resisting and justifying

There was evidence to suggest that for some women, weight was viewed as positive, and they resisted societal notions of being overweight as being

unhealthy. Anna (a black belt in Taekwondo) equated her weight to being physically fit, having always exercised throughout her adult life:

> *I think that's the problem you may look fat, but muscle is heavier than fat and a lot of people don't take that into consideration. At that point (referring to first pregnancy) my physical fitness was at its peak, and I was big, I was in a size 16 but I could still run with the best of them.* (Anna, I-1: 107-109, 34 weeks gest.)

This was supported by Sam (weightlifter) whose perspective was similar. In reflecting on her pre-pregnancy self at her postnatal interview she stated:

> *So, underneath my fat I am quite strong! (laughs)… Cus at least, you know, if you're fit and you're strong, you know, it's, it kind of gives you the feeling that you're healthy (.) Rather than (..) FAT.* (Sam, I-3: 254-262, 5 weeks p/n)

Both Anna and Sam felt compelled to emphasise the exercise they do and their level of fitness, opposing the discourses within society that thin equals healthy. They kept coming back to this throughout the interviews, as if trying to prove respectability, suggesting that the reality for them was that their weight was perceived by others to be a personal failing and they did not want me as the researcher to have the same impression. In fact, most of the women interviewed had internalised their weight, yet gave valid reasons for their BMI. Rose, for example, attributed her weight to having polycystic ovaries, citing this medical condition as why she gained weight easily. Medical reasons for weight were also cited by Sophie who had always struggled with her weight, putting it down to unhealthy eating habits due to unsociable working, but following a diagnosis of an underactive thyroid found that this was the reason for her weight gain:

> *I have always had (.) been bigger, but this is the biggest I have ever been. Not just in the pregnancy but before I got pregnant as well. I was working a lot of night shifts. So, I was doing 12-hour nights and I put on more weight. I was blaming my eating habits with working shifts, and I was worried I had a slow metabolism. So, I went to the doctors, and they said have you had your thyroid tested? Well, I had but it was several*

years before. It's in my family as well (.) Erm (.) So, they done it again and it came back really bad. So, she [Dr] *said it is probably why you have put the weight on.* (Sophie, I:1, 97-103, 24 weeks gest.)

Jasmine, however, while recognising she was 'big', did not believe her weight was due to an underlying medical issue, but saw her weight as an actual medical condition that needed to be medically managed. She discussed visiting her GP on several occasions to ask if they could do something about her weight. On one occasion she was told there was nothing the doctor could do:

…but they just said [GP]*, like, there's nothing, when I did go about my weight, they just said there's nothing they can do (.) erm (.) just to exercise and eat healthily.* (Jasmine, I-1, 126-127, 24 weeks gestation)

As well as citing medical reasons to explain their weight, familial reasons were also given as an explanation. Chloe suggested her weight was hereditary and that BMI classification was perhaps flawed, helping to ease the guilt she felt:

If you look at my family history and you look at the women in my family, we are all the same shape. So, (.) So, there's something within that. I think there's something to that. It's not official. It's not diagnosed. I am the same build as my mother, and she is the same build as her mother… BMI in some instances is quite skewed and doesn't (.) isn't actually representative of what makes a person healthy. I'm not trying to use that as an excuse for my obesity, but it does help ease the guilt, if that makes sense, of feeling that I am of a higher BMI. (Chloe, I-2: 213-225, 29 weeks gest.)

For five women, pregnancy was seen as a time to be 'bigger', expressing relief with regards to their weight once it was apparent that they were pregnant and not 'fat'. They felt they could 'legitimise' their weight, Ella stating: 'I am pregnant therefore, I am expected to be 'fat'. This appeared to be particularly empowering for Sophie who was also pregnant with twins as she could attribute her weight to having twins and felt this afforded her respectability:

> *I don't know what (.) how much (weight) I have put on or anything, they didn't say (.) Obviously it will probably by quite a bit with there being two of them…I thought oh, cos I was bigger, what if you can't tell in that I don't (.)You know, you always want to get a bump don't yeh when you've got a baby in there, but (..) you can definitely tell now.* (Sophie, I-2: 209-214, 33 weeks gest.).

Alice also felt others were more accepting of her weight once she was visibly pregnant:

> *I was scared beforehand (of what others would say about weight), but I think I do feel more at ease now and I mean (.), my bump, you can tell I'm pregnant, not just fat (laughs)* (Alice, I-2: 224-226, 28 weeks gest.)

In considering this, it appears that the women felt an acceptance of being 'obese' and pregnant and that pregnancy helped them feel less stigmatised by their weight, with society seeing their pregnancy and not their size. There was also an expectation to put on weight during pregnancy. When talking to me about this, the nonverbal communication I observed e.g., touching their 'bump', smiling and the emotion when talking about looking pregnant suggested that these women were empowered by their pregnancy being visible, perhaps lessening the stigma of living as 'obese'.

Women's pre-pregnancy perceptions of weight suggests that their weight is a constant within their lives with which they are dissatisfied. Social and cultural expectations to control their weight was described through their desire to lose weight and the yo-yo dieting that ensued. The women were acutely aware of their visible bodies and how they felt perceived socially and culturally. Those who resisted these perceptions tended to medicalise their 'obesity'. These perceptions had eroded confidence over time, affecting self-esteem, leading to guilt, blame and shame. Pregnancy, however, was seen by some to be a time where to be 'obese' was acceptable, mirroring societies expectations of the pregnant body. It was these perceptions of self that the women brought to their pregnancies.

7.4 Perceptions of care

All the women were considered 'high risk' by virtue of their high BMI when they presented in pregnancy, with some having other risk factors that exacerbated this. All were managed following national guidelines for the care and management of 'obesity' during pregnancy. This entailed extra pregnancy surveillance, including testing for gestational diabetes, and serial scanning for fetal wellbeing as well as increased monitoring and intervention during labour. Most women welcomed the extra surveillance during pregnancy, particularly the extra scanning which they found reassuring. It was clear, however, that a dichotomy existed between this extra surveillance and the desire to be 'normal', with resistance by some women evident. Also, several women did not realise that the extra surveillance was because of their high BMI, thinking that the same care was offered to all women.

The desire to be treated as 'normal' was evident in women's accounts. For some the 'high risk' status detracted from the expectations they had of an enjoyable 'normal' pregnancy and birth, fostering increased anxiety. Most women felt guilty that their weight rendered them at 'risk', and this was compounded by the negative attitudes of some of the health professionals caring for them. Added to this most women wanted their weight to be addressed but found that it was often 'skimmed over' or ignored. The ability to make pregnancy and birth choices was reduced due to fear, anxiety and wanting to do the right thing for their baby. They trusted health professionals' judgement and most took a passive role in their care because of this. These findings generated the sub-categories of: 'Normalising', 'Weight as 'risky'?', 'Here, there and everywhere', 'Elephant in the room', 'Don't judge me, you don't know me', 'Not allowed' and being 'told', 'Best for baby', and 'Positive encounters'. These make up the category of 'perceptions of care'.

7.4.1 Normalising

Eight women expressed the hope that they would be able to have a 'normal' pregnancy and birth despite acknowledging that this may not be possible due to

their weight. They all wanted to be treated like 'normal' mothers-to-be. They valued seeing their midwife and saw this relationship as being 'normal', as 'normal' women see their midwife for most if not all of their pregnancy. Alice in acknowledging that her weight meant she would not be treated as 'normal' tried to rationalise this, hopeful that she could be 'normal' but recognising her 'high risk' label:

> *I know you are at a higher risk, but I do know people who have been high end (BMI) and have been completely normal. Absolutely nothing wrong with them whatsoever. And have had normal births and everything. So, and it (.) obviously I know they have to check up on you, but it will be nice to be normal… just be treated like everyone else and not because of your BMI. Just (.) normal.* (Alice, I-1: 208-213, 14 weeks gest.)

Alice discussed her hopes for birth, wishing to be able to labour and birth in water. Having been told that because of her weight this would not be possible, she rationalised her risk:

> *I'm a bit gutted to be honest.... Just because I'm big that that has to be a problem. Yes, I know it can be a problem, but it doesn't mean that there will be a problem. Everything might go normal. (Alice, I-1: 145-146, 14 weeks gest.)*

Having a 'normal' birth was also emphasised by Carla, who in response to being told she was 'high risk' and may need a caesarean section because of her weight, resisted this: 'I want to try for a normal birth, and I hope I can prove them wrong'. (Carla, I- 1: 211-212, 39 weeks gest.). Despite these hopes, there was a recognition that the reality for them living as 'obese' would exclude them from being 'normal'. All but one woman (Isla) understood their weight would impact on their pregnancy care

7.4.2 Weight as 'risky'?

It was evident from the findings that weight was seen by the women to be 'risky';

> *… most people who are quite overweight know that they are overweight and that they should lose weight, and all of that. You don't walk in expecting everything to be straightforward.* (Carla, I-1: 239-242, 39 weeks gest.)

Most women were aware of some of the risk factors associated with their weight and pregnancy. Their knowledge was gained either from a previous pregnancy experience or from informal sources, as was the case with Ella:

> *…she [midwife] didn't say a lot really. She said you have increased risks (.) like pre-eclampsia and told me about taking aspirin then she just went through what extra things would be needed with having a high BMI (.) like extra scans and stuff like that…My cousin has just had a baby and she has a high BMI as well, so I knew a bit really* (Ella, I-1: 12-18, 12 weeks gest.)

All the women expected their weight to be discussed during their first contact with midwives at their antenatal booking appointment, with all having their height and weight taken and BMI documented. Nine women were given advice from their midwife on diet and exercise. Other than Isla, all were told by their midwife that their BMI would make them 'high risk' and that they would 'have to have' consultant care. Only Sophie, Anna and Alice said that the risks associated with high BMI in pregnancy were fully discussed with them, with Sam and Jasmine being told they would be at a higher risk of gestational diabetes and Ella being told she might have a big baby, so would need extra scans and was at risk of pre-eclampsia. For Rose and Carla (who had experience of working within health care) they felt that there was an assumption made by health professionals about their prior knowledge, suggesting this as a reason for why BMI risk was not discussed fully. Chloe also felt her pregnancy and birth risk factors were not discussed, attributing this to having had previous pregnancies, making the assumption that her midwife would expect her to know because of this.

It was evident that for some of the women they accepted the care given without question, and without the risks associated with high BMI being fully discussed.

In fact, only two women knew they were on a maternal 'obesity' care pathway and what that entailed. For many there was no discussion of what care would be offered, with care being given by virtue of the women being labelled as 'high risk', without any explanation or consideration of the women's preferences. Carla, on being sent an appointment to see the anaesthetist, spoke of being told what care she would have in labour because of her 'high risk' status:

> *She [anaesthetist] also explained that I would be cannulated as soon as I went in because she said I was at a higher risk of PPH (Postpartum haemorrhage). But again, she didn't tell me what my risk was or why, just that was it. She said I would have to have continuous monitoring (of the baby). She didn't really say why she just said this is what will happen.* (Carla, I-1: 104-108, 39 weeks gest.)

Guidelines in relation to the management of maternal 'obesity' proved to be double-edged for some women. Chloe felt well informed and happy to be medically managed, attributing her 'high risk' status to being well cared for, although in accepting her 'high risk' status she acknowledged that this limited her pregnancy and birth options. Others like Carla and Anna felt frustrated at being pigeonholed as 'obese' and therefore at a 'high risk'. Both Carla and Anna talked of how an assumption was made by health professionals that their 'obesity' would mean they would develop problems. Rather than providing individualised care, they felt they were seen by their 'obesity' and not as individuals: '…everyone should be treated as the person they are not by their BMI'. (Carla, I-1: 314, 39 weeks gest.)

All the women were subjected to increased screening and testing throughout their pregnancies and births due to their high BMI. Their bodies were scrutinised in the antenatal period through testing for gestational diabetes, serial scanning of the fetus for growth and increased consultant appointments to assess fetal and maternal well-being. For those with a BMI of 40 or above, an anaesthetist appointment was made to examine their bodies to access potential anaesthetic complications. For birth, intervention included induction of labour for seven of the women, either in line with maternal 'obesity' management to reduce the risk

of stillbirth or due to perceived problems with fetal weight on scan. Of the eight women who laboured, all were cannulated on admission and given medication in case they needed anaesthesia. Those who laboured had increased monitoring of fetal wellbeing. For some this could not be undertaken abdominally due to the CTG not being able to accurately pick up the fetal heart rate due to increased adipose tissue. This resulted in a fetal scalp electrode having to be attached to the baby's head via the vagina. They were unable to mobilise because of this. Of the women who were induced, two had vaginal births, three assisted vaginal births (forceps or ventouse) and two emergency caesarean sections. Two of the women opted for elective caesarean sections having had previous sections and one went into spontaneous labour and had a vaginal birth. How this affected choice, consent, and control was evident in how the women talked of their experiences:

> *I haven't been offered anything. No one has said would you like to have, or we usually do this, is that ok? It has just been like…you will come in; you will be cannulated. You will have an epidural. You will lie on the bed and have a CTG. You will have your baby by whichever means we say.* (Carla, I-1: 130-132, 39 weeks gest.)

The 'high risk' status attributed to the women due to their high BMI appeared to restrict choice with weight being seen and managed without consideration of the person within and without full discussion.

7.4.3 'Here, there and everywhere'

For most women, their 'high risk' status led to care being fragmented due to increased tests and monitoring, with most women having multiple appointments at different midwifery clinics as well as the consultant led maternity unit. They were expected to see their community midwife, consultant obstetrician, have serial scans and for some, appointments with other professionals such as the dietitian or anaesthetist. Fragmented care was negatively perceived by those who experienced it. They felt unable to build up relationships with health professionals and spoke of wanting continuity of care with appointments on one

day and in one place. For Sam, she felt uncomfortable having to negotiate time off work to attend multiple appointments. For others, like Sophie and Ella, they relied on others to take them to appointments which caused added stress in having to negotiate transport on a regular basis.

Jasmine struggled to attend some of her appointments due to financial constraints. She lived six miles from the consultant outreach clinic and fourteen miles from the consultant led maternity unit. There was a midwife clinic in her hometown, but due to her BMI she could not see her midwife locally due to her 'high risk' status. She had no means of transport and, being unemployed, she was unable to afford the bus fare to get to all her appointments. Jasmine stated that she had to prioritise which appointments to attend. In wanting to ensure her baby was healthy, she prioritised her scan appointments at the consultant led maternity unit above her other appointments. This led to her being seen to be a recurrent defaulter which Jasmine felt stigmatised her, when in reality she had little choice. Added to this she often had multiple appointments in short succession:

> *I've had four appointments this week… my next appointment is just a consultant appointment on its own so I'm gonna have to get the bus which is like an hour and 20 minutes…for a FIVE-minute appointment…The consultant is only there on certain days so she [midwife] said I'd have to come back the next day.* (Jasmine, I:1, 287-289, 24 weeks gest.)

Due to financial constraints, Jasmine had to make choices about her care, feeling frustrated at having to travel for a five-minute appointment. The effort of getting to the consultant clinic did not equate to the time seeing the consultant, therefore Jasmine felt it was of little value. When she did not attend for care, however, she felt guilty and blamed herself for not being able to comply to the demands made of her.

In having to attend multiple appointments, inconsistencies in care were apparent. Sam, Ella, Carla, and Jasmine all talked of mistakes being made over appointment times. For Sam:

> *The consultant appointment was quite rushed and that was because somebody had sent me a letter with the wrong time on it. So, I had to come at quarter to twelve and my appointment was at quarter to eleven, I think. And she was just leaving to go to an appointment so she kind of rushed us in, seen us and just like (.) rushed us and things and I don't think I took it all in good enough and instead of asking or saying anything I've stewed over it for two week.* (Sam, I-2, 122-127, 30 weeks gest.)

These inconsistences led to women being left with unanswered questions, and insufficient time to process the information, as well as wondering if all the appointments were necessary. Furthermore, as consultant obstetrician appointments were short, some women suggested they were meaningless, questioning why they had to attend, yet feeling they had little choice but to attend.

Where a joined-up approach to care was encountered, a more positive experience was evident. This was particularly apparent for Sophie and Alice. Sophie and Alice were both diagnosed with gestational diabetes at around 24 weeks gestation. This meant from diagnosis they had all their care at the consultant led maternity unit, seeing the midwife, sonographer for scan, consultant obstetrician, dietician, and diabetic team. They both felt the care improved once they were seeing all the health professionals on the same day in one place. They were able to get to know those caring for them and felt confident to ask questions and negotiate their care.

Although the women had different experiences of access to care, they all experienced multiple appointments, seeing multiple professionals, and often had to travel long distances to access care. Care was provided at the convenience for

the service and not the women, who had no choice in where they could access care due to their 'high risk' status.

7.4.4 'Elephant in the room'

Both Carla and Alice used the metaphorical idiom 'elephant in the room' to indicate how their weight was obvious, yet often avoided by healthcare professionals. Most of the women concurred that they perceived health professionals did not appear to want to upset or offend, but their active avoidance of the issue made them feel worse. Carla particularly wanted her 'obesity' to be addressed by the health professionals caring for her. She felt good quality care could not be given if health professionals were not prepared to speak about her weight:

> *If you are going to talk about risk, and if weight is going to impact on everything, the pregnancy and birth then they need to be honest. If midwives can't discuss the risks properly with people who are overweight and be honest with them how can they provide good care. (..) It's the elephant in the room, most health professionals are reluctant to mention it, but most women want it to be addressed. How can I make changes to my weight if no one tells me about it?* (Carla, I-1: 244-251, 39 weeks gest.)

On attending a growth scan, her BMI affected the sonographer's ability to visualise her baby, but this was never spoken about to Carla:

> *She [sonographer] said to me that the baby was in a bad position. But then you know how they do a print off for the consultant, it was on the table, and it said unable to obtain measurements due to position and maternal BMI. But she didn't tell me. I guess she didn't want to say she couldn't see the baby because of my BMI.* (Carla, I-1: 226-229, 39 weeks gest.)

Carla went on to have an emergency caesarean section after failed induction of labour and subsequent raised temperature, leading to suspected sepsis. Once on the postnatal ward she was given a larger bed. She knew this was because of her weight, yet her weight was never mentioned:

…they gave me erm (.) a bariatric bed. Obviously, I didn't need it cos I had a normal bed up until I went to theatre. I came back on a normal bed. They [midwives] came in and said 'we have got you this nice bed. It's bigger and more comfortable'. You know it was like (.) I'm NOT stupid. I was like alright, whatever. Like it was great cos it was bigger, but it did make me feel a bit like (sighs and rolls eyes) embarrassed. I knew it was because I was bigger. Why didn't they just say? (Carla, I-2: 110-115, 6 weeks p/n)

Alice also referred to her weight being avoided by health professionals:

I mean it's the elephant in the room that I do have a high BMI, you can tell my looking at me that I have a high BMI. I thought it would be mentioned a lot more than it has been. (Alice, I-2: 197-199, 28 weeks gest.)

As did Chloe who felt health professionals needed to be blunter about women's weight. She discussed how health professionals are happy to discuss smoking risks with women, but not weight. She questioned why one was more acceptable to discuss than the other. She felt health professionals needed to be open and honest about weight, and in relation to her own weight, she felt that health professionals avoided the issue:

…you need to be very blunt about it. Take away the fear of discussing it…does that make sense? How is it ever going to be addressed if you tip toe around it. (Chloe, I-1: 135-136. 20 weeks gest.)

As her pregnancy progressed Chloe felt her BMI was never fully addressed, stating that: 'Whenever BMI's come up it's just been skimmed over. To me it feels like it's been skimmed over'. (Chloe, I-3: 296-297, 34 weeks gest.)

By health professionals not addressing weight, women felt that information was lacking. All the women cited lack of information as being an issue. Ella talked about not being given information with regards to needing extra care due to her raised BMI. This was evident while talking about receiving appointments through the post with no idea why she needed them. On receiving a letter to attend the hospital to see a consultant anaesthetist, Ella stated that she was 'terrified'. She

was unaware that women with a BMI of 40 or over are routinely offered an appointment to discuss potential anaesthesia with an anaesthetist, due to high BMI increasing the risk of anaesthetic complications. Reflecting on this conversation with Ella, and from my memo writing following this interview, I decided to establish if this was an issue for other women with a BMI of 40 or over at booking. On subsequent interviews with women, I adapted my questioning to enquire if the women had been given information on seeing an anaesthetist because of their high BMI until theoretical sufficiency was obtained. Of the eight women recruited to the study with a BMI of 40 or above, all received appointments through the post, with five not knowing why they needed the appointment. For Isla, on receiving an appointment to see a consultant obstetrician she worried for the month leading up to the appointment, feeling unable to question why. All five women who did not know why they had received appointments attended them unquestioningly.

All the women wanted information to enable them to make healthy 'lifestyle' choices and decisions about their care. Nine women had been signposted to slimming services in early pregnancy. They all had engaged in slimming groups prior, and all stated they would have preferred meaningful conversations with their community midwife around their weight. By being referred to slimming groups I got the sense that this was perceived as passing the buck when actually the women wanted meaningful discussions and support with their weight by the midwives caring for them. The women talked about wanting midwives to give them information around weight management and dedicated information regarding maternal 'obesity' management for pregnancy and birth, so they understood what extra care was offered. They also would have liked increased input from midwives to complete birth plans and discuss birth choices. Lack of information from health professionals was perceived by some of the women as wanting to avoid talking about weight so as not to offend, but by others as being authoritarian and withholding information.

7.4.5 'Don't judge me, you don't know me'

Most of the women felt judged by some of the health professionals they encountered during the pregnancy continuum. They talked about being insulted, patronised, and offended: Anna was particularly vocal in expressing her displeasure at being referred to as an 'overweight geriatric mother', stating how insulting it was to be judged by people who did not know her. She talked at length of her previous pregnancies and how her weight was vilified, with her community midwife in her previous pregnancies constantly chastising her without any knowledge of Anna as a person:

> *Throughout that pregnancy the midwife was atrocious. She went, you're overweight you can't do this, you can't do that, and I constantly battled against it. I was a high-risk pregnancy because of my BMI but, I was training 3 hours a night up to six nights a week and was pregnant, you know, instead of getting the praise…well that's really good. I was getting but you are not healthy your BMI is high; you shouldn't be eating this or that. I ended up saying 'I can actually walk and run around this carpark faster than you can so don't criticise me' just because of my BMI… [The midwife said] for labour you will be strapped to a monitor, and you can't get off the bed but for me to deal with pain particularly period pains and stuff like that I have to be mobile. I have to get up and walk around, sitting on a bed wasn't for me but that's what happened, and it was just that constant criticism from that midwife that I wouldn't say it put a downer on it but it didn't make you feel good. Particularly as I was really fit at the time.* (Anna, I-1: 86-91, 34 weeks gest.)

Past experiences influenced this pregnancy, with Anna expressing relief that she did not have the same community midwife as previously. Based on previous experience, she was also able to negotiate which consultant obstetrician she saw for care, one who did not talk negatively about her weight and who she felt was approachable and non-judgmental.

Carla also found many of the health professionals caring for her were 'rude' and 'patronising'. She was upset that assumptions were made about her intellect and her lack of understanding:

> *…she (anaesthetist) was really quite rude to be honest. She was very (.) erm (Sighs), quite patronising. She was like (.) well you are only 21 and nobody has probably told you how important it is to eat healthily and so was making an assumption about me. Erm (..) which I found insulting cos I just thought actually I do know how to healthy eat.* (Carla, I-1:47-50, 39 weeks gest.)

This was reiterated by Alice who generally had positive encounters with health professionals except on one occasion with a practice nurse which left her feeling judged:

> *I went to get my flu jab and the nurse asked me how far on I was, and I said or I'm 22 weeks and she said oh, you are having an Heffalump then, you look massive (R: Oh no). And I was quite upset (.) and I said well actually I have just been diagnosed with gestational diabetes, that week. (.) So, anyways I felt like the fact that I had failed myself anyway with the GTT (diagnoses of gestational diabetes) and then she said THAT, and I was really annoyed… and she said well that will be why, because you are massive. So, I was really upset.* (Alice, I-2: 175-182, 28 weeks gest.)

Jasmine found encounters with health professionals intimidating. She was frightened to ask questions, saw them as authoritarian and went along with care imposed on her because of feeling shame and blame:

> *Well sometimes it was a bit, like, degrading and stuff, like (.) some doctors (.) were saying that it felt like sometimes they were blaming certain stuff on the fact that I was overweight (Jasmine's baby was found to have static weight on scan), …like one doctor made me feel like it was my fault and all that and I went home, and I was like what am I meant to do now? Like, I can't change anything right now when I'm just about to have him sort of thing, but like at every appointment, your BMI, your weight, stuff like that was always mentioned, like EVERY single time it was mentioned, and by the end of it you're a bit fed up, like…you know you're big, like, you don't WANT to be big.* (Jasmine I-3: 437-443, 7 weeks p/n)

On having a follow up appointment with the consultant obstetrician postnatally she was shocked when told:

…and before she left, I was a bit offended, she turned round and she said if we ever see you again, if you have another baby, hopefully you'll be a bit skinnier next time! And I looked and I was a bit like (.) right okay, I just looked and laughed when she said it and then afterwards, I was like woah (Jasmine, I-3:419-422, 7 weeks p/n)

For Carla, sadness was expressed at being made to feel she would be to blame if anything happened to her baby because of her weight:

If something was to happen to my baby it could be for any reason, but I do feel that I would be blamed because of my weight. I would blame myself because of what I have been told. I have been told that 'you have put your baby at risk, so, yeah. Very negative messages are given out from staff. So, if something happens it will be my fault because I have been told that. When really you would never know if it was my BMI. (Carla, I-1: 200-204, 39 weeks gest.)

Not being believed by staff was also noted amongst some of the women: for Anna, Helen, Sam, and Carla upon receiving a normal GTT indicating that they had not developed gestational diabetes, the midwives caring for them did not believe the results:

I had two GTT tests because the first midwife did it at the wrong time, earlier in pregnancy and said there was no way I was not diabetic when it came back normal. Then I had to have a second one at the right time in pregnancy, it was the same result and she [midwife] still didn't believe it. She said there is no way a girl of your size can't be diabetic…I can understand why they do the test. But it's not individual care. A percentage of fat people are diabetic, and <u>I am not one of them.</u> (Anna, I- 1:126-133, 34 weeks gest.)

I have had (.). Well people have doubled checked because they don't believe that my GTT could have been normal. I mean my growth scans are fine, but they keep saying are you sure your GTT was ok. It's like they can't believe it. (Carla, I-1: 175-177, 39 weeks gest.)

When discussing eating habits, some women were also not believed. Chloe commented that when she told a dietitian in her first pregnancy that she ate a healthy diet, this was met with disbelief, with Jasmine being told she couldn't possibly eat so little when quizzed on her diet. Not being believed hindered

relationship building, with Anna becoming defensive and Jasmine feeling inadequate and passive.

Assumptions also appeared to be made by health professionals depending on the woman's social status. Anna for example felt she was seen by health professionals to be uneducated by going against medical advice. For others deemed to be from lower socio-economic groups, although able to articulate to me during my conversations with them on what care they would like, when attending for care, appeared passive and accepting of being managed. Jasmine for example did not view her own needs as important:

> *I'm not the sort to bother people, like (.) before I found out I was pregnant it was very rare I went to the doctor's (.) I'd just (.) soldier on if I was ill (.) I'm not one to badger them.* (Jasmine, I-1: 419-421, 24 weeks gest.)

Judgemental attitudes of staff appears to have impacted on the women's experiences of management and care leading to feelings of blame and shame. Not being believed and being seen as uneducated added to this. This seems to have led some women to become passive in their care, with feelings of inferiority and failure apparent.

7.4.6. 'Not allowed' and being 'told'

As well as feeling judged by health professionals, it became apparent over the course of the interviews that the language the women used implied that their management and care was also controlled by the health professionals. They talked of 'having to have', 'not being allowed' and being 'told' what would happen. When trying to negotiate care, some women's requests were dismissed with no explanation given other than blaming their BMI. Ella, for example was told she had to see certain health professionals but not told why:

> *…they said I would have to see a consultant (obstetrician). They just said I would have to see the anaesthetist, so I went (.) but I didn't know (why).* (Ella, I-2: 29-31, 28 weeks gest.)

This was also perceived by Alice, who stated she had not been asked about the care she would like:

> *I don't think I have been asked (.) sort of like (.) here's your appointment (.) that sort of thing (.). I haven't been asked.* (Alice, I-2: 71-72, 28 weeks gest.)

For Jasmine, she recognised she had not had a choice in any of her care:

> *I haven't really had a choice in anything yet, as I say like no one's questioned what I want, they've just basically told me what I need to do* (Jasmine, I-2: 406-407, 34 weeks gest.)

When asked what care was offered to Chloe, she replied:

> *I'm not convinced the language the midwife used was offering to be honest. I think I was just (.) this is going to happen because you're on this pathway.* (Chloe, I-2, 1050106, 29 weeks gest.)

Chloe's perception was that she wasn't given a choice of what she wanted, rather told what care was going to be given. She considered this further in relation to accepting care without question, realising that although she thought she was well informed, it had not occurred to her that she could decline care if she wanted to. Carla also felt unable to challenge or decline care, accepting the health professionals' knowledge as being superior to her own:

> *I have gone with everything that I have been told and not challenged it. Maybe if I had challenged things it would be different. I don't know. But I think you do just do as they say* (Carla, I-1: 267-268, 39, weeks gest.).

When discussing plans for birth, Carla, Ella, Jasmine, and Alice expressed a preference to labour and/or birth in water. These requests were quickly dismissed by health professionals with safety cited as the reason but with no evidence discussed with the women. For Carla, it was a straight 'no':

I asked about using the pool and that was a definite no… I asked at antenatal classes which was with one of the hospital midwives and she said they definitely wouldn't let me go in the pool, especially with me having a BMI over 40. Cos it wasn't safe in terms of the staff. If something was to happen to me there wouldn't be enough staff to get me out of the pool (laughs)… she said that because I was heavy there wouldn't be enough midwives in an emergency to evacuate the pool safely… So, it was just a very definite no. (Carla, I-1: 132-150, 39 weeks gest.)

Carla went on to state that her midwife said she could use a pool if she had a home birth, before going on to say that she would not be allowed a home birth anyway, choice being given, then immediately taken away:

If I had a homebirth my midwife said I could use my own pool, but they won't let me have a home birth because of my weight. There's a lot of (.) like advice given or you are told this or that has to happen, but no reason is given. I think they don't always really know they just want to protect themselves. I feel like they are just following their policies. Like the midwife said I needed to deliver at the hospital because it was safer and that was what their policy says. So, anyone with a high BMI has no choice. (Carla, I-1: 151-156, 39 weeks gest.)

Ella recognised she would not be allowed to use the birthing pool due to her high BMI, therefore did not pursue the use of water for labour and/or birth even though she felt she may have benefited from it:

So, I couldn't use the water pool because you had to be low risk for that, and I wasn't low risk because I was consultant led…My friend who had her baby last week used the birthing pool and she said it was loads better than when she had her previous baby, and it was really calming and a lot less painful. So, knowing that I might have liked to use it, but I wasn't given any information about it (Ella, I- 243-250, 5 weeks p/n)

In trying to negotiate using the birthing pool Jasmine was also told no, although the midwife did suggest she may be able to use the pool during labour:

Well, I did actually say to the midwife that I wanted a water birth and she said that I couldn't (.) Because, because of my weight (.) I didn't query it to her but I just thought to myself well I wonder why but I'm sure she said it's because erm, she's monitoring it, erm, she has to monitor me at the same

> *time, and obviously if I'm in a pool I can't* (be monitored). *So (.) that was that*. W*as what I've wanted no matter what but then she's told me like (.) knock that off, so (.) she, she did say erm, if the pool was free when you're there, she said, you might be able to go in it for an hour or so, she says, but you won't be able to give birth in it. She says cus we'll have to monitor you and stuff, so (.) I was a bit gutted when she told us cus (.) I keep watching loads of stuff online and a water birth, honestly, it just looks so much easier and I just thought all along that's definitely what I want and then (.) she kinda dropped that on me and I was, I was gutted* (Jasmine, I-2: 215-232, 34 weeks gest.)

Alice's midwife said she would need the permission from the consultant obstetrician in order to be 'allowed' a waterbirth. Alice perceived her care as being paternalistic and hierarchical, suggesting the consultant obstetrician had ultimate control over what she could and could not do:

> *I want to have a waterbirth and they said that maybe I'll not be allowed because of my BMI. It's all up to the consultant. And obviously if the room (that houses the birthing pool) is free. But they did say I MIGHT be able to labour in it but not birth in it or it might be a straight no (.) it's up to the consultant to decide... It's up to them if they say no that's it… That is what I've always wanted, a water birth, that is what I've always wanted. That, and just gas and air, I think.* (Alice, I-1: 125-135, 14 weeks gest.)

Anna spoke of resistance from health professionals and feeling treated as though she did not understand the consequences of some of the choices she made. This was evident when she declined prophylactic antithrombotic medication due to her high BMI increasing her risk of venous thromboembolism (VTE) and was told she could not refuse:

> *He* [consultant obstetrician] *was very irate with me he was very in your face (.) like 'you can't refuse the Clexane, you need to take the Aspirin' When I declined, he said he would have to write it in my notes that I had refused. I said WELL, you can write it in my notes. He said I didn't understand (significance of treatment advised). I said I DO understand and if I change my mind, I will talk to my midwife* (Anna, I-1: 233-236, 34 weeks gest.)

7.4.6.1 Being coerced

As detailed above, options for birth were limited, with women appearing to be coerced into following care by health professionals that they had little or no knowledge of, making them feel as though they were putting their babies at risk. For Carla, on seeing the anaesthetist she was told that she would have to have an epidural on admission in case she needed a caesarean section:

> *She said she would like us to have an epidural as soon as we went in, in labour because most (.) She said something like most primips* (women having their first baby) *need an assisted delivery or a caesarean section.* (Carla, I-1: 55-57, 39 weeks gest.)

Carla resisted this, stating that she may labour and birth with no problems. She asked for evidence relating to her increased risk, which was not forthcoming; rather, the anaesthetist appeared to use coercion and exert control to gain compliance:

> *So, she asked about what my feelings on epidural was and I said I wasn't keen on having one but then she went on to explain that if I needed a general anaesthetic, I would be putting myself and my baby at risk. So, by the time I left I kind of felt that if I didn't have an epidural that I would end up having a general (anaesthetic) and something would happen to me or risk the baby because it would delay delivery.* (Carla, I-1: 66-70, 39 weeks gest.)

Another example of coercion was talked about by Ella. On finding out her baby was large for gestational age on scan she was told she would be induced. Ella was reluctant to be induced initially but changed her mind when told that the baby may get stuck during birth: '…they don't want it (baby) to get stuck or anything'. (Ella, I-3: 39-40, 34 weeks gest.). Coercion was apparent in the language health professionals used in relation to the health and wellbeing of the baby and this is further conceptualised below in 7.4.7. Following being induced and undergoing an emergency caesarean section, Ella felt traumatised by the process, stating that if she became pregnant again, she would not want an

induction, wishing she had been told what to expect and that she would have 'not gone along with it' if she had known.

7.4.6.2 Feeling ignored

Both Carla and Anna had made specific requests in relation to labour in their birth plans. For Carla, she had requested not to have metal staples used for wound closure if needing a caesarean section. Going on to have an emergency section under epidural anaesthesia, she suddenly realised (while on the operating table) that her request was not being upheld:

> *AND they put staples in as well. They didn't ask but obviously I heard them talking about it and she said 'oh, I think I will put staples in' it must have been to the assistant in theatre, I don't know who she said it to. I was like 'oh, no I don't want staples. I was like 'no thanks'. She was like 'we are giving you them for more support' and was actually stapling away at my stomach as we were discussing it. I guess it was better for me with being bigger. At the time though I was upset (laughs). So, I had to have them taken out. Yeah. (..) They were quite (.) like everything they did (.) well I wasn't made to feel I was a problem because of my weight, but then when you look at it. A lot (.) like the dressing was put on and the staples were just done, and they just changed my bed (.) Put me in a big (bariatric) bed (.) Just 'in you get'*. (Carla, I-2: 221-230. 6 weeks p/n)

For Anna, she had previously had a bad reaction to a PICO dressing[18], and requested for the dressing not to be used when undergoing an elective caesarean section in this pregnancy:

> *I put in my notes that I didn't want a PICO dressing this time. So, we told the midwife, please make sure it wasn't a PICO dressing (.). It burnt my skin. When I was in hospital last time. I got up to get dressed and every time I stood up, I got shocking pain around my wound. The midwife said it can't be your dressing cos they are £150 so I am not taking it off. There is nothing wrong (.). When I took it off, I had to get in the bath at home to take the dressing off after five days and me skin just came off with it. The skin had burnt underneath. I don't know whether it was the adhesive or something that I was allergic to. So, it took a lot longer to heal than with my first section. First time I just had a normal dressing and was fine,*

[18] negative pressure wound dressing used to reduce infection and improve blood flow used for women undergoing caesarean section with a raised BMI.

although second time I was bigger so maybe that's why they used a PICO dressing. Anyway, they had the PICO dressing in theatre with us and they had already opened it. If I hadn't of seen it, they would have put it on, but I saw it and said I don't want a PICO dressing. The surgeon said like, but this is the dressing we put on because of your BMI. I said that I realised that, told him to look in my notes and said that I had spoken to the midwife earlier and she assured me that they would not put that on (PICO dressing). So, they put the honeycomb one on. Loads better, it healed really well. My scars perfect. (Anna, I-2: 93-114, 7 weeks p/n)

Although listened to, Anna also had to negotiate care while on the operating table. Jasmine also talked of not being listened to in labour: she was given a general anaesthetic due to a failed epidural after a decision was made to do a caesarean section because of slow progress. While being anaesthetised, she kept protesting that her baby was being born and that she was pushing. Her baby was delivered by forceps while she went under the anaesthetic, remembering nothing of her baby's birth:

I'm pushing, he's coming NOW, erm, I don't think they were listening they were doing what they were doing (.) erm, and by the time they'd knocked us out he was already half out, so they had to use forceps while I was asleep. (Jasmine, I-3: 95-97, 7 weeks p/n)

Sam also felt her requests were denied. Sam had made it known that she wanted to be taken to theatre and have a caesarean section if things started to go wrong during labour. She did not want a ventouse (assisted birth using a suction cap):

…that was the two things I requested, I requested to be took to theatre first sign of any distress and I didn't want her to have the suction cap [Researcher: hm], *but they gave (me) the suction cap (laughs) they didn't take me to theatre, AND they cut me open.* (Sam, I-3: 48-50, 5 weeks p/n)

For Sam, not being listened to resulted in her having postnatal complications. She had a post-partum haemorrhage and a perineal haematoma that she felt could have been avoided if she had been able to have a caesarean section. A further consequence of her traumatic birth was postnatal depression.

Listening to women's stories appears to suggest that some health professionals practise in an authoritarian fashion, unwilling to listen to women and taking the approach of 'they know best'. A parent/child relationship was apparent with the health professional superior and the women subordinate. By being pregnant and 'obese', policies and practices for some women were perceived to be imposed on them, with choice and informed consent lacking.

7.4.7 'Best for baby'

All the women talked of accepting the increased management and intervention in order to do the best for their baby. The language health professionals used when providing care appeared to impact on this (see also, 7.4.6.1). There was a sense in my discussions with women that informed consent was lacking. Rather, health professionals talked about 'things going wrong', and not putting their babies at risk. Words and phrases such as 'acceptance', 'not taking a chance', 'do as they say' and 'just have to get on with it' resonated. Carla who wanted to question the evidence surrounding continuous fetal monitoring during labour felt unable to:

> *I do have a bit of background knowledge, but I still don't feel comfortable enough to say actually this isn't evidence based, where are you getting your evidence from? What is the care based on? Cos you kind of just think they know best, and I'll probably just go with it.* (Carla, I-1, 39 weeks gest.)

Her body language while talking to me suggested that she felt powerless, accepting her fate. She felt she would have to comply for the sake of her baby, suggesting that if anything happened to her baby she would be blamed.

Rose acknowledged she could decline care, but accepted increased intervention for the sake of her baby:

> *I know I can refuse care if I don't want it, but I want what is best for the baby, so you have to accept it don't you. It is important that I do what is best for the baby, so just accept it. I am happy to take professional advice.* (Rose, I-1: 108-110, 17 weeks gest.)

Chloe was told she needed extra tests during pregnancy because of her high BMI and was also accepting of this, although acknowledged that this may not be the case for all women with a high BMI:

> *Tests are there for a reason. They are there to test to make sure me and my baby are safe. So, it is as black and white as that. For me it is ok to be told but for some people I appreciate that control is being taken away from them. So, for me it is alright.* (Chloe, I-1: 64-66, 20 weeks gest.)

Chloe saw her high BMI as being positive, as by being categorised as 'high risk' meant she was getting the best care for her and her baby and trusted health professionals to guide her:

> *I know I'm unusual in the fact that I'm quite willing to trust the system and if they say 'right you need to go on this pathway' it's, as far as I'm concerned (.)you're the medical professionals, you guide me best (.)and (.)I've got no problem with being assigned in a box if that means I get the best care for me and my baby* (Chloe, I-3: 256-260, 34 weeks gest.)

This was reiterated by Helen and Sophie, who were happy to accept increased screening and testing, valuing the experience of the health professionals caring for her:

> *Well yeah, they know better than me so (.) I don't have an opinion (.) I'd rather take their advice than my own, cos obviously they're more experienced (R: umm) I know it's me that's going through it, but they know better.* (Helen, I-2: 232-234, 34 weeks gest.)

Carla, however, suggested that in doing what she was 'told' could lead to increased intervention. She talked of the possibility of a cascade of interventions once in labour due to her 'obesity' that may or may not needed:

> *They* [health professionals] *talked about if they couldn't get a good trace (of baby's heart rate on the CTG monitor) because of my BMI they would have to put a clip on the baby's head to get a better picture of what was happening with the baby. To do that they would have to break my waters.*

That would mean that they would just be intervening all the time, with one intervention leading to another. (Carla, I-1: 215-218, 39 weeks gest.)

Ella's experience of being induced highlighted Carla's concerns; due to her weight being managed, she endured multiple interventions. Her labour was induced due to a growth scan showing her baby as being large for dates (baby's weight was found to be within 'normal' parameters when born):

So, when I went in (to hospital) the consultant that I was seeing was in that day, so she came to see me and said that she had decided to induce me, so she told them [midwives] to go ahead with it. They did (.)they gave us a 24hour pessary to try and induce us, but I went into (.) erm (..) hyperstimulation... So, they took it out and gave us an injection to counteract it. I had been in seven hours, and they said that they would do something the next morning. So, the next morning they give us a pessary for six hours. That was fine, but it didn't really do anything and then they gave us another one for another six hours and then when they checked (VE) I was only 1.5cms dilated so they then said they would break my waters so, I went to labour ward, and they broke my waters and put us on to a drip to induce the labour and erm (.) I was on that for about three to four hours and when I was on that I still was only 1.5 (cms dilated on VE). They brought one of the ultrasound scanners in to check the baby and found out that (baby) was back to back as well so, they asked us if I wanted an epidural cos, I was in quite a lot of pain then. Erm (..) I had the epidural and they kept us on the drip. Because I was on the drip (baby's) heart rate kept dropping, so, I ended up having an emergency section. (Ella, I-4: 30-46, 5 weeks p/n)

Jasmine was also induced because the growth scan suggested her baby was small for gestational age (again, weight at birth was within 'normal' parameters). She also talked of a cascade of interventions:

…they tried everything and nothing worked (..)they tried one of the pessaries and his heart rate kept dropping, he didn't like it, so they pulled that out and they put another one in (.) erm (.) that didn't really work, and then they left me for a day, no, they left me for a day in between, and then the day after that they broke my waters, erm, he'd pooed while he was inside, so my waters were like lime green, they were awful, it didn't even look, oh it was awful the colour was awful, erm (.) that didn't work, nothing was happening, so they put me on the drip the, is it hormone drip summit like that? (Jasmine, I-3: 39-45, 7 weeks p/n)

It is difficult to know if the birth process and outcome for these women would have been better (or worse) had they not had their births induced. It is often stated by maternity health professionals that birth is only 'normal in retrospect' implying that birth is unpredictable. It was apparent, however, that for Ella and Jasmine the increased ultrasound scanning due to their high BMI did not accurately reflect their babies weight at birth, and as such they were induced based on scan results that were flawed, which subjected them to increased management and intervention. In doing what was best for their baby they felt out of control and had no choice but to do what the health professionals advocated to ensure a positive outcome for their baby.

For Ella and Jasmine, increased scanning caused a cascade of intervention that may have been unnecessary, however all the women spoke favourably of increased scanning of their baby. They all looked forward to their 'extra' ultrasound scans due to their high BMI, feeling it was an opportunity to see and bond with their baby. They appeared not to consider serial scanning as a tool to detect problems, rather as a chance to interact with their baby; an accepted routine and ritual afforded to all pregnant women, with their weight affording them the opportunity to be scanned more regularly. Ella, Anna, Jasmine, and Helen were keen to share their scan photographs with me, demonstrating a strong emotional response when scans were discussed.

For Anna, serial ultrasound scanning was the only aspect of her maternal 'obesity' management and care that she was happy to engage with, having rejected the fact that her 'obesity' was an issue and declining some care because of this. She appeared to be in conflict between the medicalisation of childbirth and maternal 'obesity' and the notion of wanting to be 'low risk' with minimal intervention. This juxtaposition saw her choosing surveillance that allowed her to know her baby was well while trying to maintain some 'normality' over her pregnancy.

> *I obviously went for the scans they sent me for, because I wanted to go for the scans (.) That's the only management that I am ok with cos you get to see the baby, growing and changing and such.* (Anna, I-1: 118-121, 34 weeks gest.)

It was very clear that almost all the women wanted to do the right thing to ensure a positive pregnancy and birth outcome. If this meant following a prescriptive management and care pathway for their 'obesity' they accepted this, putting their trust in the health professionals. Although they were happy to be guided and wanted to do the best for their baby, there was evidence to suggest that they did not always believe that the management and care afforded them the best possible outcome. They talked of one intervention leading to another or being subjected to a cascade of interventions that they questioned the necessity of. This juxtaposition between doing the right thing and resisting the medicalisation of maternal 'obesity' was challenging for some, with most choosing to put their faith in health professionals to ensure a healthy baby, relinquishing control in the process.

7.4.8 Positive encounters with health professionals

In contrast to feeling judged or disbelieved, there were examples of positive encounters with health professionals. Sophie found health professionals supportive and was complimentary about staff. She initially felt uncomfortable but valued open discussions around her weight:

> *Everybody has been nice. They are just professional about it they don't say it like (..) patronise you. They just say it matter of fact (.)Your BMI is up…The first few times was a bit (.). Well, you know when you are overweight (.) Do you know what I mean? So, I have got used to it. It's been alright.* (Sophie, I-1: 227-231, 24 weeks gest.)

On being diagnosed with gestational diabetes, Sophie realised that she needed to be more proactive in her own self-care, as well as negotiating care with professionals. When struggling to keep her blood sugars under control and not wanting to have to inject insulin Sophie found the diabetic team incredibly

supportive and understanding. She was able to negotiate care which she found empowering.

Alice was also diagnosed with gestational diabetes during her pregnancy and again found the diabetic team very understanding, supportive and caring. By having to modify her diet with the diagnosis she became pro-active in her care, developing a good understanding of her diet and weight and feeling like a partner in the management and care process.

It appears that if women are supported by understanding health professionals who are non-judgemental, they feel empowered, in control of their pregnancies and able to make informed choices with regards to their management and care.

Interestingly, Alice, Chloe and Sam felt empowered when their community midwives offered an insight into their own struggles with weight at their first booking appointment:

> *I just felt, and she [community midwife] was big herself so I felt like I wasn't being judged or anything… cus if she was like skinny like* (saying) *you need to lose weight or something like that I'd be like well it's easy for you to say but she obviously knew as well that it's not that easy, and we did sort of joke about (Slimming Club) cus I said that I had lost five stone previously and I put three stone back on and she said she's done something similar so she knew how hard it was (.). if she was like a size eight and saying oh, you're gonna have struggles with your weight and things like that it might have been slightly condescending (.) but I think she got it, she understood it*. (Alice, I- 1: 26-38, 14 weeks gest.)

This commonality of 'we are in it together' appeared to enhance trust and relationship building. Commonality of experience aids non-oppression, promoting an equal partnership to care. I can relate to this approach, as I myself used it in fostering a relationship with the women interviewed. Being overweight myself and having yo-yo dieted, I expressed my own struggles in order to reduce the researcher/researched hierarchy.

Chloe, who was well educated to degree level, was able to articulate her choices for pregnancy and birth, negotiating care accordingly. She was able to navigate the medical system and felt in control of her pregnancy management and care. One example of this was how having had a previous caesarean section, she was able to articulate her desire to try for a vaginal birth for this pregnancy (VBAC-vaginal birth after caesarean section) and was able to seek out the support she needed to inform her eventual decision:

> *…it was a case of tossing up between a c-section or VBAC and it was the, it was October, November-time (.) and (.) the doctor, our consultant said they wanted the decision made by the next time we saw them at the end of November, but we could go and have a chat with [consultant midwife]. She does these talks about VBACs every six weeks, but you've missed this, this one talk, the next is on 5th of December, after when he wants the decision (.) But because I'm informed (.) a bit more self-assured and because I knew that (.) I could challenge and sort of say well actually can I speak to* [consultant midwife] *sooner, and try, at least just ASK and see if I could speak to her* (Chloe I-4: 704-713, 6 weeks p/n)

Chloe went on to find out the consultant midwife's contact details and negotiated a one-to-one, face-to-face discussion with her prior to her next consultant appointment. In relation to the eventual decision she made, which was to have an elective caesarean section, she felt fully informed in the decision-making process.

It was evident from the findings that positive encounters with health professionals enhanced agency and empowered the women to be able to make informed decisions around their care. The ability to exercise choice may also be linked to education and socio-economic status, although it is acknowledged that this only applied to one women (Chloe). Further consideration of this is presented in Chapter 9 (see section 9.5).

7.5 Conclusion

This chapter has presented the findings in relation to the central question of this thesis which is: What are women's experiences of their maternity care when they present in pregnancy with a BMI of 35 or above?

Experiences of living as 'obese' appear to centre around the desire to fit into societal 'norm's with regards to weight. This was apparent in women's discussions of their struggles with weight loss and the yo-yo dieting that ensued. By weight being visible societal assumptions were internalised, equating 'obesity' to being lazy and weak willed. These perceptions of self led to low self-esteem for some. Weight was seen to be multifaceted. Those women who resisted the 'obesity' label justified their weight as either a medical condition or familial, suggesting it was beyond their control. For some, weight was attributed to being fit and strong, citing exercise as contributing to their size. Most of the women appeared to embark on pregnancy expecting to be judged because of these experiences.

All the women were considered 'high risk' during their pregnancy due to having a high BMI. All were managed accordingly, with health professionals following national guidelines on care of the 'obese' pregnant woman. Although the women expected to be managed because of their high BMI they expressed a desire to be treated as a 'normal' pregnant woman, suggesting that to have a high BMI is not 'normal'. Care was delivered often without consultation or informed discussions leading the women to be managed without being able to make choices about their care. For most, care was fragmented, often being required to attend multiple appointments, involving travelling considerable distances, with time and financial implications. This also led to inconsistencies in care with no continuity of carer.

All the women were subjected to increased screening and testing throughout their pregnancy, with most accepting this without question. Extra care was seen to be acceptable in order to ensure the safety of their baby, with most trusting

health professionals', judgement. By relinquishing control to health professionals, most women became passive in their care, with care being done to them, as opposed to with them. Often increased screening led to increased intervention over which some women felt they had no control. Those who resisted were deemed by health professionals to lack understanding or awareness.

All the women were keen to have meaningful conversations regarding their weight with health professionals; however, this was often lacking. Avoiding talking about weight was seen by some as not wanting to offend, and by others as a means to control. By avoiding having these discussions women felt they were unable to make choices about their care and felt obliged to do as they were told. Those who tried to negotiate care were often 'ignored' or told they were 'not allowed'. This was particularly apparent for those women who requested to labour or birth in water. Attitudes of some health professionals were negative, with women feeling judged and stigmatised because of their weight. Those who had positive encounters with health professionals felt empowered and able to make informed choices regarding their care.

Having presented the findings in this chapter I proceeded to further conceptualise the data, generating theory. Chapter 8 begins to unravel the emerging theory. It draws on the theoretical literature to further understanding, considering 20th Century philosophers Erving Goffman, Michel Foucault, and Simone de Beauvoir. Following this Chapter 9 will then discuss the substantive grounded theory generated in relation to the findings and subsequent analysis.

CHAPTER 8

FINDINGS CONCEPTUALISED

8.0 Introduction

The previous chapter presented the findings from the study in relation to the central question: What are women's experiences of their maternity care when they present in pregnancy with a BMI of 35 or above? It discussed women's perceptions of weight and of the care they received throughout the pregnancy continuum. How these perceptions influenced women's choices, ability to make informed decisions and have control over their care was also presented.

In this chapter I present an overview of how my grounded theory analysis led to the construction of: 'the conditioned body'; 'the (in)visible body'; and 'the contesting body'. I also discuss how the theories of Erving Goffman, Michel Foucault, and Simone de Beauvoir helped to further theorise the findings to illuminate how women experienced their management and care and provide insights and justification into the three philosophers/authors selected. Goffman offered me insights into how individuals present themselves in everyday life through the portrayal of self, as well as how social stigma affects identity. Foucault's work on knowledge and power enabled a deeper understanding of how power is constructed throughout society and the affect it has on individuals. Finally, Beauvoir's work of embodiment gave insights into how through 'Othering', women are oppressed. All three authors offered deeper understandings to help me navigate my study and develop my substantive grounded theory.

I will conclude this chapter by introducing my substantive grounded theory of the 'multiple dimensions of self'. In Chapter 9, I will present a thorough explanation of my substantive grounded theory and discuss it in the context of the wider literature in order to highlight its significance in relation to choice, consent and control.

8.1 Theory development

As discussed in Chapter 5, the coding of data, memoing and interparticipant theoretical sampling, led to the development of two categories and associated sub-categories: 'women's perceptions of weight' and 'women's perceptions of care'. Grounded theory analysis also identified the macro, meso and micro influences that impact of women's perceptions of weight and care (see also, Fig. 7.1 and Fig. 7.2). It became apparent that there was an interplay between women's perceptions and the social and cultural influences which conditioned these women to consider their weight as problematic. Added to this, maternity service provision, policy and practice views 'obesity' as 'risky' and a condition to be managed. Also, apparent, was how the interactions between the women and health professionals played out. There was evidence of power and control, more often from the health professionals providing care but also by the women. Reducing women to 'bodies' was evident across the findings. Negative, value judgements were made, with women's bodies being scrutinised, marginalised and stigmatised. Although their bodies were visible by virtue of their size, often the women were ignored. There was also evidence of contestation with some women resisting the negative assumptions made by others. What was blatantly clear was that these women presented in pregnancy expecting to be treated less favourable because of their weight. These findings provide unique understandings into how the bodies of women living with 'obesity' define them, contributing to existing knowledge and understanding of maternal 'obesity' experiences.

In considering my findings the macro, meso and micro influences affecting weight and care was significant, but I felt that this analysis was only the tip of the iceberg and that there was more to women's perceptions. An extract from my reflexive memoing demonstrates my questioning around this (Fig. 8.1).

I am still grappling with understanding what it is about being conditioned, weight being (in)visible, and how some women are able to contest. There is something about the outside influences (macro, meso, micro) that women internalise and accept as their 'normal'. It feels as though it is connected to how they view themselves. Do they take on characteristics that they think they should have because of their weight? Do they internalise weight? Do they feel inferior by virtue of their weight? Why can some women contest/resist and others cannot?

Fig. 8.1 Extract from reflexive memo writing

Charmaz (2014, p.224-245) states that theorising does not constitute a theory, rather: 'Theorising means stopping, pondering and thinking afresh…The acts involved in theorising foster seeing possibilities, establishing connections, and asking questions.' From my understanding of the data presented in Chapter 7, discussions with my supervisors, as well as having conversations with the participants about my emerging ideas (Jasmine being particularly helpful in sharing insights that helped develop my theory),[19] I began to theorise. What was key to women's stories was their perceptions and presentation of their 'obese' bodies and this appeared to have an impact on self. Women's bodies and embodiment was a recurring theme. How the women's 'obese' bodies are positioned in the world, the space they occupy and how the women negotiate through their bodies in terms of contestation and resistance was significant. This analysis led to construction of: 'The conditioned body'; 'the (in)visible body'; and 'the contesting body' moving me towards theory construction (Fig. 8.2).

[19] This was a scheduled meeting with Jasmine who had previously spoken to me about her lack of motivation, low self-esteem and feeling viewed by others as lazy.

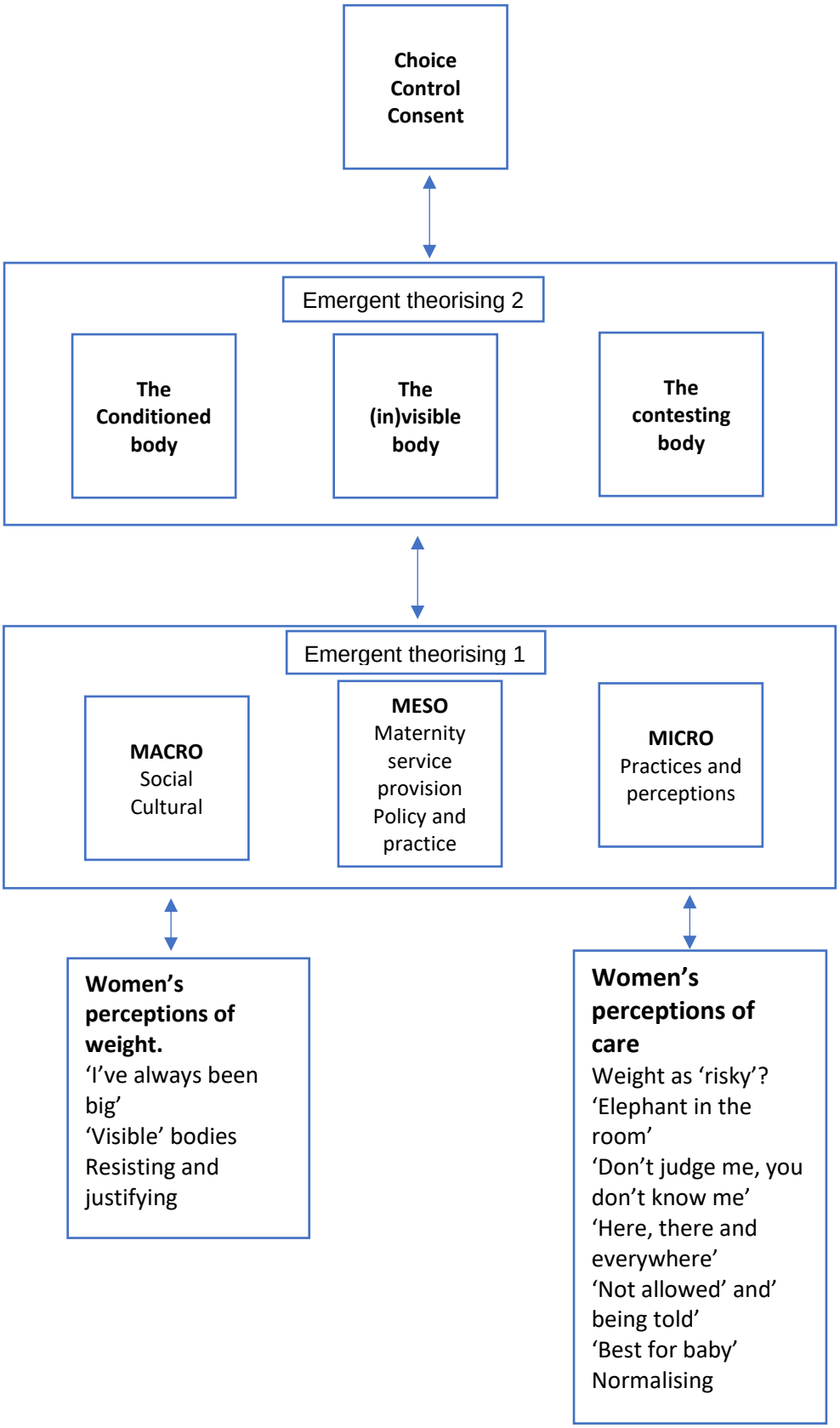

Fig 8.2 Building a theory

8.1.1 The conditioned body

This theorising came about through the woman's narrative of their perceptions of their own weight and their struggle with this. It appears that the women interviewed took on a persona that came from a societal view of what constitutes a 'normal' body size, and the subsequent weight bias which surrounds this. Self-discipline throughout their adult lives in order to lose weight, as well as internalising society's view of their 'obesity' as being unhealthy, was evident. It was also apparent that for some women, assumed personality traits associated with 'obesity' such as laziness was projected upon them and also internalised (see Chapter 7, 7.3.2). These findings concur with the wider literature considering the experiences of women living with 'obesity' and maternity care as identified in the meta-narrative review (Chapter 3). In relation to choice, consent and control, however, these insights appear to have conditioned many of the women to conform to certain care, tests and treatment by virtue of their weight.

8.1.2 The (in)visible body

The (in)visible body aims to explain the perceived experiences of women in relation to how their weight is both visible, under scrutiny by others yet often ignored:

> *Marginalized bodies are not just acknowledged and seen; they are made spectacle. They are not simply invisible; they are frequently erased or dismissed from consideration.* (Gailey, 2014, p.167).

The findings in this study suggest that the (in)visible body was exhibited in how the women were treated by others and how they wanted to be treated. This manifested in the women's perception of self in relation to the space they occupy and their place in the world as 'obese' as well as how their stigmatised bodies made them feel marginalised. Weight bias internalisation by women as well as weight bias demonstrated by health professionals was evident in the findings. Added to this health professionals as experts, often dismissed the knowledge of women, further marginalising them (see also, 7.3.2, 7.4.1, 7.4.4, 7.4.5, 7.4.6)

8.1.3 The contesting body

The findings demonstrate that for some women contestation was apparent. As discussed in Chapter 7 (7.3.3). This suggests that choice, consent, and control was achievable, but this came at a price. By contesting, the women were viewed as uneducated, difficult, and not wanting the best for their babies by the health professionals caring for them. In demanding better their sense of self was for some empowering but for others, going against the accepted 'norms' was problematic affecting self-esteem. Generally, though for those who contested, increased choice and control over their care was evident.

This theorising then led me to explore self via symbolic interactionalism. Charmaz (2014) proposes that symbolic interactionism integrates well with grounded theory. She suggests that it offers a theoretical perspective that can inform grounded theory research and methods, supporting the emergent theoretical concepts that arise from the data. With this in mind I set out to fully understand symbolic interactionism to inform my study. How women view their bodies and how bodies are viewed by the world through internalisation was evident within the findings, therefore my understanding of this led me to conclude that perceptions of self were important as I tried to construct connections between my findings (see Chapter 7) and my theorising. What was missing for me was the how and why?

8.2 Symbolic Interactionism

Symbolic interactionism is a theoretical concept that suggests human actions construct self, with language and meaning being paramount. These actions and interactions with others define who we are and how we respond to others, situations and communities (Charmaz, 2014). Its historical roots stem from the philosophy of pragmatism which proposes that people's view of the world is known through their actions. Herbert Blumer (1937) formulated the phrase symbolic interactionism; however, it was developed from the theorising of George Herbert Mead. Mead (1934) in *Mind, Self and Society: From the Standpoint of a Social Behaviorist*, suggests that language is central in developing

a sense of self and that self and mind depend on language and the use of symbolic meanings in day-to-day life. Mead, along with other pragmatists such as John Dewey (1938) and Charles Horton Cooley (1902) contributed to the development of symbolic interactionism, with Blumer (1969) adapting Mead's work, suggesting that symbolic interactions are always intentional and hold meaning which is then conveyed to others. Blumer (1969 [1998]) suggests that symbolic interactionism consists of three principles. First, people will act towards something in accordance with the meaning they attribute to that thing. Second, meanings are created through the interaction with others and thirdly, these meanings are then interpreted and adapted according to how others view the meanings.

In considering symbolic interactionism, two analogies proposed from Charles Horton Cooley (1902) and Erving Goffman (1959), both who were introduced in Chapter 2 (2.4) appeared relevant for my study. They helped me develop my understandings in relation to self, particularly the work of Erving Goffman. Both are presented below.

8.2.1 Charles Horton Cooley: The 'looking glass self'

Charles Horton Cooley (1884-1926) was an American sociologist and founding member of the American Sociological Association. He developed the concept of the 'looking glass self' to support his theory that society views people in various ways which in turn is internalised by individuals, who then go on to portray the characteristics society perceives. In his work *Human Nature and the Social Order* (1902, p.150-151) he states that:

> *In a very large and interesting class of cases the social reference takes the form of a somewhat definite imagination of how one's self- that is any idea he appropriates- appears in a particular mind, and the kind of self-feeling one has is determined by the attitude toward this attributed to that other mind. A social self of this sort might be called the reflected or looking-glass self … As we see our face, figure, and dress in the glass, and are interested in them because they are ours, and pleased or otherwise with them according as they do or do not answer to what we*

should like them to be; so, in imagination we perceive in another's mind some thought of our appearance, manners, aims, deeds, character, friends, and so on, and are variously affected by it.

Cooley suggests that we therefore view ourselves as we perceive others see us, which is then internalised, proposing three principles of self:

A self-idea of this sort seems to have three principal elements: the imagination of our appearance to the other person, the imagination of his judgement of that appearance and some sort of self-feeling, such as pride or mortification. (p.152)

This suggests that social interactions define self, triggering an emotional response of either pride or shame, which Cooley defines below:

The comparison with a looking-glass hardly suggests the second element, the imagined judgment, which is quite essential. The thing that moves us to pride or shame is not the mere mechanical reflection of ourselves, but an imputed sentiment, the imagined effect of this reflection upon another's mind. This is evident from the fact that the character and weight of that other, in whose mind we see ourselves, makes all the difference with our feeling. We are ashamed to seem evasive in the presence of a straightforward man, cowardly in the presence of a brave one, gross in the eyes of a refined one and so on. We always imagine, and in imagining share, the judgments of the other mind. (p152-153)

This response of pride or shame implies that others have a major influence on a person's self-concept which is internalised, with the person becoming what he perceives others to think. This suggests pride and shame are social emotions which render the individual to self-monitor (Scheff, 2013). Cooley's concept was further explored by Mead (1934), whose role-taking theory suggested that people continually monitor themselves to fit in with the views of others. A criticism of this is that there is an assumption that people will always want to change to fit the perceptions of others. This conflicts with Rogers (1959), who argues that self-concept consists of three elements: the view we have of

ourselves; the value we put on that; and how we see our ideal self. Therefore, not everyone will alter their self, instead staying true to themselves and resist internalising the perception of others.

Cooley (1902) also states that self is unconsciously developed depending on how we communicate within society and how we are viewed and accepted. It could be argued that the 'looking glass-self 'is a process everyone moves through in order to identify self, yet individuality can never be reached due to the societal influences that impede it. Rahim (2010) takes up this argument, suggesting that societal stereotyping causes disparity and marginalisation whereas the 'looking glass-self' can be influenced by both negative and positive social communications and actions. Interestingly, Cooley, although suggesting pride and shame are products of the 'looking glass-self', rarely discusses pride in his work (Scheff, 2013), suggesting that shame is more often a by-product of social interactions and the development of self, which would support Rahim's observations. This implies that shame is at the core of how we perceive self, unconsciously leaking into our everyday lives and how we act, thus being conditioned through social stereotyping. This unconscious view of self may influence the decisions we make at every level, restricting and oppressing us.

Another aspect of the pride and shame analysis is that Cooley makes no attempt to quantify or define these emotions. Scheff (2013) argues that the definition of pride can be seen negatively, suggesting arrogance, rather than the opposite of shame as it is implied to be. This may be partly due to the passage of time changing the definition of the word pride but nonetheless ambiguity in his analysis opens up his theory to criticism.

Cooley's 'looking glass- self' has been further explored and expanded by other prominent theorists. George Mead's work builds on Cooley's 'looking glass-self' in its analysis (as discussed above), suggesting that self is derived from role-taking as opposed to looking at one's reflection. He differs from Cooley however, in asserting that there has to be social interaction in order to have a perception

of self and that self does not exist without this, society existing before consciousness. Self-awareness only occurs following exposure to different communities, which in turn leads to certain members of a community becoming marginalised for possessing traits deemed to be undesirable within that community. Self is then conditioned through these processes, with individuals taking on a role according to how society views them.

In considering this study, the theorising of both Cooley (1902) and Mead (1934) can be applied to how those who are 'obese' internalise society's negative attitude towards them leading to harmful marginalisation and stigmatisation (Puhl, 2011, Puhl et al., 2008, 2015). Shame and blame for example was evident within the findings of this study with those interviewed expecting to be treated in a certain way by virtue of their weight. In moving my study forward, however, my attention turned to Erving Goffman. Goffman built on Cooley's work, not only recognising shame (pride) and blame but also adding embarrassment and humiliation as variations (Scheff, 2003). As Goffman offered a more developed theory of self, I used his work as a central theory in informing my study and subsequent theorising.

8.2.2 Erving Goffman: Dramaturgy and spoiled identity

Erving Goffman (1922-1982), a sociologist, was particularly interested in the mundane realities of people's lives. His early work published in the 1950's and 60's is often referred to as his Durkheimian phase[20] and was concerned with analysing social order at a micro level (Jacobson and Kristiansen, 2015). Notably, his work *The Presentation of Everyday Life* (1959), which sets out his dramaturgical analysis of how people present themselves within their communities, and *Stigma: Notes on the Management of Spoiled Identity* (1963), which explores how those who are marginalised view and adapt to the world

[20] Émile Durkheim (1858-1917) was a French Sociologist credited with being one of the forefathers of sociology which he moved into the realms of science. He claimed through the analogy of 'social facts' that society is not just a collective of individuals living in a particular region but a collection of beliefs, ways of thinking and doing which individuals hold, that when brought together with other individuals become a collective of consciences.

around them, are particularly relevant to the findings of my study. Goffman analyses interactions by suggesting that to be human is to be part of a performance, an actor on a stage: 'life itself is a dramatically enacted thing' (1959, p.72). He proposes that people are conditioned from an early age to view themselves through others' eyes, living constantly in the minds of others. He develops the thinking of Mead (1934) here, who likens this to early role play, children acting out the roles of others and interpreting what is acceptable for the role, humans being unique in being able to imagine what others might be thinking. Unlike Mead (and Cooley for that matter) however, who argue that how we are perceived when socially interacting is rooted in the imagination, Goffman suggests that the self is not found within but out with the interactions themselves (Goffman, 1959). This was particularly illuminating as it was evident in my findings that the women on presenting in pregnancy were conditioned to regulate their weight, had internalised negative characteristics associated with weight and were accepting of their 'high risk' status by virtue of their weight.

In using the analogy of the theatre, Goffman (1959) argues that there is a front and back stage, the front being what the audience sees and where the acting takes place, with the backstage being the true self, where people can relax and be themselves. What is particularly interesting about this is that Goffman suggests that because the front stage performance is the one people use the most they come to believe their front stage performance is their true self with the back stage self becoming the lie (Appelrouth and Desfor Edles, 2011).
In Goffman's analogy of performing in a theatre to portray how individuals socially interact he states:

> *..each participant is expected to suppress his immediate heartfelt feelings, conveying a view of the situation which he feels the others will be able to find at least temporarily acceptable. The maintenance of this surface agreement, this veneer of consensus, is facilitated by each participant concealing his own wants behind statements which assert values to which everyone present is likely to give lip-service.* (p.4)

This resonates with the findings from my study, with many of the women acting in a way which suppressed their own feelings and desires, surrendering themselves to care which they did not wish or desire as it was seen as the acceptable thing to do. It could also be argued that health professionals are seen as having knowledge and respectability with the woman taking on the performance of the patient, accepting of the health professional's status. In support of this Goffman (1959) goes on to state:

> *In service occupations…the specialist often maintains an image of disinterested involvement in the problem of the client, while the client responds with a show of respect for the competence and integrity of the specialist.* (p.4)

This is further acknowledged, with the health professional acting a role akin to his/her perceived status:

> *Society is organized on the principle that any individual who possesses certain social characteristics has a moral right to expect that others will value and treat him in a correspondingly appropriate way. Connected with this principle is a second, namely that an individual who implicitly or explicitly signifies that he has certain social characteristics ought to have this claim honoured by others and ought in fact to be what he claims he is. In consequence, when an individual projects a definition of a situation and thereby makes an implicit or explicit claim to be a person of a particular kind, he automatically exerts a moral demand upon others, obliging them to value and treat him in the manner that persons of his kind have a right to expect.* (p.6)

According to Goffman society holds medicine in high regard with those that seek healthcare playing the part of the patient. Historically, the patient's role is passive in response to the role of the knowledgeable health professional who commands the patients' subordination. I have experienced countless examples of this as a midwife, the most common example being when women are admitted onto a maternity ward they usually assume the role of the patient, changing into their night clothes and getting into bed, surrendering themselves to the medical profession.

In considering Goffman's work however, he makes an assumption that human behaviour is always pre-meditated and that the self we present is based not on our true self. This argument disregards the spontaneity of some individuals as well as those who remain true to themselves. Mead's theory of self (cited by da Silva, 2007, p.51) suggests self is made up of two parts: 'I' and 'me'. The 'I' is the part that supports the impulsive, creative part of self and the 'me' is when following an encounter, people look back and dissect what they did or said. People then use 'me' to modify their behaviour in future interactions thus conforming to societal expectations. Goffman on the other hand states that the 'I' is always premeditated.

If behaviour is always premediated it could also be argued that Goffman's model suggests that people are deceitful and manipulate their situation for their own ends. Although he recognised this in his work, he suggests that it actually allows people to act in socially appropriate ways which can be beneficial not just for themselves but also for the wider community. He uses the term 'impression management', which people use to portray a particular image in a particular situation by the verbal and nonverbal communication they use. Eventually this becomes common place, with people automatically assuming roles and acting the part they deem is acceptable. This may explain why most of the women in the study were passive participants in their care.

Goffman extended his dramaturgical theory in *'Stigma: Notes on the Management of Spoiled Identity'* (1963), considering how self is presented by people who are considered inferior within society. In this work, he explores three differing faces of stigma; stigma of the body; stigma in relation to a person's character; and tribal stigma concerned with race, religion, and nationality, and how self is reflected within the three.

Goffman refers to those who have one or more of the three types of stigma as having a 'spoiled identity', with these people continuingly trying to modify their social identities to be accepted. 'Obesity' is an example of 'spoiled identity', seen

as a moral issue within society, with those affected often internalising their weight, with others forming opinions based on the visibility of the 'obesity'. This opens them up to stigmatisation because they are seen to be inferior, weak and responsible for their weight (Fee and Nusbaumer, 2012).

Goffman argues that in response to having a 'spoiled identity', stigmatised people take on roles to compensate, changing their identity to fit in, gravitating towards others with the same identity, hiding, using their stigma as an excuse or criticising those they view as the 'norm'. Goffman goes on to suggest that stigmatisation is a form of social control, as well as those stigmatised adopting information control to manage their stigma to be accepted. This is achieved through using 'stigma symbols' to try to appear 'normal'.

Goffman's theories help to illuminate how women living with 'obesity' may act in a particular way throughout the pregnancy continuum in order to be accepted and why they might do this. This in turn may impact on choice, consent and control. It was evident in my findings that the women took on different personas depending on the circumstances. This led me to develop an analogy for the women in the study which aligns to Goffman's dramaturgical analysis:
The woman plays several roles but mainly the protagonist[21]. Health professionals play the antagonist[22] and foil[23] but sometimes the confidant[24]. The protagonist is conditioned (back story) to act in a particular way, taking on an imagined reality which is socially constructed. She either succumbs to this self-fulfilling prophecy or takes on the role of the anti-antagonist (observed by the antagonist/foil) to contest, putting forward her true-self and in the process often meeting resistance from the antagonist or foil. On occasions the woman is supported by a health professional who is a confidant with her best interests at heart,

[21] The leading actor in a play
[22] The villain
[23] A character who contrasts with the protagonist.
[24] Helps the protagonist, advisor, mentor, and an ally.

promoting her desires and goals. The woman as an embodied actor is on the stage for the duration of the performance, always visible, always centre stage, yet paradoxically a bystander, in the background to the others performing.

This analogy helped me to develop a multifaceted notion of self and that self-changes according to a given situation or experience. Self is heavily influenced by those around us, and the social interactions encountered. Goffman offers insights into the women's unconscious perceptions of weight and care received based on how they perceive themselves.

Following exploring self, I turned my attention the work of Michel Foucault and his work in relation to how self can be manipulated by society through social control, and how the body can be conditioned to comply or resist this. It was apparent within my findings that most of the women where conditioned to regulate their 'obesity', with 'obesity' seen as being undesirable. Societal influences and perceptions of the 'obese' body drove this, with self-regulation evident (see Chapter 7, 7.3.1). Added to this, 'obesity' was viewed as a condition to be managed with the findings highlighting the control medicine holds (see Chapter 7, 7.4.2). There were, however, opportunities for resisting the 'obesity' label as well as resisting some aspects of care (See Chapter 7, 7.3.3, 7.4.5). Therefore, Foucault's theorising on knowledge and power as introduced above (8.1.3) was important in understanding more fully the findings in my study. A further rationale for considering Foucault's work, is concerned with poststructural feminism and how his work has been influential in feminist thinking on language and the power relations within (see Chapter 4, 4.3).

8.3 Foucault's theories of discipline, control and biopower

Michel Foucault (1926-1984) is considered one of France's most important philosophers of the 20th century. His work captured the subtlety of how power is evident across all society.

In *The Birth of the Clinic* first published in 1963 and translated into English by Sheridan in 1973, Foucault presents the rise of medicine across time through radical reforms. He examined medical discourses from the late 18th century onwards and how medical thinking changed over time in relation to disease and death, moving from treating disease to preventing disease and optimising health. As opposed to medicine being a natural organic progression, it has been influenced by political, economic, and societal discourses and how illness and disease is viewed. As medicine has evolved so has the knowledge of physicians, leading to physicians increasing their power over society.

According to Foucault, knowledge goes hand in hand with power, power generating knowledge which influences individual behaviours, choice, and bodily control. Foucault writes of the scientific knowledge of medicine which sets its own boundaries and 'norms', giving medicine legitimacy to define what is 'normal' and what is deviant. Medicine pressurises individuals to conform to what is deemed to be 'normal', with those who are unable to conform vilified and disciplined. Foucault argues that medicine does not coerce or force individuals to act in a certain way, but rather generates a notion of desire. This leads to self-discipline or regulation with the individual imposing his/her own surveillance. This was clearly evident in the findings, with women self-regulating through dieting and exercise regimes as well as accepting increased medical surveillance by virtue of their weight without question. Foucault's concept of the 'clinical' or 'medical gaze' fits these women into a medical paradigm of needing to be managed, ignoring individuality and the non-medical aspects of their lives. Through this, medicine exists within an abusive power structure.

In *The History of Sexuality (Vol. 1)* (1979), Foucault further explores the power/knowledge nexus. He proposes that society has moved from one of sovereignty, with the emphasis on punishment through death, to one of enlightenment, with a power shift from repression to regulation. It is no longer acceptable to lead by killing people as the very existence of the human race is at stake. Rather, power is exerted by encouraging individuals to be model citizens,

be productive and maintain a healthy existence to ensure the continuation of the human race. This shift controls individuals through political and societal strategies which regulate and control the behaviours of all within society. This is particularly notable in how government strategies for controlling 'obesity' abound (DoH, 2020).

Foucault (1979), in extending his thinking on how power is used to manipulate and regulate, conceived the notion of 'biopower'. He suggests that 'biopower' is evident throughout all social interactions and relationships and is found across all institutions:

> *(Bio)Power is everywhere; not because it embraces everything but because it is produced from one moment to the next, at every point, or rather in every relation from one point to another.* (Foucault, 1979, p.93)

Biopower is driven by knowledge from scientific sources through which societal 'norms' are appropriated and employs mechanisms to manage and discipline the population. He likens life to being political, suggesting that both reproduction and disease are significant in keeping or hindering economic processes, therefore need to be the subject of political and social control. He describes this as the production of bodies which are docile, whereby individuals can be kept under control by institutions, with individuals being under the constant gaze of those who hold the power. He argues that society is controlled by dominant systems which over time have moved from control through physical coercion to social control through self-discipline. In *Discipline and Punish: The Birth of the Prison* (1977), Foucault writes of Jeremy Bentham a social theorist and philosopher who invented a prison system known as the Panopticon in the 1700s. The prison consisted of cells which formed a ring around a central tower from which the guards could view all prisoners while the prisoners could not see the guards. The prisoners were always visible and therefore vulnerable, regulating their behaviour due to being aware of the authoritative presence of the guards at all times, even though they could never be sure a guard was watching them. Foucault described this as the panoptic effect, suggesting that

modern society uses this form of surveillance so a 'few' can survey the 'many'. Surveillance of the population (the many) by institutions (the few) has led to the objectification of individuals. In healthcare this surveillance takes the form of examining, assessing, and classifying. Foucault (1977) also suggests this form of social control controls individuals through internalising authority leading to self-discipline.

Foucault goes on to argue that the panoptic effect produces experts within these institutions whose knowledge creates truths that define 'normality', using this power to control through 'gazing'. Individuals thus use self-discipline to conform to the accepted 'norm'. He states that:

> *…it is not necessary to use force to constrain the convict to good behaviour, the madman to calm, the worker to work, the school boy to application, the patient to observation of the regulations…He who is subjected to a field of visibility, and who knows it, assumes responsibility for the constraints of power; he makes them play spontaneously upon himself the power relation in which he simultaneously plays both roles; he becomes the principle of his own subjection* (Foucault, 1977, p.202-203).

Politically, this 'gaze' has been fostered, encouraging society to conform at minimal cost:

> *An inspecting gaze, a gaze which each individual under its weight will end by interiorising to the point that he is his own overseer, each individual thus exercising this surveillance over, and against, himself…power exercised continuously and for what turns out to be at minimal cost.* (Foucault, 1980, p.155)

From a feminist perceptive, Foucault's panopticon model has been drawn upon to explain patriarchal power constructs and the constructs of femininity (Bartky, 1998; Bordo, 1993; Deveaux, 1994; Jagger and Bordo, 1989). Bartky (1988, p.63), although critical of Foucault in the sense that his writings did not differentiate between men and women agrees with his model to some extent:

> *treat(ing) the body throughout as if it were one, as if the bodily experiences of men and women did not differ and as if men and women bore the same relationships to the characteristic institutions of modern life.*

She suggests that to be feminine is socially constructed and women are subjected to self-regulation to conform to an ideal. The diet and beauty industries perpetuate this, with women socially conditioned to think in a certain way, either lacking the will to resist or fearful of the repercussions. Deveaux (1996), however, in her critique of Foucault and feminism and empowerment rejects Bartky's views, suggesting that to focus on the lower level forms of patriarchal power such as fashion and beauty regimes fails to acknowledge the wider oppression women suffer socially, economically, and politically. Either way, it could be argued that self-regulation, coercion, and the wider constructs that arguably oppress women, transcend the conscious and sub-conscious impacting on the notion of self. In relation to this thesis, the added pressure on women living with 'obesity' to conform to beauty ideals further exacerbates this.

A further argument is offered by King (2004) who argues that Foucault's gender neutral approach fails to acknowledge differences between the sexes. She suggests that Foucault fails to recognise the discourses of the female body, which subjects women to increased scrutiny and control, arguing that Foucault's work compounds the fact that modern day theory, politics and culture is predominantly sexist with Foucault being male and therefore writing from a position of power. This is supported by Hartsock (1990), who in concurring with the work of Said (1986) argues: 'Foucault's imagination of power is ''with'' rather than ''against'' power…[he] understands the world from the perspective of the ruling group' (p. 167). Therefore, he does not write for women because he is unable to see women's perspectives. On a personal level I would argue against this to some extent. Foucault was a homosexual, so although male and part of the ruling group he faced stigma and marginalisation because of his sexuality therefore his work resonates with me as a woman. Also, in considering his work which was gender blind and thus seen as problematic for many feminist thinkers

(McNay, 1992), it could be argued that in today's society where gender is much more fluid his work was ahead of its time. It is also important to note that Foucault (before his untimely death in 1984) had been planning to write about women, biopower and the sexualisation of the female form (Sawicki, 1991, 1996). Unfortunately, we will never know what his theorising on women and biopower would have entailed.

Although there are criticism of Foucault's work his theories help to understand how maternal 'obesity' is medically managed through regulation and control from both a societal and political perspective as well as self-regulation in order to comply to social and medical 'norms'. His work on opportunity for resistance also helps to illuminate how some women within this study were able to resist these 'norms', maintaining self agency.

Foucault to a greater extent focuses on how subjects are the products of power, however he does acknowledge that there is opportunity to resist disciplinary power: 'Where there is power, there is resistance, and yet, or rather consequently, this resistance is never in a position of exteriority in relation to power' (Foucault, 1978, p.95-96). He proposes that a society based on discipline and surveillance should be challenged, encouraging people to rise up, and change their circumstances and argues against normalising power (Foucault, 1980). Foucault moves away from this anarchist approach in later work, suggesting working within social order and power in order to facilitate change and reform, rather than trying to rebel from the outside. He suggests that there is an element of freedom within power structures, and one cannot exist without the other:

> *[P]ower is exercised only over free subjects, and only insofar as they are free. By this we mean individual or collective subjects who are faced with a field of possibilities in which several ways of behaving, several reactions and diverse comportments may be realized…freedom must exist for power to be exerted.* (Foucault, *Subject and Power*, 1982, p.221)

This suggests the possibility of autonomy and agency, albeit limited within a power paradigm but evident none the less. This may indicate however, that although we think we are free and have autonomy we only have autonomy at a basic level that does not compromise the control exerted on us. Foucault also proposes that for some, power is both positive and productive, with subjects happy to relinquish control. This links with this study in the sense that most of the women were happy to relinquish control to the medical 'experts' to do what was best for baby. It is difficult to have true autonomy when you are not an expert in the field, so you have to hope that those who deem themselves to be experts give enough information to make informed choices rather than use their knowledge to control and coerce. This dichotomy is further explored in Chapter 9.

Foucault (1979) goes on to argue that resisting power is also a form of power, and that power relations exist due to resistance. He talks of a 'plurality of resistances' (p.94) that make up power relations within society. This comes about through a subject gaining knowledge to question the context of a given action. Tensions arise, with those involved entering a power relationship of which both sides recognise and enter into. A power struggle is then played out, with the victor grabbing the power for themselves. This was particularly evident in the findings in how Anna resisted medical 'obesity' discourses and is further conceptualised in Chapter 9.

There are claims that Foucault's notions of resistance and subsequent autonomy is weak as well as contestation that if autonomy is only possible through resistance of the social constructs subjects are part of, then this refutes others claims of autonomy being a personal entity (Chokr, 2004). Foucault argues that autonomy is dependent on the social discourses that subjects are exposed to, therefore autonomy only exists through subject's interactions within their institutionalised, conditioned lives. This therefore limits choice depending on their ability to resist, and the social constraints placed upon them at any given time (Chokr, 2004). Again, this reflects what was happening for some women in

my study. The social discourses surrounding 'obesity' limiting the ability to resist the 'obesity' label, particularly evident for the women who saw themselves as physically fit, yet with a high BMI.

In relation to the theorising being generated from this study, Foucault is relevant as he offers an explanation of how biopower operates within institutions, exerting control, which is relevant to maternity care provision, as well as how self-regulation is internalised and leads to the disciplining of self, which reflects how society imposes its views of 'obesity' onto individuals. With both pregnancy, birth and 'obesity' being medicalised and medicalisation being an increasingly dominant form of power exerted within society, Foucault's work offers an understanding of this phenomena. Added to this his work on resistance is significant for this study. Whether resistance is achievable in the confines of a power paradigm is questionable, although Foucault suggests that rather than power being exerted from above there are multiple power relations in existence, suggesting women may be able to manipulate and exert power through contesting care and rejecting the 'obese' label. It was evident within the findings that some women were able to resist the 'obesity' label and others were able to articulate their wishes with some success.

Drawing on Goffman's theorising on self, and Foucault's theorising on power relations I began to consider how the identities of the women studied are constructed within society by virtue of being 'obese'. This led me to consider Simone de Beauvoir's theorising on embodiment to inform my understandings of the findings.

8.4 Simone de Beauvoir: The female body

A French philosopher, writer, and author, Simone de Beauvoir (1908-1986) considered women's lived experiences, positioning women at the centre. Her seminal work, *The Second Sex* first published in 1949 and consisting of two books, *Facts and Myths* and *Lived Experience* (translated to *Women's Life Today*

in the American version read to inform this thesis), challenged the current thinking of the time, that women's bodies are naturalist. She also proposed that societal influences impose restrictions on women's bodies defining their roles, responsibilities, and status. She famously asserted that 'One is not born, but rather becomes, woman' (1949, [1997, p.293]). Although disputed in recent times, her work led to a plethora of feminist studies exploring how women's bodies are socially constructed throughout the life course and how this in turn is internalised, rationalised and understood by women themselves (Martz, 2019). Beauvoir begins her work by considering women's subordination within society in *Facts and Myths.* Through historical, biological, and psychological interpretations and analysis Beauvoir suggests that there is no reason for women to be subordinate to men despite their sexual/gender differences yet finds that historically society has become programmed to treat women less favourably. She transcends biology in stating that the body is not a thing but a situation and is the lived body of the subject not the biological suggesting that definitions of woman are constructed.

Beauvoir asserts that: 'to be present in the world implies strictly that there exists a body which is at once a material thing in the world and a point of view towards the world' (1949, [1997, p.39]). Although this viewpoint has been pursued by others, such as the prominent existentialists phenomenologists Merleau- Ponty[25] and Jean Paul Sartre[26] whose works Beauvoir draws on, Beauvoir makes the distinction that the lived experience is different between men and women. In considering reproduction and menstruation she states: 'Woman like man, is her body; but her body is something other than herself' (1949 [1997], p 61).

[25] Maurice Jean Jacques Merleau-Ponty (1908-1961), French phenomenological philosopher. His work was associated with the existentialist movement focusing on the embodied experience and perception. He was influenced by Marx, Husserl and Heidegger and was associated with Simone de Beauvoir.

[26] Jean Paul Sartre (1905-1980) was a French philosopher who developed existentialism and phenomenology, extending the work of Edmund Husserl on conscious experience. He developed the concept of human consciousness as the opposite to being. He was Simone De Beauvoir's lover and life-time partner, although they never married or lived together.

Beauvoir therefore rejects the naturalist position of women in favour of the embodied subject.

In the second section of her seminal work, *Lived Experience,* Beauvoir examines the life course of women to develop her argument. She suggests that at birth and in early childhood there are no differences between the sexes and if uninfluenced equality would ensue. It is the influence of others that ultimately distinguishes between the male and female form. As the child grows she talks of a 'second weaning' (p.298) which is socially constructed, encouraging boys to be independent and superior and girls dependent and inferior, with the young girl soon learning that to be accepted she must make herself admired by others. In submitting to this passivity:

> *…the girl also agrees to submit unresistingly to a destiny that is going to be imposed on her from without, and this calamity frightens her. The young boy, be he ambitious, thoughtless or timid, looks towards an open future; he will be a seaman or an engineer, he will stay on the farm or go away to the city, he will see the world, he will get rich; he feels free, confronting a future which the unexpected awaits him. The young girl will be wife, mother, grandmother; she will keep house just as her mother did, she will give her children the same care she herself received when young- she is twelve years old and already her story is written in the heavens.* (Beauvoir, 1949 [1997, p.325])

Throughout childhood, Beauvoir suggests that girls, although treated differently remain autonomous until puberty, when the female body is transformed and becomes vulnerable to hormonal changes and the transformation to the adult female form. This renders her even more passive and dependent. This is not to say that there is no resistance to this and Beauvoir touches on this to some extent, particularly in relation to her own life choices, but ultimately argues that social constructs play out for the majority.

Beauvoir's claims suggest that the female form and femininity are socially constructed and that the patriarchal society we live in does not celebrate sexual difference, but rather controls and manipulates it. Beauvoir acknowledges sexual

difference arguing that women are able to function equally to men but are deprived of that privilege. Ultimately men oppress women, with women being defined as 'the Other' (p.16). The man being the subject, strong and independent and the woman the object, weak and dependent on man. Woman is constructed by man which renders the woman to always be 'the Other' as the man is always the 'seer'. She suggests that what it means to be a woman is male driven with 'the Other' borne from a man's point of view, with women seeing themselves through a male 'gaze'.

In arguing the situation of women through the life course and as 'the Other', Beauvoir explores the concepts of 'transcendence' (p.28) and 'immanence' (p.29), the conditions which render freedom possible. Transcendence for Beauvoir is the ability to be able to pursue one's desires and goals, opening up a field of opportunities, with immanence being passive and the possibility of freedom unachievable. She argues that both men and women through their existence are both transcendent and immanent, however, as suggested above, it is social traditions that dictate which concept is achievable. The focus of her work centres round women being subjected to oppression by men rendering them immanent, denying them the freedom of the transcendent man. Ward (1995) agrees, interpretating Beauvoir to mean that for a woman her body condemns her to immanence due to the consequences of social, political and economic subordination by men throughout time, rendering women's bodies as derogatory, unworthy and something to be ashamed of. This internalisation by women of their female body subsequently leads to them seeing and believing themselves as 'the Other'. This is further conceptualised by Arp (1995) who argues that society conditions women to the extent that they accept their oppression, and this oppression is perpetuated through body alienation based on the ideals of man.

This is not to say that there is no resistance and Beauvoir touches on this to some extent, particularly in relation to her own life choices, with women able to attain freedom if they truly desire it. Ultimately, however, she argues that social

constructs play out for the majority. It could be argued that Beauvoir had to adopt masculine traits in her own life to be able to attain the freedom she so desired, reflected in the fact that she remained single and childless, resisting the social constructs and her biology. This is supported by Pilardi (1995) in her critique of Beauvoir's *The Second Sex,* in which she examines feminist interpretations. She draws on Dinnerstein (1976), who in: *The mermaid and the minotaur: Sexual arrangements and human malaise* suggests that transcendence is only possible for women if they enter a man's world.

As Beauvoir moves through the stages of a woman's life, she discusses pregnancy and motherhood as being both a positive fulfilling experience and a violation of the woman's body. Her accounts move between the burden of motherhood and the saintly qualities of being able to bring new life into the world (1949 [1997p.512]):

> *…pregnancy is above all a drama that is acted out within the woman herself. She feels it is at once an enrichment and an injury; the fetus is part of her body, and it is a parasite that feeds on it; she processes it and is possessed by it.*

She goes on to suggest that the woman is merely a vessel to house the fetus (1949 [1997, p.512]), '…the pregnant woman is plant and animal, a storehouse of colloids, an incubator, an egg' and renders pregnancy and motherhood as being merely a biological function. Although she often gives a negative account of pregnancy and motherhood, Beauvoir argues that its value is dependent on the woman's circumstances. In highlighting this, Beauvoir rejects nature, maternal instinct, and maternal love, suggesting it is socially constructed. Women are expected to find pregnancy and motherhood rewarding, however depending on their situation this is not always the case. Beauvoir's writings on pregnancy also reflects modern Western maternity care and the move towards the medicalisation of childbirth with its fetus-centric approach which is particularly relevant in considering the management of maternal 'obesity'.

The main criticisms of Beauvoir centre around masculinity and the negative attitude she adopts towards the female body throughout her work, as well as her interpretations of biology suggesting the need for women to rise above their bodies. Her revulsion at the female form has been criticised, suggesting that either her strict upbringing or the influence of her lover Sartre was influential in this (Arp, 1995).

In considering masculinity, Beauvoir's critics suggest drawing on the concepts of other notable philosophers, particularly Sartre, Beauvoir was heavily influenced by male thinking on the female body (Ward, 1995). In suggesting that all female animals can reproduce but only a human man is above other animals in his superiority, through taking risks and rising above the body, Beauvoir valued transcendence above biology (Siegfried, 1985). Hartsock (1985) concurs, arguing that Beauvoir made assumptions about the superiority of man, with her value judgement on risk-taking and man being superior to that of reproduction, thereby dismissing female biology. By rising above the female body, Beauvoir implies that women have to take on male characteristics to be able to be free, further emphasising her masculine approach.

It could also be argued that Beauvoir's work is outdated and reminiscent of a time gone by. Society may have moved on in relation to some of the previously taboo discussions on the female body such as menstruation, sexual intercourse and pregnancy (Arp, 1995), however the objectification of women still remains a contemporary issue, continually debated by feminist writers in modern times. Western culture perpetuates the female body as sexualised, with a certain body form being more desirable than others. Wonderbra's famous *Hello Boys* billboard is well etched in my mind, featuring the model Eva Herzigova in a provocative pose, with the emphasis on the male gaze that Beauvoir mooted. Although over 27 years old now, evocative advertising using women's bodies is still widespread, more recently the *Are you beach body ready?* campaign by Protein World promoting body shaming in 2015. Despite causing a backlash from feminists, the brand still went on to increase sales on the back of this campaign

(Carr, 2020). The *#MeToo* movement which grew out of a desire to combat the sexual harassment and oppression of women is also a recent example of the continuing patriarchal oppression of women (Knowles, 2019). I would argue, therefore, that the relevance of Beauvoir's work persists today.

On reflecting on the relevance of Beauvoir in modern Western society I cannot help but muse over my own experiences. I would like to think that I am an independent, professional woman, able to support myself financially and having the freedom to pursue my desires and goals. However, there are aspects of Beauvoir's 'Other' evident in my own life. This is apparent in the division of domestic labour in my household. I take on the traditionally 'female' household chores and childcare, whereas my husband does the traditionally 'masculine' chores such as DIY, gardening and (a standing joke) putting the bins out. In fact, in supporting Beauvoir's transcendence/immanence argument, it is well recognised in relation to our now older children that they come to me for emotional support and their father for financial support, which reinforces the stereotypical roles society construct.

Beauvoir offers a theory that is relevant to this study as her concepts consider the social construction of the female body which is rooted in patriarchy still prevalent in modern Western society today. Added to this, societal expectations of what constitutes the ideal female form exacerbates this and further oppresses and marginalises women who are 'obese'. The woman as 'Other' impacts on the notion of self and how women perceive themselves through the life course, the choices available to them and whether they feel free to exercise those choices. In relation to pregnancy and motherhood the medicalisation of childbirth further renders women as 'the Other', with the management and care of maternal 'obesity' with its fetus- centric approach personifying this.

8.5 Further development of the theory drawing on Goffman, Foucault, and Beauvoir

Emergent theorising discussed within this chapter helps to explain women's experiences and their management and care when they book with a BMI of 35 or above and how choice, consent and control is experienced for these women. These were 'the conditioned body; 'the (in)visible) body; and 'the contesting body'. As a key issue underpinning this theorising related to women's conceptions of self, I decided to explore the work of Goffman and his studies on self, Foucault and power relations and Beauvoir's insights into the female body and 'Othering'. All three authors offered insights to help extend the initial theorising and to develop the emerging grounded theory of this study. From insights grounded in the data and the selected theorists it became clear that self is a central factor in how women perceive their weight and the care afforded to them throughout the pregnancy continuum.

The in-depth reading of the three key authors, and further consideration of the findings led to an understanding of self as being multifaceted and fluid, changing depending on women's circumstances and how they feel they are situated in the world. This led to further theorising to create a substantive grounded theory of 'multiple dimensions of self'. Six notions of self were identified; 'disciplined self; 'surrendering self; 'embodied self'; 'marginalised self'; 'resisting self'; and self-agency'. An example of how I came to identify these six notions of 'self' through 'messy maps' and diagramming (Charmaz, 2014; Clarke et al., 2018) can be found in Appendix O. How these intersect with the theorising and the selected theorists are presented in Table 16:

Table 16: Self in relation to women's perceptions of weight and care when they present in pregnancy with a BMI of 35 or above.

	Women's perceptions of weight	**Women's perceptions of care**	**Theorists**
The conditioned body	Disciplined self	Surrendering self	Goffman Foucault Beauvoir
The (in)visible body	Embodied self	Marginalised self	
The contesting body	Resisting self	Self-agency	

The substantive grounded theory of 'multiple dimensions of self' offers a nuanced and theoretical understanding of how women living with 'obesity' are managed during the pregnancy continuum, and ultimately how choice, consent and control are impacted. It provides an understanding of how women's notion of self changes depending on the situation and the interactions they have with health professionals as well as the interactions they encounter within the wider community. These dimensions of self often come from a position of shame, even for those who try to resist and to some extent have self-agency. This shame is perpetuated by being a woman and living with 'obesity'. A thorough examination and interpretation of this substantive grounded theory is offered in the following chapter.

8.6 Conclusion

This chapter has presented an overview of how: 'the conditioned body; 'the (in)visible body'; and 'the contesting body' came to fruition. A discussion around symbolic interactionism and its relevance to constructive grounded theory was offered with the major works of Erving Goffman, Michel Foucault and Simone De Beauvoir critiqued and presented in support of the emergent theorising. These theorists offered illuminating insights into the notion of self which helped to develop the substantive grounded theory of 'multiple dimensions of self', comprising of self being identified as: 'disciplined self'; 'surrendering self'; 'embodied self'; marginalised self'; 'resisting self'; and 'self-agency'. Women presenting in pregnancy with a high BMI bring 'multiple dimensions of self'

which impact on their experiences of management and care throughout the pregnancy continuum, and which ultimately impacts on choice, consent, and control.

The following chapter will discuss the substantive grounded theory of: 'multiple dimensions of self.' It will consider this in the context of the wider literature, offering both theorising and discussion.

CHAPTER 9

MULTIPLE DIMENSIONS OF SELF

SUBSTANTIVE GROUNDED THEORY AND DISCUSSION

> *Our experiences are shaped by the social contexts in which we live. Our interpretations of these experiences are in turn shaped by the constructions we have about ourselves. In this way there is an interactive process between the social constructions of ourselves and the variety of our experiences. This creates the possibilities of alternative construction of the self from the dominant models in society. Hence there is no real self that is waiting to be discovered by the objective other (e.g., scientist or therapist) but differing versions of the self. No one perspective is more right than the other but each exists to embrace different aspects of experience. There can be more than one self, as different versions of self may be perceived by the person or by others as the self evolves over time and across different contexts*. (Hart, 1996, p.44- 45)

9.0 Introduction

The previous chapter introduced the theorising of: 'the conditioned body'; 'the (in)visible) body; and 'the contesting body'. It conceptualised the findings through consideration of the theory of 'self', with regards to the work of Goffman, Foucault's theorising on discipline, control and biopower and Beauvoir's work on the female body. From this theorising a substantive grounded theory of 'multiple dimensions of self' was developed comprising of six notions of self: 'disciplined self'; 'surrendering self'; 'embodied self'; 'marginalised self'; 'resisting self'; and 'self-agency'.

'Multiple dimensions of self' offers an in-depth, theoretical understanding of how self impacts on choice, consent, and control for the women in this study and is discussed within this chapter. How this substantive grounded theory intersects with the wider literature will also be explored, offering new insights into women's experiences.

9.1 The multiple dimensions of self

It is well recognised that lack of choice throughout the pregnancy continuum reduces women's sense of self, resulting in feelings of loss of control, disempowerment and worthlessness (Byrne et al., 2017; Jomeen, 2006; O'Brien, Casey and Butler; 2018). This study supports this, going further in identifying through the 'multiple dimensions of self' the effect self may have on women when they book with a BMI of 35 or above. Yuill et al. (2020, p.18) in their systematic review considering informed choice and woman's decision-making during pregnancy and birth reflects this, through consideration of the sense of self and embodiment:

> *Embodied experiences are central to maternity, evidenced by the importance mothers place on bodily autonomy and integrity, and how indicative emotions are within this. Anthropologists have suggested that emotions affect how the body is experienced and are connected to images of well or poorly functioning social bodies.*

It could be argued therefore that the 'multiple dimensions self' are intrinsic in relation to choice, control and consent, and the women's ability to achieve these.

The substantive grounded theory of 'multiple dimensions of self' highlights how in this study the women's capacity to exercise choice, provide consent and feel in control was impeded or enhanced through how they view self (Fig.9.1). As introduced in Chapter 8 (see, 8.5), the notion of self is multifaceted depending on the situation and changes accordingly, influenced by the cultural and societal landscape in which women live.

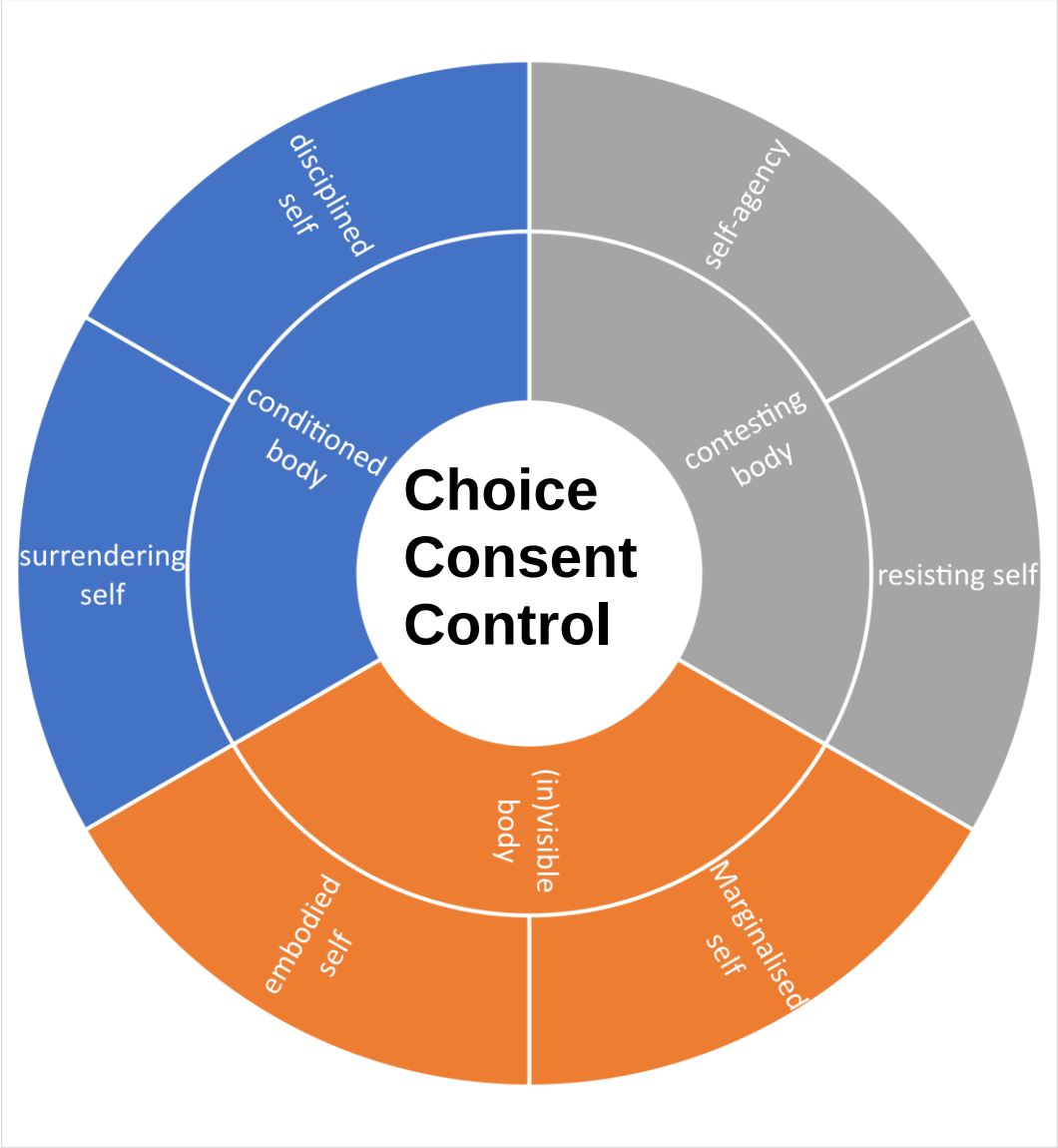

Fig. 9.1 The multiple dimensions of self

The 'multiple dimensions of self' situates the women studied across six notions of self, that are at play at any given time: 'disciplined self'; 'surrendering self'; 'embodied self'; 'marginalised self'; 'resisting self'; and self-agency'. Each is described below and contextualised in relation to the wider literature.

9.2 The disciplined self

The notion of the: 'disciplined self' initially arose from the ideas of Goffman and Foucault. On engaging with Beauvoir's work, however, it became clear that self-discipline could also be attributed to unconscious systematic patriarchal oppression. Goffman (1959, 1963) suggested that generally, when presenting

one's self people monitor their behaviour and change according to how others perceive them with individuals making assumptions about others based on their outward characteristics (p.12):

> *When a stranger comes into our presence, then, first appearances are likely to enable us to anticipate his category and attributes, his `social identity'…Typically, we do not become aware that we have made these demands or aware of what they are until an active question arises as to whether or not they will be fulfilled. It is then that we are likely to realize that all along we had been making certain assumptions as to what the individual before us ought to be.*

This unconscious bias 'stigmatises' individuals leading to those experiencing the 'stigma' attempting to address their 'failings':

> *How does the stigmatized person respond to his situation? In some cases, it will be possible for him to make a direct attempt to correct what he sees as the objective basis of his failing…* (Goffman, 1963, p.19-20)

This self-regulation or self-discipline of the body was apparent within the study, with all of the women interviewed reflecting Goffman's assumptions. They all had previously engaged in diet groups and exercise to control their 'obese' bodies.

Foucault (1973) concurs with Goffman suggesting that the perception of self is orchestrated through political and societal discourses that foster personal responsibility of self, which encourages individuals to be self-governing. A good citizen is one that cares for their own health and wellbeing, this neoliberalist approach being essential for productivity and economic growth (LeBesco, 2011). This then becomes the 'normal' behaviour of those who are self-regulating, with others perpetuating this through stigmatisation (Goffman, 1963). Goffman (1963) and Foucault (1973) agree that society has developed the concept of a 'normal person' through medical and political discourses. The stigmatised person may feel they have many of the desired attributes to be 'normal' however they can never be 'normal' unless they can self-regulate. From a medical perspective

Kwan and Graves (2013) propose that Western societies fixation on healthism has led to individuals making choices in line with public health campaigns that aim to correct personal failings with those who fail being morally accountable, 'obesity' being an example.

A further argument made my Foucault in a recorded seminar in 1982 and published in 1988 after his death is around technologies of self. Foucault suggests that individuals can bring about change and perceptions of self through employing practices of power at a micro level through gaining knowledge that makes them both the object and the subject. This would suggest that the weight loss strategies and exercise regimes undertaken by the women in this study may have been self-initiated as opposed to disciplinary, suggesting the women have free choice. Anna and Sam for example, in undertaking martial arts and weight lifting, afforded them power at a micro level in justifying their weight allowing them an element of control. It is difficult to see, however, how the 'conditioned body' can make free choices. The women appeared when questioned to exercise free choice when talking about losing weight but how much of this was driven by the subconscious and the conditioned 'obese' body, may be questionable.

Beauvoir (1949 [1997]) meanwhile suggests that for women, any desire is directly linked to patriarchal oppression. It could be argued that women may think they have a choice in their desire to lose weight however they are not conscious of the patriarchal influences that make them self-regulate, reflecting Beauvoir's position on the woman as 'the Other'. Systematic oppression over time leading to immanence. Beauvoir's position has been taken up by other feminist thinkers, Bordo (2003) for example argues that due to gender oppression women are more likely to engage in practices to modify the body, with women conditioned to maintain a bodily form which shows restraint and sacrifice, befitting of a woman in a culturally male dominated world. This supports earlier feminist work from Bartky (1982) who suggests that women often strive for unachievable high standards perpetuated by the 'fashion- beauty complex' which further oppresses women through patriarchal capitalism. This

may bring women benefits in the short term through gratification and adoration by others, but the constant pressure to live up to other's expectations often leads to disempowerment, negatively impacting on physical and mental well-being (Piran and Teall, 2012).

In this study the 'fashion-beauty complex' ideal was evident in how some of the women talked about their weight, from not being able to find clothes that made them feel 'nice', to self-loathing in unable to find clothes that fitted their 'obese' bodies. Even the act of attending slimming groups is argued to be surrendering to the capitalist system of which these groups in seeming to support weight loss actually have a financial interest in keeping people 'fat' (Lupton, 2013a; Lyons, 2009).

All of the women talked, in their struggle to be thin, of losing weight and then putting weight back on, and more, in their quest to have an acceptable body size. This act of yo-yo dieting (see Chapter 7, 7.3.1) suggests, however, that self-regulation is not sustainable. Evidence supports this, suggesting that dieting is unsustainable with dieting being a predictor of weight gain in the long term (Mann et al., 2004, 2007; Pietiläinen et al., 2012). Subsequently, this leads to yo-yo dieting, which is associated with increased risk of depression, cardiometabolic diseases and eating disorders (Montani, Schutz and Dulloo, 2015). Choice therefore is a catch 22, in trying to conform to societal 'norms' the risk to health may be equitable to remaining 'obese'. Added to this, weight stigma can actually perpetuate weight gain, with evidence to suggest that those subjected to weight stigma being more likely to turn to food to manage their emotions (Tomiyama, et al., 2018). Midwives offering slimming class referrals in early pregnancy perpetuate this weight cycling which the women in the study felt was not supportive. Rather, they wanted meaningful conversations around weight, which is supported in the wider literature (Adolfsson, Andresen and Edgren, 2013; Furness et al., 2011; Heslehurst, Bell and Rankin, 2011, 2015; Lindhardt et al., 2013) and evident within the meta-narrative review findings (see Chapter 3).

Wider research contests the eat less, move more mantra portrayed by public health initiatives to combat 'obesity', suggesting this approach is too simplistic (Sharma and Padwal, 2010). It has been argued that campaigns such as the UK government's *Better Health* campaign (Public Health England, 2020) and the Cancer Research UK anti-obesity campaign of 2019 (CRUK), although well intentioned, further stigmatises, with critics suggesting these campaigns imply that individuals can control their weight (Brown, Flint, Batterham, 2022; Rathborne, Jetten, Barlow et al, 2020; Talbot and Branley-Bell, 2021; Varshney, 2020). CRUCK for example, framed its campaign in relation to 'obesity' increasing the risk of cancer as something individuals could prevent through changes in 'behaviour' (Spratt, Jebb, Aveyard, 2020). The reality for many is that 'obesity' is associated with the social determinants of health, particularly in high income countries, with poverty, food security, education, access to health care, and the politics impacting on weight, contesting the eat less, move more approach to weight management (Adams, 2020; Lee et al., 2019; Noonan, 2018; Ogden et al., 2017; Randolph and Stephens, 2022).

It is accepted that 'obesity' is a low grade chronic inflammatory condition and is associated with metabolic disorders and insulin resistance (Bays, 2011, Lorenzo et al., 2019; Stolarczyk, 2017). Weight regulation has been found to be closely linked to inflammation of adipose tissue (O' Rourke, 2008, Stolarczyk, 2017, Zatterale et al., 2020). Other causes of 'obesity' have been linked to genetics, epigenetics, and the environment (Thaker, 2017). Historically, however, 'obesity' (as discussed in Chapter 1 and 2) is associated with appearance, identity, and morality (Grønning, Scambler and Tjora , 2012). These traits are still very much engrained within society which leads to those living with 'obesity' to self-regulate and the yo-yo dieting that ensues. It is argued that by focusing on 'obesity' as a disease the associated stigma may be reduced, with individuals being able to seek support to reach and maintain a healthy weight which moves responsibility away from the individual (Puhl and Heuer, 2010; Puhl and Liu, 2015). Also, it paves the way for more resources and research to aid treatment and prevention (Rosen, 2014).

It was apparent within my study that some of the women recognised their weight as being linked to pathology. Sophie for example recognised her hypothyroidism as directly impacting on her weight. Despite this, she still internalised the social discrimination she faced, evident in not wanting to go on a family holiday because she could not find anything 'nice' to wear for her body size. This highlights how ingrained weight stigmatisation is, with Puhl and Heuer (2010, p. 1019) arguing that: 'Throughout history, stigma has imposed suffering on groups vulnerable to disease and impaired efforts to thwart the progression of those diseases'.

It appears that more needs to be done to support women to make choices around their health which is sustainable. This includes addressing women's psychological relationship with food and the wider socio-economic, societal, and environmental influences that drive 'obesity' (Dutton and Perri, 2015; Hruby and Hu, 2015). A move from the eat less, move more approach to weight management, to one which seeks to combat the inequalities that exist within society that drive 'obesity' are needed.

Not only does society appear to seek to promote the desire to lose weight, but it also expects women to be good mothers and do the best for their families (Verseghy and Abel, 2018). Hays (1996), in '*The cultural contradictions of motherhood*' promotes the concept of 'intensive mothering', suggesting that the mother is primarily responsible for all aspects of a child's life, to the detriment of her own. Society sets women up to fail, putting unrealistic expectations on them, further promoting this ideology (Christopher, 2012; Thurner, 1995). It could be argued in an era where 72% of women in the UK are in employment (Office of National Statistics, 2021), the pressure to meet the high standards of motherhood might have subsided, with fathers/other parent sharing the load. It is interesting to note, however, as I write up this thesis in the middle of a global COVID-19 pandemic that a recent survey of 20,000 working mothers suggests that women are bearing the brunt of childcare, with childcare facilities and schools being closed, resulting in redundancy, having to reduce hours or having

to give up work altogether (Adams-Prassl et al., 2020; Pregnant Then Screwed, 2021). In considering this it is understandable that the pressures of motherhood, family and work commitments may impact weight, limiting choice. The findings support this.

Choice and control for the women in this study appeared to be a paradox. In trying to self-regulate in one aspect of their lives they may lose control in another. Having a 'normal' weight appeared to be seen to equate to being a good mother but in putting the needs of the family first a 'normal' weight may not be attainable. In using Goffman's dramaturgical analysis (1959), the women in this study appeared to be always trying to act on the frontstage and portray an image of the good mother, while their actual backstage self was minimalised, with no break from performing. These findings provide some insight into how society controls and manipulates, with the patriarchal oppression that still exists in Western society that values motherhood, family, and women as carers, (O'Reilly, 2010), conditioning women and ultimately setting them up to fail.

The women in this study appeared to be conditioned to self-regulate through stigmatisation to conform to societies expectation of an acceptable body size. Failure to self-regulate carries consequences, however, of which the women in the study acknowledged. This led to most of the women surrendering themselves to health professionals and the medicalisation of maternal 'obesity' when they presented in pregnancy. For the majority, this involved being complicit and passive in their care.

9.3 Surrendering self

Foucault's work was particularly illuminating in developing the concept of surrendering self (see Chapter 8, 8.3). The findings of this study suggest that the women may have become complicit in their own oppression and Foucault's work offers an understanding to explore this. There was a general acceptance from the women in this study of the care afforded them, with comments such as 'It is what it is', 'there is nothing I can do', 'I have no choice' being cited. Being

complicit does not imply that women have no choice, however, rather as Knowles (2019, p.246) suggests:

> *The unfreedom of complicity is not simply something that is imposed from without, as is the case with most instances of oppression. Rather… unfreedom of complicity is something that is embraced from within.*

In choosing to surrender to the medicalisation of pregnancy and childbirth it may appear to women that they are exercising free choice, however this choice is within the confirms of 'the conditioned body' with women conditioned to view the 'obese' body as contentious. As Gregg proposes (2011, p.27) 'choice is a social construction that makes people feel free even in the context of oppression'.

Compliance may also be achieved through what Foucault (1977, 1978, 1982) terms the ritual of confession. Historically the religious act of confession developed to become a form of social control, extended, following enlightenment to institutions of science, including medicine. Disclosures may be used to manipulate individuals to submit to intervention in order to maintain well-being, as well as continuing to foster the importance of self-regulation. This in turn renders the individual as passive and more easily controlled as well as the individual becoming complicit in the control. It could be argued that the 'obese' body is a visual disclosure, a confession of deviance, increasing the likelihood of compliance.

The act of surrendering self was also evident in how some women resigned themselves to the fact that as a consequence of their weight they were willing to accept increased surveillance and intervention (Chapter 7, 7.4, 7.4.2). Surrendering of self to the medical discourse associated with maternal 'obesity', with maternal 'obesity' seen as problematic, appears to objectify these women, with many of the women becoming passive observers of the care afforded. An example of the 'clinical gaze' (Foucault, 1973), women were expected to (and did) surrender to the practices

promoted through medicine to regulate and control. Martin (2001) suggests that medicine controls, through discounting women's expertise over their own bodies. Women's ability to trust their own bodies to birth becomes diminished, increases the fear of childbirth and perpetuates the use of birth technologies and intervention to manage birth regardless of the women's risk status (Rydahl et al., 2020). This is even more apparent for women who are deemed 'high risk' and clearly evident in this study. Carla for example was given intravenous oxytocin despite contracting and wanting to have time to labour spontaneously. Jasmine was prepped for an emergency caesarean section despite telling those caring for her that she wanted to push. On realising that Jasmine was birthing her baby, the surgeon proceeded to undertake a forceps birth, without Jasmine's knowledge as she was anaesthetised (see Chapter 7, 7.4.6.2).

Rendering the body to constant scrutiny leads to regulation through policy and practice which disciplines and coerces the body to conform (Foucault, 1977), with risk compliance obtained by being guided to make decisions based on the health professional's preference. It could be argued that health professionals believe they are offering choice to women, but they do so in the confines of hospital policies and guidelines. A common argument is that choice is an illusion (Crossley, 2007; Yuill et al., 2020) with women steered into making choices of which health professional's favour (Lothian, 2008). Edwards (2005) argues that in order to have choice and control over pregnancy and birth women need to be respected and valued by those offering care. If this is not achievable women are coerced and manipulated, becoming passive and relinquishing control. Borges (2018) suggests that coercion during childbirth amounts to violence, with women in America having choice overridden by both obstetricians and the legal system if the fetus is deemed to be at risk. Within the UK, maternity discourses driven by risk aversion arguably also risks subjecting women to obstetric violence. There is a fine line between informed consent and coercion, with evidence to suggest that the latter is common place and evident within my own findings (Kotaska, 2017; Miller et al., 2016; Nelson, 2021).

Control was particularly evident in the discussions women had with health professionals around labouring and birthing in water (Chapter 7, 7.4.6), with safety issues due to their high BMI being cited as a reason for refusal but with no evidence provided to support this. Lothian, (2008, p.36) suggests that:

> *The safety issue underlies and powerfully influences women's choices and decision-making. In the current system, the experts hold the keys to safety and ultimately to choice. Obstetrics holds sway over and dictates "safety," both determining what it is and dictating how to insure it. Despite the lip service we pay to choice, there is still an assumption that obstetrics knows best and that, if women have the "right" information, they will make the "right" choices. If the right choices are explained well enough, women will listen to the experts' advice. It is extremely difficult—even for knowledgeable, assertive women—to resist obstetric coercion.*

It could be argued that access to the birthing pool is restricted through eligibility guidelines and maternity unit culture for many women (Cooper, McCutcheon and Warland, 2019; Milosevic et al., 2019; Young and Kruske, 2013) despite NICE (2014) recommending its use for uncomplicated labours and births. It is unsurprising therefore that its use was restricted for the women in the study who were deemed as 'high risk', despite the NHS advocating informed choice for all (DoH, 2012).

Measuring, examining and testing the body throughout the life course, has become the accepted 'norm' (Foucault, 1973). The findings of this study echoed this. The women accepted care often without question with tests and other appointments arranged without them knowing why or without consent. Most of the women spoke of not being asked, being 'told' what would happen with regards to their care and 'not allowed' certain care. There was a general acceptance that due to their high BMI they 'had no choice' but to do as they were told. Comments such as 'I'll do as I'm told', 'I literally just done what I was told really' was common, again suggesting passivity and compliance (see Chapter 7, 7.4, 7.4.5). Perceived control by health professionals was also implied when some women in trying to negotiate choice were told 'no', with comments such

as ‘It’s up to them, if they say no that’s it’, ‘What do I know?’ being common place. It could be argued that rather than questioning care and expecting more, the women accepted their fate feeling unable to challenge a system of which they felt they had little or no knowledge. Chloe for example talked of the midwives and consultant caring for her having trained for many years therefore they knew best. Crossley (2007), in consideration of her own birth and its medicalisation reflects this view, suggesting that it is difficult to question care due to being unqualified and therefore felt unable to make an informed choice and give informed consent. Although not medicalised due to ‘obesity’, Crossley supports the findings in this study, her evidence also suggesting that lack of choice for women transcends maternal ‘obesity’. Although this is not a consideration for this thesis, it needs to be acknowledged that medicalisation of childbirth is an issue for many women and not just for women who are ‘obese’, with a plethora of evidence to support this (see Chapter 2, 2.2). In conforming to the notion that health professionals know best (see Chapter 7, 7.4.7), and being the experts, most of the women in this study failed to recognise their own unique expertise by virtue of being ‘obese’ and pregnant. This again highlights how some of the women were implicit in their own oppression due to a passive acceptance.

Foucault (1973, 1977) argues that routine practices transcends all institutions, expecting compliance, with individuals following routines which limits the ability to make own decisions. This control erodes an individual’s agency rendering them passive. Foucault does concede however, that the power medicine holds is not a deliberate attempt to dominate but rather a belief that crosses all social groups of the importance of medicine, which was echoed in the findings with nearly all of the women trusting the health professionals caring for them. He suggests medicine is a productive as opposed to repressive power, although it could be argued that for most of the women in the study this was a double edged sword.

It was apparent that most of the woman in this study wanted to have choice to make their own decisions about care, however, they also viewed the extra surveillance which denied them choice as a means to ensuring a safe outcome for the baby. They trusted health professionals implicitly (see Chapter 7, 7.4.7). The investment in trusting health professionals may suggest some relinquishing of autonomy, although it could be argued that there may be mutual trust and respect, with the women engaging in practices of the self for the benefit of their health and wellbeing and that of the baby. Whether this engagement comes from a position of knowledge and understanding or from being conditioned to think of medicine as always a force for goods is debatable. Lupton (1997, p.105-106) argues that patients may present themselves as the model patient, acting in a way that they think they should, to portray respectability (as proposed by Goffman, 1959), but this suggests that the individual is always aware of what they are doing and does not account for the unconscious origins of human motivation:

> *At a less conscious or irrational level patients may behave in assertive or hostile ways because of their very dependence on doctors…Or they may willingly engage in a relationship with their doctor that echoes the parent-child relationship, because of the emotional comfort that offers.*

Also, all the women were happy to have extra scanning of the baby in pregnancy suggesting some advantages to surveillance. This may suggest that surrendering self when it is beneficial perpetuates Foucauldian thinking on power and how power is everywhere, intrinsic throughout all levels of society. It could be argued therefore, that all the women, in surrendering self to certain aspects of surveillance, were possibly able to exercise power in doing so.

With increased surveillance, however, comes increased intervention (Brownlee et al., 2017; Jansen et al., 2013; Miller et al., 2016). An example of this is induction of labour. Routinely part of the management of pregnant women with a BMI of 35 or above, recent evidence suggests that the disadvantages of this procedure for women whose only risk factor is a characteristic such as weight

may outweigh the benefits and ultimately may not be needed (Seijmonsbergan-Schermers et al., 2020). Seven women within this study were routinely induced with two ending in an emergency caesarean section and three, instrumental births. Of those, two women were induced due to ultrasound scanning indicating a problem with fetal growth that was actually unfounded. One will never know if birth outcome was as a direct result of intervention or whether those women would have needed intervention anyway. A good outcome for both mother and baby is paramount, but when a one size fits all approach is adopted the risk of harm may also increase. Added to this, evidence suggests that operator error in the use of ultrasound technology is a common reason for fetal weight inaccuracy (Milner and Arezina, 2018), with high maternal BMI found to reduce ultrasound accuracy (Aksoy et al., 2015; Kritzer et al., 2014; Paganelli et al., 2015). This highlights the caution needed when using technology to assess risk as it may lead to women agreeing to intervention they may not ultimately need.

Childbirth perpetuates risk discourses, conceived through the medical model of childbirth which through science is deemed to be the truth, thus exerting control (Lupton, 1999). Newnham (2014, p.255) in considering birth and control in Australia concurs, suggesting that the medical discourses in maternity care:

> *…directs, more than listens to women, and expose*(s) *the nerve of deeply held beliefs pertaining to risk and safety. The continuing, and even increasing, risk-driven, one-policy-fits-all approach to maternity care by the obstetric systems leaves some women little choice.*

Thus, surrendering self may be the only choice women are able to exercise.

9.4 Embodied self

The language used to define 'obesity' is contentious and is ladened with cultural beliefs on how society views weight (Rich and Evans, 2005). Negative assumptions arising from this lead to embodiment, with the women in this study conscious of this and how their 'obese' bodies portrayed them to be.

Internalisation of the negative traits associated with 'obesity' was apparent with some women talking of being 'lazy', 'lacking motivation' and being 'abnormal'. This weight bias internalisation is well documented in the literature (e.g., Pearl and Puhl, 2018; Pearl, Puhl, Lessard et al., 2021) with those living with 'obesity' coming to accept these cultural representations of themselves as the 'norm' (Williams and Annandale, 2019). In view of this both Goffman's stigmatisation theorising and Beauvoir's work on embodiment has been useful in developing the: 'embodied self' and its impact on choice, consent and control for women living with 'obesity' accessing maternity services.

As introduced in Chapter 2, (2.3) embodiment, as conceptualised by Merleau-Ponty (1962) pertains to the body as lived. As Chrisler and Johnston- Robledo (2018, p.8) proposes 'everything we know, everything we do, and everything we are is mediated by the body'. Inspired by Merleau-Ponty's work on embodiment, Beauvoir (1949 [1997], p.66) suggests that the female body is a situation that forms women's lived experiences: 'The body is not a thing, it is a situation: it is our grasp on the world and the outline of our projects'. In relation to the findings in this study it was clear that all the women were conscious of their body, which being visible instantly showed them as different. Chloe for example stated that she knew she was big but was not concerned about her weight as she ate healthily and exercised, yet she was being treated differently due to her weight when others such as those who smoked could easily hide their smoking, but she could not hide her size. She resented being 'othered' because of this.

All the women talked of their 'obesity' as being separate from self, their visible bodies being reflective of who they were perceived to be by others. They talked of being defined by their weight, with assumptions being made about them. Anna for example spoke of how she felt judged as soon as she walked in a room, by professionals who did not know her: 'don't judge me you don't know me' (Chapter 7, 7.4.5), suggesting that her embodied self was perceived by others as a reflection of her as a person. It is well documented that society through historical, cultural, political and medical discourses view the 'obese' individual as

having undesirable personal and moral characteristics (Nutter et al., 2016; Puhl and Heuer, 2009; Swift et al., 2013), with this study supporting this. Interestingly, positive relationships were more often made with midwives with similar bodies which may suggest that this commonality afforded the women care from a position of understanding on the part of the midwife. When positive relationships were fostered, women felt that they had more control over their care and were able to have open and honest discussions around weight risk, enhancing informed choice and enabling informed consent. This concurs with other literature in the field (Heslehurst, 2013; Lavender and Smith, 2015; Mills, 2013), who suggest that when information surrounding maternal 'obesity' risk and management is given in a honest, open, non-judgmental way, women's experiences are perceived more positively.

'Embodied self' was also evident in how some of the women talked about how their bodies did not conform to the 'normal' standards expected, therefore were problematic. They wished to be 'normal' and to be able to have care afforded to those of 'normal' weight and have a 'normal' birth (see Chapter 7, 7.4.1). Goffman (1963, p.16) suggests that:

> *The stigmatized individual tends to hold the same beliefs about identity that we do; this is a pivotal fact. His deepest feelings about what he is may be his sense of being a `normal person', a human being like anyone else, a person, therefore, who deserves a fair chance and a fair break.*

'Embodied self' therefore appears to internalise weight bias, viewing self as 'abnormal'. Chritiansen et al., (2012) argue that 'obesity' is dehumanising under societies gaze (as proposed by Foucault, 1977, 1982) leading to exclusion and marginalisation. The female 'obese' body is further scrutinised and vilified through gender stigmatisation (Bordo, 2003; Boero, 2012; Tischner, 2013) with increased intervention and management of maternal 'obesity' objectifying the body, attempting to 'normalise' and control, perpetuating the desire to be 'normal'. Added to this feminist critique of choice in childbirth often rejects the medicalisation of childbirth,

promoting 'normal' birth, empowering women to reclaim pregnancy and childbirth form medicine (Beckett, 2005). This stance rather than support women may actually cause more harm than good, setting women up to fail when 'normal' is not their reality (Crossley, 2007).

9.5 Marginalised self

The 'marginalised self' was conceived through the discussions women had in relation to feeling stigmatised, judged and ignored. The findings of the study concur with other research undertaken on the experiences of women living with 'obesity' and pregnancy care, particularly in relation to stigmatisation, judgement and attitudes of health professionals (see Chapter 3, meta-narrative review). Also apparent was how the women were marginalised through medical discourses that positions health professionals as knowledgeable experts. Foucault (1980) suggests that particular forms of knowledge are viewed more highly than others, with power and knowledge being inseparable from one another. Those who come from a position of privilege influence power and their knowledge reinforces this. The knowledge of those who are not privileged is said to be subjugated knowledge. Foucault (1980, p.81-82) explains this as:

> *A whole set of knowledges that have been disqualified as inadequate to their task or insufficiently elaborated: naive knowledges, low down on the hierarchy, beneath the required level of cognition or scientificity.*

For the women in the study, it was evident that their knowledge was often dismissed or trivialised, with health professionals imparting knowledge from a position of power.

Health professionals controlling the women through their privileged position is further supported by Goffman (1963) and Beauvoir (1949[1997]) who suggest that those who are dominant, through their meanings, create through 'othering', identities that become over time the 'normal'. Those who do not meet the expected standards attributed are oppressed. The dominant view is internalised

by those who are marginalised, with further marginalisation taking place, with the consequence of scrutinising themselves through the dominant's viewpoint:

> *The central feature of the stigmatized individual's situation in life can now be stated. It is a question of what is often, if vaguely, called `acceptance'. Those who have dealings with him fail to accord him the respect and regard which the un-contaminated aspects of his social identity have led them to anticipate extending and have led him to anticipate receiving; he echoes this denial by ending that some of his own attributes warrant it.* (Goffman, 1963, p 18).

This can be further evidenced through how many of the women in the study appeared to treat their wishes and beliefs as being less important than health professionals wishes, making them feel inferior to others by virtue of their 'obesity'.

Further examination of the findings in relation to subjugated knowledge suggests that the woman's social status also impacted on how they were perceived by health professionals, further marginalising, and restricting choice, particularly for those from lower socioeconomic groups. There appears to be a difference in how women from different socio-economic backgrounds are perceived in relation to the knowledge they hold and the recognition of that knowledge by health professionals. Those from lower socio-economic backgrounds appeared to be seen as being less educated, were less likely to be listened to and were less likely to 'bother' professionals that they deemed to be more knowledgeable. This further supports Foucault's analysis of subjugated knowledge and Goffman's (1963) work on stigma and 'spoiled identity'. It is well recognised that 'obesity' is associated with lower socio-economic status (Heslehurst et al., 2010; Heslehurst et al., 2011; Mayor, 2017; Ng et al., 2014; Pavela, 2016; Sobal and Stunkard, 1989) which was reflected in the socio-economic status of the women recruited to the study (See Chapter 6, Table 14). It appears however, that in this study women from lower socio-economic backgrounds were further marginalised because of their weight. Only Chloe (social status by occupation 2) was able to effectively articulate her wishes, suggesting that perhaps she was

able to do so by virtue of her higher socio-economic status. What is unclear however is whether these women would have been marginalised anyway by virtue of their socio-economic status or whether this was exacerbated due to their 'obesity'. What is clear however, is that socio-economic status appears to impact on choice for these women.

In support of the correlation between social status and choice, Elbert et al. (2014) suggests that women from socially disadvantaged backgrounds are less likely to engage in talks with health professionals with regards to their pregnancy and birth preferences even though they want to. They believe they are inferior and unknowledgeable and are often excluded from decision making by health professionals because of this. Also, these women are more likely to be deemed 'high risk' due to their social disadvantage (Knight et al., 2019; Royal Collage of Midwives, 2020), with 'obesity' compounding this. Maternity care for these women has been found to be of lower quality than those from higher socioeconomic backgrounds, paternalistic and discriminatory (Rayment-Jones et al., 2019). Lack of information and guidance from health professionals has also been found to reduce the ability to make an informed choice and give informed consent to the care offered (Elbert et al., 2014; McLeish and Redshaw, 2019).

Further marginalisation through weight bias was also apparent in how the women were seen but often ignored. The 'elephant in the room' was evident with health professionals often avoiding talking to women about their weight (see Chapter 7, 7.4.4). Smith and Lavender (2012) argue that this may be due to health professionals not wanting to offend, however in relation to this study most women viewed this as making assumptions about the 'obese' body, with the women actually wanting and expecting their weight to be recognised (Dinsdale et al., 2016; Keely et al., 2011; Lindhardt et al., 2013; Thorbjörnsdottir et al., 2020). For most women pregnancy is a time when they seek evidenced based information in a bid to improve their health (Olander et al., 2012), however the study highlighted that this information was lacking, women unable to make informed choices about their care because of this. For two women

however weight was discussed, with these women feeling further stigmatised as a result. Difficulty arises for health professionals therefore in not wanting to offend but needing to ensure women are aware of the potential risks of maternal 'obesity' as well as offering support in relation to diet and physical activity. It is argued that midwives lack confidence and the appropriate counselling skills to discuss pregnancy weight management as well as there being a lack of specialist education and access to specialist care (Heslehurst et al., 2013; McCann et al., 2018; Olander et al., 2011; Olander, Hill and Skouteris, 2021; Smith and Lavender, 2012). This raises questions for maternity service providers in meeting the needs of these women.

Some of the women talked of not being believed, both in discussions around their eating and exercise habits, and how when increased surveillance revealed no abnormalities, health professionals showed shock and disbelief (see Chapter 7, 7.4.5). This may suggest that there is an expectation that 'obese' pregnant women cannot possible eat healthy and exercise, with the dominant discourses that frame 'obesity' as a disease expecting problems in the pregnancy to occur, thus perpetuating stigmatisation. The wider literature supports this with evidence to suggest that not being believed is a result of the discrediting stereotypes associated with 'obesity' (Malterud and Ulriksen, 2011; Puhl and Heuer, 2010). This supports Goffman's stigma theory (1963, p.3) who states that stigma is embedded in everyday life through subtle nuances, which is evident in the assumptions made by the health professionals in the findings with 'obesity' being viewed as a 'deeply discrediting' trait.

For the women in the study, it appears that marginalisation through weight bias and stigma had an adverse impact on their pregnancy and birth experiences and for some impacted on future reproductive decision making. It is well recognised that choice and informed consent are fundamental rights for those accessing health care within the UK (Coulter and Collins, 2011), yet this is impeded when women are faced with care that marginalises by virtue of weight.

9.6 Resisting self and Self-agency

Whether individuals choose to resist is dependent on multiple factors, notwithstanding the 'multiple dimensions of self'. Davis and Fisher (1993, p.6) propose that women through gender discourses that marginalise, negotiate 'at the margins of power' in order to gain some control over their situation which was evident within the findings of this study. Although subtle there was a sense of maintaining some control through resisting the 'obesity' label and the negative assumptions connected with this. Conversations included the emphasis on how they tried to eat healthily, exercised and the desire to prove those caring for them wrong, in hoping for a 'normal' birth. Several called into question medical control when intervention suggested their babies would be small yet were not, and when testing for gestational diabetes returned negative, again proving the health professionals wrong. Armstrong and Murphy (2011, p.317) suggest these 'more nuanced and subtle conceptualizations of resistance' are important in understanding how women try to overcome power discourses, gaining control over their situation.

Resistance to the medical management and care of maternal 'obesity' however came at a price. Anna for example declined certain aspects of her care. In doing so she was made to feel as though she did not understand the consequences by the obstetrician. This may suggest that in resisting she was seen to be going against the expert advice of the doctor, his scientific knowledge superseding the perceived subjugated knowledge of Anna. Armstrong and Murphy (2011) argue that the social and cultural context in which individuals decide whether to accept care (or not) is not necessarily through defiance or lack of understanding, rather previous experience being a deciding factor. Anna had not encountered any problems with her previous pregnancies; therefore, her resistance may have been from a position of knowledge as opposed to lack of understanding. In contrast to this, it could also be argued that lack of informed choice may impact on women resisting care through lack of understanding. In omitting to offer information health professionals may inadvertently be faced with women making choices which are not informed (Weedon, 1997).

Weight was also viewed as a medical condition of which some women felt that they had no control, subsequently resisting weight stigma because of this (Chapter 7, 7.3.3). Evidence suggests that classifying 'obesity' as a disease can help reduce associated stigma, with many people living with 'obesity' supporting this (Puhl and Heuer, 2010; Puhl and Liu, 2015). Controversy exists, however, on whether 'obesity' should be labelled a disease, despite its recognition as such by the World Health Organisation in 1997 (WHO, 1998) and more recently the American Medical Association in 2013 (Kyle, Dhurandhar and Allison, 2016). Those in favour of the proposition, suggest that 'obesity' as a disease can have a positive impact on those living with it, with increased access to diet and exercise support, medical treatment, and psychological support (De Lorenzo et al, 2019; Rosen, 2014). Those against, however, suggest that 'obesity' is a normal response to the environment people live in, with global food markets and social determinants driving the increase in 'obesity' levels, suggesting it is these that need to be urgently addressed (Müller and Geisler, 2017; Swinburn et al, 2011). Added to this, the Health at Every Size® approach calls for size acceptance, suggesting that size is not an indicator of health status (Penney and Kirk, 2015).

Those who suggest 'obesity' is a normal response to the environment they live in fail to consider how environmental factors actually contribute to the disease process. With the advent of cheap processed foods, lack of access to good quality food, poverty etc., those who are genetically susceptible build up an accumulation of adipose tissue causing an inflammatory response leading to metabolic changes impacting on health (Bray, Kim and Wilding, 2017). It needs to be recognised therefore that the causes of 'obesity' are multifaceted needing effective strategies to manage.

As well as resisting weight stigma some women in accepting 'obesity' as a disease felt there was nothing they could do to address their weight. This fait accompli approach may actually be harmful. Richard Pile in debating whether

'obesity' should be considered a disease (Wilding, Mooney and Pile, 201, p.2) states:

> *If labelling obesity as a disease was harmless then it wouldn't really matter. But self-determination is vital when it comes to individuals taking control of their lives and making the best decisions for themselves. Labelling obesity as a disease risks reducing autonomy, disempowering and robbing people of the intrinsic motivation that is such an important enabler of change. It encourages fatalism, promoting the fallacy that genetics are destiny.*

It could be argued therefore that the resisting self may sabotage the ability to make changes to self through accepting medical discourse that sends out confusing messages. Therefore 'obesity' as a disease may be problematic.

It could also be argued that the very fact of engaging with my research offered the women studied an opportunity to resist and to take control over their care. Gailey (2014) in her seminal work *The Hyper(in)visible Fat Woman* suggests that stereotyping 'fat' women and blaming them for their oppression shifts the focus from the social constructs and structures that exist which is the real cause of oppression. She proposes that this dominant position exerted by those deemed privileged, maintains control. By supporting these woman to tell their stories, they become the subject as opposed to being objectified or seen as 'the Other', becoming knowing subjects thus enabling them to take control of their lives. For Alice it gave her the confidence to talk through her management plan when on being diagnosed has a gestational diabetic she was told she had to take medication. In talking about her experiences with me, she was able to take control of her care and have meaningful discussions with those caring for her which resulted in her controlling her diabetes through diet alone. Sophie talked of feeling empowered to take a more active role in her care following recruitment to the study and Jasmine who was deemed to be a defaulter and disengaged with her care felt empowered to make healthier life style choices. Shaw (2013) proposes that an outcome of resistance is empowerment which

enables women to have control over their bodies which is supported within the findings.

9.7 Conclusion

This chapter has presented the substantive grounded theory 'multiple dimensions of self' to explain women's experiences of choice, consent and control throughout pregnancy, childbirth and the early postnatal period when they book with a BMI of 35 or over. This theory has been developed and underpinned by the theory of Goffman, Foucault and Beauvoir. Consideration of how this grounded theory intersects with the wider literature has also been considered. This chapter offers a new and original perspective in considering women's experiences through the lens of the self.

The following chapter will consider the original contribution this study offers and the strengths and limitations of the study. It will also discuss the implications for policy, practice and further research.

CHAPTER 10

EVALUATION, STRENGHS, LIMITATIONS, AND RECOMENDATIONS

10.0 Introduction

This thesis set out to answer the question What are women's experiences of their maternity care when they present in pregnancy with a BMI of 35 kg/m² or above? The question arose in relation to current maternity services policy and practice in the UK and whether women are active participants in and are able to make informed decisions about their care. It collectively considered women's accounts of their management and care throughout the pregnancy continuum, exploring women's experiences of choice, consent, and control. Three original research components were presented. First, a meta-narrative review showing the evolvement of maternal 'obesity' discourses over time and between research disciplines was undertaken to establish how women's experiences have been studied and how their choice, consent, and control has been impacted. Second an empirical study was conducted. This study used a longitudinal constructivist grounded theory approach, adopting poststructuralist feminist methods to answer the central question to this thesis. Third, a theoretical interpretation of the study findings was undertaken drawing on the work of Erving Goffman, Michel Foucault, and Simone De Beauvoir. From this, a substantive grounded theory of 'multiple dimensions of self' was developed and presented. In this chapter I begin by evaluating the substantive theory using Charmaz's (2014) evaluation criteria for grounded theory studies. This will consist of examining credibility, originality, resonance, and usefulness. It also presents the studies strengths and limitations as well as offering recommendations for policy, practice, education, and further research.

10.1 Evaluating the substantive grounded theory

As proposed by Charmaz (2014, p.338): 'A strong combination of originality and credibility increases resonance, usefulness, and the subsequent value of any contribution.' As previously discussed, methodological rigor was addressed using these criteria (see Chapter 5, 5.12). In order to demonstrate that this study is of

high quality, the four criteria are further explored below providing evidence to support this.

10.1.1 Credibility

In conducting this study, the depth and range of data collected was sufficient in order to support the substantive grounded theory. This was achieved by undertaking a longitudinal study, which enabled data to be collected and analysed in real time, with recruitment ongoing until 'theoretical sufficiency' was obtained as proposed by Dey (1999, p.257) and discussed in Chapter 5 (5.2.1). Examples of coding, memoing and mapping are included in this thesis (see Chapter 5), as well as direct quotes from participants (see Chapter 7) and illustrations of theory building (see Chapter 5, 7, 8 and 9), which all serve to support credibility. Strong, logical relationships between the data and subsequent generated substantive grounded theory have been made, demonstrated from the consideration of the findings in Chapter 7, through development of further understanding in Chapter 8 and discussions of the substantive grounded theory in Chapter 9.

The findings were co-constructed with the participants through prolonged engagement and interparticipant theoretical sampling as discussed in Chapter 5. My own personal views were explored through keeping a reflexive diary, discussions with peers and supervisors and demonstrated through the reflexive narrative provided throughout this thesis.

10.1.2 Originality

In considering the existing literature on the experiences of women living with 'obesity' and maternity care, this study's original contribution has extended understanding and added to the body of knowledge in this field. It has done this in a unique way, through theorising. This study's original contribution also steams from the unique focus on both maternal 'obesity' and choice, consent, and control, undertaking a meta-narrative review, the research design using a modified grounded theory approach (Chapter 4 and 5) and the subsequent

substantive grounded theory generated (as discussed in Chapter 9) from the research findings (Chapter 7). This study appears to be the first to consider choice, consent, and control exclusively in relation to maternal 'obesity' as well as being one of only a few studies focusing on women with a BMI of 35 or above. There are few studies considering the phenomena in question using a longitudinal approach to data collection, therefore this study provides a complete picture of women's experiences across the pregnancy continuum. It is also the first study to be undertaken exploring women's experiences of management and care in the locality studied, which has one of the highest 'obesity' rates in England. I could find no evidence of other poststructuralist feminist grounded theory studies being undertaken with regards to the phenomena being studied, although grounded theory as an approach is a well-established methodology used within health care (Mediani, 2017; Watling and Lingard, 2019). Undertaking a grounded theory approach to this study is unique, as to the best of my knowledge both women's experiences living with 'obesity' and their pregnancy journey, nor choice, consent and control in maternity have been explored through a constructivist grounded theory approach and theory generation. In generating new theory of 'multiple dimensions of self', this study has offered insights into how self impacts on choice, control, and consent. It is particularly illuminating in how it highlights that women who live with 'obesity' expect to be treated negatively and differently to other women and how this is internalised. Although self has been considered by others in relation to motherhood (De Groot and Vik, 2021) and 'obesity' (Williams and Annandale, 2019), I could find no evidence of studies considering the effect of self in relation to maternal 'obesity'. This study therefore offers a differing perspective on maternal 'obesity', one of the psychology of self. This is particularly useful in raising awareness for maternity care providers when planning and implementing maternal 'obesity' care.

10.1.3 Resonance

Resonance was ensured by undertaking a longitudinal study where multiple in-depth interviews were conducted. The participants were selected based on them

being best placed to inform the study. Their situated knowledge being central to understanding their lived experiences. By including extensive quotes in the findings in Chapter 7, the women's narratives were captured. As the study progressed, I shared my findings with them to ensure my analysis was true. Substantive grounded theory was constructed (Chapter 9) offering insights into the 'multiple dimensions of self' which may resonate and be applicable to other women living with 'obesity'. The substantive grounded theory generated from this study may also be transferable to other groups of marginalised women who access maternity services within the UK.

10.1.4 Usefulness

Usefulness according to Charmaz (2014) implies that the study has led to theoretical interpretations that can be used to inform the lives of others as well as contributing to the existing body of knowledge to inform ways of improving people's lives. As stated in the originality section (see 10.1.2 above), this study adds to the existing body of knowledge as well as offering a different perspective 'multiple dimensions of self' to inform policy and practice which will improve the lives of women who have 'obesity'. It offers health professionals an alternative viewpoint by highlighting how they, maternity service provision, and the wider social and cultural constructs surrounding 'obesity' can positively or negatively impact on women's sense of self. Although the psychosocial impact of maternal 'obesity' has been raised as a concern by others (Furness et al., 2001; Heslehurst et al., 2011) this study develops this further by endeavoring to understand women's experiences through perceptions of self and the effect this has on choice, consent, and control. By understanding the deep-rooted beliefs women hold about themselves and how this manifests itself through societal, cultural, and medical discourses this study offers a way to truly understand the lived experiences of women who have 'obesity' and how this impacts on choice, consent, and control. In considering usefulness, recommendations for policy, practice, education, and further research is presented in section 10.3. First, however, in concluding my evaluation of the study its strengths and limitations will be examined.

10.2 Strengths and limitations of the study

This study's strengths lie in the original contributions to the subject of maternal 'obesity', choice, consent and control in maternity care and psychology of self as well as how this intersects with feminist literature on 'obesity' and childbirth. Being a longitudinal study, it captured women's experiences across the pregnancy continuum which adds to its strengths. It allowed me to follow the women throughout all or part of their pregnancy, with data captured in real time. Added to this, patterns that emerged as I analysed the data could be further explored with the women, particularly through interparticipant theoretical sampling. A transparent approach was adopted in undertaking the research, with a clear evaluation offered to support trustworthiness, further strengthening the work.

The limitations of this study centre around the design and recruitment. First, a limitation was highlighted in the inclusion and exclusion criteria. The upper age of 45 years as a recruitment cut off point was found to be arbitrary as previously discussed and reflected upon in Chapter 5 (5.5). Second, the study was designed to undertake interviews with participants across the pregnancy continuum at around 12 weeks gestation, 24-28 weeks gestation, 34-36 weeks gestation and six weeks postnatal. The reason for this was to capture women's experiences at pivotal points across the continuum where increased medical intervention was offered in line with current policy and practice (Denison et al., 2018). This was to enable interviews to take place nearer to the time of care received to capture experiences in a timely manner.

Only three women were actually recruited in early pregnancy, with only two undertaking the full four interviews. Most of the women were recruited at 24 weeks gestation when they attended for diabetic screening. Several reasons could be attributed to this. First, I was reliant on community midwives giving out information packs to women at booking and found that many midwives forgot, or were selective in who they gave packs to, thinking that they were helping by only giving packs to those who they felt might engage. Wanat (2008) suggests

that time constraints, understanding of the study and the relationship the potential participant has with recruiters can slow down recruitment, which may have contributed in this instance. Second, it is well recognised that health information overload is an issue in health care (Khaleel et al., 2020), perhaps getting an information pack about the research at booking was too early for women to give thought to being part of the study. By 24 weeks of pregnancy women seemed more receptive to engaging with the study, which may also be reflective of the fact that I personally attended clinics in order to recruit. Having a face-to-face conversation with women yielded the majority of participants, which suggests that face to face contact with the researcher offers an opportunity for the participant to build a relationship prior to committing to be interviewed, which is supported in the literature (Ekambareshwar et al., 2018; Felson et al., 2010; Liu et al., 2020). Also, the women did not have to think about having to take the initiative to reply to me on receiving an information pack, thus taking away a barrier through minimalising effort.

Eleven women were recruited to the study in total. It could be argued that being a small sample size the findings cannot be representative of the wider maternal 'obese' population and therefore cannot be generalised. In saying this however, given the 'obesity' discourses that exist throughout society these women's experiences may resonate and align with similar groups, both in terms of 'obesity' management but also with other women who are labelled as 'high risk' in pregnancy.

Another consideration is the sensitivity of the topic studied which may have hindered recruitment. Research suggests that shame and fear of stigmatisation may be a barrier to recruitment, with face-to-face interviews generating worries of being judged negatively by the researcher (Furber and McGowan, 2010; Tierney et al., 2010). Recruitment was slow and I was conscious that this could be due to the sensitivity of the topic acting as a barrier. I was also acutely aware that those women who participated in the study would carefully construct their conversation to justify their situation, steering conversations to deflect from

their own discomfort at times, denying me access to their true thoughts and feelings in order to protect themselves. Also, the women may have constructed their stories to meet the expectations of myself as the researcher and the research aims which may not actually represent their reality. This was counterbalanced by undertaking a longitudinal study as it allowed me to build up a relationship with the women (as discussed in Chapter 5, 5.8.2). I found at subsequent interviews the women were more relaxed and more open in their conversations which allowed the collection of rich data. This further strengthens the reasons for undertaking a longitudinal study.

All the women in the study identified as White British, reflective of the population in the locality studied. My criteria for inclusion/exclusion to the study excluded women if they did not speak sufficient English, therefore potentially reducing recruitment possibilities. It is well documented that recruiting ethnic minority groups to research can be problematic with language barriers (Gill et al, 2012), mistrust and social determinants of health (Vickers et al, 2012), all impacting on recruitment. The findings are therefore not representative of ethnic minority groups, and this is recognised as a limitation

As well as being White British, eight of the eleven women recruited had a BMI of 40 or over at booking. This may be representative of the rise of 'obesity' in recent years, however, this is a limitation as the study does not represent women evenly across the BMI range (35 or above). More research across the BMI range being studied may be needed to understand more fully these women's experiences.

A further observation in relation to the women recruited was the number of women who had, had a previous miscarriage as well as one woman who had a late miscarriage following recruitment to the study (n= 5). It could be argued that having had a previous miscarriage (or complications in previous pregnancies for that matter) may have influenced how these women perceived their care and the choices they made particularly with regard to wanting the best for their baby

(See Chapter 7, 7.4.7). Added to this, miscarriage has been found to be increased for women with a higher BMI, therefore its significance is important. In this study comparisons although commented on were not specifically made, and this is recognised as a limitation. Further analysis of this has been prioritised for post doctorate study.

Theoretical sampling was not utilised effectively due to ethics approval being granted before constructivist grounded theory methodology had been decided upon. A modified constructivist grounded theory methodology was therefore developed in order to meet the study aims while working within ethics approval processes. This is a limitation as it was apparent as the data were collected and analysed that undertaking interviews with other health professionals to understand their perceptions of management and care in conjunction with understanding the experiences of women would have provided a deeper insight into women's perceived experiences. In defense of this, however, interparticipant theoretical sampling provided rich data and comparisons between women's experiences, therefore could be considered a strength. Also, by modifying my approach it could be argued that this has moved on grounded theory methodology. Charmaz (2014) promotes this, suggesting that although the principles of grounded theory should remain the same, development and modification should occur, with grounded theory methodology being a continual evolving methodology.

Finally, it needs to be recognised that throughout the study my own pre-understandings may have overtly affected the quality of the research undertaken. My previous knowledge and understanding of maternal 'obesity' care was difficult to set aside as well as living as an overweight person with my own experiences of weight prejudice. To reduce bias, throughout this thesis I have engaged in offering a reflexive account of my journey. I have also shared insights and interpretations with my supervisors, gained peer reviewed feedback as well as discussed my findings with the women to ensure truthfulness and credibility. Added to this I have kept a reflective diary throughout. I recognise,

however, that unconsciously my views may have dominated certain aspects of the study.

10.3 Getting to the root of the issue rather than papering over the cracks: Recommendations for policy, practice, and further research.

The substantive grounded theory generated from this study has far reaching implications for policy, practice, and the education of health professionals. This study has highlighted that 'multiple dimensions of self' have a direct impact on choice, consent, and control. As such it is important for policy makers, health professionals and educationalist to ensure that the social, cultural, and medical discourses that impact on self is recognised and systems put in place to minimize the impact of these.

10.3.1 Policy

National policies promoting autonomy for women and legal and ethical frameworks surrounding choice, consent, and control as discussed in Chapter's 1 and 2 should be kept at the forefront of those who plan and deliver maternity services. This includes health professionals that provide direct care to women. Service users need to be actively involved in policy and guideline development at both local and national levels in order for their voices to be heard. Having engaged with Maternity Voices Partnership to disseminate my work and support their public health initiatives it is clear that women want to be actively involved in shaping maternity service provision. To date lobbying by women to be included in guideline development has proved unsuccessful in the locality this research was undertaken. I suggest service user involvement needs to be a priority, and in disseminating my work to health professionals this recommendation is stressed. It is unacceptable that women continue to be ignored when national policy shapers (Coulter and Collins, 2011, p.2) advocate that:

> *Shared decision-making explicitly recognises a patient's right to make decisions about their care, ensuring they are fully informed about the*

options they face. This involves providing them with reliable evidence-based information on the likely benefits and harms of interventions or actions, including any uncertainties and risks, eliciting their preferences and supporting implementation.

10.3.2 Practice

The substantive grounded theory proposed in this study has multiple implications for practice. The need for health professionals to be self-aware is paramount in understanding the 'multiple dimensions of self' that women living with 'obesity' present with during the pregnancy continuum. Found to be instrumental in developing positive relationships (Younas et al., 2020), self-awareness can be fostered through encouraging reflective practice, peer discussions and continuing professional development.

This study concurs with previous studies examining 'obese; women's experiences of maternity care that recommend that women are included in all discussions surrounding care and that an equal partnership is fostered through relationship building and positioning women at the centre of care (Heslehurst et al., 2011; Lavender and Smith; 2015, Mills et al., 2013). Current maternity transformation initiatives including the implementation of continuity of carer (NHS England, 2016) as discussed in Chapter 1 (1.3) and Chapter 2 (2.1), may go some way to address this, particularly in relation to those from lower-socio economic backgrounds who appear less likely to have a voice and therefore less likely to be able to negotiate care. It is well evidenced that continuity of carer improves outcomes for both women and their babies (Sandall et al, 2016). Adopting this approach where women presenting in pregnancy with a high BMI are cared for by a known midwife has the potential to positively impact on both outcome and experience, through the formation of positive relationships leading to shared decision making. However, to effectively implement continuity of carer, staffing levels, particularly retention and recruitment of midwives across England needs to be addressed, with the recent Ockenden Report (2022) recommending that midwifery continuity of carer be suspended because of concerns over safety due to poor staffing levels. Added to this, not all women may feel comfortable being

cared for primarily by one known midwife who they may not be able to relate to, so caution is needed.

Negative experiences appeared to be increased when women had multiple appointments at various maternity sites, seeing multiple health professionals adding to negative perceptions of self. Several women acknowledged that a more joined up approach to care was preferable with Sophie and Alice who were referred for diabetic care highlighting an improvement in experience once they were being seen in one place on one day. This may suggest the need for a one stop service approach to management and care where women can be seen by all concerned with their care in one place on one day. This would avoid the inconvenience of multiple appointments and fragmented care. It is acknowledged that some maternity services in England provide specialist clinics, although there is wide variation and inconsistencies in care provided (Fair, Marvi-Dowle, Arden et al, 2020). Where specialist clinics exist, they have been positively appraised, particularly in relation to reducing risk and supporting weight loss (Denison et al., 2017; Fair, Marvi-Dowle, Arden et al, 2020; Furness et al., 2011). This suggests that specialist clinics empower women to make positive changes which in turn may increase women's autonomy. Added to this, research suggests that providing specialist antenatal services for women who have morbid 'obesity' reduces the risk of stillbirth (Denison et al., 2017), further supporting the roll out of specialist clinics for pregnant women living with 'obesity'.

It needs to be acknowledged, however, that there are disadvantages to having a specialist clinic for pregnant women living with 'obesity'. Women may feel further marginalised through being asked to attend specialist clinics (Kirk et al, 2014, Heslehurst, Dinsdale, Sedgewick et al., 2015) as well as clinics risking being overwhelmed due to the increasing incidence of 'obesity' among the pregnant population. This study therefore calls for further research to be undertaken to ascertain the best approach to care, with women's views central in developing maternity services fit for purpose.

10.3.3 Education

On reflecting on the study findings, I was drawn to consider what education health professionals receive in human psychology. As a midwifery lecturer, I have to acknowledge that human psychology in our midwifery curriculum although evident is limited. A recommendation therefore is that higher education institutes offering medicine and health programmes ensure that students have a comprehensive understanding of human psychology in order to understand how self impacts on patient care. Opportunities also need to be given for students to explore their own sense of self and how this may impact on the care they provide.

Continual professional development for health professionals is needed for development of compassionate communication skills with consideration of the language used that may upset and offend. Strategies to instigate meaningful conversations with women around 'obesity', their risks as well as ensuring an in-depth knowledge of public health strategies and the actual risks associated with pregnancy and weight is needed. In an era where maternal 'obesity' is on the rise, with nearly 40% of women embarking on a pregnancy being either overweight or 'obese' by BMI definition in the UK (Public Health England, 2019), health professionals need to be educated to provide meaningful care at each contact. Education should also include a wider understanding of the social and cultural influences that affect women who live as 'obese' which would help to reduce stigmatisation, blame, and shame. Fostering positive relationships with women living with 'obesity' will reduce some of the negative dimensions of self, reducing feelings of marginalisation and increasing autonomy.

10.3.4 The need for further research

The findings from this study have highlighted the need for further research and should consider:

- A qualitative study exploring the experiences of women in relation to choice, consent and control who present as 'obese' in pregnancy across differing characteristics than those held by the women in this study. It is

important given the diversity of maternal 'obesity' that those across all ethnic groups are represented and their voices heard.

- A follow-up study involving purposeful recruitment of 'obese' pregnant women from both disadvantaged groups and non-disadvantaged groups to compare understandings of choice, consent, and control between the two.
- A follow up study considering specialist maternity services for women living with 'obesity' and the advantages and disadvantages of this.
- Research considering the language used by maternity health professionals that invokes feelings of blame and shame in women may identify the context of when and how these feelings arise. These insights could then be used to develop practical tools to further support health professionals knowledge and understanding in relation to self.
- Further research also needs to focus on the specific findings from this study particularly examining the 'multiple dimensions of self' and how these can be addressed to ensure equity of care, which is woman centered, an area which may not have come to light if constructivist grounded theory had not been utilised.

10.5 Conclusion

This chapter has evaluated this poststructural feminist ground theory study, considering credibility, originality, resonance and usefulness. The studies strengths and limitations have been discussed with recommendations for policy, practice, education, and further research. As a final conclusion the following chapter will present through a reflexive narrative, 'self'. In tribute to the amazing women who allowed me during a poignant time in their lives to understand their experiences I feel it is only fitting to portray my own self in the context of this work.

CHAPTER 11

SELF

11.1 Introduction

This concluding chapter provides a reflexive account of my own background which has influenced this study. I cannot separate myself from this work and as such have acknowledged below my own preconceptions of how my life has been shaped through my own struggles with weight and my feminist positioning. I conclude by presenting my lived experiences while undertaking this study, how I have been changed both personally and professionally and how the work has been disseminated in the hope that it makes a difference to women's lives.

11.2 Step away from the cake!

Understanding of the wider social and political constructs around 'obesity' has made me reflect on my own experiences of yo-yo dieting. The amount of money I have spent in my adult life on diet food stuffs, the countless joining of diet groups with the initial euphoria of losing weight and then the inevitable sense of failing when the weight loss was unsustainable, with the subsequent guilt and self-loathing has been palpable. I do not consider myself as vulnerable, being a white middle-class well-educated and privileged woman, yet I have spent years on the same treadmill (literally) trying to conform to societies expectations of being 'thin', equating 'thin' with being healthy. I and many like me have been drawn into this illusion, constantly trying to self-improve in the belief that I have a free choice. Public Health messages from a 'nanny' state feed into this illusion, who through biomedical constructs take it up on themselves to feed me constant reminders that I am not a good enough citizen because I can't keep away from the cake! I am a wife, a mother, sister, daughter, midwife, working hard to provide a better life for my loved ones, busy juggling what society expects of me as a woman, with the added burden of trying to achieve a 'normal' body mass index. Part of me is angry that I have been sucked in by a capitalist system, bearing the responsibility for my failings through societies neoliberal attitudes towards weight, yet part of me feels empowered to throw

away the diet books, feeling the solidarity with the women interviewed in *Fat Lives* by Tischner (2013) whose voices have resonated strongly with me. Drawing on these interviews in Chapter 5, *Health, well-being and the responsible fat woman* Tischner found that:

> *….health and life were construed as a lot more complex than just looking after one's weight….The multiple and dynamic subject positions taken up and rejected by the women, entrenched not only in the discourses of health and weight, but also in those of familial commitment, time pressures and economic circumstances, also draw attention to the inappropriateness of the ill-conceived health promotion strategy of targeting certain sectors in the population delineated by their body mass index only.*
> (Tischner, 2013, p.93)

Can I have my cake and eat it? Probably not, but a deeper understanding of the complexities surrounding the 'obesity' phenomena in Western society has certainly given me opportunity to reflect and be more accepting of self. Reflecting on my own experiences has allowed me to explore my own prejudices and reveal any contestation in order to minimise bias as I navigated through my PhD journey.

11.2 Feminism- So, what?

My Great Grandmother was involved in the Suffrage movement, a strong independent woman who ran a post office and grocery store in the impoverished dockland area of her hometown. She was also the first woman in the area to stand for the local council elections. Although not elected, her legacy lives on through our family 'folklore', and a woman to live up to in a family dominated by women.

I was a child of the 1970s and early 1980's from a working-class background, my mother stayed at home raising me and my four sisters and my father was a miner. One of my earliest recollections of inequality and thinking how unfair

women were treated was when my older sister[27] expressed an interest to my father of wanting to go down the mine. Women weren't allowed 'down't pit' and anyway 'it was man's work'. Some years later when recalling my sisters desire to follow in her father's footsteps he told us how grateful he was that he had daughters and no sons. He followed his forefathers into mining and would have hated to have had a son who would have followed in his footsteps. He said the work was hard, gruelling and the pay poor (although we always had an endless supply of coal for the fire). I remember feeling a little affronted at this, so as a woman I couldn't do a man's work. However, I understood his viewpoint was borne out of love and in some ways my father was (and still is) a feminist, with five daughters he perhaps has had little choice, but he has always advocated for us and pushed us to reach our potential, being a firm believer in education as the key to a better life, something that was not afforded to him.

Growing up in the 70's and 80's and being exposed to the fight for women's equality as second wave feminism swept Western society has certainly influenced my own perspectives. I grew up being exposed to 'Women's Lib', with Germaine Greer being the feminist my friends and I as young girls had heard of, buying into the concept of not having to conform to a patriarchal society. We could be who we wanted to be, not defined my societal expectations of being 'good', getting married, having children. The World was ours to take. Although in recent years Greer has been controversial, with many modern feminists distancing themselves from her stance, she was for me an early influence that shaped some of my own values and beliefs. Greer was of her time, defined by the female politics of the era, a time when women could not get mortgages or credit cards without their husbands or fathers signature, condemned to a future of marriage and motherhood. This attitude was universal; my mother often recalls my grandmother buying a home appliance and my father (apologetically) having to sign the hire purchase forms for her to be able to get credit. This was a woman who had raised my mother on her own following divorce, working in

[27] My sister did get to go down the mine, although just for a visit, before it eventually closed in the mid-80s.

fulltime employment, owning outright her own home. This still shocks and angers me.

When I was younger, I would identify as a Liberal Feminist. A firm believer in equality for women. This has evolved into wanting equality for all and the notion that everyone is unique, each coming from different standpoints. I feel this shift of thinking over time (and no doubt influenced by life experience) makes me identify as a postmodernist feminist.

Ironically, I went on to qualify as a nurse and then a midwife (woman's work) although I have always felt working in a female dominated environment has enabled me to advocate for women and with women. Mary Wollstonecraft, whose a *Vindication of the Rights of Women* (1792) was often quoted by a (now retired) head of midwifery who I had the pleasure of working with in her pursuit to rally midwives in advocating for women. She also likened being an advocate for women as having the courage of Emily Pankhurst in her pursuit of votes for women in the UK during the late 19th and early 20th Century. Her passion has stayed with me although empowering women to make informed choices has often been difficult due to policy and practice being entrenched in a male dominated medical model of care provision as discussed in my work.

My career has seen me work closely with marginalised women that I have found are further discriminated against by virtue of being from marginalised groups, unable to navigate the medicalised management of pregnancy and childbirth, their voices unheard. It is hoped this study has given a voice to women who present in pregnancy with a BMI of 35 or above, who are often marginalised by society, their bodies scrutinised and put under increased surveillance during pregnancy and birth limiting choice, consent and control.

11.3 It's not over until the fat lady sings

As my supervisors will vouch, one of the biggest challenges for me in undertaking this PhD was time. I was under no illusion that this venture would be hard work. I

had been forewarned by those who had gone before me of the trials and tribulations, as well as the euphoric eureka moments and joy of immersing oneself in studying ones passion. It has been a roller coaster of a ride though, highs and lows, tears of frustration, coupled with tears of happiness when suddenly a light bulb would go off in my head (usually at 2am in the morning, which saw me resort to having notepad and pen next to the alarm clock to record my early hours musings). Time though has often alluded me. Pulling me in many directions, from personal to professional, always there ticking away, with me ever conscious of it running out.

My two daughters were 11 and 15 years old when I set out on this journey in 2015. I thought with them being older this was the ideal time to study, however puberty, GCSEs, A Levels and moving off to university, and the adolescent angst which accompanies those things meant they needed me more than ever. Added to this, the global pandemic, COVID-19, made for at times a white-knuckle ride. We all survived though. Everyone was kept fed, warm, safe, supported, cajoled, moved from one student flat to another, and time moved on.

The next biggest challenge of my PhD journey was the frustration of not understanding. Someone once told me that 'you don't know what you don't know' and this became my mantra throughout. I would say it over and over as I read and read until such time I did know. At which point I then moved on to the next 'you don't know what you don't know', slowly building on my knowledge and understanding. I also downloaded a dictionary app, as every other word I encountered I either could not pronounce, did not understand, or could not spell.

Understanding the underpinning feminist and philosophical theory was particularly challenging. I thought I knew something about feminism, I now know I knew nothing. Also, as I began to know and understand, I found myself questioning many aspects of my own life. I realised that I often unconsciously colluded with patriarchy both personally and professionally, yet consider myself

forward thinking, independent and strong. I never realised how much I had been conditioned to think and act in order to conform to societal expectations of me as a mother, wife, and woman. I have acquired knowledge that has also made me scrutinise my own sense of self, my front stage and backstage, my conscious and unconscious. Foucault particularly messed with my head, and I am unable to watch or read current affairs without notions of power and governmentally swirling around my brain, and the frustrations that brings. I cannot however undo what I now know, so will be forever changed.

Data collection was both challenging and rewarding. I felt an affinity with the women I interviewed and a deep desire to ensure their stories were heard. I was extremely privileged to be part of their pregnancy and childbirth journey and never once took that for granted. I laughed with them, I cried with them, I walked in their shoes. I had hoped I would never lose sight of that, but there were occasions when coding the data, I felt I was reducing them to objects to be studied. On those occasions I perceived I was letting them down. This has not been comfortable for me.

On reflection, I have constantly worried that constructed grounded theory perhaps was not the most appropriate methodology to use. I wanted to tell the women's stories and constructive grounded theory may have hindered that. Having said that using constructive grounded theory enabled me to look beyond the story, by generating theory from the data it led me down the path to conceptualising the 'multiple dimensions of self' which I feel goes far beyond the lived experience which would have been captured through using an alternative methodology.

There was so much more I wanted to talk about in this thesis, which would have given further insight into maternal 'obesity' and the women's lived experiences, but this would have taken me away from my original aims. I have been able, however, to discuss my work at various forums, most notably within the study locality, at the local Maternity Voices Partnership. Talking to users of the service

as well as practice staff and local council public health advisors, generated further discussion and debate and my work has been taken forward for further consideration on how to improve services for women with high BMI. I believe this is where the work needs to be disseminated, supporting women and those who provide services to women to implement change to maternity services at grass roots level. One of the participants from the study was able to attend one of my talks and afterwards spoke to me about how pleased she was that the research she had been involved in was being a driver for change. For me, this is what I had hoped to achieve, and if my work makes a difference to one woman, then job done.

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APPENDICES

Appendix A: Criteria for appraising qualitative research studies (Walsh and Downe, 2006, p. 114-115)

Stages	Essential Criteria	Specific Prompts
Scope and purpose	Clear statement of, and rationale for, research question/aims/purposes	Clarity of focus demonstrated Explicit purpose given, such as descriptive/explanatory intent, theory building, hypothesis testing Link between research and existing knowledge demonstrated
Design	Study thoroughly contextualised by existing literature Method/design apparent, and consistent with research intent	Evidence of systematic approach to literature review, location of literature to contextualise the findings, or both Rationale given for use of qualitative design Discussion of epistemological/ontological grounding Rationale explored for specific qualitative method (e.g. ethnography, grounded theory, phenomenology) Discussion of why particular method chosen is most appropriate/sensitive/relevant for research question/aims Setting appropriate Were data collection methods appropriate for type of data required and for specific qualitative method? Were they likely to capture the complexity/diversity of experience and illuminate context in sufficient detail? Was triangulation of data sources used if appropriate?
Sample strategy	Sample and sampling method appropriate	Selection criteria detailed, and description of how sampling was undertaken Justification for sampling strategy given

		Thickness of description likely to be achieved from sampling Any disparity between planned and actual sample explained
Analysis	Analytic approach appropriate	Approach made explicit (e.g. Thematic distillation, constant comparative method, grounded theory) Was it appropriate for the qualitative method chosen? Was data managed by software package or by hand and why? Discussion of how coding systems/conceptual frameworks evolved How was context of data retained during analysis Evidence that the subjective meanings of participants were portrayed Evidence of more than one researcher involved in stages if appropriate to epistemological/theoretical stance Did research participants have any involvement in analysis (e.g. member checking) Evidence provided that data reached saturation or discussion/rationale if it did not Evidence that deviant data was sought, or discussion/ rationale if it was not
Interpretation	Context described and taken account of in interpretation Clear audit trail Data used to support interpretation	Description of social/physical and interpersonal contexts of data collection Evidence that researcher spent time 'dwelling with the data', interrogating it for competing/alternative explanations of phenomena Sufficient discussion of research processes such that others can follow 'decision trail' Extensive use of field notes entries/verbatim interview quotes in discussion of findings Clear exposition of how interpretation led to conclusions
Reflexivity	Researcher reflexivity demonstrated	Discussion of relationship between researcher and participants during fieldwork Demonstration of researcher's influence on stages of research process Evidence of self-awareness/insight Documentation of effects of the research on researcher

		Evidence of how problems/complications met were dealt with
Ethical dimension	Demonstration of sensitivity to ethical concerns	Ethical committee approval granted Clear commitment to integrity, honesty, transparency, equality and mutual respect in relationships with participants Evidence of fair dealing with all research participants Recording of dilemmas met and how resolved in relation to ethical issues Documentation of how autonomy, consent, confidentiality, anonymity were managed
Relevancy and transferability	Relevance and transferability evident	Sufficient evidence for typicality specificity to be assessed Analysis interwoven with existing theories and other relevant explanatory literature drawn from similar settings and studies Discussion of how explanatory propositions/emergent theory may fit other contexts Limitations/weaknesses of study clearly outlined Clearly resonates with other knowledge and experience Results/conclusions obviously supported by evidence Interpretation plausible and 'makes sense' Provides new insights and increases understanding Significance for current policy and practice outlined Assessment of value/empowerment for participants Outlines further directions for investigation Comment on whether aims/purposes of research were achieved

Each study is graded using the following grading system developed by Walsh and Downe (2006)

A= No or few flaws. The study credibility, transferability, dependability and/or confirmability are high.
B= Some flaws, unlikely to affect the credibility, transferability, dependability and/or confirmability.

C= Some flaws that may affect the credibility, transferability, dependability and/or confirmability.
D= significant flaws that are likely to affect the credibility, transferability, dependability and/or confirmability.

Appendix B: Quality assessment tool for quantitative studies

COMPONENT RATINGS

A) SELECTION BIAS

(Q1) Are the individuals selected to participate in the study likely to be representative of the target population?

1 Very likely

2 Somewhat likely

3 Not likely

4 Can't tell

(Q2) What percentage of selected individuals agreed to participate?

1 80 - 100% agreement

2 60 – 79% agreement

3 less than 60% agreement

4 Not applicable

5 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

B) STUDY DESIGN

Indicate the study design

1 Randomized controlled trial

2 Controlled clinical trial

3 Cohort analytic (two group pre + post)

4 Case-control

5 Cohort (one group pre + post (before and after))

6 Interrupted time series

7 Other specify _____

8 Can't tell

Was the study described as randomized? If NO, go to Component C.
No Yes

If Yes, was the method of randomization described? (See dictionary)
No Yes

If Yes, was the method appropriate? (See dictionary)

No Yes **RATE THIS SECTION**	**STRONG**	**MODERATE**	**WEAK**
See dictionary	1	2	3

C) CONFOUNDERS

(Q1) Were there important differences between groups prior to the intervention?
1 Yes

2 No

3 Can't tell

The following are examples of confounders:
1 Race

2 Sex

3 Marital status/family

4 Age

5 SES (income or class)

6 Education

7 Health status

8 Pre-intervention score on outcome measure

(Q2) If yes, indicate the percentage of relevant confounders that were controlled (either in the design e.g., stratification, matching or analysis)?
1 80 – 100% (most)

2 60 – 79% (some)

3 Less than 60% (few or none)

4 Can't Tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

D) BLINDING

(Q1) Was (were) the outcome assessor(s) aware of the intervention or exposure status of participants?

1 Yes

2 No

3 Can't tell

(Q2) Were the study participants aware of the research question?

1 Yes

2 No

3 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

E) DATA COLLECTION METHODS

(Q1) Were data collection tools shown to be valid?

1 Yes

2 No

3 Can't tell

(Q2) Were data collection tools shown to be reliable?

1 Yes

2 No

3 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

F) WITHDRAWALS AND DROP-OUTS

(Q1) Were withdrawals and drop-outs reported in terms of numbers and/or reasons per group?

1 Yes

2 No

3 Can't tell

4 Not Applicable (i.e. one time surveys or interviews)

(Q2) Indicate the percentage of participants completing the study. (If the percentage differs by groups, record the lowest).

1 80 -100%

2 60 - 79%

3 less than 60%

4 Can't tell

5 Not Applicable (i.e. Retrospective case-control)

RATE THIS SECTION	STRONG	MODERATE	WEAK	
See dictionary	1	2	3	Not Applicable

G) INTERVENTION INTEGRITY

(Q1) What percentage of participants received the allocated intervention or exposure of interest?

1 80 -100%

2 60 - 79%

3 less than 60%

4 Can't tell

(Q2) Was the consistency of the intervention measured?

1 Yes

2 No

3 Can't tell

(Q3) Is it likely that subjects received an unintended intervention (contamination or co-intervention) that may influence the results?

1 Yes

2 No

3 Can't tell

H) ANALYSES

(Q1) Indicate the unit of allocation (circle one)
community organization/institution practice/office individual

(Q2) Indicate the unit of analysis (circle one)
community organization/institution practice/office individual

(Q3) Are the statistical methods appropriate for the study design?
1 Yes

2 No

3 Can't tell

(Q4) Is the analysis performed by intervention allocation status (i.e. intention to treat) rather than the actual intervention received?
1 Yes

2 No

3 Can't tell

GLOBAL RATING

COMPONENT RATINGS
Please transcribe the information from the gray boxes on pages 1-4 onto this page. See dictionary on how to rate this section.

		STRONG	MODERATE	WEAK	
A	Selection bias	1	2	3	
B	Study design	1	2	3	
C	Confounders	1	2	3	
D	Blinding	1	2	3	
E	Data collection method	1	2	3	Not applicable

GLOBAL RATING FOR THIS PAPER (circle one):

1 STRONG (no WEAK ratings)
2 MODERATE (one WEAK rating)
3 WEAK (two or more WEAK ratings)
With both reviewers discussing the ratings:
Is there a discrepancy between the two reviewers with respect to the component (A-F) ratings?

No Yes
If yes, indicate the reason for the discrepancy

1 Oversight

2 Differences in interpretation of criteria

3 Differences in interpretation of study

Final decision of both reviewers (circle one): 1 STRONG, 2 MODERATE, 3 WEAK

Quality Assessment Tool for Quantitative Studies (2009) At:
http://www.ephpp.ca/PDF/Quality%20Assessment%20Tool_2010_2.pdf
[Accessed 31 March 2017]

BMI at antenatal booking appointment	At booking appointment -ideally before 10 weeks of pregnancy	At 24-28 weeks of pregnancy	At 28-36 weeks of pregnancy	Labour/birth	Postnatal period
BMI 35 or above	Discuss diet and eating habits Dietetic advise should be given by an appropriately trained professional Discuss exercise- 30 minutes per day Arrange Vitamin D 10mcg for throughout pregnancy Arrange Folic Acid 5mg until 12 weeks of pregnancy Discuss antenatal complications including VTE, gestational diabetes, hypertension, abnormal fetal growth and undiagnosed fetal abnormality Offer antenatal chromosomal anomaly screening giving women advice that these tests are slightly less effective with a raised BMI Referral for consultant led care Discuss place of delivery Arrange scans at 28/34 weeks Assess additional risk factors for pre-eclampsia Consider Aspirin if more than one moderate risk factor for pre-eclampsia Thromboprophylaxis if three or more risk factors for VTE Arrange Glucose Tolerance Test Use appropriate size cuff for blood pressure measurements for all appointments	Discuss infant Feeding and promote breastfeeding Discuss possible intrapartum and postnatal complications including VTE, Slow labour progression, Difficult fetal monitoring, anaesthesia, Shoulder dystocia, Emergency caesarean section, Primary postpartum haemorrhage, Wound infection, stillbirth Undertake Oral Glucose Tolerance Test for gestational diabetes	Consider re-weigh in third trimester Growth scans at 28 and 34 weeks	Weigh on admission Advise antacids Advise active management of third stage of labour to reduce incidence of PPH Inform theatre staff if weight above 120kg and operative delivery indicated Discuss elective induction of labour at term as it may reduce the chance of a c-section Where macrosomia is suspected consider induction of labour Offer prophylactic antibiotics if c-section as at increased risk of wound infection	Anti-embolism stockings and early mobilisation If receiving antenatal thromboprophylaxis continue for six weeks post delivery Thromboprophylaxis for 7 days postnatal if one or more additional risk factors Encourage breastfeeding Discuss diet and exercise If gestational diabetic arrange Oral Glucose Tolerance Test at 6 weeks postnatal. Offer support to lose weight and referral to weight management services

	Screen for mental health problems throughout pregnancy as women with a high BMI are predisposed.				
BMI 40 or above	As above **Plus** Refer for anaesthetic review Advise delivery in a consultant led unit	As above	As above **Plus** Assessment by anaesthetist Manual handling assessment if required Documented risk assessment in third trimester to consider tissue viability	As above **Plus** Inform senior obstetrician of admission. Senior obstetrician to attend for operative, assisted delivery On call anaesthetist to be informed of admission Lead midwife to ensure bariatric equipment is readily available if needed Tissue viability assessment undertaken Consider continuous fetal monitoring IV access in early labour and consider siting a second cannula	As above **Plus** Thromboprophylaxis for a minimum of 7 days postnatal regardless of mode of delivery and for six weeks if multiple risk factors

Appendix C: Care pathway for women with a booking BMI of 35 or above during pregnancy, birth and early postnatal period. Policy and practice. Taken from Local Trust Guidelines (2018), Dennison et al. (2018), and NICE (2010) and amalgamated.

Appendix D: Letter for community midwife

Dear Community Midwife,

I am a Senior Lecturer in Midwifery and qualified Midwife working at the University of Cumbria. I am currently undertaking a PhD via MPhil at the University of Central Lancashire (UCLan).

My research study focuses on maternal obesity and seeks to explore women's experiences of their management and care throughout the pregnancy continuum with particular regard to issues of choice, control and consent. My research aims to consider maternal obesity through a feminist lens and will use feminist methodology in its approach.

This research study is being supervised by Dr. Carol kingdon, Lead Supervisor, Dr. Gill Thomson and Prof. Fiona Dykes from UCLan. I have support from XXXXX, Associate Director of Midwifery at XXXXX and I am being supported in the Trust by XXXXX, Consultant Midwife and XXXXX, Research midwife.

I will be undertaking a longitudinal study commencing in January 2018, which will involve undertaking four interviews with women at around 12 weeks of pregnancy, at 28 weeks, 36 weeks and six weeks postnatal. I am looking to recruit women between the ages of 18 and 45 years who have a booking BMI of 35 or above, have a singleton viable pregnancy, can speak English and give informed consent.

I kindly ask if you would be able to support me in this research my giving out an information pack to all women that present at your booking clinic that meet the above criteria.

Prior to each interview I would like to contact you to ensure nothing has changed with regard to the women's pregnancy/birth which would make it inappropriate to carry on with the study.

Should you require further information regarding this study, I can be contacted at XXXXX or on XXXXX.

Your support for this research is greatly appreciated.

Your sincerely,

Appendix E: Participant covering letter

I am a Senior Lecturer in Midwifery and qualified Midwife working at the University of Cumbria. I am currently undertaking a PhD at the University of Central Lancashire (UCLan). I have an interest in public health in midwifery and for my PhD I am studying women's experiences of pregnancy and birth. I am particularly interested in the management and care throughout pregnancy, birth and following birth of pregnant women who book with a body mass index of 35 or above. I am currently undertaking research in this area, and I am looking to interview women about their experiences. The information sheet enclosed explains the research in more detail. If you would be interested in taking part or would like more information, please complete the response slip and return in the stamped addressed envelope enclosed.

Thank you.

Yours Faithfully

Christina Feltham

Appendix F: Participant information sheet

Exploring women's experiences of pregnancy and birth

I would like to invite you to participate in a research study exploring women's experiences of pregnancy, birth and the early weeks following birth. Before you decide if you would like to take part, please read the following information carefully and talk to others if you wish. If you need more information, please contact us on the contact details provided.

Why am I doing this study?

This study is part of my PhD, which I am undertaking at the University of Central Lancashire. As a midwife and midwifery lecturer, I have a specialist interest in public health in a maternity context and I am very interested in women's experiences of the management and care they receive in relation to their weight when they are pregnant, during birth and in the postnatal period after birth.

Why have you been asked to take part?

You have been asked to take part as you are currently pregnant, over the age of 18 and have a booking BMI of 35 or above.

What will taking part involve?

The aim is to recruit between 10 and 12 participants onto the study. There may be up to four interviews in total, but this may be less if the data needed is achieved sooner.

Interviews will take place at around:

o Your first scan appointment (approximately 12 weeks of pregnancy)

o 24-28 weeks of pregnancy

o 36 weeks of pregnancy

o Six weeks after the birth of your baby

The interviews are more like having a conversation and will last between 30-60 minutes and will take place at your local maternity unit, antenatal clinic or in your own home. I will contact you to arrange each interview by telephone.

The interviews will be informal and with your consent, they will be digitally audio recorded. During the interview, I will also take written notes to help me understand your experiences.

I will be asking you about your experiences of the maternity care you are receiving/have received as well as information about your age, body mass index (BMI), due date, type of birth, birth weight of your baby and how you are feeding your baby. I will also be asking you about any care you receive in relation to your BMI. BMI is the relationship between your weight and height, which is associated with how much body fat you have and how this may affect your health and the health of your baby. I will ask for consent to look at your medical records during the study to ensure you and your baby are well prior to each interview as well as to cross reference what you discuss with me at each interview with care you received. I would also like to collect data on your pregnancy outcome (type of birth, weight of baby, feeding). I will ask for your consent to access your medical records at each interview. All information you share with me during interview and from your medical records will be anonymised.

What will happen to my information?

All information you give will be kept confidential within the research team. Regulatory authorities may look at the information collected but this will be to check that the study is being carried out correctly.

All information you provide will be stored digitally on password protected/encrypted computer files at the University in line with the Data Protection Act (1998). All information will be anonymised using a code and any personal data will be stored separately. The interviews will be digital audio-recorded and will be transcribed by the Universities Research Report Team into a written document and then destroyed/deleted.

Direct quotes may be used in my dissertation, reports and any presentations I give. On all occasions, no identifiable information will be included to ensure your anonymity.

In line with UCLan data protection guidelines any identifiable data will be destroyed 6 months after the final data collection and anonymised data will be kept for no longer than five years and then will be destroyed/disposed of securely.

You will be able to remove your data from the study up until one month following the final interview.

When I have completed the study, I will produce a summary of the findings which I will be more than happy to send you if you are interested.

How much of your time will participation involve?

Four interviews lasting between 30 and 60 minutes each.

What are the advantages of taking part?

You may find the study interesting and enjoy answering questions about your experiences of the management and care you receive throughout your pregnancy, birth and after your baby is born.

Once the study is finished, it could provide information which is useful to maternity healthcare professionals and the care they provide and may help develop services in this area.

Are there any disadvantages of taking part?

It could be that you are not comfortable talking about your experiences, or you may get upset or distressed talking about your experiences. If you do feel uncomfortable talking about your experiences, you can stop the interview at any time, and I will advise you to seek support from your community midwife or GP. If you disclose any issues of harm or significant risk, then I will be professionally obliged to address these issues. If I feel you may need support from other services, I will signpost you to them e.g., GP, Community Midwife with your consent. Any issues with regards to poor care/practice will be forwarded to the Associate Director of Midwifery.

If you wish to make a complaint about the care you are receiving, I will direct you to the Associate Director of Midwifery for the Trust. If you wish to make a complaint about me (the researcher) details can be found at the end of this information sheet.

Do you have to take part in the study?

No, your participation in this study is voluntary. You are not obliged to take part; you have been approached because you have a BMI of 35 or above

If you do not wish to take part, you do not have to give a reason and you will not be contacted again. Taking part or not taking part will not affect the care you receive or your legal rights.

If you do agree to take part, you are still free to withdraw at any time during the study and without giving a reason. During the interviews, you do not have to answer all of the questions and can stop the interview at any time. You can also request to have your information removed from the study up until one month after the interview has taken place.

What happens now?

If you are interested in taking part in the study, please complete the attached response slip and return it to me in the pre-paid envelope provided, within 2 weeks of being given this information pack. Once I have received the slip, I will contact you, so we can arrange to meet at a time that is convenient for you.

What do I do if I have a complaint about this study?

If you have any concerns or complaints about this study, please contact the University Officer for Ethics at XXXXX or University of Central Lancashire at XXXXX

Contact details: Research Team

Researcher: Christina Feltham, PhD Student, University of Central Lancashire

E-Mail: XXXXX Tel: XXXXX

Director of Studies: Dr Carol Kingdon, Senior Research Fellow, School of Community, Health and Midwifery, University of Central Lancashire, Preston, PR1 2HE. E-Mail: XXXXXTel: XXXXX

Supervisor: Dr Gill Thomson, Senior Research Fellow, School of Community, Health and Midwifery, University of Central Lancashire, Preston, PR1 2HE. E-Mail: XXXXX Tel: XXXXX

Supervisor: Professor Fiona Dykes, Professor of Maternal and Infant Health, School of Community, Health and Midwifery, University of Central Lancashire, Preston, PR1 2HE

E-Mail: XXXXX Tel: XXXXX

PALS – The Patient Advice and Liaison Service:

XXXX

Thank you for taking the time to read this information sheet

Appendix G: Reply slip

If you are interested in taking part in this study, please fill in the details below and send to me in the stamped addressed envelope within two weeks of receiving this information. I will then contact you to arrange to meet to discuss the study, sign the consent form if you wish to participate and undertake the first interview.

Alternatively, you can contact me on the telephone number below or email me at:

XXXXX

Name……

Contact details

Telephone……..

Email address……..

Thank you

Christina Feltham

PhD Student, University of Central Lancashire

Tel: XXXXX

Appendix H: Distress protocol

Protocol for managing participant distress during interview

Distress Indicated	Response from researcher
• Participant states they feel stressed/ anxious/distressed • Participant shows/demonstrates behaviour consistent with increased stress/anxiety/distress e.g., crying, withdrawing, closed body language.	• Stop the interview • Offer immediate support • Review the situation • If participant able to carry on, resume interview • If participant unable to carry on with interview; terminate interview and encourage participant to contact their GP or community midwife • With participant consent offer to contact the participants community midwife for further advice and/or support • If in antenatal clinic, refer participant (with consent) for immediate support from midwife/appropriate available health professional • With participant consent follow up at a later date with a telephone call. • If participant indicates they do not want support, encourage them to contact their community midwife or GP if they experience any increase in stress/anxiety, ensuring they have appropriate contact details

Protocol for managing potential researcher/transcriber distress during interview and subsequent data collection and analysis

Managing researcher/transcriber distress
• The researcher should be aware of the possible physical and emotional effects of undertaking research which examines participants life experiences • The researcher will make regular contact with the supervisory team for debriefing • The researcher will use reflexivity to note own thoughts. Keeping a reflexive journal will be kept • The researcher will have contact details of UCLan support services e.g., Research Office, counselling services, supervisory team

- Any difficult interviews that have the potential to cause distress should be communicated to the transcriber to ensure that the transcriber is supported following UCLan health and safety at work policies
- A safe working environment will be provided following UCLan policies, including adherence to UCLan 'Lone Worker Policy'

Adapted from: Draucker, C B., Martsolf, D S., Poole, C. (2009) 'Developing Distress Protocols for Research on Sensitive Topics'. *Archives of Psychiatric Nursing* 23 (5) 343-350

Haigh, C., Witham, G. (2015) *Distress Protocol for qualitative data collection*. At https://www2.mmu.ac.uk/media/mmuacuk/content/documents/rke/Advisory-Distress-Protocol.pdf [Accessed 25th September 2017]

Appendix I: Consent form

CONSENT FORM

Title of Project: **Exploring women's experiences of pregnancy and birth**

Name of Researcher: Christina Feltham

Please read the following statements and initial the box if you agree.

Please initial box

1. I confirm that I have read the information sheet dated..... for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I agree to take part in four interviews over the course of my pregnancy and after my baby ☐

   has been born

3. I understand that I am free to leave the study at any time, at any time without giving any reason, without my midwifery/medical care or rights being affected. ☐

4. I understand that I will be audio recorded during the interview. ☐

5. I understand that I do not have to answer all of the questions during the interview(s) and can end the interview(s) at any time, and without giving a reason. ☐

6. I understand that I am able to withdraw my data/information from the study – however, this will only be possible up until one month following the interview. ☐

7. I understand that anonymised information and quotes collected during this study may be ☐

used within reports, publications or presentations, but I will not be identifiable.

8. I agree to my community midwife being informed of my participation in the study ☐

9. I understand that my information may be looked at by individuals from the University, ☐

from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in

this study. I give permission for these individuals to have access to this information.

10. I agree to the researcher having access to my medical records to cross reference aspects of the interviews with care reviewed as well as to check prior to each interview that it is appropriate to make contact i.e., if medical status has changed

☐

11. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

Please tick if you would like to be sent a summary of the study findings

☐

Appendix J: Demographic information sheet: Completed prior to first interview.

Demographic Information Sheet

Please can you complete the short questionnaire prior to your first interview.

How old are you?

How many pregnancies have you had before this one?

How many children do you have?

What was your booking BMI (you can find this on your antenatal notes)?

What is your occupation?

What is your Nationality?

What is your ethnic group (circle the one that best describes your ethnicity)?

White/White British

Asian/Asian British

Black/ African/Caribbean/Black British

Other ethnic group

Appendix K: Demographic information sheet: Completed at postnatal interview

Demographic information sheet

Congratulations on the birth of your baby.

Please can you complete the short questionnaire prior to your last interview.

How did you birth (please circle)?

Vaginal birth

Forceps or ventouse (suction cap)

Caesarean Section

Did you go into labour yourself or was your labour induced?

How are you feeding your baby?

Appendix L: Interview schedule

Interview Schedule

Interviews will take place across the pregnancy continuum at/or as near to: -

1) 12 weeks gestation or at the earliest possible opportunity following the dating scan (Following the 12-week dating scan to ensure a viable pregnancy)
2) 24- 28 weeks gestation
3) 34-36 weeks gestation
4) 6-8 weeks postpartum (to capture the woman's birth experience and early postnatal experiences)

A scheduled time will be arranged between the researcher and the participant in private, either in an NHS facility or in the participant's home.

There will not be a structured interview guide. The researcher will build up a rapport with the participant allowing the participant to open up and express their experiences in their own way and time. This will allow participants to discuss their experiences in as much detail as they wish, and a relaxed informal atmosphere will allow a more open and honest response

All interviews will be audio taped and field notes/memos will be taken post interview.

Focus

The focus of the interviews will be around the participant's experiences of the management and care of their pregnancy up to the point in time of the interview. Participants will be asked to talk about their care and any interventions and procedures carried out in relation to them having a BMI of 35 or above. Where they are receiving care and by whom will also be explored.

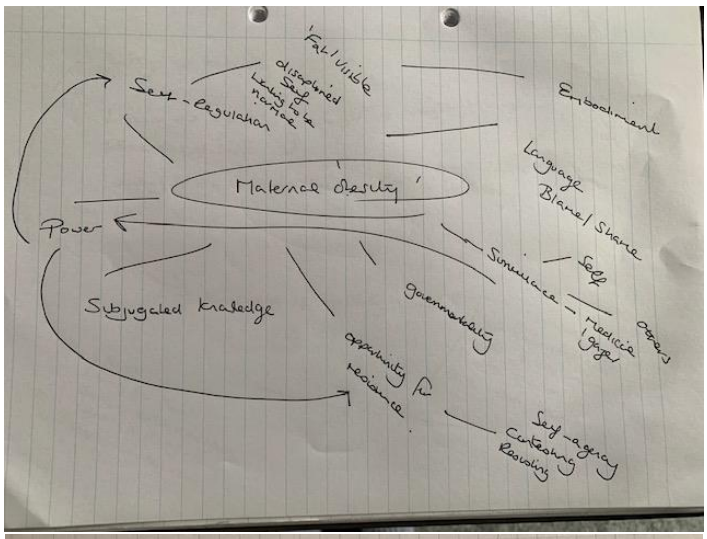
The researcher will guide the interview my using open-ended prompts to gain more information such as:

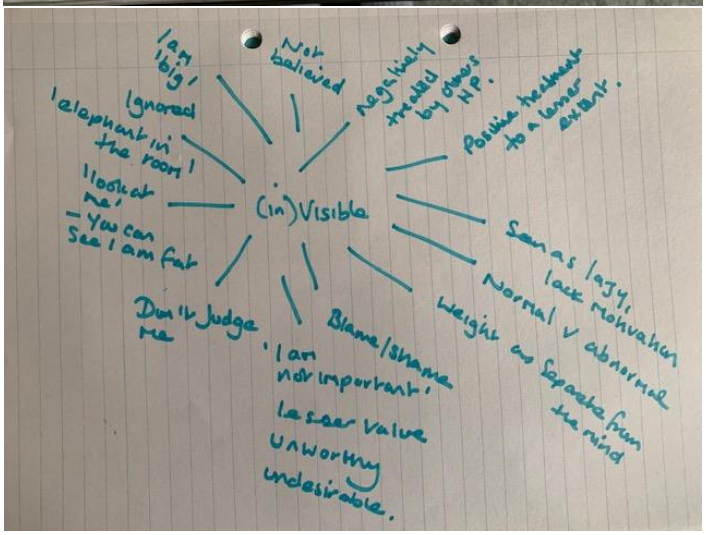
How did/does that make you feel?
Why do you think this was/is?

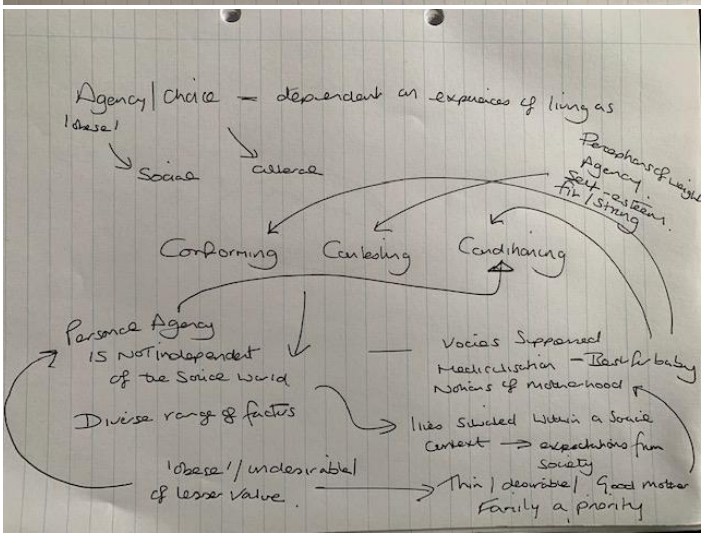
What was/is your understanding of XXX?

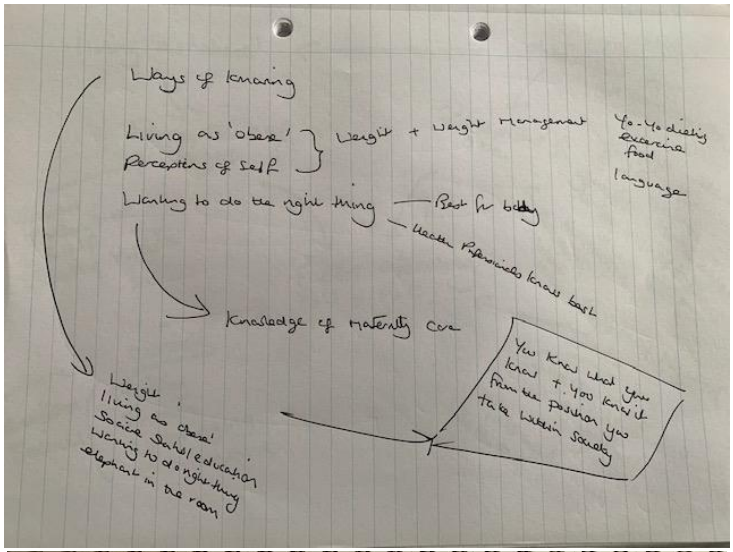
Responses and prompts will change depending on the information shared. The researcher will clarify what is said if needed by recapping on any points made that needed clarification.

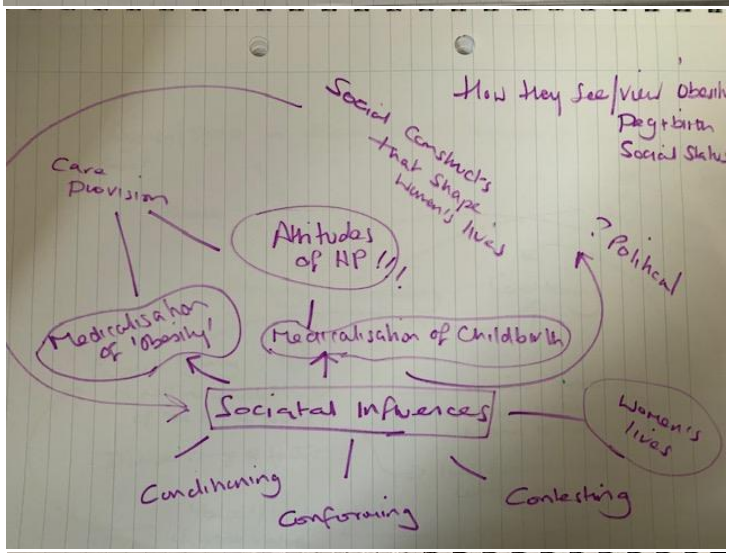
APPENDIX M: Examples of 'messy maps' used to sort and make sense of the data

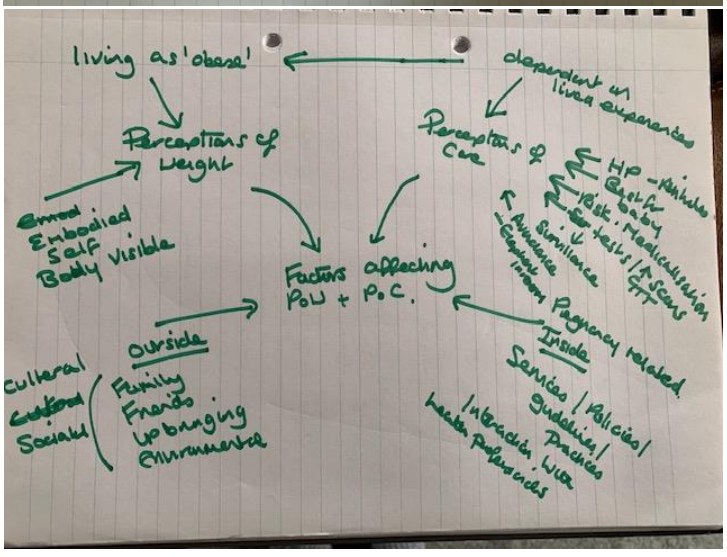







Ways of knowing
Living as 'obese'
Perceptions of self
Weight + Weight Management
Yo-Yo dieting
Exercise
Food
language
Wanting to do the right thing
Best for baby
Knowledge of maternity care
You know what you know & you know it from the position you have within society
Weight
living as obese
Social Stuff/education
Wanting to do right thing
elephant in the room


How they see/view Obesity
Social Constructs that Shape Women's lives
Care Provision
Attitudes of HP !!!
Political
Medicalisation of 'Obesity'
Mearalisation of Childbirth
Societal Influences
Women's lives
Conditioning
Conforming
Contesting


living as 'obese'
dependent on lived experiences
Perceptions of Weight
Perceptions of Care
HP - Attitudes
Baby
Risk - Medicalisation
Surveillance
Tests / Scans
Awareness
Pregnancy related
Inside
Services / Policies / Guidelines / Practices
Interaction with Health Professionals
Factors PoW + PoC.
affecting
Embodied
Self
Body visible
Outside
Cultural
Social
Family
Friends
Upbringing
Environment

Appendix N

NS-SEC Analytic classes

1 Higher managerial, administrative and professional occupations

1.1 Large employers and higher managerial and administrative occupations

1.2 Higher professional occupations

2 Lower managerial, administrative and professional occupations

3 Intermediate occupations

4 Small employers and own account workers

5 Lower supervisory and technical occupations

6 Semi-routine occupations

7 Routine occupations

8 Never worked and long-term unemployed

* L15 Full-time students

* L16 Occupations not stated or inadequately described

* L17 Not classifiable for other reasons

Office of National Statistics (2010b) *The National Statistics Socio-economic classification (NS-SEC).* [online] Available at: https://www.ons.gov.uk/methodology/classificationsandstandards/otherclassifications/thenationalstatisticssocioeconomicclassificationnssecrebasedonsoc2010 [Accessed 11 December 2019]

Appendix O: Example of 'messy mapping' to demonstrate evolvement from emergent theory 2 to 'the multiple dimensions of self': The conditioned body