Rejecting Maternal Healthism: A Grounded Theory

by

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Abstract

Many women of childbearing age are living with a higher BMI. Challenges among women living with a higher BMI as they become mothers include experiencing weight stigma and judgment from health care providers. Seven women were interviewed, and a grounded theory methodology is used to understand how women cope with the increased physiological risks and the stigma associated with obesity as they become mothers. *Maternal healthism* places the responsibility for the health of the baby on maternal behaviours leading to feelings of shame when mothers are unable to meet the expectations of what is "healthy." *Rejecting maternal healthism* is a productive response to negative judgment; women living with a higher BMI recognize that the problem is *maternal healthism*, not their body, and not their ability to be a good mother. Education of health care providers related to *rejecting maternal healthism* can help to better support women as they become mothers.

Dedication

I dedicate this thesis and the years of time my husband Christopher, the most supportive partner I could have wished for. To my parents for their belief in me and to my children for their patience and encouragement. And finally, to the amazing mother who inspired this research, Jean Baxter.

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BMI-Body Mass Index

GWG-Gestational Weight Gain

HAES-Health at Every Size

HCP-Health Care Provider

Introduction and Background

Obesity is widespread in Canada's population and particularly in New Brunswick. In 2018, 30% of Canadians and 43% of New Brunswick residents over the age of 18 were identified as being obese (Statistics Canada, 2023). In epidemiologic studies weight is generally defined using the body mass index (BMI; weight/height^2) with a BMI greater than 30kg/m^2 defined as obesity (Wharton et al., 2020). These statistics are reflected in women of childbearing age with 26.1% of women 18 to 34 identified as being overweight and 21.2% are identified as being obese (Statistics Canada, 2021). Considerable research has reported the detrimental health effects of obesity including infertility and increased rates of miscarriage (Talmor & Dunphy, 2015); venous thromboembolism, gestational diabetes, gestational hypertension, and pre-eclampsia (Alves, 2024); and complications in birth including induction of labour and caesarian section (Carlhäll et al., 2020). Increased risks for newborns of mothers with a higher BMI are associated with preterm birth, within a higher percentile of weight for gestational age at birth, and admission to a neonatal intensive care unit (Pratt, 2020). With this knowledge, strategies to support the well-being of this population is critical.

My area of nursing expertise is maternal-child nursing, primarily in caring for mothers and families during labour and birth. My role is supporting mothers and families during this period of transition. As a labour and birth nurse, I felt challenged on many levels to provide optimal care for women living with a BMI higher than the defined normal weight of a BMI between 18.5–24 kg/m^2 (Health Canada, 2003). There were the logistical challenges related to a lack of appropriate equipment and supplies to provide care for women with a higher BMI, including gowns, stretchers, and blood pressure

monitors. Care could be more challenging as women with a higher BMI frequently had pre-existing or pregnancy induced complications; monitoring the health of mother and baby was at times difficult due to the mother's abdominal girth impeding the ability to use the external ultrasound (U/S) transducer to monitor fetal heart rate and palpate for uterine contractions. Women with a higher BMI experienced discrimination including negative judgments from health care providers, increasing the feeling of shame due to weight stigma.

A close family member with a higher BMI and three children shared her experience of becoming a mother. In preparation for childbirth, she made many efforts to avoid inconveniencing the nurses. She had her husband help mobilize her in the hospital bed and turn as necessary, insisted on an internal monitor to make monitoring easier for the nurses, and relied upon her husband for assistance in moving during the postpartum period. She was very concerned about being a "good" patient so as to avoid burdening the hospital staff with any additional care that may have been required due to her higher BMI. This contrasts with how I, a person who does not have a higher BMI, prepared for the birth of my children as I focused on ensuring my comfort and considering the needs of my baby.

My professional and personal experiences caring for women with a higher BMI in pregnancy and during the postpartum period have led me to consider the stigma, stereotypes, and discrimination affecting the women. Upon reflection of other populations of pregnant women who also have increased health risks for themselves or the fetus, I was struck by health service provider narratives from my clinical practice. For example, pregnant women with substance use issues are also discriminated against and

blamed for their substance use similar to how women may be blamed for having a higher BMI.

In light of these observations, the purpose of this study was to understand the process of how women living with a higher BMI become mothers, given the challenges they experience as they live in a society with negative attitudes related to obesity. Examining how women with a higher BMI become mothers and how they cope with physiological risks and discrimination and the stigma is important to providing more appropriate health care and support to facilitate the transition to motherhood. Indeed, DeJoy and Bittner (2015) asserted that obesity stigma may have a role in poor birth outcomes, mental health issues, avoidance of health care, and negative interactions with health care providers (HCP).

Using grounded theory to render a substantive theory that describes the process of becoming a mother among women living with a higher BMI may have important policy and practice implications in reducing weight stigma and improving the care women receive during pregnancy and during the postpartum period. These improvements may have positive reverberations in women's capacity to parent on an ongoing basis which may then support childhood development. Grounded theory moves beyond descriptive renderings of participants' experiences to identify explanatory concepts and their relationships. A mid-range theory will facilitate the development of interventions or approaches to better meet the needs of women with a higher BMI as they become mothers. Understanding this process from women's perspectives and the sharing of this perspective may help reduce discrimination and stigma associated with obesity, especially among pregnant women and mothers. Although there is much knowledge

related to the challenges that women with a higher BMI experience as they become mothers, knowledge of how women with a higher BMI transition through pregnancy to becoming mothers is limited. In an area of research where little is known, grounded theory is an effective approach to capture the perspective of individuals, to study the concept within the constraints of everyday life, and so secure rich descriptions of individuals in their social world (Denzin & Lincoln, 2005).

Literature Review

Some grounded theory authors indicate that a literature review is not needed prior to data collection within a grounded theory study (Glaser, 1992; Nathaniel, 2006). However, a literature review may be useful to demonstrate that the research topic has not been studied previously and establish a basic understanding of how the topic is conceptualized within the literature (Stern & Porr, 2011; Wuest, 2012).

Search Strategy

A literature search was undertaken using the search terms "(obesity or high bmi or bmi of >30) AND (pregnancy or pregnant or birth or childbirth or perinatal or antenatal or postnatal or postpartum or intrapartum or motherhood or mother or maternal) AND (qualitative research or lived experience or phenomenology)" in databases of CINAHL, PsycArticles, PsychInfo, Social Work Abstracts, SocIndex and Women's Studies International. Included in the 69 relevant studies identified were studies related to experiences of pregnancy and birth, experiences breastfeeding, women's experiences with HCPs and antenatal services, and experiences with perinatal obesity services. Most studies used interviews to elicit the perspectives of women, a few used focus groups, one analyzed blogs related to their experience of pregnancy with a high BMI, one used a

survey, and another study used repertory grids to learn about pregnant women's beliefs related to BMI.

Themes within the literature include a history of a higher BMI, stigma, lack of communication or avoidance of the topic of weight, limited appropriate information, and conflicting expectations of pregnancy.

Living with a Higher BMI

Women reported long histories of struggling with their weight (Dinsdale et al., 2016; Knight-Agarwal et al., 2016a; Lauridsen et al., 2018) which included feeling ashamed and uncomfortable (Dencker et al., 2016; Faria-Schützer et al., 2015; Heslehurst et al., 2015; Lindhardt et al., 2013; Mills et al., 2013; Nash, 2012), and engaging in multiple weight loss attempts (Dencker et al., 2016; Heslehurst et al., 2015; Keely et al., 2017). Women with a history of a higher BMI frequently experienced stigma including negative labelling and discrimination (Knight-Agarwal et al., 2016a), personal devaluation (Hodgkinson et al., 2017), socio-economical inferiority, and isolation (Jarvie, 2017). Some women described discomfort and sadness about their weight (Faria-Schützer et al., 2018). Women "saw themselves first as an overweight woman and then as an overweight pregnant woman" (Mills et al., 2013, p. 312). Their formative experiences of being overweight were inseparable from their experiences of becoming a mother.

Stigma

Stigma is an overarching theme for women with a higher BMI. In his seminal work on stigma, sociologist Erving Goffman (1963) described stigma as "an attribute that is deeply discrediting" (Goffman, 1963, p. 12). Goffman focused on the shame and stigma that occurs among people who possess a distinguishing characteristic from the

norm. Overtime, conceptualizations of stigma veered from the individual toward understanding stigma as a broader issue involving power imbalances and the abuse of power. Link and Phelan (2001) wrote that stigma is the result of the convergence of labels, stereotypes, separation, status loss, and discrimination. People with distinguishing and features that are culturally deemed to be different are labelled and "placed in distinct categories so as to accomplish some degree of separation of 'us' from 'them'" (Link & Phelan, 2001, p. 367). For stigmatization to occur, power must be exercised. Obesity-related stigma includes labeling persons as obese or "fat," contributing to stereotyping and discrimination. Weight stigma leads to separation or isolation from society and personal devaluation.

Label of "Obese"

While obese is the clinical term for a BMI above 30, women do not feel comfortable with this term. The label of obese is addressed across numerous studies. The label obese for some women occurred for the first time during pregnancy (Jarvie, 2017). Despite being labeled as obese, many women did not perceive themselves as being in the category of "obese" (Cunningham et al., 2018; Jarvie, 2017; Kominiarek et al., 2015; Lauridsen et al., 2018; Norris et al., 2020). Women described the label of obese as "horrible" (Jarvie, 2017, p. 82), "terrible", "shocking" (S. Atkinson & McNamara, 2017, p. 60), "degrading" (Cunningham et al., 2018, p. 600), "hurtful" (Bombak et al., 2016, p. 98) and "abhorrent" (Nagpal et al., 2021, p. 115). Other women believed the label of obese referred to people who were not physically active or were confined to the house (Kominiarek et al., 2015). Women who identify as having a higher BMI prefer the terms having a high BMI, "weighing too much", or "being big" (Lauridsen et al., 2018, p. 880).

Some women preferred using the medical term BMI in comparison to other weight-related terms because they perceive this term as a clinical measurement rather than a subjective judgment (Dinsdale et al., 2016) while other women reported that there are no 'nice' terms to describe having a higher BMI (Kominiarek et al., 2015). Given the judgement associated with the term obese, the term "higher BMI" is used throughout this thesis and is not defined by BMI but rather women defining themselves as having a BMI higher than expected, higher than considered normal or higher than desired.

Label of "At Risk"

Pregnant women with a higher BMI are labeled as being "at risk", a judgment that has a negative connotation. The label of "high risk" was difficult for women living with a higher BMI: women reported being emotionally affected by the label, including feelings of guilt, shock, and self-blame (Norris et al., 2020). When made aware of possible complications such as diabetes or hypertension, some women felt singled out and felt the need to defend themselves, that their weight was not necessarily a factor in the high risk label (Jarvie, 2017; Keely et al., 2011; Kominiarek et al., 2015; Lingetun et al., 2017; Norris et al., 2020). Indeed, the fact that even women with "normal" BMIs experience these complications in pregnancy gave women in these studies fodder for their assertion that their higher BMI was not to blame, or that the complications were not their fault (Jarvie, 2017; Keely et al., 2011; Kominiarek et al., 2015; Lingetun et al., 2017; Norris et al., 2020). Keely et al. (2011) writes that women with a higher BMI and complex medical and obstetrical histories falsely describe themselves as healthy and are in denial about pregnancy risks related to their weight. While some women living with a higher BMI have limited understanding of the risks of gestational weight gain (GWG; Fathnezhad-

Kazemi & Hajian, 2019; Loh et al., 2018; Norris et al., 2020) making assumptions about their perceptions may have negative effects of their well-being.

Feelings of anxiety and frustration were provoked by the continual reminder by health care professions that having a higher BMI put them at risk of complications in pregnancy and in the birthing process (Lingetun et al., 2017). The labelling of a high-risk pregnancy among women with a higher BMI negatively affected the maternity care provided and emotional experience of pregnancy. Being described as high-risk during pregnancy among women with a higher BMI led to feelings of fear and anxiety (Mills et al., 2013). Women living with a higher BMI sought to minimize the health risk through weight management during pregnancy, attempting to lessen risks related to treatments commonly used during pregnancy and birth such as avoiding pharmaceuticals in labour, and agreeing to increased medical management of a higher BMI despite women's preferences not to receive said treatment (Pausé et al., 2019).

Stereotyping

Studies report that women with a higher BMI are concerned about negative stereotypes related to weight. Women with a higher BMI wanted to be recognized as individuals but felt that they were stereotyped as sharing the same characteristics as other obese women simply based on their weight (Thorbjörnsdottir et al., 2020). They experienced stereotyping from the general public such as being lazy (Heslehurst et al., 2015; Mills et al., 2013), eating all day (Denison et al., 2015; Mills et al., 2013), and eating unhealthily (Denison et al., 2015; Knight-Agarwal et al., 2016a). Women with a higher BMI also engage in stereotyping other women with a higher BMI. This includes stereotypes of being careless, self-indulgent, less health conscious, weak, and stupid;

however, they did not attach these labels to themselves (Hodgkinson et al., 2017). The women also had a negative construal of midwives with BMIs over 40, labelling them as vulnerable, self-neglecting, self-indulgent, and lazy (Hodgkinson et al., 2017).

Women with a higher BMI were concerned about judgment from their HCP (HCP; Dinsdale et al., 2016). Some women reported HCPs use of negative and shaming language toward women with a higher BMI (Greenfield & Marshall, 2022). In one study, participants reported feelings of uncertainty and fear of being judged by the HCPs at each new consultation with an HCP (Jensen et al., 2022). Negative stereotyping by their HCP included assumptions that they had a higher BMI because they did not exercise enough or not at all, or had a high caloric and less nutritious diet (DeJoy et al., 2016). HCPs have also been found to make assumptions about how women's weight would affect the pregnancy (Lauridsen et al., 2018). In a study of the experiences of women who are obese and pregnant, women perceived that HCPs made assumptions that the GWG would be excessive and they would be unable to adequately mobilize in the postpartum period (Furber & McGowan, 2011). HCPs were found to automatically attribute any pregnancy complaint to obesity (Nagpal et al., 2021), contributing to women feeling that their concerns were minimized and the belief that others were judging them as being ignorant about health (Lauridsen et al., 2018). Women living with higher BMI also reported feeling that they were seen as less intelligent (Heslehurst et al., 2015; Lauridsen et al., 2018).

Stereotypes about weight are also related to the babies of women with a higher BMI. Women with a higher BMI who delivered large babies worried about being judged as being irresponsible, deficient mothers as if they were to blame for their babies' weight

(Furber & McGowan, 2011; Jarvie, 2016, 2017). They were concerned that they would be seen as prioritizing their own needs over their baby's health (Jarvie, 2016). Women experienced "hyper-concern" from their HCPs related to possible fetal outcomes including stillbirth, developmental delays and birth defects (Bombak et al., 2016, p. 98). This hyper-concern also manifested itself as worry about their children growing up overweight (Keely et al., 2017). In a study of women with coexisting maternal obesity and gestational diabetes, participants identified negative labels associated with larger babies including "porker", "monster", or "heifer" -- a stark contrast to the historical conception of larger infants being positively labelled as "bonny" babies (Jarvie, 2016). Women perceived others to have an obsession with the size of their babies (Jarvie, 2016) and experienced having their large babies treated as a medical curiosity (Keely et al., 2017). These experiences contributed to women feeling a loss of identity as a good mother (Jarvie, 2016; Pausé et al., 2019). As mothers, women living with a high BMI were further concerned about the future stigma their child could face due to their parent's size. They felt responsible for the size of their infant and struggled to accept that infants self-regulate their appetites (Keely et al., 2017). Some mothers expressed feeling that they failed to meet the expectations of responsible motherhood as discourses and practices in pregnancy care as their bodies were understood as a risk to their babies (Pausé et al., 2019).

Devaluation

Pregnant women living with a higher BMI experienced personal devaluation related to their bodies. After interactions with unsupportive HCPs, women reported feeling ashamed of their bodies, experiencing judgment, blame, and stigmatization,

leading to feelings of shame (Lingetun et al., 2017; Norris et al., 2020; Nyman et al., 2010; Thorbjörnsdottir et al., 2020), humiliation (Furber & McGowan, 2011; Furness et al., 2011; Shahbazzadegan & Pishvaei, 2019), and guilt (Cunningham et al., 2018; Heslehurst et al., 2015; Norris et al., 2020; Parker & Pausé, 2018). These feelings often resulted from insensitive communication with HCPs (DeJoy et al., 2016) including being called "that obese [patient]" rather than by name (Shahbazzadegan & Pishvaei, 2019, p. 151), frequent discussions about their weight (Furber & McGowan, 2011), comments about challenges in providing an assessment (Furber & McGowan, 2011; Furness et al., 2011), and being weighed (Cunningham et al., 2018; Lingetun et al., 2017). Women expressed discomfort about their bodies in pregnancy and during the birth process and concern about HCPs' negative perceptions their body (Mills et al., 2013). Negative interactions sometimes led to negative feelings about the pregnancy (DeJoy et al., 2016; Parker & Pausé, 2018). Many women with a higher BMI sought support during pregnancy; however, they reported experiencing a sense of isolation due to derisive remarks from family and friends (Keenan & Stapleton, 2010) and a lack of warmth and respectful care from HCPs (Pausé et al., 2019). The negative encounters and feelings of shame contributed to some women avoiding follow-up postpartum care (DeJoy et al., 2016).

Personal devaluation and shame negatively affected women's status as mothers. In one study, most participants reported at least one experience of feeling depersonalized when their weight became the dominant focus of an encounter with their HCP (DeJoy et al., 2016). Women experienced self-loathing and negative self-evaluation which resulted in a loss of enjoyment of their pregnancy and a lack of confidence in their mothering

abilities (Pausé et al., 2019). Internalization of the stigma contributed to a loss of identity as a good mother (Jarvie, 2016).

Women living with a higher BMI also responded to weight stigma in proactive ways. Some women with a higher BMI with partners who were also larger resisted weight stigma and refused to accept blame for their weight and supported each other by breaking their restrictive diets as a team and instead eating healthfully on their own terms (Keely et al., 2017). Other women normalized their higher BMI by making favourable comparisons to larger women or highlighting the habits of other people that they themselves did not participate in such as smoking or drinking, attributing these habits as being riskier than having a higher weight (Keely et al., 2017). In another study, women responded to stigma by resisting the discourse of risk, countering the idea that they were "bad mothers" for putting their baby at risk, but diverted this blame discourse toward mothers with a higher BMI who were a part of lower social-economic groups than themselves (Bombak et al., 2016). Jarvie (2016) reported how some women living with a higher BMI resisted the stigma of having larger babies through (a) denying responsibility in citing genetics (e.g., large babies running in the family), (b) normalizing the bigger baby as being more common now, (c); denying that being large was injurious to the baby while expressing that injury was more concerning for the small baby, and (d) condemning the "moral panic" over obsession of the size of babies. Some women believed that large babies and high infant weight gain were associated with contentedness and expressed pride with the size of their infant (Jarvie, 2016). Other women interpreted high symphysis-fundus measures or fetuses deemed large for gestational age as an indication of a healthy pregnancy (Lingetun et al., 2017).

Factors Contributing to Judgment

Socioeconomic Stress

Women with a high BMI may have with a lower socioeconomic status. Some reported experiencing financial instability (Denison et al., 2015; Dinsdale et al., 2016; Garner et al., 2017; Jarvie, 2017; Lavender & Smith, 2016) and concern that their socioeconomic status negatively impacted their ability to control their weight (Jarvie, 2017). Women reported that unhealthy eating and inactivity were more likely when living alone (Furness et al., 2011). Barriers to physical activity included a lack of accessible facilities (Denison et al., 2015; Dinsdale et al., 2016; Fathnezhad-Kazemi & Hajian, 2019) and not feeling safe in their neighbourhoods which impeded their ability to be active outside (Denison et al., 2015). Living with financial constraints added stress to their pregnancy as more frequent appointments were required due to the increased risks related to a higher BMI (Jarvie, 2017).

Physical Symptoms

Many women experienced symptoms of discomfort related to the pregnancy and are heightened for women living with a higher BMI. For example, pregnancy discomforts of a sore back, swollen feet, varicose veins, fatigue, breathlessness, and being less mobile were reported as being more difficult with increased weight (Mills et al., 2013). These physical changes became a hindrance and although women desired to make changes to improve the symptoms of a heavier weight during pregnancy, they identified challenges to being more physically active during pregnancy, including experiencing fatigue, musculoskeletal discomfort, and bladder problems (Denison et al., 2015; Fathnezhad-Kazemi & Hajian, 2019; Petrov Fieril et al., 2017).

Feelings about Pregnancy

Although initial feelings about pregnancy were primarily positive, the judgment and stigma experienced by women living with a higher BMI affected their feelings about the pregnancy. Women reported that the negative attitudes directed toward them were even worse in pregnancy than before pregnancy (Lindhardt et al., 2013). The increased stigma within society overshadowed the initial joy and excitement with feelings of fear, guilt, and anxiety (Parker & Pausé, 2018). Feelings of disappointment related to their pregnancy included not being recognized by others as pregnant due to the pregnancy not being as visible in women with larger bodies (Furber & McGowan, 2011; Lingetun et al., 2017; Mills et al., 2013; Nash, 2012). Women also felt guilt and frustration of unexpected imposed dietary restrictions by HCPs due to having a higher BMI (Lingetun et al., 2017). Some women reported that physical discomforts and complications took the pleasure out of the pregnancy (Lingetun et al., 2017). Other negative experiences about pregnancy included feeling a "burdensome duty to their unborn children" as they tried to manage their weight and minimize the risks to their baby (Spencer & McIntosh, 2016, p. 183), and feelings of guilt, low self-esteem, defeat, and anxiety (Nyman et al., 2010; Pausé et al., 2019; Shahbazzadegan & Pishvaei, 2019).

Many women living with a higher BMI initially had positive feelings about the pregnancy (Pausé et al., 2019). They experienced happiness and excitement (Pausé et al., 2019). For some women living with a higher BMI, pregnancy was a "refuge from fat-shaming" (Faucher & Mirabito, 2020, p. 532). One study examined the feelings of women living with a higher BMI related to their body prior to pregnancy and their feelings about their body while pregnant. Most of the women who had negative feelings

before pregnancy had more positive thoughts with the pregnancy changes in their body (McCloud & Barosso, 2021). They also described healthy behaviours they incorporated such as healthy eating (Jarvie, 2016; Keely et al., 2017; Pausé et al., 2019), physical activity (Pausé et al., 2019), nutrition supplementation (Pausé et al., 2019), and avoidance of smoking and drinking (Jarvie, 2016; Keely et al., 2017; Pausé et al., 2019).

Challenges in Breastfeeding

For some women with a higher BMI, the ability to breastfeed confirmed motherhood; being able to produce milk and feed their baby elicited feelings of satisfaction and joy (Claesson et al., 2018). Yet, some women who were unable to breastfeed or ceased breastfeeding prematurely reported defeat and guilt (Claesson et al., 2018). Mothers living with a higher BMI experienced additional challenges to breastfeeding that included increased exposure of their body (Claesson et al., 2018; Keely et al., 2015; Lyons et al., 2019), medical complications such as caesarean sections (Lyons et al., 2019), and physical challenges such as larger breasts (Garner et al., 2017; Keely et al., 2015).

Breastfeeding, especially in the immediate postpartum period, frequently involved significant exposure of the body that created feelings of discomfort, anxiety, loss of confidence, and vulnerability (Claesson et al., 2018; Keely et al., 2015). Experiencing weight stigma has been reported by women as a barrier to breastfeeding (O'Reilly et al., 2023) and seeking assistance to breastfeeding (Thorbjörnsdottir et al., 2020). The importance of confidence was highlighted in another study related to breastfeeding and weight stigma. Women living with a higher BMI may have experienced other challenges with positioning and latching related to their size that could require nipple shields, greater

need for pillows and props, and extra assistance to achieve optimal positioning or hold breast tissue so their baby could breathe (Garner et al., 2017). Women reported feeling disempowered when the HCP sometimes took over, in a sometimes "rough and aggressive manner" rather than showing how the mother could attach her baby to the breast (Massov, 2015, p. 27). Women also discussed the feeling of exposure of the body with public breastfeeding as well as the unwanted touching by HCPs well as lack of privacy in the hospital with shared rooms, difficulty closing curtains, and health care providers touching their breasts (Claesson et al., 2018; Keely et al., 2015). Even when breastfeeding was more established, some women found it difficult to maintain coverage of their body and were reluctant to risk showing their abdomen when lifting their shirt (Keely et al., 2015). This was compounded by difficulty finding appropriately sized and reasonably priced nursing bras, tank tops, or other clothes designed for discrete breastfeeding (Garner et al., 2017; Lyons et al., 2019).

Complicated birth experiences such as prolonged labour, inductions, and caesarean sections also affected breastfeeding. These complications had consequences for the infant that could interfere in establishing breastfeeding such as low blood glucose, supplementation with infant formula, separation of mother and infant, and complicated feeding regimens (Garner et al., 2017; Keely et al., 2015). The medicalized experiences may have left women feeling a lack of control and the expectation that breastfeeding would be more difficult, reinforced by delays in the initiation of breastfeeding (Lyons et al., 2019).

HCPs' beliefs, attitudes and behaviours also affected the experience of breastfeeding. In a study examining hospital breastfeeding practices, women with a

higher BMI were less likely to breastfeed in the first hour following birth, breastfeed exclusively in the hospital, be offered help breastfeeding by a staff member, receive advice to breastfeed on demand, or be given a telephone number for lactation support following discharge (Kair & Colaizy, 2016). Although health care providers were supportive of breastfeeding and discussed the benefits of breastfeeding for both mother and infant, women living with a higher BMI felt a lack of support (Claesson et al., 2018) due to perceptions of societal expectations for larger women to be covered, to avoid exposing their body, and not having representation of larger women in patient education literature (Lyons et al., 2019).

Most women with a higher BMI intended to breastfeed, considering it the norm that a mother should breastfeed due to the positive effects like promoting attachment with the infant; but, some women had an underlying feeling that they may not be capable of breast feeding (Claesson et al., 2018). Although breastfeeding may contribute to weight loss, this knowledge increased stress and pressure to lose weight, thereby contributing to negative feelings about breastfeeding (Faria-Schützer et al., 2018). Some women who continued to breastfeed despite experiencing challenges described it as stressful and time-consuming (Claesson et al., 2018).

Expectations to Managing Weight during Pregnancy

Women living with a higher BMI have a range of feelings about pregnancy as a time to manage their weight. Some were motivated for change out of concern for their health and the health of the baby (Cunningham et al., 2018; Lauridsen et al., 2018; Mills et al., 2013; Spencer & McIntosh, 2016) while others were comfortable with their weight (Lingetun et al., 2017; Mills et al., 2013; Weir et al., 2010). For some women, weight

gain in pregnancy was perceived as normal and inevitable and expected that they would lose weight after the birth (L. Atkinson et al., 2013; Cunningham et al., 2018; Keely et al., 2017; Kominiarek et al., 2015; Lingetun et al., 2017; Weir et al., 2010).

Many women believed that losing weight was not appropriate during pregnancy due to concerns about the welfare of the baby, myths such as "eating for two," and pressure from family and friends to increase intake for the baby (Petrov Fieril et al., 2017). The physical changes and symptoms of pregnancy also interfered with efforts to manage weight as feelings of cravings (Hanley et al., 2023; Nagourney et al., 2019), nausea, and appetite changes made healthy eating difficult (Lauridsen et al., 2018; Petrov Fieril et al., 2017; Spencer & McIntosh, 2016). Barriers to becoming more active included feelings of embarrassment, negative thoughts, lack of motivational support, and concerns for the baby (Fathnezhad-Kazemi & Hajian, 2019; Weir et al., 2010). Making significant lifestyle changes in pregnancy could be overwhelming when feeling vulnerable (Lauridsen et al., 2018). There was often a desire to address weight loss in the postpartum period, however, women found it difficult to make lifestyle changes as they focused on making changes to roles and responsibilities to meet the needs of the new baby (Faria-Schützer et al., 2018; Lauridsen et al., 2018). For many women, managing their weight in pregnancy or in the immediate postpartum period was not a priority and they wanted to focus on becoming mothers.

Interactions with Weight Management Programs

For women living with a higher BMI, maternity care often included engagement with programs to manage GWG. Women in one study reported that a focus on diet could have interfered with family events that included food, and exercise for weight

management or general fitness may not have been sources of enjoyment (Pausé et al., 2019). Women expressed mixed feelings about weight management programs and being approached to participate. For some, the implication was that they were unable to make good choices for the health of themselves and their baby (L. Atkinson et al., 2013); whereas when offered as an extra service available to them, women were more positive (Lauridsen et al., 2018). Motivators for engaging with weight management programs included health of the baby, fear of excessive weight gain in pregnancy, and anticipation of the difficulty in losing weight postnatally (Heslehurst et al., 2015; Loh et al., 2018; Petrov Fieril et al., 2017; Weir et al., 2010).

Women also worried that increasing physical activity could negatively affect their baby (Weir et al., 2010) and were concerned about eating too little for the health of the baby (Petrov Fieril et al., 2017). Their social support networks may have reinforced these beliefs (Denison et al., 2015; Petrov Fieril et al., 2017). The physical discomforts of pregnancy also impeded participation with weight management programs (Fathnezhad-Kazemi & Hajian, 2019; Olander & Atkinson, 2013; Petrov Fieril et al., 2017). Pragmatic issues such as constraints related to work and caring for family, lack of transportation, and inconvenient times also affected participation (Olander & Atkinson, 2013; Petrov Fieril et al., 2017).

The participation of women with a higher BMI in weight management programs was enhanced by being nonjudgmentally(Furness et al., 2011; Petrov Fieril et al., 2017). Group services rather than individual counselling were usually preferred as women felt less vulnerable alongside other mothers with similar challenges (L. Atkinson et al., 2013; Furness et al., 2011).

Interactions with Health Care Providers

Quality of the relationship between the HCPs and women with a higher BMI was a common theme in the literature. Continuity in care, and seeing the same professional consistently is important to developing a relationship and leads to trust and feeling supported (Faria-Schützer et al., 2015). Positive encounters included respectful, supportive, and nonjudgmental care (DeJoy et al., 2016; Faria-Schützer et al., 2015; Mills et al., 2013; Nyman et al., 2010). Women were sensitive to judgment of HCPs as expressed through both the nonverbal aspects of providing care, such as avoiding touch or facial expressions as well as judgmental verbal communications about weight (Mills et al., 2013). Some women living with a higher BMI believed their HCP blamed all of their health problems on obesity and limited treatment to advise on losing weight (Nagpal et al., 2021; Shahbazzadegan & Pishvaei, 2019). Negative encounters with HCPs were distressing and comments about weight from HCPs were often taken more seriously than comments from friends or family (Lingetun et al., 2017; Nash, 2012). A focus on risks by their HCP evoked feelings of anxiety and shame and a feeling that failure was expected because of their weight (Thorbjörnsdottir et al., 2020). Some women spoke of health care providers communicating risks as certainties including having a macrocosmic baby, developing gestational diabetes, or requiring a C-section (DeJoy et al., 2016). Other health care providers suggested that their higher weight would impede their preparation to becoming a mother such as highlighting the challenges they would have in breastfeeding their baby (Lindhardt et al., 2013). Women with a higher BMI seeking fertility and reproductive services were sometimes refused care, leaving them feeling undeserving of compassionate care and “less than human” (Bombak et al., 2016, p. 98).

Many of these encounters caused feelings of humiliation and self-stigma (Lindhardt et al., 2013). Even when encounters were not overtly negative, some women felt the care focused on fetal well-being and maternal screening rather than holistic care of mother and infant (Furber & McGowan, 2011).

Women coped by recognizing these negative encounters as being wrong, excusing the behaviours of health care providers as "having a bad day," or processing the event or staff as being "absurd" (Lauridsen et al., 2018). Although many women experienced positive encounters with health care providers as they became mothers, most had concurrent negative interactions that influenced their experience of becoming mothers.

Avoidance of Topic

Although women were subject to hyper-vigilance of pregnancy and experienced weight stigma some women expressed feeling that the topic of weight was avoided by HCPs or provided with information that was unwanted, not useful, or contradictory. Women reported some health care providers ignored their weight that may have been measured but not addressed (S. Atkinson & McNamara, 2017; Cunningham et al., 2018; Lavender & Smith, 2016; Mills et al., 2013) in terms of how to lose weight (Heslehurst et al., 2017; Mills et al., 2013; Weir et al., 2010) or the possible associated risks (S. Atkinson & McNamara, 2017; Keenan & Stapleton, 2010; Lavender & Smith, 2016). Some studies found that the topic of weight was not discussed or was addressed in a vague manner (Furness et al., 2011; Keely et al., 2017; Lindhardt et al., 2013). Other women were referred to weight intervention programs without being informed (L. Atkinson et al., 2013; Dinsdale et al., 2016; Heslehurst et al., 2017). Women wanted the

topic addressed in an open, nonjudgmental and supportive manner; however, this was not always the case (Dencker et al., 2016; Mills et al., 2013).

Medicalization of Pregnancy

Women with a higher BMI as they become mothers are affected by medicalization of both the pregnancy and the body. “Medicalization describes a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illness and disorders” (Conrad, 2007, p. 4). Inappropriately sized equipment (e.g., chairs, beds, examination tables, and gowns) left women feeling ostracized and vulnerable (DeJoy et al., 2016; Keenan & Stapleton, 2010; Lindhardt et al., 2013; Shahbazzadegan & Pishvaei, 2019). Women also identified challenges with diagnostic and monitoring equipment that included scarcity of large blood pressure cuffs, cardiotocography, and ultrasound technology to effectively monitor the mother and her baby. Visualizing the fetus or monitoring the fetal heart could cause discomfort and pain with the increased pressure required to compress abdominal tissue (Mills et al., 2013). For some women living with a higher BMI, increased surveillance was reassuring as they experienced a sense of safety when ultrasound scans were normal (Loh et al., 2018). Whereas typical monitoring equipment is not created to suit the needs of women with a higher BMI, women experienced upset and humiliation when they had to compensate for the inadequacy of the monitoring equipment by being asked to hold their abdomen in place or hold the monitor in a particular way to increase the capacity for the equipment to assess what it is intended to measure (Furber & McGowan, 2011; Mills et al., 2013). One participant reported that HCPs did not complete routine monitoring procedures due to the challenges of her larger body (Mills et al., 2013). Women living with a higher BMI

wanted the same routine treatment as other mothers (Lingetun et al., 2017; Mills et al., 2013). Clearly, unsuitable equipment affected the quality of care and contributed to emotional distress. Increased medicalization of pregnancy created a sense of fear, limiting women's choices of care provider and birth plans. In a study of the childbearing experiences of women with a higher BMI, Doughty (2022) asserts that a medicalized care pathway reduces birth choices, agency and the ability of women to support their own health. Women recognized the risk of pregnancy complications due to their higher BMI (Knight-Agarwal et al., 2016a; Knight-Agarwal et al., 2016b), but believed that their weight dictated the care without their individual health concerns or histories being assessed. Increased surveillance of pregnancy occurred in pregnancies that were uncomplicated; for example, pregnant women with high BMI were monitored as if diagnosed gestational diabetes despite negative tests or referred to high risk clinics without pregnancy complications (DeJoy et al., 2016). Multiple assessments and screenings continued despite continuously normal results (Thorbjörnsdottir et al., 2020). One woman discussed her experience of having an uncomplicated obstetrical history with previous children with a midwifery clinic at a weight of 99 kg; however, at a higher weight of 102kg with her next pregnancy, she was required to attend an obstetrical clinic (Mills et al., 2013).

Early in pregnancy women were encouraged to consider labour and birth preferences. As the pregnancy progressed, the options became more limited and included transfer to obstetrical care even when midwifery care was preferred by women (Bombak et al., 2016; DeJoy et al., 2016) as well as choices for labour and birth. Women were excluded from the decision-making process as consults with anesthesia were arranged by

their care provider without discussion (Furber & McGowan, 2011) and felt coerced to have inductions or caesarean sections despite having no other complications (DeJoy et al., 2016; Furber & McGowan, 2011; Keenan & Stapleton, 2010). Not being involved in the decision-making process evoked feelings of being ignored (Nyman et al., 2010), helpless (Keenan & Stapleton, 2010), and coerced (Thorbjörnsdottir et al., 2020).

Information

Contradictory Information

Women frequently found that the information and guidance related to their weight was contradictory. Women reported they had been treated as low risk by their primary HCP and then referred to anesthesia who identified them as high risk (Keely et al., 2011). Advice regarding GWG was particularly unclear, as women received mixed messages and contradictory advice from different HCPs (Heslehurst et al., 2017; Knight-Agarwal et al., 2022; Kominiarek et al., 2015; Lindhardt et al., 2013; Mills et al., 2013). Women wanted unambiguous guidance from their HCP (Furness et al., 2011) as they were exposed to conflicting advice about nutrition and activity from the media (Furness et al., 2011; Weir et al., 2010), commercial weight management programs (S. Atkinson & McNamara, 2017), and friends and family (S. Atkinson & McNamara, 2017; Kominiarek et al., 2015; Loh et al., 2018; Weir et al., 2010). New mothers also discussed contradictory advice related to breastfeeding as they were encouraged to increase their calorie intake to maintain milk supply while expecting breastfeeding to help with weight loss (Lyons et al., 2019).

Unwanted Information

Women with a higher BMI identified the negative experience of receiving unwanted information or information that was not useful. This included a constant focus on their weight (Lauridsen et al., 2018) and on the risks associated with having a higher BMI without providing the individualized care desired (Bombak et al., 2016; Lingetun et al., 2017). Other women shared the frustration of being given specific information, such as the importance of losing weight preconception, at a time when it could no longer be used (Lingetun et al., 2017). For some, the provided information related to nutrition was repetitive (Heslehurst et al., 2017; Thorbjörnsdottir et al., 2020), too prescriptive (L. Atkinson et al., 2013), or unrealistic if living with a higher BMI (Denison et al., 2015).

Wanted Information

Women with a higher BMI identified the information that they were seeking related to weight management. Women were advised to lose weight without guidance to achieve this outcome (Faria-Schützer et al., 2018; Keenan & Stapleton, 2010). They desired timely, personalized and nonjudgmental counseling from their HCP (Faucher & Mirabito, 2020). Women with a higher BMI also suggested that health promotion material and images related to physical activity should include all body types and avoid stereotyping women with a higher BMI as sedentary (Nagpal et al., 2022). Women who had previous attempts at losing weight wanted to focus on the underlying issues as they reported already being aware that they should eat less and move more (Dencker et al., 2016; Nagpal et al., 2021). Women living with a higher BMI also wanted information related to GWG during the pregnancy (Allen-Walker et al., 2020; Cunningham et al., 2018; Lavender & Smith, 2016). Some HCP provided little to no information related to

GWG and so women resorted to looking to other sources including magazines (Lavender & Smith, 2016), and the internet for nutritional information (Knight-Agarwal et al., 2020). Some women living with a higher BMI also wanted nutrition information for themselves and their babies (Cunningham et al., 2018; Dencker et al., 2016; Knight-Agarwal et al., 2020; Knight-Agarwal et al., 2016a; Lavender & Smith, 2016). Frequently, a need for more information related to safe physical activity during pregnancy was identified (Cunningham et al., 2018; Denison et al., 2015; Fathnezhad-Kazemi & Hajian, 2019; Faucher & Mirabito, 2020; Furness et al., 2011; Heslehurst et al., 2017; Loh et al., 2018). Women's need for more individualized dietary and exercise advice was reported in numerous studies (Dinsdale et al., 2016; Knight-Agarwal et al., 2016a; Nagpal et al., 2021). In one study women with a higher BMI reported a lack of follow-up from HCPs regarding healthy weight loss postpartum (Murray-Davis et al., 2019).

Women living with a higher BMI often received information about the benefits of breastfeeding rather than the practical information they needed to support their intention to breastfeed (Claesson et al., 2018; Keely et al., 2015; Lyons et al., 2019) and information about breastfeeding and bottle feeding concurrently (Claesson et al., 2018; Keely et al., 2015). Breastfeeding support beyond what is typically and narrowly focused on achieving a latch (Lyons et al., 2019) was also desired, and positions recommended while in hospital were not always practical in public (Claesson et al., 2018; Keely et al., 2015). Home visits were desired by breastfeeding women with a higher BMI to support breastfeeding (Keely et al., 2015). This lack of information extends beyond health care as

women expressed a need to learn where to find appropriate sized and priced nursing clothes (Lyons et al., 2019).

Gaps in the Literature

Experiences and perspectives of women living with a higher BMI during pregnancy, labour, birth, breastfeeding, and postpartum periods are described in the literature. Many studies focussed on interactions with the health care system and providers or experiences with weight-management interventions during pregnancy. Challenges in pregnancy, birth, and breastfeeding are well documented in the literature; however, there is a gap regarding the experiences of becoming a mother with a higher BMI.

The foundational work related to the transition involved in becoming a mother is Rubin's work related to maternal role attainment (Rubin, 1967). Rubin (1976) described "four maternal tasks in pregnancy: (1) seeking safe passage for herself and her child through pregnancy, labour, and delivery; (2) ensuring the acceptance of the child she bears by significant persons in her family; (3) binding-in to her unknown child; and (4) learning to give of herself" (p. 369). Seeking safe passage and ensuring acceptance involve the external world and are therefore likely to be influenced by maternal experiences including stigma. The third and fourth tasks involve the development of the relationship between mother and baby and will be influenced by her feelings of self as a woman with a higher BMI. Mercer (2004) expanded on this theory to develop the Becoming a Mother (BAM) for the process of developing a maternal identity. There is a need to look at how Canadian women with a higher BMI achieve a maternal identity that Mercer (2004) describes as "a sense of harmony, confidence, satisfaction in the maternal

role, and attachment to her infant" (Mercer, 2004, p. 227) while navigating the challenges of living with a higher BMI. How women living with a higher BMI resolve achieve a positive maternal identity is a research question that remains to be answered.

Methodology

Research Design: Grounded Theory

The purpose of grounded theory is to generate theory about dominant social processes (Barroso & Cameron, 2018). Becoming a mother is a social process in which social interactions and women's meanings ascribed to these situations are central to the transition into motherhood. Grounded theory facilitated the development of a middle-range theory of the transition to motherhood based on the perceptions of women living with a higher BMI.

This research was completed using the traditional Glaserian grounded theory method with a feminist perspective. Although Glaser (1992) asserts that a literature search is not needed other authors suggest that a literature review may help to understand how the topic is conceptualized within the literature and to demonstrate a gap in knowledge (Stern & Porr, 2011; Wuest, 2012). The completed literature review informed my understanding of some of the challenges experienced by women with a higher BMI as they became mothers and demonstrated the paucity of literature related to the process of how women become mothers given these concerns. Grounded theory is primarily an inductive method of research, as theory will be generated from data (Glaser, 1998). However, deductive reasoning is a necessary part of the process as data is analyzed and the theory is generated (Glaser, 1978). The process of developing a grounded theory begins with inductively deriving codes, developing ideas about properties and

relationships that are then checked deductively with old and new data (Wuest, 2012). Grounded theory, an approach that explores a basic psycho-social process of how people manage a central problem or health issue (Wuest, 2012), was helpful in the examination of the social and psychological aspects of how women living with a higher BMI become mothers. A feminist perspective yielded theoretical sensitivity to issues of difference related to gender and other social and critical factors as being helpful to recognizing variation in emerging concepts (Wuest & Merritt-Gray, 2001). Glaser (1998) asserts that grounded theory supports the development of hypotheses in a substantive area. Grounded theorists generate middle-range theory that are useful in practice (Glaser & Strauss, 1967); therefore, the goal of this study was to develop a theory that can be used in nursing practice to support women living with a higher BMI.

Although challenges among women living with a higher BMI as they become mothers is documented in the literature, little is written about resolving these challenges. The purpose of this research was to develop a theoretical understanding of women's experiences that account for conditions and other factors that influence their transition to motherhood, including social determinants of health that may not be obvious to participants. Substantive theory derived from rich descriptions in the data and a constant comparative analysis that raises descriptive data to a higher level of abstraction (Glaser, 1998) is useful in the identification of influencing social and systemic factors that can then be targeted for interventions to support women.

Grounded theory focuses on a process resulting in identifiable stages, synthesizing descriptive data into concepts and relational statements (Morse, 2001a) foundational to a middle range nursing theory. Middle range theories bridge the gap

between grand nursing theories and nursing practice as they describe phenomena with clear propositions that can be used to derive testable hypotheses (McEwen & Wills, 2019). This methodology is well-suited to generating substantive theory through fieldwork and other sources of data (Glaser & Strauss, 1967).

Theoretical Perspective

The transition to motherhood among women living with a higher BMI is an experience that involves interactions between women and society. As such, symbolic interactionism, a theoretical approach in which grounded theory is rooted (Corbin et al., 2008; Kendall, 1999), is appropriate in understanding motherhood. Symbolic interactionism is an approach to understanding human behaviour through the underlying meaning that motivates it (Milliken & Schreiber, 2001). Data is analyzed and interpreted through memoing and coding, informing the analysis about the meaning that participants derive from their life experiences (Milliken & Schreiber, 2001). Symbolic interactionism moves the theory beyond a description of the experience toward the meaning of the problem for the participants and the process participants use to continually resolve the problem.

This research also has a feminist perspective. Within a feminist framework it is necessary to be attentive to issues of difference, to minimize power imbalances within the research process, and to remain aware of opportunities for political and social justice advocacy (Hesse-Biber et al., 2004). Women living with a higher BMI have unique experiences as they become mothers in comparison to women without a high BMI, such as weight stigma and discrimination. Feminist theory tenets, including respect for participants, avoidance of oppression, usefulness of findings, and reflexivity (Wuest &

Merritt-Gray, 2001) were incorporated in this research. For example, the process is grounded in a participants' agency as demonstrated by resisting oppression related to weight stigma. In a detailed reflection of their feminist grounded theory studies, Wuest and Merritt-Gray (2001) recommended that researchers engage in a process of reflexivity to increase women's empowerment during the research process. I was reflexive during the data analysis through discussions with my supervisor, memoing about emerging concepts using a critical lens, paying attention to power imbalances and maintaining ethical considerations as a guide throughout the research process. The concept of rejecting the social narrative of defining health as a value that is demonstrated through the control of weight is different from the assumption that women living with a higher BMI are in denial about the risks of living with a higher BMI. The narrative that women living with a higher BMI are in denial presumes a willful ignorance of reality rather than questioning the veracity of the narrative.

While interviewing women for this study, the tenets of feminist including respect for participants and avoidance of oppression (Wuest & Merritt-Gray, 2001) were paramount. The priority was to provide women with the space to share their experiences. in the way that was most comfortable and safe for them. Providing this space for women to discuss their experience of becoming a mother avoided the oppression of assumptions made about their knowledge and capabilities. I sought to increase comfort for participants by offering an option to complete the interview through video and audio or audio only and actively listening to help women expand on their experiences. A resource list was provided to each participant for sources of support for women with any difficult feelings that may have arisen from the interview (see Appendix D). Providing relevant

accessible resources of support within their community can also help support the participants to address their needs (Wuest, 2012). Women were free to discuss their experience without

The Grounded Theory Process

Grounded theory is completed in iterative steps of data collection, coding, memoing, theoretical sampling, sorting, and writing using the constant comparative method (Glaser, 1998). Although each stage is distinct, generating theory requires simultaneous collection, coding, and analysis of data in order to continue with theoretical sampling (Glaser & Strauss, 1967, p. 71).

Data Collection

Collecting qualitative data is an ongoing, cognitive process and includes representations of events, accounts, or other materials related to the subject matter from the participants and authors (Morse & Richards, 2002). Although the time to achieving a maternal identity may vary depending on a variety of factors including maternal variables such as birth experience, experienced stress, and available support or infant variables, including temperament and health status, most women feel self-confident and competent by about four months postpartum (Mercer & Walker, 2006). With this knowledge, initial recruitment sought women who are more than four months postpartum. Women in a study exploring pregnancy and difficulties related to weight shared that they were more comfortable with telephone interviews rather than face-to-face due to self-consciousness about their perception of having a larger body (Tierney et al., 2010). Tierney et al. (2010) also identified that recruitment was more successful on a women's health website in comparison to in-person health care appointments; therefore, recruitment for this study

occurred over social media groups of interest to new mothers. Inclusion criteria included participants who identified as women and living with a higher BMI. A gendered approach is important to this study as living with a higher BMI is different between men and women, principally the internalization of weight stigma that is more pervasive and impactful for women (Keirns et al., 2022). Anther inclusion criteria was self-identification as being a mother. Parents who identified as male, non-binary, or other genders were not included because of the difference in the impact of weight stigma for women. The experiences of these parents who identify as male, non-binary, or other genders separately may provide a contrast that can contribute to an understanding of the nuances of this experience between genders.

A predetermined number of participants is not decided upon before beginning a grounded theory study (Glaser, 1998); theoretical sampling determines the sample number as the emerging theory guides the process (Wuest, 2012). Glaser and Strauss (1967) suggested that the main categories tend to emerge very quickly, and the scope of this study was limited to achieving saturation for the core category. Saturation occurs when similar instances appear repeatedly such that the researcher can develop the properties of the category (Glaser & Strauss, 1967). In this study, semi-structured interviews were completed with seven participants. After the first four interviews, concepts began to emerge, including that woman had a new understanding of their body as functional, and experiences of feeling cared for as a mother. Women in this study identified negative experiences and feelings prior to achieving a more positive self-concept and self-confidence, including a history of being judged negatively and HCPs' and family members' judgemental attitudes that the women were unhealthy and

irresponsible. This informed my theoretical sensitivity to these judgements, facilitating a more thorough examination of these concepts in three subsequent interviews. The basic psycho-social problem was identified as *Maternal Healthism* and the basic psycho-social process the women in this study used to address this problem is *Rejecting Maternal Healthism*. The goal was theoretical completeness, explaining the core category with the fewest possible concepts, with the greatest possible scope and variation within the concepts (Glaser & Strauss, 1967) and this was achieved for the *maternal healthism* and *rejecting maternal healthism*.

Factors that need to be considered in data collection are the nature of the research topic, data quality, study design, and the use of shadowed data (Morse, 2000). Shadowed data is "information that participants give us about the types, characteristics, and dimensions of concepts, perceptions, behaviors, and opinions of others" (Morse, 2001b, p. 291) that women may choose to share, as they describe the experiences of others or compare their experience to others. Participants may share not only personal experiences but may also discuss the experiences of others (Morse, 2000). The nature of this research topic may be a challenging subject to discuss for some women; therefore, I used a sensitive approach in the interviews, including attending to non-verbal cues that could indicate discomfort, asking open-ended questions so that women could guide the sharing process, and provided brief verbal cues to support women. The primary source of data was semi-structured interviews using videoconferencing, increasing their comfort level as they were able to participate in the study in a place of their choosing. These interviews yielded rich data. For example, all participants discussed understanding their body as functional, accepting and connecting with the body differently as they became mothers. I

was also attentive to shadowed data as some participants compared themselves to the experiences of others, a process that informed the data analysis. For example, one participant was worried that she would be expected to lose weight, “I have friends who have horror stories of doctors that they’re like ‘You need to lose 10 pounds’ and they’re like, ‘I’m already skinny,’ so I was terrified.” This story contributed to the participant anticipating negative experiences. Other participants compared themselves to women perceived as having a “normal” BMI, comparing their health and experiences. This shadow data also helped to reach saturation for the development of the theory.

Data Analysis

Data analysis initially involved line-by-line open coding with minimal preconception, coding the data based with the goal to code all possible units of meaning every way possible (Glaser & Holton, 2007). Line by line coding minimizes the risk of missing important categories and ensures that categories are grounded to the data (Glaser & Holton, 2007). Hunches and reflection on possible relationships between codes were kept through memoing as emerging concepts were integrated into theory (Glaser, 1998). Memos were the method of writing ideas about codes and theoretical relationships as well as capturing and keeping track of the emerging theory (Glaser, 1998). Sorting and using memos following open coding ensured theoretical analysis and avoiding a descriptive analysis of the data (Glaser, 1978). The qualitative research software NVivo was used for coding and analysis. Concurrent coding, analysing through constant comparison, and memoing facilitated theoretical sampling for new data as well as previously collected qualitative data (Glaser & Strauss, 1967). Data gathering and

analysis continued until theoretical saturation was achieved, meaning that additional data were not adding new information to the properties of a category (Glaser & Strauss, 1967). Analysis continued with theoretical coding as I organized and memoed my thoughts about how the codes related to each other. Codes were collapsed into categories and relationships between categories were identified, raising the data to a higher level of abstraction (Wuest, 2012). The core category that represented the central problem, and the core process used in resolving the problem are identified. The properties of each category are described as the theory of *rejecting maternal healthism* was developed.

Constant Comparative Method

The constant comparative method is an iterative and rigorous analysis process that continuous until a substantive mid-range theory is developed (Glaser & Strauss, 1967). There are four stages to the method: (1) comparing incidents, that is the substantive indicators in the data, applicable to each category, (2) integrating categories and their properties, (3) delimiting the theory, and (4) writing the theory (Glaser, 1965). During analysis, these stages occur simultaneously as earlier stages continue to occur until writing the theory is completed (Glaser, 1965). As coding occurs, categories begin to emerge and each incident within that category are compared to previous incidents within that category, this constant comparison begins to generate properties of the category (Glaser, 1965). The theory develops as categories and their properties become integrated as constant comparison guides the theoretical development through the comparisons (Glaser, 1965).

Open Coding. The data was analyzed by coding each sentence while considering what is happening in the data and what the incident(s) may indicate for participants

related to their transition to motherhood. Incidents were compared to others and categories began to emerge. Some data was initially coded as *blaming self, feeling guilty, feeling shame* and *feeling disappointed in self,* often related to weight. These codes were collapsed into the *internalization of maternal healthism,* a consequence of *maternal healthism*. This contrasted with other codes of *knowing, loving, and accepting of the body* that eventually collapsed into the code, *knowing the body as functional*.

Theoretical Coding. During this process it is important to interrupt coding and memo any new ideas that occur during this analysis (Glaser (1978). Integration of categories and their properties occurred as the analysis continued. During the theoretical coding process, memoing about the codes *knowing, loving, and accepting of the body* led me to consider that the code *knowing the body as functional* might be central to the change in perception of themselves and their identity as a mother. I also began to wonder about factors that may have influenced women's acceptance of their body, a change of attitude women had made about their body.

The core categories of *maternal healthism* and *rejecting maternal healthism* were identified and the properties and connections were identified as the relationships between categories were developed. Theoretical relationships began to emerge using theoretical coding, including the six C's theoretical coding "family" where the causes, contexts, contingencies, consequences, covariances, and conditions of the core categories were examined (Chenitz, 1986). Glaser (1978) described the 6 C's as the "bread and butter" (p.74) of theoretical coding as it helps to organize the codes into an ordered theory, limiting coding to variables that relate to the core variables, properties, and connections to related categories (Glaser & Holton, 2007). The 6 C coding family was used to

develop the relationships of the theoretical codes within each core variable. For example, the core process of *rejecting maternal healthism* is contingent upon *knowing the body as functional*, this theoretical code encompasses the initial codes of *knowing, loving, and accepting of the body.*

Core Categories. The core categories of *maternal healthism* and *rejecting maternal healthism* were identified. Challenges to becoming a mother were represented by negative experiences related to having a higher BMI before becoming pregnant were collapsed into the code *history of being judged negatively related to weight*. Codes that related to these negative experiences were participants' *internalizing weight stigma, judging weight negatively,* and *questioning their value as a mother*, codes that were collapsed into a larger code named *experiencing anxiety anticipating negative reactions related to weight.* Through memoing and a reflexivity process, it became apparent that the code *internalized maternal healthism* helped me recognize that the core problem was *maternal healthism.* The 'smaller' codes that accounted for the broader category that represented the basic psycho-social process *rejecting maternal healthism,* included *knowing the body as functional*, *feeling cared for as a mother*, and identifying the *fallacy of maternal healthism.*

Theoretical Sensitivity

Conceptualizing and formulating theory from the data required theoretical sensitivity. Theoretical sensitivity is being open to the theory emerging from the data rather than forcing the data into predetermined categories or concepts (Glaser, 1978). The initial step to achieving theoretical sensitivity is to hold few predetermined ideas as preconceived hypotheses can limit observations and insights (Glaser, 1978). This was

achieved through two processes. Firstly, the I was conscious of the knowledge of theory such as Maternal Role Attainment (Rubin, 1967) and BAM (Mercer, 2004) and secondly, a literature review was conducted related to women living with a higher BMI as they become mothers. The knowledge related to these sources of literature were consciously set aside to avoid organizing codes to fit into previously held knowledge. Constant comparison and the use of the 6 Cs theoretical coding family grounded the theory in the data, a process that requires remaining open, tolerating confusion, and allowing for conceptual emergence (Glaser & Holton, 2007). Although there is a need for suspending knowledge (Glaser, 1998) to avoid forcing data into previously held assumptions, theoretical sensitivity necessitates sufficient immersion in the subject area while retaining enough detachment to think theoretically about the data. *Rejecting maternal healthism* emerged from the interview data and was not forced into previous theories.

Theoretical Sampling

Theoretical sampling is used to both deductively check derived properties and relationships, and inductively, continuing to develop other theoretical hunches (Wuest, 2012). In grounded theory, theoretical sampling is used to further develop an emerging conceptual framework (Glaser, 1978) and aims to discover categories, properties, and interrelationships to develop a theory (Glaser & Strauss, 1967). Theoretical sampling involves selecting participants for similarities and differences to understand categories, their properties. and interrelationships in the development of substantive theory (Glaser & Strauss, 1967). Following the development of initial hypotheses from the data, new salient data is sought to modify the emerging theory (Wuest, 2012). After the first few interviews, concepts related to the feelings participants had about their bodies were

emerging; therefore, to examine this further, I added a probe to the interview guide during subsequent interviews related to how becoming a mother had changed their perception of their bodies. Codes related to *changing understanding of the body* was identified and later emerged as a property of r*ejecting maternal healthism*.

Rigour

The quality of grounded theory research is judged on fit, workability, relevance, and modifiability of the theory related to the substantive area (Glaser, 1998). Fit amy be understood as validity: concepts should adequately express the pattern in the data (Glaser, 1998). Workability refers to the way that concepts and hypotheses in the theory account for the core problem and how it is continually resolved (Glaser, 1998). *Rejecting maternal healthism* works to explain the relevant behaviour of how women with a higher BMI confront the problem of *maternal healthism*. As women with a higher BMI come to know their bodies as functional and feel cared for as a mother, they begin to question the veracity of *maternal healthism*. Women with a higher BMI came to know the body as functional, knowledge that contradicted the societal belief that a larger body implies ill health resulting from a lack of self-control. *Rejecting maternal healthism* results in decreased stress and anxiety, a more positive self-concept and increased self-confidence. Relevance of the research is ensured by considering the main concerns of the participants (Glaser, 1998). The concerns raised by participants include a *history of being judged negatively related to weight*, feeling judged by others, especially HCPs as they experienced *maternal healthism in action*, resulting in *anxiety and anticipating negative reactions*. *Maternal healthism* reflects the main concerns of the participants in this study. Theories are neither right nor wrong but instead can be modified with new and changing

data (Glaser, 1998) and this is the case with *rejecting maternal healthism*. For example, over time the progress of the body positivity movement (Lazuka et al., 2020) may decrease the instances of being judged negatively, potentially impacting the concept of the *history of being judged negatively*. The rigour of a study is supported through preparation as a researcher both in terms of subject area and the methodology of grounded theory (Morse & Richards, 2002). Preparation of the subject area included knowledge of theories related to the transition to motherhood including the theory of BAM Mercer (2004) and preparation through a literature review related to women with a higher BMI in the perinatal period. The grounded theory methodology requires that theory development form the data, starting with open coding, progressing to the development of theoretical codes, considering the relationships and properties of the theoretical codes to develop a theory grounded in the data. The data was not organized into previously known theory such as the stages of BAM as this was consciously set aside, and codes and categories emerged from the data. The basic psychosocial process, *rejecting maternal healthism*, is a novel finding that emerged directly from the interview data: it was not forced into fitting into previously developed theory. Discussions related the ongoing analysis using the constant comparative method occurred with my supervisor and members of my thesis committee with expertise in the subject matter and methodology to ensure theoretical sensitivity and rigour of this study. These discussions were particularly important in identifying the core problem and process. The sub-process of *knowing the body as functional* emerged early in the analysis, however through discussion it became apparent that this was not the core process as this did not correlate with a core problem. With reflexive discussions, including the identification of patterns

of social factors that accounted for variation in the theory, I realized that the problem emerging in the data was not the function of the body but rather the societal belief that a higher BMI signifies not valuing health and a lack of self-control.

Another important criterion of rigour in qualitative research is its transferability, that the study findings have meaning to others in similar situations (Speziale et al., 2011). The problem of *maternal healthism*, that is placing the responsibility and blame for the baby's health on the woman's behaviours and choices is transferable to other populations who may also struggle to meet parental expectations and are blamed when societal expectations are unmet. This is likely to be a problem for other people who may be shamed and blamed for behaviours or the choice to become a mother in challenging circumstances. This may include persons who use substances, persons underlying health conditions, persons with differing physical abilities and persons in lower socioeconomic circumstances. Transferability is strengthened through dense descriptions of the data (Speziale et al., 2011). In the description of the theory, I include verbatim participant quote to demonstrate how the theory is grounded in the data. For example, within the findings section, I write about a participant's experience at an initial prenatal appointment and the meaning she derived from this experience, including expressions of guilt and feeling of individual responsibility for her choices. It also illustrates *maternal healthism* in action, as it describes her perception was that she was failing to meet the expectation of a good mother. This focus on her weight and associated risks reinforces the societal narrative that her weight is central to her value as a mother, overshadowing other health markers. These descriptions enable the reader to apply findings in similar situations

Findings

The basic psychosocial problem of how women with a higher BMI transition into motherhood is *maternal healthism.* Central to *maternal healthism* is weight stigma, the labelling, stereotyping and devaluation associated with having a higher BMI. Weight stigma results in negative judgments and social narratives related to the underlying reasons for having a higher BMI, including being lazy, indulgent, ignorant and lacking self-control. Amid weight stigma, the problem associated with becoming a mother is *maternal healthism*. *Maternal healthism* values health as the primary focus of being a good mother. *Maternal healthism* exists in a context of societal beliefs that link a higher BMI to poor health and women living with a higher BMI are judged as not valuing health as evidenced by having a larger body and are blamed as not being in control. *Maternal healthism* represents the societal narrative that women with a higher BMI do not value health and lack self-control, characteristics believed to be incompatible with the role of a good mother.

The basic psychosocial process used to manage *maternal healthism* while transitioning to motherhood is *rejecting maternal healthism*. The physiological processes of pregnancy and birth help women to understand their body as functional, contradicting the assumption that they are inherently unhealthy. Belief in *maternal healthism* is further weakened as women experience the care and support of others who view women living with a higher BMI as capable of being good mothers, trusting women to make decisions for their health and the health of baby. *Rejecting maternal healthism* is freeing as women reject the veracity of the social narratives that limit attitudes and behaviours. This is clearly identified in the following statement from a participant:

> And I just said enough. Enough is enough. Like I look the way I look, I am the way I am. Why? Why does it mean I shouldn't have fun or enjoy my life or do the things I want to do. Like why? Why is this stopping me from doing all the things I want to do? I said and it shouldn't.

Seeing herself as healthy and capable has led to *rejecting maternal healthism*. *Rejecting maternal healthism* leads to increased confidence and agency with increased capacity to advocate for and access needed care for women and their babies.

Maternal Healthism

The basic psychosocial problem of becoming a mother while living with a higher BMI is *maternal healthism. Maternal healthism* is the societal belief that the primary focus for being a good mother is the health of both mother and baby as achieved through individual responsibility and control over her body size and is understood as a moral good. *Maternal healthism* places the responsibility (and blame) for the health of the baby on maternal behaviours and choices which leads to feelings of shame when mothers are unable to meet the expectations of what is "healthy." This belief implies that being a "good" mother requires demonstrating the valuing health by engaging in the behaviours associated with achieving a 'normal' weight.

Expecting to be judged as being unhealthy and therefore, unfit mothers based on their higher BMI is central to *maternal healthism*, reducing self-confidence, and self-worth. *Maternal healthism* acts as a weight with each new encounter with HCPs as negative judgments related to weight and therefore the ability to be good mothers are anticipated. The participants' experience of anticipating negative judgment causes stress,

affects development of relationships, and decreases the ability to ask for support for fear of being judged as inadequate.

Maternal healthism is experienced in the context of stigma and assumptions about being heavy. Having a higher BMI is associated with inherently being of lesser value, including being not as disciplined, and less healthy than thinner people leading to the devaluing of people living with a higher BMI devaluing themselves as moral or good. *Maternal healthism* is situated within traditional and historical ideologies of women's role as carers. In relation to motherhood, therefore, societal expectations suggest that the bodies of those who plan to bear a child ought to be in an optimal state to bear a safe and healthy child. Direct communication by HCPs that women are not good mothers due to having a higher BMI is not required for *maternal healthism* to exist. Indeed, HCPs did not verbalize these sentiments to the participants. Rather, *maternal healthism* exists within the power of societal ideologies that suggest women have somehow failed to prepare themselves to be a good mother because they allow themselves to be heavy. These societal narratives were silent, but no less strong, and lead to fear and shame while seeking help. *Maternal healthism* is also influenced by modern societal assumptions that to be healthy is to be 'good.'. Gendered expectations to be 'good' intersects pressures to be healthy, along with long standing medical assumptions a higher BMI implies being unhealthy.

Although HCPs did not directly communicate the judgment to the following participant that she was not going to be a good mother, the judgment was perceived, and she was experiencing *maternal healthism*. In the context of assumptions in society that being heavy is the individuals' fault, *maternal healthism* presents itself when HCPs fail to

recognize weight stigma while communicating medical concerns related to their motherhood. The following statement illustrates an example of perceived external judgment at an antenatal appointment:

> Like our first doctor's appointment, he was like "It's very high risk." These are the things, and he said it so much that when I got out of there, I was kind of freaking out and I was like, "Oh my god, like what have we done, like maybe this wasn't such a good idea."

The power of weight stigma and expectations to be a good mother is doubted when the negative aspect of having a higher BMI is mentioned by HCPs who represent knowledge and status about what is required to be healthy, and thereby, good. She interpreted the focus of the appointment, pregnancy risks related to her higher BMI, as being her responsibility; therefore, she believed that becoming pregnant meant she was being irresponsible, contributing to her feeling immoral due to the pressures to make responsible decisions as a mother. She felt not only the judgment of the HCP but also questioned whether her actions were those of a responsible mother.

Women living with a higher BMI as they become mothers live in a society that values individual responsibility and control over body size as a moral good. This judgement makes it difficult to understand for women to view themselves as good mothers and must continually confront this judgment. The effects of *maternal healthism* are intensified with multiple interactions with health care professionals and others, circumstances that are demanding of women to meet HCPs who may judge them, may include exposing themselves for examination or require being weighed and these possibilities are anxiety provoking as negative judgment is anticipated. There is also an

increased focus on the body by both them and others with women considering how their body is changing and whether they look pregnant or just "fat." One participant shared that she did not have maternity pictures taken because of her size and another participant did have photos taken but did not feel that she looked pregnant. Women living with a higher BMI also connect weight to moral choices and their value as a mother as one participant expressed, "I obviously am not in a spot where I'm making the best choices, and I need to make better choices to show to be a better example." Negative judgments from society are perceived by women living with a BMI as devaluing of themselves as moral or good.

M*aternal healthism* accounts for the variation among participants in their experiences of the problem and *rejecting maternal healthism* accounts for the variation in women's experience of the processes they used to become mothers. There is significant variation within the associated properties of *maternal healthism*. Variation in the property of *having a history of being judged negatively* was determined by time and intensity of effect. Some participants described negative experience a long time ago during childhood, for weight stigma existed for a short amount of time, not until their adulthood. *Maternal healthism* intensity of effect varied for participants; it was felt more acutely when judgment came from family. Having a *history of being judged negatively related to weight* and experiencing *maternal healthism in action* increased *anxiety and anticipation of negative reactions.* Participants experiencing more positive encounters with HCPs had decreased *anxiety and anticipation of negative reactions*.

Maternal healthism occurs in the context of a social narrative that assumes that living with a higher BMI is inherently unhealthy, and that having a higher BMI is related

to not valuing health. Not valuing health is seen as a moral failing and women living with a higher BMI are less worthy and therefore not capable of being good mothers. Living with a higher BMI is assumed to result from individual lifestyle choices, as well as a lack of self-discipline and willpower. These judgments contribute to stereotyping of women living with a higher BMI as lazy and not valuing health. Implicit in these assumptions is an understanding of having a higher BMI as immoral, evidence of not placing a high enough value on health. This is especially problematic in pregnancy as women gain more weight:

> I was stressed like the weight gain was, that's all I heard through my whole pregnancy. Like I love my family doctor. He's amazing. Like he's treated me so well and I understand his worry for me, but he did not want to see me gain any more weight like he didn't want me to gain weight during that pregnancy at all. Which was really hard.

This assumption that a higher BMI equates to being unhealthy occurs without evidence of ill health, even when women are not experiencing complications. *Maternal healthism* is powerful and persistent. Despite evidence demonstrating signs of health or lack of illness, health care providers minimized or ignored these signs and continued to assume participants' risk of illness. For example, "It was kind of weird they were really monitoring my sugars too. They were watching my weight and my sugars all at the same time because I was a bigger person." The hypervigilance of monitoring health, or assuming ill-health without direct evidence is a judgment that weight is intrinsically linked to ill-health. Within the medical model, having a higher BMI is understood in to be the result of poor choices and a lack of self-control, behaviours incongruous with the

basic expectation of being a good mother. Having a higher BMI is seen to symbolize not valuing health.

Maternal Healthism in Action

More frequent encounters with health professionals are required during pregnancy, birth, and the immediate postpartum period. In each of these encounters, women anticipate negative judgment related to their weight. Their weight and associated risks became the focus of many appointments. “I left that appointment not wanting to tell, you know, my boyfriend about it because it’s just so mortifying and it would I don’t know that whole appointment was just a horrible experience.” Encounters such as this increase anxiety and fear of being judged. Even when the encounter was positive, it was understood to be unexpected, “I’ve been really lucky with my doctors, they’ve been very understanding of my size.” Anticipating negative encounters and judgment is an added burden for these women as they become mothers.

History of Being Judged Negatively Related to Weight

Varying degrees of *maternal healthism* exist within a context of a societal narrative that equates a higher BMI with being unhealthy and lacking in self-control. Healthism is a challenge for women living with a higher BMI even before motherhood contributing to feelings of devaluation. Discrimination against women with a higher BMI being is heightened as women become mothers with the additional expectation for mothers to be healthy for baby. Women in this study experienced discrimination and judgment about their higher BMI for significant periods of time prior to becoming pregnant. Weight discrimination occurred in childhood with bullying and exclusion related to their size. Although these childhood experiences were not directly related to

health, the experiences of feeling devalued because of their weight are significant. Some have experienced pressure from family to lose weight. This pressure can be linked to health, as one woman discusses her mother's comments, "And she said she's mentioned a few times in my pregnancy how once I have the baby, 'we'll get you weight loss and we'll get you down and get you healthy'," despite not having any current health challenges.

The pressure was more than just about health, it was also about appearance and body image, including comparison with others, "I think because I spent a lot of my life not liking the way I looked and was seeing, wishing I was something else." The pressure includes health but is not limited to health, affecting their feelings of self-worth. Many have also had negative experiences with health professionals including advice to lose weight with little guidance, setting them up for failure as this expectation was not met. Assumptions about their health, physical activities, and eating habits also do not reflect their experiences. These assumptions include the idea that having a higher BMI means that they are lazy and gluttonous. This history of negative experiences preceding motherhood sets the stage for women to anticipate judgment related to not valuing health as exemplified by their weight and therefore their moral fitness and these social narratives transfer to the present as women are becoming mothers.

Internalized Maternal Healthism

After years of being judged as unhealthy and more importantly not valuing health, as women with a higher BMI are perceived as lazy and lacking in self-control. Eating well and being physically active represent valuing health, enacting moral good. When a higher BMI is equated with eating poorly and being physically inactive the belief is that

women with a higher BMI do not value health. These judgments are internalized, and women can believe their body and weight need to change, believing that their size equates to being unhealthy. The weight normative societal belief is that a higher BMI is unhealthy and can be changed by an individual making moral choices to exercise greater self-control by eating less and being more physically active. These individual changes in behaviour to lose weight are understood to be moral choices when health is valued. Having a higher BMI is evidence that they do not value their own health and are not moral and not a responsible mother. Not meeting weight normative expectations and being judged as not valuing health is especially challenging during pregnancy when women feel responsible for not only their health but also for that of their baby.

Women living with a higher BMI live in the social milieu of norms that having a higher BMI is incongruent with being healthy. Women living with a higher BMI can make similar assumptions themselves, or have the assumptions introduced by HCPs, as they identify as high risk related solely to weight despite not experiencing complications. One participant describes having a healthy pregnancy without complications but still identified as high risk, believing herself to be unhealthy: “The pregnancy was actually really good because I mean because of my age, because of my weight, it was so it was very high risk, but my blood pressure was good the whole time.” *Maternal healthism* implies that having a higher BMI is inexorably linked to poor health, leading to increased surveillance and the disregard of reassuring findings. Initially, participants felt positive about the pregnancy, but the negative judgment related to weight increased stress and negatively impacted this optimism. Participants were assumed to be physically inactive, and some HCPs assumed that women with a higher BMI would gain excess weight in

pregnancy, implying women were making poor decisions about their health. One participant stated, "I was stressed like the weight gain was, that's all I heard through my whole pregnancy." Weight concerns became the focus of pregnancy. *Maternal healthism* robs women of feeling like they are good mothers. This leads to increased stress and anxiety when being a good mother is falsely defined by valuing health as evidenced through the control of body size. One participant discusses this feeling of responsibility as it relates to her children this way:

> Most of my friends, my mom, friends or relatives are not overweight so I feel as though I stand out like a sore thumb and already at four years old, I feel like I'm not what I should be in my daughter's eyes

This acknowledges not meeting her own expectations in terms of her weight but also feels that she does not meet the expectations of her daughter and others as a mother.

The internalization of *maternal healthism* is further heightened by experiences of *not fitting in.* This physical experience of not fitting in includes a lack of necessary space, health care equipment that does not meet requirements, and even challenges in accessing appropriate clothing. Participants noted limited space in hospital rooms, making it difficult to move around, decreasing ambulation during recovery. This lack of space also negatively affects the ability to care for baby as a lack of space around the bed and cot makes it difficult to access supplies to change baby, difficult to pick up baby for feeding and difficult to return the baby to the cot for safe sleeping. The beds themselves are small, uncomfortable for larger women, contributing to the feeling of not having much room to move, "I wasn't able to leave the bed, which I found really difficult as a big person 'cause I have a hard time getting comfortable.*"* Other pieces of equipment that are

not readily available for women living with a higher BMI including medical equipment such as blood pressure cuffs, making it difficult to have an accurate blood pressure reading. The lack of appropriate equipment and spaces to meet the requirements of women reflects a lack of consideration of their needs, heightening the experience of *not fitting in*. Pelvic discomfort in pregnancy is often treated with pelvic support bands that do not conform well to larger bodies, creating more discomfort. The increased pressure needed to use abdominal ultrasound with a larger abdomen can be very uncomfortable. This feeling of exclusion for larger bodies is also heightened by clothing. Pregnancy creates a need for new clothes to fit her changing body. Participants reported that finding appropriately sized clothes can be challenging, selection is often limited, and prices are generally higher than smaller size clothing. These experiences of not fitting in contributes to the sense that they are not the norm, not expected to become mothers and their needs are not valued.

Anxiety and Anticipating Negative Reactions

The consequences of *maternal healthism* for women living with a higher BMI are anticipating negative reactions and feeling afraid to be judged as to their capacity to be good mothers. This anticipated judgment can involve both personal and professional relationships. The anticipation of negative reactions results from both the understanding of the social narratives related to having a higher BMI as well as the internalization of *maternal healthism* resulting in feelings of shame. Carrying this knowledge and shame results in women anticipating negative reactions, projecting judgment from others often without basis. One woman addresses this as she is reluctant to leave the house following

the birth of her most recent child, believing that she is not meeting her daughter's expectations:

> I haven't been out yet and I think that's another struggle is you know most of my friends are not big. Most of my friends, my mom, friends, or relatives are not overweight so I feel as though I stand out like a sore thumb and already at four years old, I feel like I'm not what I should be in my daughter's eyes.

She is anticipating negative judgment, feeling shame that she is not meeting the expectations for being a good mother, as if her weight is a signal that she is not in control of her body and does not value health. This anxiety and anticipation of negative reactions includes a fear of being judged by HCPs, "I was nervous to have a doctor that was going to make me feel bad about my size." Having a higher BMI is associated with lacking in self-control, weight is blamed on individual behaviours related to eating and physical activity, inducing a sense of shame in women. Health status and being seen to value health through lifestyle behaviours are moral imperatives for being seen as a good mother; having a higher BMI is incongruent to being seen as a good mother. Understanding that having a higher BMI is linked to not valuing health leads women to anticipating negative reactions.

Figure 1

The Problem: Maternal Healthism

Rejecting Maternal Healthism

Rejecting maternal healthism is the basic psycho-social process used to address the basic psycho-social problem and involves setting aside or discarding the assumptions attached to *maternal healthism*. The assumption that underlies *maternal healthism,* that women with a higher BMI do not value health, is untrue. Women living with a higher BMI do value the health and enact this value as they care for baby. This care includes meeting physiological needs such as feeding, engaging with baby, as well as seeking care from HCPs as needed. *Rejecting* occurs as *maternal healthism* is determined to be inaccurate. Women in this study recognized that to be a good mother is not primarily achieved through individual responsibility and control over body size but rather on caring for baby. Women recognize that they are good mothers as they develop a belief in their own ability to care for baby. The assumption that having a higher BMI is unhealthy is also rejected as the larger body is understood as functional in that it has created new life. *Rejecting maternal healthism* occurs as the physical experience of pregnancy and birth imply that the body is functional and the experience of caring for baby demonstrates that the woman is a capable mother. Women living with a higher BMI become mothers in this milieu of judgment related to assumptions about valuing health as the focus of being a good mother. Through this transition women begin to understand their bodies as functional, experience feeling cared for as a mother without judgement and begin to reject the premise of *maternal healthism* with the consequence of rejecting the stigma and blame associated with weight.

Rejecting is a process used to resist the judgments associated with *maternal healthism*. Within the process itself there is variation as some women are beginning to

question the premise of *maternal healthism*. Namely that a higher BMI signifies not valuing health and a lack of self-control, ideas that are contrary to the expectations of a good mother, while other participants are more confident and have a more positive self-concept. These participants have moved beyond questioning the premises to complete *rejection*, no longer experiencing the consequences *of maternal healthism*. One participant discussed how much more confident she was in her abilities and no longer anticipating negative reactions from others. She shared how this enabled her to seek the support of others she needed to reach her full potential rather than trying to prove herself capable by not asking for support. She had *rejected maternal healthism*. Variation of the process exists as women have more experiences of *knowing the body as functional*, *rejecting maternal healthism* is easier.

Knowing the Body as Functional

Rejecting maternal healthism is contingent upon the recognition of the body as functional and healthy. The biological processes of becoming a mother: becoming pregnant, pregnancy, birth, and recovery have demonstrated the functionality of their body, “I still feel like that right now, like even when I went for ultrasounds and the nurses would tell me like this is her brain or this is her heart or whatever and I be like, it’s so amazing.” The experiences of pregnancy and birth are evidence of a capable body, a healthy body.

Women in this study recognized their ability to care for their infants with competence. When unsure of how to meet the needs of baby there is confidence that they are a good and capable mother:

> But still now sometimes there's stuff that I have no idea like sometimes she cries and I'm like I don't know. I'll try to change her. I'll try to give her some food. I'll try it and put her to sleep like I don't know what she wants. Whichever one works, that's what it is.

In reflecting on caring for baby, this participant shares the confidence in her ability to meet the needs of the baby, understanding that she is learning, she is capable and adaptable as a mother. She may not immediately know what is needed but she is confident in her ability to meet the needs of her baby. She is not worried about her ability to be a good mother to baby. Other challenges related to becoming a mother are addressed with similar confidence. This was also seen in the description of one woman's experience as baby was given formula after birth and was now experiencing challenges establishing breastfeeding, "We will overcome this formula thing." There is confidence in their ability to be a good mother, a belief that the body is functional and capable.

Feeling Cared for as a Mother

The condition for women to reject *maternal healthism* is feeling cared for as a mother. This requires that people caring for her believe in her ability to be a good mother, that she will meet the needs of the baby. Trusting that others believe in her ability to be a good mother means that these encounters do not provoke anxiety but help her to feel safe rather than anticipating negative reactions. These relationships can be personal with a friend or family member, or professional with a health care provider. One of the primary factors contributing to a good relationship with a health care provider is one without negative judgments related to body size. Women wanted their health care provider to trust that they were going to make decisions that were positive for their own health and

that of baby. A physician offered the choices in planning the birth for one participant. In this scenario the woman needs to decide whether she would like to induce labour and try for a vaginal birth or plan a caesarian section. She felt empowered by her physician in that she would make the best decision for her and baby. This trust was further supported by her partner:

> So, I came home, and me and my boyfriend talked about it and he basically said like it's your body, it's your choice, do what you want but like I said I still want to discuss it with you and so we've decided we're going to try the induction.

Feeling cared for as a mother requires belief in their ability to be a good mother. This belief is demonstrated by HCPs trusting women to make the best decisions for themselves and their baby. Partners, families, and others demonstrate this belief to women living with a higher BMI as they become mothers through emotional and practical support. These relationships contribute to a feeling of being cared for as a mother:

> But the support of my family and my boyfriend or my spouse, it's he's been amazing. He works from home, so sometimes he'll hear like, just her crying, so he'll go on like on a break and just come down and be like, OK, we'll take 5 minutes and just catch your breath.

She explains how her partner supports her to be calm and able to manage her role as a mother and is based in a belief in her ability to be a good mother. Another woman shared that her mother moved in with her so that she could continue in school. Other women described support from extended family as they transitioned to becoming mothers, including helping with lifting the car seat as a woman recovered from a caesarean section

and cared for baby. Having someone to lift the car seat helped decrease isolation as it enabled her to leave her house. Support was provided so that the woman could care for baby and be a good mother.

For one woman, this included a friend who encouraged her to get pregnancy pictures done despite the woman not feeling like she looked pregnant, looking back at the pictures she is able to see that her body did look pregnant and not just "fat."

> When I was in it, I couldn't tell. But I can tell now like now that I see myself like in the pictures even before when we got the pictures. I was like you can't really tell that I'm pregnant. It just looks like my regular belly. But now that I'm after now, I can tell, I'm like oh my god, yes, you can tell I was pregnant.

This friend saw her as a pregnant woman, respected and supported her as a mother, the friend encouraged her to see herself as a mother. The friend did not accept *maternal healthism* and through her care was able to help the woman begin to reject it as well.

Feeling cared for as a mother, being valued for their capability as a mother, for by health care providers is important to rejecting *maternal healthism*. When a woman feels cared for (and respected) as a mother, it negates the societal belief of *maternal healthism*, that their value as mothers is not determined by BMI.

> He didn't try to make me feel bad. He just told me how it was. Cause I have friends who have horror stories of doctors that they're like 'you need to lose 10 pounds' and they're like, 'I'm already skinny,' so I was terrified, and I felt very blessed that he was so understanding of my experience.

Another woman spoke of a nurse who recognized how much she was struggling being separated from her first child following the birth of her second. This nurse arranged for a

short visit with her first child and then she was able to focus on mothering baby. The woman is able to reciprocate that trust as the anxiety and stress of anticipating negative judgments is diminished as she is seen as a good mother. When women receive support from therapeutic relationships as unconditional upon their weight, they are better able to reject the judgment and labels of *maternal healthism* not relevant to their experience. Women felt supported when HCPs had a caring attitude and valued their decisions and choices. These health care encounters contributed to a sense of security that they could trust and rely on the HCP.

Others expressed confidence and faith in women's mothering by noticing their strengths and communicating these to the women, helping women living with a higher BMI trust their capacity to make decisions for themselves and their families. This is a catalyst to dismantling the women's perceptions that they are not knowledgeable and capable of caring for themselves and their babies. Being recognized as a good mother contributes to women's perceptions that they are good mothers. These relationships, personal and professional, during the time women become mothers contribute to women feeling cared for and important, leading to the confidence required to *reject maternal healthism*.

The Fallacy of Maternal Healthism

The primary cause for the process of *rejecting maternal healthism* is the experience of being good mothers with a higher BMI. *Maternal healthism* comes to be recognized as a fallacy, through dismantling the two components of the definition: firstly, that their body is functional as there is a healthy baby and they are well so having a higher BMI and not being healthy has been disproved; and secondly, they understand

themselves to be good mothers while living with a higher BMI. Women recognized the assumptions related to a higher BMI and health were often wrong. One woman shared the inaccurate judgments about her physical activity level:

> It was clearly based on a number like I was like, you've never met me. You've never seen me. You don't even ask about my activity level, which like, considering that I worked at [workplace] and I'm a [professional] which is pretty high [physical jobs], I was like OK, whatever.

Others identified negative predictions about the health and well-being of themselves and baby that did not come to fruition. One participant was predicted to have a baby over 10 lbs (it was not) and another woman was advised that she was likely to have an inadequate milk supply, but her experience differed:

> I always had really fatty, really rich thick milk and always an overabundance like I ended up donating for a while to some other families because I had a deepfreeze full, and I couldn't do anything with it.

Women living with a higher BMI do experience health challenges but the experience of becoming a mother defies the catastrophizing that assumes that size equates to a body that is not functional. Weight loss may be desired but there is an understanding that living with a higher BMI does not equate to not valuing health, not being healthy and not being seen as a good mother.

Consequences of Rejecting Judgment

The consequences of rejecting stigma include a more positive self-concept and a self-confidence in a being a mother. Women also begin to have an acceptance and greater

connection to the body, no longer seeing it as separate, an entity that requires changing but rather that the body is also capable, functional, and well:

> I actually loved my body most when I was pregnant because I had a reason, you know what I mean? Like there was some reason my belly was round and so I loved me belly and I loved knowing they were in there and that I was keeping them safe.

This acceptance and understanding of herself as a good mother helps her to *reject maternal healthism* as false both in that the body is recognized as functional and well, and that she is a protector and a good mother.

Another consequence of *rejecting maternal healthism* is decreased stress and anxiety related to the anticipation of negative judgment. Although it may still be present as a societal belief, it is viewed as not being true; it does not reflect the experience of becoming a mother. Feelings of shame and blame are diminished, resulting in increased confidence in the woman's sense of being a good mother. Asking for help requires confidence. Mothers do not want to be seen as not capable, particularly when they are already anticipating negative judgment related to their ability to be good mothers. As women reject the judgment from other people as well as their own internalized judgment, they are more able to advocate for themselves and their child. Women are able to advocate for the support needed to succeed. One woman living with a higher BMI discussed how this confidence made it possible for her to ask for the support she needed from friends, family, and others. She shared an example of needing extra time between classes to breastfeed her infant and talking with her professors about her situation:

> I wouldn't have been able to do that without the confidence of being able to do it, you know, because she was what, three or four months old. And without the confidence of being able to talk to my professors too, about it. So, because they were always aware that, you know, like there was this one class that would, I would always be 10 minutes late for because it just took that much time to run back and get back to class.

The increased confidence in her ability to be a mother occurs with varying degrees as women living with a higher BMI experience success and recognize the falsity of the premises *maternal healthism,* that the primary focus for being a good mother is the health of both mother and baby as achieved through individual responsibility and control over her body size and is understood as a moral good. Anxiety related to being judged as not being good mothers is diminished, making it less stressful to seek the help needed to be successful.

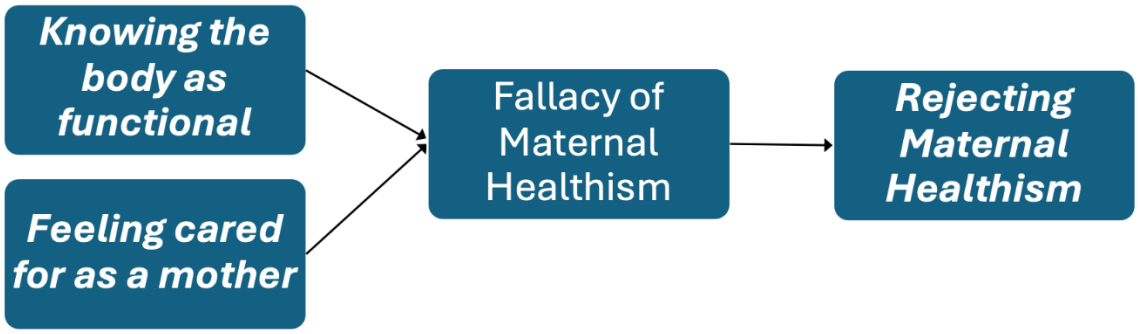
> You definitely need that you know self-motivation to reach out for that kind of help as well. And you know, I find that I didn't get that until I was further along with, like, my having the third child.

This confidence leads to a greater sense of agency, and belief in their own ability to meet the needs of themselves and baby. This results in women accessing health care for themselves and baby, having the confidence to identify when the care was not meeting their needs, and to advocate for the care needed, including seeking help for postpartum depression, and advocating for treating ankyloglossia to improve breastfeeding. With this agency women can seek the expertise of health care providers to meet the needs of

themselves and their baby with the confidence that seeking help is not seen as further evidence of not being a capable mother.

Figure 2

The Process: Rejecting Maternal Healthism



Discussion

Rejecting maternal healthism is an important addition to the literature as no other studies describe how women living with a higher BMI navigate the transition to motherhood. There is an abundance of literature related to the health risks and challenges of pregnancy, birth, and the postpartum period among women with a higher BMI. This literature is limited, however, as much of the research is situated within the biomedical model, reflecting the standpoint of HCPs and neglecting understandings of the subject from the women's perspectives. *Rejecting maternal healthism* reflects the process of becoming a mother within a feminist worldview, focusing on women's perspectives and societal factors that have historically oppressed women, including gender expectations to be perfect and care for others, toxic pressure that is detrimental to mothers today (Henderson et al., 2016). A feminist approach aims to share power within the research process and develop knowledge collaboratively with research participants (DeMarco et al., 1993). In this way, study findings were developed through women's knowledge and sharing, yielding findings that are grounded in the rich descriptions of their experiences.

Guided by a feminist lens, *rejecting maternal healthism* addresses immorality that is dominated by a privileged male perspective. Hekman (1993) asserted that "moral notions, like the subjects who hold them are contextual and relational. They are constituted by the discourse or language games of the societies in which those subjects live" (p. 159). Historically, theories of morality have been developed by men with the primary subjects of study also being male, with the experiences of women and girls discounted and sometimes seen as deficient in moral theory (Gilligan, 1982) and a male perspective has informed the definition of morality. *Rejecting maternal healthism* challenges notions of morality by challenging the discourse that health and morality are linked or that being physically healthy is a moral obligation.

The literature reflects the experiences of participants in this study including: a history of struggling with their weight (Dinsdale et al., 2016; Knight-Agarwal et al., 2016b; Lauridsen et al., 2018), feeling the burden of being labelled as "at-risk" (Norris et al., 2020), being treated as at-risk during interactions with HCPS provoking feeling of anxiety and shame (Thorbjörnsdottir et al., 2020), and the medicalization of becoming a mother with a higher BMI (Pausé et al., 2019), consistent with the findings from this study.

Situating the Problem in the Literature

Healthism, a term introduced by Crawford (1980) that describes the medicalization of health and well-being, supports the meaning of *maternal healthism*. Healthism situates difficulties in wellness and responsibility for health and illness at the level of the individual. Achieving health and wellness is viewed as a moral obligation and that being 'healthy' is synonymous with personal value, thereby, the narrative is that

healthy people are ‘good’. Further, the measure of health and being a ‘good’ person is dictated by the measure of physical health, while neglecting the importance of mental, psychological, or emotional health. If being physically unhealthy is viewed as being the fault of the individual, as a higher BMI is blamed on being lazy and lacking self-control, then having a higher BMI is seen as a moral failing. The social narrative within the medical field and broadly within society that a higher BMI is evidence of poorer health, combined with social expectations to have a BMI within the normal range or to have the appearance of not being overweight, contributes to the idea that living with a higher BMI is a personal moral failing. Conceptualizing health and illness through medicalization involves defining conditions in medical terms, usually as an illness or disorder, and uses medical interventions to address conditions (Conrad, 2005). Pathologizing human conditions such as sadness (Horwitz & Wakefield, 2007), shyness (Lane, 2007) disabilities (Franklin et al., 2020), and weight (Bombak et al., 2016) results in conditions being seen to require medical interventions, often pharmaceutical to change what may be a normal experience or perhaps be better addressed with other interventions. This is problematic for individuals living with a higher BMI in two ways: (1) the condition is labelled as an illness or disorder that must be addressed and (2) medical interventions are aimed at individuals that do not consider the sociopolitical factors underlying having a higher BMI. Labelling of a higher BMI as an illness or disorder leads to the assumption that the condition requires treatment and medicalization places the responsibility to address the problem on the individual rather than the other factors that contribute to a higher BMI, such as the socioeconomic and genetic factors. There are higher risks associated with a higher BMI in the perinatal period including developing venous

thromboembolism, gestational diabetes, gestational hypertension, and pre-eclampsia (Alves, 2024), complications in birth (Carlhäll et al., 2020) and increased risks for their newborns (Pratt, 2020). Although the risk is higher with a higher BMI, all these complications can also occur with women with any BMI and most women with a higher BMI without pre-existing conditions will have an uncomplicated pregnancy. Assumptions that underly the bias against having a BMI outside of a determined ideal weight range include that this is an unhealthy state, individuals are at fault for having a higher BMI, and that weight loss must be prioritized (Walsh et al., 2023).

Maternal healthism is a form of medicalization, situating a woman's BMI as a pathological condition that must be addressed for the health mother and baby, at the individual responsibility of the mother. The term is used elsewhere in relation to reproductive health, and traditional views of health, with a primary focus on physical health. The moral imperative of being a good mother or good reproductive citizens (Potvin, 2018) parallels with the moral good that characterises maternal healthism in the context of mothers with a higher BMI. (Potvin, 2018) uses this term as a concept describing the women's responsibilizion and the expectations of maternal sacrifice to protect the health of the fetus and its impacts for reproductive freedom.

In this study of women with a higher BMI, the concept emerges from the participants. Defining the problem experienced by women living with a higher BMI as they become mothers as *maternal healthism* is novel as it situates the problem as arising from harmful societal beliefs rather than women's weight accounting for the strengths and challenges of the transition to motherhood. Many women living with a higher BMI do not perceive themselves as obese (Cunningham et al., 2018; Jarvie, 2017; Kominiarek

et al., 2015; Lauridsen et al., 2018; Norris et al., 2020) and do not identify with the defining characteristics of obesity, including physically inactivity (Kominiarek et al., 2015). An underlying message within the literature is that women with a higher BMI are in denial of their obesity and that it is a serious problem. Conceptualizing a higher BMI and obesity as pathology, without considering social context, women's perspectives of their health, and their strengths in motherhood, results in time and energy being wasted on pressuring women to change. Whereas this study found that women are aware of the health risks of a higher BMI, *maternal healthism* meant that they received unhelpful pressure to focus on their BMI. Other studies support these findings. Health care for women with a higher BMI is centered around convincing them of the risks of obesity (Keely et al., 2011; Kominiarek et al., 2015; Loh et al., 2018; Norris et al., 2020; Spencer & McIntosh, 2016) and behavioural treatment plans to lose weight, including increasing physical activity and changing eating patterns (L. Atkinson et al., 2016; Heslehurst et al., 2011; Petrov Fieril et al., 2017).

Health and moral assumptions about motherhood among women with a higher BMI that underlies *maternal healthism* are reinforced by known health risks. Women with a higher BMI have a higher risk of miscarriage (Malasevskaia et al., 2021), of developing venous thromboembolism, gestational diabetes, gestational hypertension, and pre-eclampsia (Alves, 2024) and complications during birth (Carlhäll et al., 2020; Maxwell et al., 2019) in comparison to women who do not have a higher BMI. Health risks place health care professionals on alert, turning the treatment focus to weight to reduce harm in their patients, without considering the harm caused by this singular focus on weight. It is possible that health care providers are influenced by obesity stigma,

informing their assessment and treatment practices, overlooking non-weight related issues in pregnancy, birth, and motherhood important to women with a higher BMI. Jasper (2020) provided a philosophical dialogue of the medicalized approach that is influenced by globalism and growing technologies that helps to situate *maternal healthism*. Within an epidemiological landscape of risk statistics and the capacity to control health outcomes with growing technologies, the collection of demographical information that targets groups of people with health statuses that are highly influenced by social and political factors, risks a diagnostic and surveillance environment wherein health inequity thrives (Jasper, 2020). Medicalization of having a higher BMI overshadows the experience of becoming a mother, centering the focus of care on weight-related issues without considering the experience and knowledge of women becoming mothers. The medical model assumes that the individual woman is responsible for the health of her and baby; her individual health behaviours demonstrate that she does not value health and therefore is not a good mother.

Maternal healthism is symbolic of the messages women receive from others, often HCPs, related to their responsibility for the health of their baby and particularly the ways that the body size represents poor choices and a lack of self-control. It symbolizes immoral choices when striving, or being seen to strive, for health and wellness is understood to be a moral obligation. In a thematic analysis study of memorable messages of women with a higher BMI received while trying to conceive, when pregnant or postpartum, Basinger et al. (2023) identified themes including “fat mothers are bad mothers” (p. 3072), denial of competent care, and a weight normative commentary in which others made assumptions about health status based on size. These themes parallel

the findings in this study. The message that "fat mothers are bad mothers" ((Basinger et al., 2023, p. 3072) resonates with *maternal healthism* as the societal belief that having a higher BMI is linked to not valuing health, a moral imperative for a good mother. Denial of competent care included structural barriers such as inappropriate or ill-fitting equipment, issues also identified by participants in this study. Basinger et al. (2023) also identified a lack of compassion and a limited education for treating larger bodies as ways that women were denied appropriate care, factors that contribute to experiencing *maternal healthism in action*. The weight normative commentary theme included assumptions that smaller bodies are better, and that weight loss should be prioritized after pregnancy, assumptions that reflect *history of being judged negatively related to weight*. Participants in both this study and the Basinger et al. (2023) thematic analysis experienced HCPs assuming illness such as high blood pressure or gestational diabetes despite no diagnostic findings on the basis of BMI.

Parker & Pausé (2018) examined the experience of pregnancy and concluded that faulty narratives within society about having a higher BMI conflicts with the image of what is it is to be a good mother, beliefs that are highly influenced by the World Health Organization declaration that obesity is an epidemic (Obesity & World Health, 2000). Maternal healthism is an example of biopolitics, in which individuals "are made aware of their responsibility to conform to expert advice concerning the monitoring, regulation and disciplining of their bodies" (Lupton, 2012, p. 335). Parker & Pausé described how policy, procedures, and the medical narrative that prioritize ending obesity may harm mothers' self-worth. Women living with a higher BMI set aside their own knowledge of their pregnancy and enjoyment of pregnancy through the experience of the medical

management of their pregnancies and biopolitics as their bodies were problematized as a threat to the health of their baby (Parker & Pausé, 2018).

The weight stigma of *maternal healthism* is supported by a well-established body of literature that recognizes negative social stereotypes and labels such as referring to those living with a higher BMI as being "lazy, awkward, sloppy, non-compliant, unintelligent, unsuccessful and lacking self-discipline or self-control" (Obesity Canada, n.d.-b, para. 4). Women living with a higher BMI both perceive and experience weight related stigma. The intersectional experience of women living with a higher BMI as they become mothers involves oppression related to the experience as a woman (Hekman, 1995), oppression related to weight (Pausé & Taylor, 2021), and the oppression related to reproduction (Morgan & Roberts, 2012) that have social and systemic manifestations that create barriers and challenges to having agency in the world.

The agency and power demonstrated in *rejecting maternal healthism* is a novel and significant contribution to understanding motherhood among women living with a higher BMI because this concept diverges from the dominant narrative of women's oppression in the context of gender expectations to be a perfect mother, weight stigma, and other versions of healthism. *Rejecting maternal healthism* captures the knowledge of health, wisdom and experiences of women as opposed to labelling their resistance as denial when weight management is not their priority.

Embodiment is "lived experience of engagement of the body with the world" (Piran & Teall, 2012, p. 171). The developmental theory of the experience of embodiment (Piran, 2016) aligns with maternal healthism and *rejecting maternal healthism*. Dimensions of the construct of embodiment include body connection, agency

and functionality, and resisting objectification and each dimension can have negative and positive aspects. In Piran's theory (2016), body connection refers to the quality of connection to the body and comfort within the body. When negative this is part of the concept of *internalized maternal healthism* as women are uncomfortable in their own body. When this dimension is positive women and girls are able to engage in constructive self-talk (Piran, 2016), similar to the positive self-identity resulting from *rejecting maternal healthism*. The dimension of agency and functionality aligns with the consequences of *rejecting maternal healthism* as women develop a more positive self-concept, confidence and the ability to advocate for themselves and their babies. Resisting objectification is "inhabiting the body as a subjective site (vs. and objectified site)" (Piran et al., 2020, p. 118), meaning the body is described in terms of function, resisting judgment of the body related to its appearance. *Knowing the body as functional* varies from accepting the body to loving the body with the understanding of its functionality.

Rodgers et al. (2024) found that women with a higher BMI experienced a positive connection with their body, recognizing its functionality and that it is capable of producing life, realizations that lead to positive feelings towards changes in their appearance, shape, and weight (Rodgers et al., 2024). The findings from that study are transferable to the theory of *rejecting maternal healthism*, particularly in relation to the property of *knowing the body as functional*.

A phenomenological study examining women's perceptions of risk associated with having a high BMI rejected labelling as overweight and at-risk. This was identified as being in denial (Norris et al., 2020). Denial implies that women living with a higher BMI are unaware or not accepting health risks that are associated with having a higher

BMI. Accusing women of being in denial about their weight reinforces HCPs' efforts to convince women of the risks and place pressure on women to lose weight (Norris et al., 2020). Believing women are in denial is to assume that they are rejecting reality, a belief that is contradicted by *rejecting maternal healthism* as women in this study did not deny the risk of having a higher BMI and were aware of the possible negative health outcomes during pregnancy and birth. However, *rejecting maternal healthism* involves dismantling the idea that weight control is a moral imperative. Instead of a focus on weight, rejecting maternal healthism is a prioritization of care for their new baby, family, and themselves. Health care providers view pregnancy and the immediate postpartum period as a time to promote weight management (L. Atkinson et al., 2016; Fathnezhad-Kazemi & Hajian, 2019; Olander et al., 2016); however, women with a higher BMI view pregnancy as a time when being larger is acceptable with reduced pressure to control their weight (Denison et al., 2015; Keely et al., 2017; Lingetun et al., 2017; Loh et al., 2018; Olander & Atkinson, 2013; Weir et al., 2010). Weight stigma and weight bias are prevalent in society and being part of this society, women understand the judgments of *maternal healthism*.

Rejecting maternal healthism is a resistance of women's oppression related to weight stigma, adding to women's sense of agency. *Rejecting maternal healthism* is a productive response to negative judgment: women living with a higher BMI recognize that the problem is *maternal healthism*, not their body, and not their ability to be a good mother. The process of *rejecting* parallels the body positivity movement as women push back against oppressive body pressures of unrealistic standards of beauty in the media (Lazuka et al., 2020) by rejecting the expectations of body size for women becoming

mothers. There is a parallel movement related to health care for people living with a higher BMI, Health at Every Size (HAES) which advocates for access to compassionate and comprehensive health care for people of all sizes, free from anti-fat bias and with a focus on well-being care and healing (Association for Size Diversity and Health, 2024). One of the principles that underly HAES is that health is a sociopolitical construct that reflects the values of society, and as such there is a need to critically examine how health, illness, and disease are defined. This reflects the problem of *maternal healthism* as controlling weight is seen as a moral value and that women living with a higher BMI are rejecting this requirement to be seen as a good mother.

Implications

Maternal healthism and *rejecting maternal healthism* have applications in health care at the level of individual interactions between women and HCPs, policy development, and education. *Maternal healthism* represents a call for dismantling societal beliefs related to body image, weight, and health which lead to judgments that influence health care delivery. A gender lens will help to challenge assumptions about health and weight in the context of motherhood. Indeed, the body positivity movement within the last couple of decades within popular media (R. Cohen et al., 2019) and academic literature (Rodgers et al., 2022; Rupp, 2023) and more specifically about health in the Health at Every Size movement (Association for Size Diversity and Health, 2024; Rupp, 2023; Smith, 2019), have identified the need to move beyond the emphasis on weight and weight loss in health care delivery. The intention of these movements to strengthen a weight-inclusive approach facilitates a more positive self-concept as women unlearn a history of weight stigma and internalization of the thin ideal (Rupp, 2023). Dismantling

weight stigma will strengthen women with a higher BMI to *reject maternal healthism.* Women with a higher BMI may experience anxiety and other psychological distress anticipating negative HCP reactions when accessing care during pregnancy, birth, and the postpartum period. HCPs can reduce psychological distress in women with a higher BMI by avoiding an emphasis on weight to reduce the risk of women's perception that they are being shamed for being unhealthy and lacking self-control. Indeed, Pausé et al. (2019) found that the medicalization of obesity or treating the body with higher BMI as an illness in pregnancy failed to improve maternal and infant health, reduced the mothers' sense of well-being, disrupted their maternal identity, and created anxiety and hypervigilance about their children's weight.

The finding that *maternal healthism* may result in women living with a higher BMI avoiding or delaying accessing health care related to weight stigma and bias, is evidence of the critical need for low barrier services for mothers living with a higher BMI, study results that are transferable to non-mothers with a higher BMI. Women living with a higher BMI have been found to delay or avoid health care due to fear and embarrassment of confronting HCPs' negative attitudes, being weighed, health care equipment that fails to accommodate bigger bodies, having to undress for examinations, and being advised that they should lose weight (Puhl & Heuer, 2009). Low barrier health care for women with a higher BMI includes education for HCPs on the harms of weight stigma and the universal design of spaces and equipment (crutches, wheelchairs etc.) to be accommodating and readily available for larger bodies.

A positive maternal identity is strengthened by confidence and competence. HCPs can support women's positive maternal identity by helping them to *reject maternal*

healthism through believing in their mothering abilities, involving women in their care plan, and trusting that they are doing their best to care for themselves and their babies. Helping women with a higher BMI to recognize the ways that their body is functional by producing and sustaining life can support the woman's readiness to *reject maternal healthism*. Education of HCPs to recognize and acknowledge maternal healthism will increase their capacity to reduce harm both by resisting assumptions that a woman with a higher BMI is unhealthy or that she lacks self-control and does not value health. Although a higher BMI is linked to a higher risk of developing venous thromboembolism, gestational diabetes, gestational hypertension, and pre-eclampsia (Alves, 2024) and experiencing birth complications (Carlhäll et al., 2020) it is important to avoid equating a higher BMI with being unhealthy. Although there are heightened health risks, most women without pre-existing illnesses will experience uncomplicated pregnancies even with a higher BMI (Relph et al., 2021); therefore, women with larger bodies should not be discriminated against. Supporting women to question and *reject maternal healthism* may help to reduce negative self-identity, increase health care access, and support the development of a positive maternal identity. Supporting women to *reject maternal healthism* and achieve a positive maternal identity will foster a strong relationship between mothers with a higher BMI and their babies. Whereas false assumptions about BMI and maternal health impedes HCPs' ability to provide accurate and appropriate support. Maternal health education ought to be more reflective of the data on obesity and risk. For example, a Canadian study found most women with a BMI in the obesity category without early complicating factors or pre-existing conditions, had

uncomplicated pregnancies (Relph et al., 2021). Adopting balanced facts and information about living with a higher BMI will help HCPs to reduce *maternal healthism*.

Recognizing that a higher BMI is the result of multiple complex factors including genetics, environment, and psychosocial factors is important for avoiding a focus on individual lifestyle behaviours to managing health in the context of a higher BMI. Dominant strategies for responding to a higher BMI are behavioural in nature, with the focus on changing lifestyles such as diet and physical activity (Obesity Canada, n.d.-a), approaches that risk blaming the individual and have limited effectiveness without resources and supports targeting the social determinants of health (SDOH). Indeed, people with a higher BMI experience higher rates of economic difficulties related to employment discrimination, including earning lower wages than people without a higher BMI (Puhl & Heuer, 2009). Further, intimate partner violence (Alhalal, 2018), lower education levels (A. K. Cohen et al., 2013), adverse childhood experiences (Schroeder et al., 2021), and lack of community amenities (Dixon et al., 2021) contribute to a higher BMI and are generally beyond a person's control. Managing a higher BMI requires targeting SDOH instead of blaming individuals for their problems. Governments, health care authorities, and other agencies and services can make policy and procedure change to support women. Health policy currently focuses on prevention of health risks associated with a higher BMI. Broadening the focus of maternal health care for women with a higher BMI beyond risks and harms associated with weight-related conditions encompasses policies could mitigate *maternal healthism*. A public health movement to considering the SDOH and how to better support women in *rejecting maternal healthism*

by avoiding a singular focus on the BMI score to guide health care decisions can change the narrative on the maternal treatment and care.

Changing social narratives that a higher BMI does not imply that the person does not value health, and that a higher BMI is not a moral failing nor that is associated with having a deficit in the ability to be a good mother will strengthen HCPs capacity to support women. Disrupting the societal assumptions that underlie *maternal healthism* involves HCPs' challenging personal biases that a higher BMI is associated with lack of self-control. Dismantling the assumptions that underlie *maternal healthism* can help HCPs to reject these assumptions, which will facilitate their capacity to support women with a higher BMI to do the same.

Supporting women in *rejecting maternal healthism* includes emphasizing women's strengths as well as the progress of the pregnancy, growth and development of the baby, and postpartum recovery can help women understand the body as functional. Listening to women's experiences of pregnancy and trusting women to make health care decisions that are right for them will contribute to feelings of safety when seeking health care and may increase women's self-concept. With this approach, HCPs can help women to feel good about their mothering.

Incorporating a variety of health indicators such as elevated blood glucose and elevated blood pressure to guide health care decisions may reduce automatically and inappropriately attributing potential health problems to weight. These changes may reduce shame and stigma among mothers or women preparing to be mothers who live with a higher BMI but also strengthen the capacity of women to *reject maternal healthism*. Supporting women to *reject maternal healthism* is important for those

experiencing complications related to a higher BMI such as gestational diabetes or hypertension during pregnancy, and a difficult birthing process, conditions and situations that may make developing a positive maternal identity more challenging.

Limitations and Directions for Future Research

A lack of sample diversity is a limitation to transferability in this study. Seven women agreed to participate in this research following posts to related social media groups, a sample size usually sufficient for an initial grounded theory. Only one participant identified as a racialized minority; therefore, future research ought to include purposeful sampling for racial diversity for recruitment methods. All participants were cis-gender females and had male partners; therefore, future research ought to include gender diverse participants and non-heterosexual relationships. There was more diversity in socioeconomic status; however, the core categories and properties did not vary among participants. Nevertheless, a larger sample may have yielded variations among participants that were accounted for by diverse socioeconomic factors.

Replicating a grounded theory analysis with a more diverse sample will help to examine how the concepts within the rejecting maternalism theory emerge. Aiming for theoretical saturation with a larger and more diverse sample would expand transferability of the findings. Another area of future research is to explore the possibility of variation in rejecting maternal healthism through potential subprocesses. Indeed, *internalizing maternal healthism* became apparent through the analysis process but did not survive the constant comparative process. As the analysis evolved, *internalizing maternal healthism* was not the core problem but rather a category related to the core problem of *maternal healthism*. Theoretical sensitivity to these concepts in a future study may broaden

understandings of the theory. In addition, future studies focused on knowing the body as functional in the context of living with a higher BMI throughout the transition to motherhood may strengthen efforts to support women in becoming mothers.

Despite these limitations, the present study has added to the understanding of how women living with a higher BMI become mothers. It has identified that the problem is not women's lack of control or body size but rather it is *maternal healthism* and therefore the processes women use to navigate this challenge are not related to weight control, it is rejecting the veracity of *maternal healthism* and the judgments and shame associated with it. This theory has been developed from women's perspectives, recognizing their strengths and agency used to resist the societal belief and social narrative of *maternal healthism* in forming a positive maternal identity.

Conclusion

Women with a higher BMI are exposed to the problem of *maternal healthism* as they become mothers. Rejecting maternal healthism as a value and in its judgments allows women to form a positive maternal identity within the dominant social narrative that the control of body size indicates valuing health and is a moral imperative for mothers. There is a need to both examine this narrative and to support women in the process of *rejecting*. Knowledge translation of these findings is necessary to achieve these goals. These findings will be shared in presentations at conferences and developing a poster to share this knowledge. Strategies to share these finding include participating in conferences with the intention that this work can contribute to future research with a more diverse sample, consider the transferability of the theory to other populations and to

examine subprocesses such *as internalizing maternal healthism* and *knowing the body as functional*.

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Appendix A – Letter of Information

Letter of Information

Research Project

How women living with a higher BMI become mothers.

Researcher

Carolyn Baxter, Registered Nurse and Master of Nursing Student, University of New Brunswick. Email: Carolyn.baxter@unb.ca

For further questions about this research, you may contact the Chair of the UNB Research Ethics Board, Dr. David Coleman by email at dcoleman@unb.ca or by telephone 1 506 451 6977

Supervisor

Dr. Petrea Taylor, RN MH PhD, Faculty of Nursing, Moncton Campus
University of New Brunswick
Email: petrea.taylor@unb.ca
(506) 962-4690

What is the study about?

The purpose of this study is to learn about the experiences of women living with a higher BMI as they become mothers.

What will happen during the study?

- I will be invited to talk about the experience of becoming a mother. This will be done in a private video interview online with Carolyn. The interview will last about 1 hour. The video-call software is “Microsoft Teams”. UNB uses this software with built-in security to ensure privacy. Carolyn will email me instructions on how to set up “Microsoft Teams” as a guest user.
- Our voices during the interview will be recorded and typed word for word. This data will be saved in a secure file folder on a password-protected computer. Participants will have the choice of whether to use visual or audio only.
- Carolyn will tell me about some of the results of the study via email if wanted

Privacy

- No one else but Carolyn and her supervisor will see the typed interview files.
- My real name and contact information will not be on the interview file, only an ID code.
- Carolyn is the only person who knows which interview is mine. Any of my personal information will be kept in a different and secure place from the interview files. My name will not be used in the final report or in any public use of the study findings.
- Interview recordings and interview transcripts will be kept in a secure file in password protected computer for 2 years after the study. After this time, the documents will be erased.

Benefits

- Sharing my experiences in this study may assist other women with a higher BMI as they become mothers.
- Talking about my experiences might help me to see my strengths as I have gone through this transition.
- Being in this study will help educate health care workers to improve services for women with a higher BMI.

What about risks?

- Talking about the challenges I may have experienced could cause me discomfort and stress.
- Carolyn will help me to connect to resources that can help me deal with discomfort or stress.
- I may contact any one of the services available to help mothers and families if I need to discuss concerns or feelings that come up while being in this study. A list of these services will be provided to me.

Other notes

- I know that my participation is completely voluntary.
- I know that I may choose not to answer any question. I can also choose to stop the interview at any time. I may withdraw from the study at any time without having to give a reason. A list of support services will be given to me if I choose to stop the interview or withdraw from the study.

- I know that the study's findings will be shared with others as a thesis and may also include presentations and articles to educate others. In the case of another study, Carolyn would apply for ethics approval before using the information
- If I experience any distress during the interview, Carolyn will ask how I would like to proceed. She will offer a break from the questions and offer me support. I can choose to stop at any time or do the interview at another time.
- If I wish, I will have a copy of the final report summary at the end of the study.
- I have been given a chance to ask questions and all have been answered to my satisfaction.
- This project has been reviewed by the UNB Research Ethics Board and is on file as REB 2021-133.

Appendix B – Sample Advertisement

Sample Advertisement

Are you a mother living with a higher BMI with a baby or toddler?

If so, you may be interested in taking part in a research study about becoming a mother as a woman with a higher BMI. Participating in this research will include about a 1 hour interview with a nursing researcher from the University of New Brunswick through a video-call to talk about your experience of becoming a mother. Please contact me through email at carolyn.baxter@unb.ca. Must identify as a woman living with a higher BMI with a baby or toddler, live in New Brunswick, at least 19 years old, English-speaking, have access to the internet, an email address, and have a phone or computer with a camera that is video or audio-capable.

This project has been reviewed by the UNB Research Ethics Board and is on file as REB 2021-133.

Appendix C – Interview Guide

Interview Guide

I would like to understand your journey of becoming a mother. This includes considering becoming a mother, possible fertility issues, pregnancy, and postpartum experiences.

General Interview Probes:

- ***Tell me about becoming his/ her mother.***
- ***Please talk about when you learned that you were pregnant.***
- ***Tell me about your pregnancy.***
- ***I would like to hear about your birth experience.***

Probe to explore supportive and challenging encounters.

o ***If participants identify supportive encounters, I will ask what made them positive.***

o If participants identify challenging experiences, I will ask how they coped in those encounters.

Example Probes based on Theoretical Sampling:

If some women identified the importance of a supportive partner following a challenging encounter, a follow-up probe for subsequent interviews could be*: Some women have found that having a supportive partner was beneficial to their ability to cope with challenging situations; can you tell me how having a supportive partner has helped you in a challenging situation?*

Example of Probe to Close Interview:

Is there anything else you would like to tell me about your experience as woman living with a higher BMI becoming a mother?

Demographics

- ***Would you mind sharing some demographic data with me?***
    - ***Your age?***
    - ***Do you live in an urban or rural setting?***
    - ***Is this your first child? How many children do you have?***
    - ***What level of education do you have?***
    - ***What is your approximate family income?***
    - ***Do you identify as a racialized person or as a member of an ethnic minority?***

Appendix D – Resources Handout

Resources Handout

Free/ Publicly Funded Parenting Resources:

New Brunswick Association of Family Resource Centres

Email: nbafrc@frc-crf.com

Website: https://frc-crf.com/

Family Enrichment and Counselling Service Inc. (FECS)

356 Queen Street, Fredericton, NB, E3B 1B2

506-458-8211

http://familyenrichment.ca/

Area Served: New Brunswick

Family Plus Life Solutions, Inc.

Professional Therapeutic Services, Counselling and Education

199 Chesley Drive, Suite 204, Saint John, NB, E2K 4S9

506-634-8295

http://www.familyplus.ca

Area Served: New Brunswick

Healthy Pregnancy and Early Childhood Resources from New Brunswick Public Health

http://www2.gnb.ca/content/gnb/en/departments/ocmoh/healthy_people.html

Breastfeeding Resources:

La Leche League Canada / Ligue La Leche:

https://www.lllc.ca/

International Breastfeeding Centre (Dr. Jack Newman):

https://ibconline.ca/

New Brunswick breastfeeding Facebook page:

https://www.facebook.com/BreastfeedingNB.AllaitementNB

Other Resources

Tele-Care: Call 811

A FREE and confidential service that provides access to bilingual registered nurses who can offer health advice and information 24hrs a day, 7 days a week to all residents of New Brunswick.

Emergency Care:

In an emergency, dial 911 or visit your local emergency department

Curriculum Vitae

Candidate's full name: Carolyn Michelle Baxter

Universities attended: Dalhousie University, Bachelor of Science Nursing (2004)

Dalhousie University, Bachelor of Arts (Biology) 1995

Conference Presentations: UNB Nursing Research Day 2021, 2024