

MATERNAL BODIES AND OBESITY: RETHINKING DOMINANT PERSPECTIVES,
EXPLORING A PATH LESS TRAVELLED

by

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DEDICATION

I dedicate this work to your memory Daddy. You were always (and your memory remains) the wind beneath my wings. You nurtured in me a passion for social justice and the common good, and the belief that such a stance is simply an ethical and moral human imperative. In the course of this journey, in my darkest moments, you were the glimmer of light that cleared the darkness and reminded me what this work represents, and therefore that giving up was simply not an option.

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ABSTRACT

A perceived global obesity epidemic, accorded the imprimatur of the WHO, has led to a moral panic and quest for causation fuelled by a dominant biomedical discourse that constructs obesity as a facile issue of individual lifestyle choice, and a consequent spotlight on maternal bodies as a probable source of obesity. This thesis utilizes a feminist poststructural methodology in tandem with a SDOH lens to explore the meaning ascribed by two pregnant women to their everyday experiences of obesity. The result indicates a submersion of maternal obesity in a biomedico-moral discourse epitomizes their everyday experiences of constraining power relations. Notably, a singular biomedical approach to the multifaceted issue of maternal obesity in preclusion of a kaleidoscope of contextual factors, leads to a labeling of these women based on their bodyweight and upholds social inequities that make, paradoxically, the very maternal-fetal health it ostensibly seeks to promote the ultimate casualty.

LIST OF ABBREVIATIONS USED

AIDS	Acquired Immunodeficiency Syndrome
APNs	Advanced Practice Nurses
BMI	Body Mass Index
BML	Biomedicalization
CAD	Coronary Artery Disease
CPHA	Canadian Public Health Association
CS	Caesarean Section
CVD	Cardiovascular Disease
DA	Discourse Analysis
GDM	Gestational Diabetes Mellitus
HIV	Human Immunodeficiency Virus
ICD	International Classification of Diseases
ICN	International Council of Nurses
IOL	Induction of Labour
IOM	Institute of Medicine
KFC	Kentucky Fried Chicken
LGA	Large for Gestational Age
NICE	National Institute of Clinical Excellence
NIH	National Institute of Health
OECD	Organization for Economic Co-operation and Development
PHAC	Public Health Association of Canada
QI	Quetelet Index
SDOH	Social Determinants of Health
SES	Socio-Economic Status
SOGC	Society of Obstetricians and Gynecologists of Canada
TOS	Technologies of the Self
VBAC	Vaginal Birth After Caesarean Section
WHO	World Health Organization
WHR	Weight-to-Hip-Ratio

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CHAPTER 1 Introduction

“When we engage in writing or telling a story, we create alternative pathways to meaning that are imaginative and analytical; that are guided by a narrative (rather than propositional) rationality; and that are relational in the production of meaning, they connect the teller of the tale to the listener or reader of the story. The very act of writing a story, or telling a tale in public or just to a friend changes not so much how or what we know (although telling a good story well can certainly do that), it alters the way we think about what we know and how we know it..... We provide perspectives on the unfolding events in ways that create empathy (or not) with the plight of those persons we depict as persons; we historicize and contextualize meanings; and we determine the ending and whether justice is done. To be drawn to stories as a researcher is to be drawn into a way of life that gives meaning and value to those sources of knowledge that can be gotten in no other discursive way. Narratives are our way of knowing”. Goodall, H.L., 2008, p.14-15.

Problem Statement

1.1 Obesity in the General Population

Conferred the status of the “world’s number one health problem ” (Fox, as cited in Gard & Wright, 2005), and the most recognized “yet most neglected public health problem” (World Health Organization, WHO, 2008) of contemporary times, the centuries old factious issue of obesity has for the last decade (and currently with intensifying momentum) attracted an array of frenzied multi-disciplinary scholarship (Gard & Wright, 2005; McPhail, 2009). Political philosophical and moral debates about the veracity of its pathologization (Campos, 2004; Oliver, 2006), causality, consequences and solutions (Campos, Saguy, Ernsberger, Oliver & Gaesser 2006; Gard & Wright, 2005: Monaghan, 2005) as well as its ideological and moral underpinnings (Saguy & Riley, 2005; Townend, 2009) are prolific. Accordingly, Wright (2009) notes that “no where is the

divide between the biophysical and medical sciences and socioculturally-informed research and theorizing more evident than around this issue. Nor is the power of science to establish the normative position more clearly demonstrated” (p.5). Debates, largely about obesity causality and disease status, are profoundly steeped in philosophical, political and moral frames about which Brownell (2005) observes that for many “an explanation of obesity can be predicted from political persuasion” (p.959), and which Gard and Wright (2005) summarily dismiss as “a complex potpourri of science, morality and ideological assumptions about people and their lives” (p.3).

Nonetheless, amid growing reports of a dramatic rise in global prevalence (Chopra, Galbraith & Darnton-Hill 2002; Drewnosky & Damon, 2005; Kelly, Yang, Chen, Reynolds & He, 2008; WHO, 2008), obesity has variously been referred to historically as “one of the four horses of the Apocalypse” (McPhail, 2009 p.1030), and more recently an “epidemic” (WHO, 2008), a “pandemic” (Tillotsen, 2004), and a “time bomb” (Donaldson, as cited in Lang & Rayner, 2005, p.302) among others. Further more the WHO has declared obesity “a major killer disease of the millennium on par with HIV and malnutrition” (WHO as cited in Krishnamoorthy, Schram and Hill, 2006, p.1134) that threatens to outpace research efforts and health care resources in both developing and developed countries (National Institute of Health - NIH, 2004).

While these “apocalyptic” predictions may border on the “hyperbole” (Guard and Wright, 2005), they nonetheless convey a growing concern and panic across societies about the rising tide of obesity.

1.2 Maternal Obesity

By all accounts, in terms of prevalence, the social gradient in obesity is comparatively more consistent and steeper for women (Cawley, 2007; Henderson, 2007; Molarius, Seidell, Sans, Tuomilehto & Kuulasmaa, 2000; Slater, Green, Sevenhuysen, O'Neil & Edginton, 2009; Wilkinson & Pickett, 2010; WHO, 2008) and among poor women than rich women (Henderson, 2007; Wilkinson and Pickett, 2010). Additionally, the psychosocial consequences of obesity may be more potent in women (Azarbad & Gonder-Frederick, 2010; Swinburn & Egger, 2004) making obesity a gender issue. Similarly the escalation in obesity prevalence in the general population is mirrored by a concomitant rise in the number of obese pregnant women (Kirk, Cramm, Price, Penney, Jarvie & Power, 2009; Morin and Reilly, 2007; Stotland, 2009; Yogev & Catalano, 2007).

Maternal obesity is considered the most significant high-risk obstetric condition with profound implications for maternal, fetal and new born health (Morin & Reilly, 2007; Stotland, 2009; Yogev & Catalano, 2007). Obesity in pregnancy is associated with a multitude of prenatal, intrapartum, postpartum and long-term maternal health complications, as well as fetal and neonatal health complications and sequelae (Catalano & Ehrenberg, 2006; Derbyshire, 2008; DiLillo, Hendrix, O'Neil & Berghella, 2009; Gunderson, 2009; Kirk et.al, 2009; Petite & Clow, 2010).

This has implications for women's health as well as the health care services required during pregnancy, childbirth and beyond. Yet notwithstanding an extensive but biomedically-situated discourse on maternal obesity and its related implication for women's health and wellness (Graves, 2010; Morin & Reilly, 2007; Mottola, 2009;

Stotland, 2009;) there remains a limited comprehension of how it impacts service and care delivery (Kirk, et.al, 2009). Additionally, an urgent need for the development for protocols and guidelines specific to the care of obese pregnant women has been identified (Barry, Brescoll, Brownell & Schleisinger, 2009; Birdsall, Khazaezadeh & Oteng-Ntim, 2009; Kirk et.al, 2009; Krishnamooty, Schram & Hill, 2006).

Amid these gaps, and consistent with a generally predominant biomedical framing of obesity (Beausoleil and Ward, 2009; Hobbs, 2008; Maziak & Ward, 2009), current strategies for prevention under the auspices of health promotion focus on individual lifestyle issues of diet and physical activity (Allender, Gleeson, Crammond, Sacks, Lawrence et.al, 2009; Hobbs, 2008; Maziak & Ward, 2009). While politically expedient and economically convenient and feasible, this approach deflects focus from social responsibility, and has consistently been shown to be largely ineffective and non-sustainable (Hawe, 2009; Hobbs, 2008; Maziak & Ward, 2009). More significantly it precludes the important role of “social justice, health inequalities and the lived experiences of people within the larger social context” (Raphael & Bryant, as cited in Beausoleil & Ward, 2009, p.10).

Additionally, while the science of maternal obesity is extensively documented in a predominant biomedical discourse (Petite & Clow, 2010), the human experience and how that experience has come to be what it is, has not been given voice, nor the human face revealed. There is a need for studies that aim to promote alternate and innovative ways of understanding the human experience of obesity through the accounts of the women who live it. A search in the literature yielded no study that has explored the experience of obesity from the perspective of pregnant women. Concurrently, a recent review of the

literature on maternal obesity by Petite and Clow (2010) found no such study.

1.3 Study Purpose

The purpose of the study was therefore, to explore and describe the meaning ascribed by pregnant women to their embodied experiences of obesity within the context of their everyday life, and in their encounters with health professionals. The research questions were:

1. How do pregnant women perceive the experience of obesity prenatally, and how have these experiences come to be?
2. How have the experiences, as narrated by obese pregnant women, been discursively constituted or constructed by social relations, prevailing dominant discourses on obesity and encounters with health care professionals?

1.4 Study Goal

The overarching goal was:

To give voice to the meaning obese pregnant women ascribe to their experiences for the purpose of illuminating the nexus between the subjective experience of obesity and the social and discursive construction of obesity.

1.5 Situating The Study - Theoretically

From a feminist perspective, understanding the context of women's lives is crucial to the advancement of women's health (Wuest, 2006). Wuest, Merrit-Gray,

Berman and Ford-Gilboe (2002) encourage research approaches that go one step further to transcend reliance on biomedical and epidemiological knowledge so as to critically interrogate previously taken for granted social assumptions and norms that construct and impact women's experience of health. They further suggest a focus on women's everyday life experiences to provide insight into the pathways through which social factors that determine health intersect "with the health of specific groups of women" (p, 795). A feminist poststructural orientation takes up the notion of experiences further, and contends that experiences come to be only in so far as they are human-constructed through language and discourse, which produce the very experiences they set out to describe (Jagger, 2008).

Accordingly, a feminist poststructuralist approach has congruence for my subject of inquiry. It incorporates Foucauldian concepts of knowledge, power and governmentality in advancing the nexus of experienced subjectivities and the role of dominant discourses in the construction of subjectivity (Cheek, 2000, Powers, 2001; Weedon, 1987). These concepts also advance recognition of the inextricability of the politics of obesity framing and the current milieu of neoliberal governance and political economy (Butler, 1992; Colls & Evans, 2009). The study will also draw on the concept of the social determinants of health (Raphael, 2006; Reutter & Kushner, 2010; Solar & Irwin, 2006) to address and acknowledge feminist concerns about the confluence of social, cultural, political and economical factors that define and impact women's everyday experiences of health and wellness (Sicchia & MacLean, 2006; Wuest, 2006; Wuest, Merrit-Gray, Berman & Ford-Gilboe, 2002). Together both lenses allow a view from which to interrogate dominant frames of knowledge about obesity, open up space

for previously unacknowledged, muted voices and suppressed view points, and the possibility for resistance and change (Butler 1992; Cheek, 2000; Powers, 2001; Weedon, 1987). It thus acknowledges the possibility for transformation and transcends the traditional feminist premise of the validity of women's subjectivities. The goal of the study should be the generation of knowledge that raises consciousness about oppression and empowers women to transform their lives (Roman & Apple, 1990; Nielson, 1990). In raising consciousness for the possibility of transformation, both the researched and the researcher are empowered (Lather, 1991), because as Lather further points out empowerment is the culmination of both individual and collective efforts mustered to transform oppressive relations and conditions. Empowerment can never be the often misconstrued, simplistic notion of someone empowering another, as it is a process one undertakes for oneself. Thus, consistent with the crux of the notion of empowerment, in the mutual sharing and construction of knowledge the researcher and the researched enter into a circle of transformation wherein they both "come(ing) into a sense of their own power, a new relationship with their own contexts" (Fox in Lather, 1988, p.4). Additionally an integration of feminist and poststructural approaches serves as checks and balances by "drawing on their respective strengths, while eliminating their weaknesses" (Fraser & Nicholson, 2008 p.352) with poststructuralism compensating for, inter alia the philosophical limitations of feminism and the latter, the inadequate critical social perspective of the former (Fraser & Nicholson, 2008).

1.6 Situating the Research: Motivation for Selection of Methodology

The search for an appropriate methodology was not an easy quest. My initial choice was phenomenology given my desire was not only to give voice to, but also to attempt to present the human experience of obesity during pregnancy through the eyes and soul of those who live it. In retrospect this choice was also influenced by my subscription to some existentialist principles inter alia belief in a Supreme Being and the notion of situated freedom.

Following consultation with my thesis supervisor, subsequent readings, engagement in self-reflection and introspection as well as serious contemplation of my motivations for the pursuit of this study (beyond fulfilling academic requirements), I decided to use a feminist poststructuralist approach. It goes beyond the phenomenological focus on description of the “lived experience ----to unmasking the context of that experience” (Anderson, 1991, p.1). It has, as I hope the next section of this chapter reflects, a compatible fit with my worldview. Its political orientation allows for a political statement. Engaging in this study stems in part from a quintessentially human desire to contribute even in a minuscule measure, to advancing the health and wellness of women. I implicitly believe women have the potential, and are positioned to represent a vital albeit consistently over looked link to achieving health for all. To this end, MacDonagh and Goodman (2001) observe that in assuring the health of women, society assures the health of their offspring, and by extension the health of nations and future generations.

1.7 Unmasking the Researcher: Personal Situatedness

As an approach to social and human science inquiry qualitative research is underpinned by particular philosophic assumptions that are methodology-specific. Hence researchers are therefore obliged to make transparent the underlying assumptions of their chosen framework (Creswell, 2007). It is equally acknowledged that researchers come to the inquiry with their own repertoire of beliefs and values collectively known as their worldview – the window, lens or vantage point from which they discern the world (Creswell, 2007). Consequently, the research process and interpretation are situated within the researcher’s frame of reference and is thus co-constituted by both the inquirer and the inquired, and represents their interactions (Cresswell, 2007; Koch & Harrington, 1998). The researcher is therefore also required to make explicit the preconceptions, experiences and values she/he brings to the inquiry. These experiences cannot, and should not be distanced from the research (Davies, 2007) but rather it should be placed within the research, and its impact on the research process and interpretation acknowledged (Cresswell, 2007; Davies, 2004).

From a feminist poststructural perspective, the subjective self “is an embodied, multifaceted and fluid experience of the self that is shaped by, and shapes the social world” (Rice, 2009, p.246). Therefore, the researcher’s situatedness, inter alia, personal histories and experiences, and physical appearance “informs the theoretical stories they tell” (Rice, 2009, p.246) and their “ideological assumptions” frame the research (Kincheloe & McLaren, as cited in McLaren 2009, p.4). McLaren (2009) further observes that engagement in the self-reflexive process of laying bare the researcher’s “lived experiences” and “truths”, allows the researcher “to work with and against their own

discursively formed meanings” (p.8). Concurrently, Koch and Harrington (1998) posit that revisiting one’s “personal history - - can raise our situation to consciousness in order to monitor the way in which it deals with texts and traditions” (p.888). Disclosing the researcher’s personal situatedness mitigates the power differential by positioning the researcher on the same “critical plane” as the researched (Rice, 2009, p.249), acknowledges and makes transparent preconceptions, and can lead to meaning-rich, authentic results (Rice, 2009). It can also afford readers of the research report an insight into how the researcher’s situatedness may have influenced the research process and interpretation (Rice, 2009).

Against this backdrop, my own socially constructed subjectivity and the discursive social and cultural processes that have thus far shaped it follows.

I am a black, middle-aged indigenous African born woman (now a Canadian citizen for a little over twenty years). I am also a separated single mother of three, and a maternal child health nurse by profession. My sense of self and understanding of the world emanate from and are rooted in these multiple subject positions. My belief in God and the fact that all humans are created in His image makes me value human life and dignity regardless of orientation, color, creed or race and underpins my repertoire of values and beliefs. In addition to keeping me grounded through life’s uncertain highways, it has instilled in me an ethic of caring and an interest and concern for the human condition. This worldview has been influenced and nurtured by my upbringing and life experiences.

I grew up in a polygamous family (of twenty-three) and within a culture that values the extended family system and community. The spirit of communal living based

on respect, sharing and interest in the welfare of others was not only instilled in me, but also role-modeled by adult family members. Hence I subscribe to the notion of peaceful coexistence, the right to self-determination, and the fundamental right of others to differ. Appreciation for self-determination was largely instilled in me as a child growing up in a country with a colonial past, a history of British rule and several years of resistance to foreign domination. It was also reinforced by two life experiences. The political incarceration of my father for advocating freedom of speech and self-expression (the significance of which did not escape me) was the impetus for my resolve to resist oppression in whatever shape or form. Secondly, and of equal significance, my choice to attend a Catholic high school and subsequent conversion to Catholicism (in hindsight perceived as a deliberate and willful act of testing and asserting my right to self-determination and self-expression) was accepted non-judgmentally and respected by my predominantly Islamic family. Years later my marriage to a man of Islamic faith would be testament to these values and my embrace of difference.

Additionally, a father who believed that its pursuit would lead to ‘liberation’ and a ‘good life’ instilled the value of knowledge in me. Knowledge, as I came to understand it, transcends literacy and academics. It includes a healthy interest and awareness, at all times possible, of what surrounds one and in turn what one surrounds. To be in this kind of ‘know’ facilitates open-mindedness and flexibility, and a readiness to glean issues from others perspectives even if it does not lead to acquiescence. With this was the awareness too that knowledge confers some measure of power and control, as well as independence from feeling enslaved and beholden onto things and others. Sharing that power so others can empower themselves also confers the greatest sense of self-

empowerment. Nonetheless with respect to power, the African adage “a chief is a chief if others agree to submit to the role of subjects”, has for me, great import for the role of self-agency in situations fraught with issues of power and control.

Subsequent life experiences as both black and female further sharpened my awareness of power issues and oppression and played a role in several momentous occasions when my consciousness was raised to the socio-political, cultural and economic inequities that so profoundly impact women’s lives. The first of these experiences was the writing of a paper for a sociology course in 1978, which highlighted the injustices faced by women in the immediate post-World War Two period between 1920 and 1935. After being used conveniently to perform jobs left vacant by military men, denied employment benefit and equal wages, worse yet having their wages paid directly to their husbands, they were just as conveniently legislated out of employment on the return of service men. A woman’s place was in the home, a woman’s job was to bear children and influence those around her into dutiful civic submission. More than a decade later, my attention was further drawn to the socially constructed plight of women after reading a United Nations report on the state of the world’s women. It provided insight into the gender-based, sociocultural, political, economic and environmental processes that define, shape and impact every facet of women’s lives. The resulting cumulative epiphany, in addition to my own life experiences was the impetus for my subsequent interest in women’s health and eventual decision to pursue a career that would provide a platform to impact change for equitable conditions for women.

Today, as a practicing maternal-child health nurse in Nova Scotia, Canada, I frequently encounter women who courageously yet at times almost hopelessly try to

navigate life in the face of a persistent array of socioeconomic, political and environmental impediments that impinge upon their ability to achieve health. Overtime, the issue of poverty has stood out for me, and appeared to be in my estimation at least, the overarching determinant of women's health.

The inspiration to undertake this research sprung from a discussion with a colleague about the increasing number of obese pregnant women who present to the hospital to either deliver their babies or be admitted for some pregnancy-related complication, and the lack of specific guidelines in place for the care of these women. A subsequent review of the literature showed obesity is considered a growing public health issue among the general population, and increasingly among pregnant women. Additionally an association to poverty had import particularly for the latter and thus aroused my interest.

The information gleaned from the literature notwithstanding, a major deciding factor was a recollection of a clinical encounter, which to me, at the time, epitomized the social, economic and political constraints that confront women who live on the margins of society. My encounter was with a 19 -week pregnant woman with Type II diabetes who was admitted following presentation to the emergency room with complications of abdominal pain. On further review of her chart she was described in the nursing notes as “a black female with uncontrolled diabetes, obese with poor knowledge of nutrition for diabetes”. The obstetrician's notes described her as “non-compliant, has not made any effort for dietary changes, or to keep prenatal appointments”. Given the opportunity to tell her story, it turned out: she and her four year-old daughter lived at home with her parents; the father of her unborn baby was a seasonal worker who comes to Canada

during the harvest. The family owned one vehicle shared by all, hence her difficulty making it to her prenatal appointments. She was awaiting a social assistance cheque, which was held up in the process because of some income she may have received from babysitting. Therefore while she had a glucometer, she had no strips hence her inability to manage her blood glucose at the time. From discussions with her she was knowledgeable about her diabetic condition. Subsequent documentation about these issues from her perspective led to a revision of the label “non-compliant” and a connection with resources to mitigate her particular health and social problems. Boero (2007) captures this vignette aptly in her contention that obesity is a “post-modern epidemic in which ostensible concern for [the individual’s] health is diverted from structural forces and the focus is turned squarely on the individual” (p.58).

As a practising nurse who lives in Canada, I am not only privy to the medical ‘knowledge’ and practice ‘knowledge’ about obesity, but I am also exposed to a bombardment of representations, both textual and iconic, of obesity. As a consequence I do not need a scale to ‘know’ my weight is less than ‘ideal’. My positionalities compel me to be conscious of my weight. I am also aware of the benefits of physical activity to mental and physical health, and maintenance of a healthy diet. Nonetheless, I grew up in a culture where, at the time, plumpness was equated with wealth and health, and thinness with poverty and disease, and where my overweight status would not necessarily be conflated with my identity or capacities. Thus I do not see my weight as a marker for who I am, or what my capacities and capabilities are.

CHAPTER 2 LITERATURE REVIEW

2.1 Obesity – A definition

The medical definition of obesity as “a state of increased body weight, more specifically adipose tissue of sufficient magnitude to produce adverse health consequences” (Spiegelman & Flier, 2011, p.531) aligns with the WHO (2008) definition of obesity “as abnormal or excessive fat accumulation that may impair health.” The WHO further endorses the use of the body mass index (BMI) as a criterion for defining, measuring and classifying obesity along a numerical continuum (WHO, 2008).

2.2 The BMI – The Happenstance Discovery of a ‘Reliable’ Scientific Tool

As a gender-neutral weight classification system, the BMI is a measure of a person’s weight relative to her/his height. It is expressed as a ratio weight (in kilograms) divided by height (in metres) squared, and is applied to all adults (with some “limitations”) except for pregnant women (WHO, 2008). Given that pregnancy is considered a natural-weight –inducing condition, a prepregnancy BMI is used for defining obesity in pregnant women (March of Dimes 2005). By WHO standards, overweight is defined “as a BMI equal to or more than 25, and ‘obesity’ as a BMI equal to or more than 30”. A BMI of 20 to 24.9 is considered normal weight (WHO, 2008). Obesity is further classified in terms of degree of health-related risk. A BMI of 30-34.9 is conferred class I to denote high risk, a BMI of 35-39.9 as Class II to denote very high risk and a BMI of 40 or greater as Class III to denote extreme high risk (WHO, 2008). The Canadian guidelines for body weight are adapted from the WHO classification system (Health Canada, 2003, Starky, 2005). Similarly, the BMI is internationally recognized

and informs most clinical guidelines on weight (Monaghan, Hollands & Pritchard, 2010). Given that “the BMI is a central tool in the production of obesity knowledges” (Colls & Evans, 2009, p.1018) any reference to it will be incomplete without placing it in historical context.

As a condition currently associated with “well-defined complications” (Eknoyan, 2008, p.47), obesity is prehistoric, and at least 20,000 years old (Bray, 2009). For most of human history, obesity was associated with wealth (Bray, 2009), and with “good health and --- an advantage” (Eknoyan, 2008, p.47). It evolved as a condition linked to disease in the late 18th century (Bray 2009; Eknoyan, 2008). It had thus been a subject of scientific interest among ancient European, Roman, Arabic, Greek and Indian physicians, among others (Bray, 2009). In fact the term ‘obesity’ is traced as far back as the 17th century and evolved, with attempts to classify it, from the Greek word “polysarcia” (much flesh) to the Latin word “obesitas” (fatness) in the 19th century. Yet for all that history, obesity defied quantification/measurement and definition for much of that time (Bray, 2009).

By all accounts, the declaration of obesity as a massive social problem preceded the discovery of a means with which to define, measure and track its prevalence (Eknoyan, 2008; McPhail, 2009). The BMI was first conceptualized in 1832 by Belgian, Adolphe Quetelet who initially as a painter and sculptor developed an interest in the human body, and later as a mathematician and statistician, set out to define the “normal man” (Eknoyan, 2008, p.49). In the course of searching for defining features of a ‘normal’ human build, he undertook and pioneered a cross-sectional study on the relationship between height and weight in newborns and children. He later extended his

study to include adults. From his studies, he concluded that with the exception of weight increases during periods of growth spurts in the newborn, and during puberty, human “weight increases as the square of the height” (p.23) a hypothesis which became known as the Quetelet Index (QI) (Eknoyan, 2005). Quetelet’s interest was in human weight at different ages and not obesity and as such never intended the use of this index for defining or measuring obesity (Eknoyan, 2009).

Nonetheless, while the QI did not generate much interest in the medical circle, it was used by insurance companies to develop a table of normal weights for policy holders (Eknoyan, 2009; McPhail, 2009). The medical community however came to define obesity “as anywhere from 20% to 30% above the ideal weights listed on” (p.1028) the weight tables even though they continued to dispute their reliability (McPhail, 2009).

The scramble to find a reliable means of measuring body weight assumed urgency in the post-World War II era, in the wake of concern about the association of body weight and cardiovascular disease with an “increased mortality rate of [their] overweight policy holders” (Eknoyan, 2008, p.47). Similarly, in Cold War Canada, epidemiological studies (sponsored by insurance companies, medicine and government) attributed “everything from cardiovascular disease to varicose veins, --- from accidents to suicides” (McPhail, 2009, p.1028) to obesity, fuelling anxiety and frustration about the lack of a mechanism by which to generate data about obesity prevalence (McPhail, 2009). It also led to more power posturing and disputes between medicine and insurance companies about the aetiology of obesity, even as the former continued to use the controversial weight-for height tables (McPhail, 2009). This was compounded by media claims that “anywhere from one fifth to one half of Canadians were too fat” (McPhail, 2009, p.1028).

The quest for a reliable marker continued as studies sought to test the validity of the QI. The fourth series of the Framingham study was one of the “first studies to confirm the validity” of the QI (Eknoyan, 2009, p 48). The Framingham Study is credited with the prevailing knowledge about cardiovascular disease and its association with healthy diets, exercise and body weight (Mendis, 2010).

In 1972, following a study that compared existing markers for weight, Ancel Keys, an American scientist concluded the best marker available for calculating the percentage of body fat was the QI, reconfirmed its validity, and renamed it the body mass index (BMI) (Eknoyan, 2009).

2.3 The BMI – ‘Reliability’ Submerged In Controversy

While the BMI seemed to provide a solution to the problematic of the lack of a reliable index of weight, it is not without limitations. It has limited utility for other ethnic populations because the cut-off points were determined using data primarily from Anglo-Saxon populations (Eknoyan, 2009; Health Canada, 2003). It also does not account for differences in human physique, on the different make-up of fat, muscle or bone. Thus it may over-estimate body fat in people who are very muscular (as in athletes) or underestimate body fat in people who have lost a lot of muscle mass (as in some older individuals) (Aronne, 2000; Gard & Wright, 2005). Given its drawbacks, the BMI is often used in conjunction with other assessments or criteria to determine health status (Health Canada, 2003). Nonetheless other measures, the waist circumference (which determines body shape and how excess weight is carried) and the weight to-hip-ratio (WHR) are not as widely used as the BMI. The latter (WHR) measure is not well studied and therefore not endorsed for use (WHO 2003, Health Canada, 2003).

Notwithstanding its flaws, the BMI easily established credibility in the 1980s following its endorsement by the WHO “as an international weight comparison measure” (p.48); around the same time obesity was fast becoming established as a global epidemic (Monaghan et. al, 2010). With its advantage of simplicity, convenience and affordability, the BMI continues to be the most widely accepted and frequently used measure “for defining and diagnosing obesity” (Evans & Colls, 2009, p, 1052). It facilitates the identification of individuals and populations who are obese or at risk of obesity (Evans & Colls, 2009; Gard & Wright, 2005), and generates data used for mapping and identifying ‘obese’ locations and communities (Evans & Colls, 2009) as well as for establishing the link between body weight, morbidity and mortality (Gard & Wright, 2005). The BMI also serves in research as an indicator of risks and success of interventions or treatments (Evans & Colls, 2009; Gard & Wright, 2005). Within health care organizations, it is used to define and measure obesity as well as to establish criteria for some procedures and the basis of clinical guidelines for weight management. It serves as a guidepost for determining how much weight a woman should gain during pregnancy based on her pre-pregnancy weight (Institute of Medicine- 10M, 2009, Society of Obstetricians and Gynecologists of Canada- SOGC, 2010). Given its function as a significant player in the construction of obesity, it is little wonder that the BMI also “forms the basis for obesity policy projections and targets” and thus “drives” public policies aimed at treatment, reduction and prevention of obesity (Evans & Colls, 2009, p.1052)

Critics of the BMI see it as a mechanism used to police weight and deplore its arbitrary use in the social construction of obesity (Evans & Colls, 2009; Gard & Wright, 2005; Monaghan et. al, 2010). A classic case cited is the ramification of the decision in

1998 to collapse into one, and further drop the initial BMI cut-off for overweight of 27.8 for men and 27.3 for women to 25. Overnight, millions of previously ‘normal weight’ individuals suddenly became classified as overweight (Gard & Wright, 2005; Monaghan et. al, 2010). This revision is attributed, by some critics, to the influence of WHO expert advisors in the weight loss industry (Campos, as cited in Monaghan et. al, 2010; Evans & Colls, 2009). Critics also contend that BMI advocates “often fail to reflect upon, or even acknowledge” its shortcomings (Evans & Colls, 2009). Yet on the contrary, advocates of the BMI do acknowledge its drawbacks, but rationalize its use on the basis that it is the most investigated and “useful indicator” (Health Canada, 2003, p.13), in other words the best option there is so far of weight-related health risks indicator (WHO, 2008a).

Hence in the absence of a better option, the BMI retains its powerful position as the ‘tool’ that enables definition and classification of obesity and by extension the ability to trail its prevalence. As Jutel (2009) aptly observes, “with the ability to quantify corpulence comes the potential to track its distribution, prevalence and correlates” (p.69).

2.4 Obesity – The Making of an Epidemic

A mainstay of the scientific enterprise of epidemiology is the measurement of disease “occurrence in a given population” at a given time (Gard & Wright, 2005,p.88). In the case of obesity, this measure also known as prevalence, functions as a surveillance mechanism to monitor trends for the purpose of informing public health programming and policy decision-making regarding prevention, intervention and control (Gard & Wright, 2005; Health Canada, 2003). The WHO (2000) concurrently explains that the generation of data about prevalence is required to, inter alia, identify at-risk groups,

inform policy and public health programming in the “mobilization and reallocation of resources” to control obesity and to provide the basis for monitoring and evaluating interventions and programmers (WHO, 2000). In the course of gathering data on obesity prevalence, data on the incidence and risk of associated diseases or co-morbidities is generated. Collectively these data provide the basis for conferring obesity the status of “disease” and “epidemic” (Evans & Colls, 2009; Gard & Wright, 2005; Monaghan et. al, 2010) as opposed to among others, a symptom of a social problem of poverty.

2.5 Obesity – The Scale of the Issue

According to the WHO (2008b), obesity is on the rise in all regions of the world, and it “threatens to overwhelm both developed and developing countries”. Approximately 312 million people worldwide are classified obese (Chopra et. al, 2002; Drewnowski & Damon, 2005) and this figure is expected to more than double to 700 million by 2015 (WHO, 2008a). Concurrently, Kelly, Yang, Chen, Reynolds and He (2008) portend that by 2030, 3.3 billion people worldwide will either be overweight or obese. The prevalence in obesity is reported to be higher in developed/industrialized countries than in developing countries. For instance, in the United States (US), a world leader in obesity, the rate of obesity rose by 80% over two decades (WHO 2008a) and in 2004, 64.5% and 30.5% more American adults were considered overweight and obese respectively (Friedman & Fanning, 2004). The dramatic increase in obesity prevalence is reported in Europe, Australia, in the Mediterranean and in Latin America (Chopra et. al, 2002). However there is a significant variation in trends from country to country and recent data lists rates from as low as 5% in China, Japan and some African countries to as

high as over 75% in Pacific Samoa (WHO 2008a).

2.6 Obesity – The Canadian ‘Pandemic’

In Canada, while on a lower scale relative to the United States, obesity is similarly reported to have reached a “pandemic” scale (Katzmarzyk & Arden, 2004; Shields, Carrol & Ogden, 2011; Spanier, Marshall & Faulkner, 2006), with Atlantic Canada registering the highest rates of obesity (Beausoleil & Ward, 2010; Colman, 2000; Starky, 2005). Approximately 6.8 million and 4.5 million Canadian adults were classified as overweight and obese respectively in 2004 (Starky, 2005). The prevalence of adult obesity increased from 13.8% in 1979 to over 23% in 2004. Correspondingly studies undertaken between 2000 and 2004 report that 58.8% of Canadian adults (65.2% of men and 52.4% of women) were either overweight or obese in 2004 (Starky, 2005). Concurrently, a report by the Organization for Economic Co-operation and Development (OECD, 2010) describes obesity rates in Canada as high comparative to most member countries. Regionally in Canada, Atlantic provinces register some of the highest rates of obesity (Colman, 2000; Starky, 2005). In Nova Scotia, in a 12-year period between 1985 and 1997, the prevalence of adult overweight and obesity rose more than twofold (Moulton, 2000), and in 2000 the adult obesity rate of 18% surpassed the “national average of 12%” (Colman, 2000, p.9). These were nonetheless based on self-reported data and may have been underestimated. Results of a measured 2004 national community health survey indicate the prevalence of obesity remains high in Atlantic Canada (Starky, 2005). For instance, in Newfoundland and Labrador, the obesity prevalence in both men (34.5%) and women (33.3%) significantly exceeded the national average of 23.7% and 23.2% respectively. Similarly in Nova Scotia, the prevalence of obesity in women

(30.3%) notably surpassed the national average (Starky, 2005).

2.7 Obesity – The Economic Fall-out

Along with an increased prevalence, the repercussion, both in human and economic terms, framed variously as the “disease burden of obesity”, the economic burden of obesity, “the cost burden”, etc. is extensively reported to be massive (Anand, 2006; Colman, 2000; Katzmarzyk & Janssen, 2004; Public Health Association of Canada – PHACa, 2011; Tjempema, 2006). For instance, the annual direct (healthcare) cost of obesity in the U.S is estimated at U.S \$90 billion, and indirect cost in terms of mortality is estimated at 300,000 deaths (Friedman & Fanning, 2004). It is portended that by 2030 obesity will cost the U.S more than U.S \$860 billion. Relatedly the fiscal fallout of maternal obesity is reported to be ‘massive’. The cost incurred for prenatal care of obese women is estimated at 5-16 times the cost associated with non-obese women (Misra & Grasson, 2006).

In Canada, the conservative estimated cost of obesity based on eight obesity related diseases, rose from Canadian \$3.9 billion in 2000 to Canadian \$4.6 billion in 2008, and Canadian \$7.1 billion based on 18 obesity-linked diseases (PHAC, 2011b). Most recent data on obesity-related mortality indicates the number of deaths attributed to overweight and obesity rose from 2,514 in 1985 to 4,321 in 2000, and that Eastern Canada (which includes Atlantic provinces) has “consistently higher death rates” (Katzmarzyk & Arden, 2004, p.18). Concurrently in 2000, the annual direct cost of obesity in Nova Scotia was estimated at Canadian \$120 million, and indirect cost secondary to lost productivity at Canadian \$140 million, while the number of deaths

attributed to obesity was estimated at 1000 a year (Colman, 2000).

2.8 Obesity – The Human Fall-out

Escalating economic costs associated with a rising prevalence of obesity stems from the health impact obesity has at the personal/individual level. Obesity is clinically known to pose significant risks for an array of renal, metabolic and cardiovascular chronic diseases (Francischetti & Grenelhu, 2007). A massive biomedical literature cites obesity as a significant risk factor for, among others, cardiovascular disease (CVD), type 2 diabetes, high blood pressure, high blood cholesterol, coronary artery disease (CAD), gall bladder disease, osteoarthritis, obstructive sleep apnea, urinary and bladder problems, and some cancers including, colon, kidney, and for men prostate cancers (Colman, 2000; Friedman & Fanning, 2004; National institute of Health-NIH, 2004; Shortt, 2004; Starky, 2005; Tjekpema, 2006; WHO, 2008b).

2.9 Obesity – Interrogating the Science of an Epidemic

In addition to the physiological consequences of obesity, the burden on individual psychosocial health and wellbeing are equally profound and defies quantification. The framing of obesity as an out-of-control ‘disease; of overeating and physical inactivity, and an economic burden on society, paints a negative portrait of obese individuals. It also fuels widespread discrimination, prejudice and social injustices against obese individuals and leads to social and psychological problems that create a vicious cycle, further exacerbating obesity (Jutel, 2009a; Monaghan et. al, 2010; Murray, 2009). Critics of this perspective of obesity decry the pathologization of obesity and the notion that obesity is ubiquitous, an “everyone, everywhere” phenomenon (Gard & Wright, 2005, p.17). They

question the veracity of the data about prevalence, and science that situates obesity as a growing epidemic and contend that the inadequacy of the BMI as a measure of body fat implies inadequate data (Evans & Colls, 2009; Monaghan et. al, 2010). The correlation of obesity with disease is also questioned on the basis that: data about prevalence is “related to the incidence of various diseases over relatively short periods of time” (Gard & Wright, 2005, p.102); population risks do not necessarily imply individual risk (Gard & Wright, 2005; Monaghan, 2005); the evidence that links obesity with disease is weak and conflicting in the face of extensive studies that provide evidence to the contrary (Gard & Wright, 2005; Monaghan, 2005; Monaghan et. al, 2010); there are just as many obese people who are healthy and in fact outlive their thin counterparts; obesity may be a symptom of, not a cause of disease; while some very fat people may suffer from debilitating health problems, so too do many thin people yet there is no-labeling of “thinness as a disease “ (Gard & Wright, 2005, p.95); by the WHO’s own admission there are “difficulties in evaluating the actual health consequences of obesity” (Gard & Wright, 2005; p.102). The assumption that there is one universal explanation for obesity - a simple imbalance of intake and output that is easily rectified by the individual is questioned (Gard & Wright, 2005; Jutel, 2009a; Monaghan et. al, 2010).

Concurrently, Boero (2007) refers to the current state of obesity as a “postmodern epidemic”, the hallmarks of which are, among others, its construction as both a social problem and an epidemic, albeit one devoid of a “clear pathological basis” (p.432), leading to the micro management of a macro problem. Similarly, weighing in on the issue, Rice (2007) observes that the framing of obesity as an escalating epidemic based on prevalence data, has served to further compound panic and “fear of a pandemic of fat

people” that pose a threat to the collective social values of “health and fitness” (p.161). Furthermore, it has conferred “obesity epidemic discourses” an unbridled centrality and prominence in Canada and in other countries to the exclusion of alternative viewpoints (Rice, 2007, p.161).

Nonetheless, as Monaghan et. al (2010) declare, the intent of interrogation is not to deny the potential for adverse health problems, but to politicize and to critically question the science that sets out purportedly to advance and promote health but winds up, either advertently or in advertently hampering health and promoting widespread bigotry and assault on the identities of obese persons.

2.10 Obesity – The View from a Biomedical Lens

The makings of obesity as an epidemic enabled through the ability to track its prevalence and associated health risks in a substantial body of scientific literature, is evidential of its bio medicalization (Boero, 2007; Gard & Wright, 2005; Jutel, 2006; Sorbal, 1995).

Medicalization is the process by which “medical knowledge and expertise” is expanded to encompass previously non-medical human problems, and entails reframing behavior deemed socially or morally deviant (Zola as cited in Boero, 2007). Conrad (1992) delineates medicalization as a “sociocultural process (of) defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem or using a medical intervention to ‘treat’ it” (p.210). The process of medicalization in contemporary society has not only become more “widespread” but has shifted into more “complex, multi-sited, multidirectional” arenas,

leading to the term, biomedicalization (Clarke Shim, Mamo, Fosket & Fishman 2003 p.162). Biomedicalization denotes the progression of medical authority into “more complex technoscientific” arenas of risk and surveillance with the capability of “effecting the transformation of bodies and lives” (Clarke, as cited in Clarke et. al, 2003p.165). An account of the biomedicalization of obesity necessitates situating it in historical context as this helps to advance some understanding of obesity as a phenomenon of as much sociocultural as biomedical making (Jutel, 2006; Jutel, 2009a, Sorbal, 1995).

2.11 Obesity – The Genesis of a Medicalized Social Issue

As a concept, obesity has featured in medicine for generations. Its conceptualization as a risk factor to health goes back in time to ancient human eras (Bray, 2009). Ancient Greek physicians, Hippocrates and Galen were among the first to link obesity with ill health (Bray, 2009; Haslam 2007). Hippocrates noted that ‘fat’ individuals were more apt to die suddenly than their ‘thin’ counterparts, and that “it is injurious to health to take in more food than the constitution will bear, when, at the same time one uses no exercise to carry off this excess”. He further held that “exercise empties the body” and returns it to a state of balance and “perfect health” (Haslam, 2007, p.32). Galen advanced three descriptors of the body - pachis (fat), efsarkos (chubby) and polysarkos (obese) (Papavramidou, Papavramidis & Christopoulou- Aletra, 2004). He considered the first two to be natural, healthy body states. The third (polysarkos) he associated with a deviation, manifested when “the person cannot walk without sweating, cannot reach the table, cannot breathe easily, cannot give birth, cannot clean himself”. He further maintained that aesthetically they had “wet, warm temperament, pale face, slow hair growth, large fat” accumulation (Papavramidou et. al, 2004 p.632). For these, Galen

prescribed diet exercise, baths and massage (Haslam, 2007; Papavramidou et. al, 2004).

The word obesity was first used in a “medical context” by a British physician, Tobias Venner in a treatise in 1660. He prescribed the waters at Bath “to make slender such bodies as are too grosse---- for by the use of them they may not only preserve their health but keep their bodies from being unseemly corpulent” (Haslam, 2007, p.33). As obesity became common, the medical literature saw the elimination of associated elements “of discomfort or shortness of breath” as “the benefits to be gained from its reduction” (Haslam, 2007, p.33). As a subject, obesity initially featured in “general text” and gradually attracted scholarly interest (Bray, 1990, p.909). In the eighteenth century, the first treatise on obesity alluded to excess food consumption and the environment as causes of ‘corpulence’ and prescribed a lean diet as treatment (Bray, 2009).

2.12 Obesity – The Value-laden Process of Nomenclature

Naming a condition is an initial step in the medicalization process. The nomenclature for obesity varied back and forth from one period to the other and reflected the values and concerns of the times (Gard & Wright, 2005; Sorbal, 1995). Thus with shifts in social values, medical language used to represent obesity semantically shifted from lay terms to high-sounding medical terms or labels (Sorbal, 1995). Historically therefore, terms such as “plump”, “corpulent” and “porky” semantically reflected perspectives of body fat as amoral and ignominious (Sorbal, 1995, p.70) and correspondingly mention of diet and exercise in medical texts was in relation to “the preservation of health rather than the cure of disease (Haslam, 2007, p.33). Concurrently, Jutel (2001) observes that body weight in this era, was “qualitatively” conceptualized with an emphasis placed on “visual and functional assessment” rather than body weight

(p.285), albeit with moral undertones.

The use of the terms overweight and obesity in relation to symptoms and risks increasingly became the norm in the late 1970s, signifying an increasing trend toward medicalization (Sorbal, 1995).

Following a review of medical publications from 1864 to 2004, Jutel (2009a) found that reference to overweight evolved from being “a sign or symptom” to “a condition with its own set of risk factors, typologies, outcomes, treatment and prevention, all suggestive of overweight as a disease” (p.63). Similarly, a content analysis of 73 editions of a major U.S medical textbook undertaken by Chang & Christakis (2002) showed an analogous trend. While the reductionist notion of energy imbalance remained constant, obesity progressed from a “presumably unambiguous and cohesive object of knowledge” to a concept “quite independently of definitive experimental evidence” between 1927 and 2000 (Chang & Christakis, 2002, pp. 152, 154). Concomitantly, a depiction of an obese individual went from an overeating societal parasite to an overeating societal of contemporary consumerism (Chang & Christakis, 2002). King (as cited in Jutel, 2009b, p.289) observes that historically medical construction of disease is based on “pattern recognition which takes on new and different forms as knowledge changes” hence what one era deems as disease is deemed as symptom in another.

2.13 Obesity – The Assignment of a Disease Label

In contemporary society, obesity is not only measured, quantified and diagnosed, it is commodified (Gard & Wright, 2005; Jutel, 2006; Jutel, 2009a; Sorbal, 1995). The development of a mechanism - the BMI - with which to objectively capture and describe the physical attributes of populations paved the way for the proactive biomedicalization

(BML) of obesity (Jutel, 2006). By the late nineteenth century, there were several medical perspectives of obesity, ranging from a genetic deviance to personality disorder and addictions models (Sorbal, 1995). The existence of several claims and viewpoints generally diluted the power of these positions, and rendered them collectively more susceptible to challenge by alternative disciplinary perspectives. This realization led to negotiations that saw obesity officially codified in the International Classification of Diseases (ICD) (Sorbal 1995), with an accompanying declaration of obesity as an epidemic by the WHO (Bray, 2009). Thus the nineteenth century was a watershed period for the BML of obesity, marked by “increasingly frequent, powerful and persuasive claims” by medicine to support the need for social control of obesity in the interest of obese individuals and society (Sorbal, 1995, p.69). The ensuing claims represent the assumptions upon which the biomedical perspective of obesity is premised. A long-standing, entrenched and commonly lambasted notion is that obesity is a disease of overconsumption and sedentary lifestyle, leading to an energy imbalance where energy intake exceeds output (Gard & Wright, 2005; Monaghan et. al. 2010; O’Hara & Gregg, 2006; Saguy & Riley, 2005). Other assumptions are that: the BMI can, and does enable assessment of current state of health, as well as predict future state of health; strategies for successful weight loss hinge on lifestyle changes around diet and physical activity, that weight loss will confer improved health, and that successful weight loss is within the individual’s control (O’Hara & Gregg, 2006; Saguy & Riley 2005).

These assumptions underpin the intersection between Western science’s singular, positivistic focus on objectivity and a tenacious Western sociocultural valorization of the thin physique, what Jutel (2009a) refers to as the two “cornerstones” of Western society

that enable the “transformation of overweight from statistical deviance to disease” (p.64).

The Western scientific community’s emphasis on numbers, measurement and quantification is rooted in medicine’s flagship evidence-based model, an approach to research and clinical practice that evolved from a series of lectures by epidemiologist Archie Cochrane (Evans, 2006, Williams 2010). What constitutes good scientific evidence is that which is objective, devoid of bias (if that were possible), is measurable and quantifiable (Gard & Wright, 2005, Jutel, 2006). Thus in an age of evidence-based medicine and practice, the BMI, its shortcomings notwithstanding, “provided easily determined efficiency indicators” that formed the basis for the generation of dominant biomedical knowledges which foreground the case for obesity as an epidemic, and the need for social control via pathologization (Monaghan, 2005, p.308). In his explication of the concept of diagnosis, Rosenberg (2002) contends that with diagnosis, “uncertainty is replaced - for better or worse - by a structural narrative” –structured in the sense that the disease label allows obesity to “be operationally understood and described,---- measured in units, represented in the visible forms of curves or continuous tracings” (pp. 237, 244). The BMI can therefore be said to function as a “pathology-defining threshold and a statistically-derived risk factor system” (Rosenberg, 2002). Yet, it can be argued that even an ostensibly omnipotent medical community could not have pulled this off without the sanction of the broader society. As Jutel (2006) explains, even though the ability to measure and quantify weight was instrumental in earning obesity a disease label, “before it can be measured” it had to have been considered a problem “worthy of measurement” (p.272). Similarly, Rosenberg (2002) notes that the authority implicit in naming a disease not only resides in the “world of medicine” but also “in the larger culture” (p.239). He

further concurs that the disease label is invoked to “ perform the cultural work of enforcing norms and defining deviance --- to naturalize and legitimate conceptions of difference and deviance” (p.251). Therefore medicine’s ability to confer a disease status is aided by society’s need to have its “values and status system legitimized” (p254).

2.14 Obesity – The Social Control of Deviance

Regardless of the conventional “standard of beauty”, thin or plump, it is the deviation from the prevailing norm that often represents a problematic in society (Jutel, 2006). Through the ebbs and flows of Western cultural shifts, a preoccupation with human exteriority has been constant, only varying in terms of connotation. Zones (1997) makes the observation that “of all the characteristics that distinguish one human being from the next, physical appearance has the most immediate impact” (p.249), and can, depending on its conformity with prevailing cultural canons about appearance, pack a lot of social purchase or social anguish (Townend, 2009; Zones, 1997). A real problematic with this cultural engrossment with appearance is the presumption that a person’s identity, moral fibre and very human core is visibly inscribed on their exterior physical appearance (Jutel, 2009a). In past times, obesity was linked to wealth and good health, and functioned to ensure survival as hypothesized by the thrifty gene theory (fat storage in times of plenty protected health against starvation and disease in lean times) (Bray, 2009; Sorbal, 1995). Only the rich and powerful could afford resources to access plentiful food, and the luxury to be exempt from energy-depleting work (Bray, 2009; Sorbal, 1995). Beauty was also synonymous with virtue (Jutel, 2006). As societies became progressively industrialized, food became abundant and easily accessible, and with it came the impetus for a reversal of values (Bray 2009; Sorbal, 1995). With a cultural shift,

obesity came to be associated with deviance in Western societies and evoked concern and anxiety, while slenderness became valued and actively sought (Jutel, 2006; Jutel, 2009a; Sorbal, 1995). The preeminence of slender bodies over obese bodies has been, and continues to be particularly salient for females (Levenstein, Garfinkel & Garner as cited in Sorbal, 1995; Jutel, 2006). Concurrently, by the end of the nineteenth century “while virtue once inscribed itself on the body in the form of beauty, health is the new beauty” (Jutel, 2006, p.2273) and “references to good health pervade(d) discussions of beauty” (Jutel, 2009a, p.65). Spitzack (as cited in Jutel, 2006, p.2273) states that “an aesthetics of health” requires among others “slenderness”. In essence as Boero (2007) points out, “the moral and medical models of body size reinforce each other (to) situate obesity as an epidemic” (p.46). Thus as a condition that deviates from societal norms, obesity attracts a need for definition and social control. This has led to the emergence of models and discourses that advance moral, medical and ideological claims about causation and solutions, culminating in a dominant biomedical discourse presiding over what course society takes. Nevertheless, in making “judgments” about the normal and abnormal, the medical profession is not immune to culturally approved “visual and perceptual preferences” (Stafford, Puma & Schiedermayer as cited in Jutel, 2006 , p.2273).

2.15 Obesity – Implications of a Disease Label

The disease label itself pales in comparison to its profound ramifications and the “intractable social dilemmas” it creates (Jutel, 2006 p.2274). Rosenburg (2002) sets out some of the implications of a disease label to facilitate a more cogent understanding. As a central feature in the naming and “managing” of a social condition as a disease, diagnosis is a “ritual” (p.240) with multiple functions. A particularly salient function is that it

“defines and predicts, and in doing so, helps constitute and legitimate the reality that it discerns” (p.240). The biomedicalization of obesity thus not only makes the experience of obesity discernible through scales and weight classification systems, it imbues life into, and “help(s) create that experience” (p.250). As a social reality or “actor”, a disease entity shapes and reshapes the everyday “lives of real men and women” and can thus be “life-altering” (p.250). Last but not least, for the “disease owner”, a disease label is a double-edged sword, it can become “a form of social equity” for some, or a “form of stigmatization” for others (p.252). In the case of obesity, the latter is the case (Boero, 2007; Carryer, 2001; Gard & Wright, 2005; Jutel, 2009a; Monaghan et. al, 2010; Nyman, Prebensen & Flesner, 2010; Saguy & Riley, 2005; Sorbal, 1995; Thomas, Hyde, Kurunaratne, Herbert & Komesaroff, 2008; Townend, 2009). These effects manifest variously at the individual, health care and societal levels.

Despite a plethora of scholarly work across disciplines, critiquing the dominant biomedical notion of an obesity epidemic, this perspective remains dominant in the landscape of health and has garnered significant leverage in the public consciousness (Beausoleil & Ward, 2009; Boero, 2007, Gard & Wright, 2005; Saguy & Riley, 2005). Biomedicine has thus become a dominant and potent lens through which people culturally read, appraise and organize their conception of their bodies in the quest to improve or perfect their bodies and lives (Clarke et.al, 2003, Evans & Rich, 2005, Gard & Wright, 2005; Jutel, 2009a; Sorbal, 1995).

By advancing the supposition that obesity is entirely preventable and curable, presumably through simple, common-sense lifestyle changes in diet and physical activity, the biomedical paradigm conveys a view of obesity as an issue of individual lifestyle

choice and behavior (Beausolil & Ward, 2009; Gard & Wright, 2005; Monaghan et.al, 2010). The individual is blamed and at the same time the medical profession remains firmly in control as to what a cure entails. Obesity much like AIDS, is socially controlled by three powerful professional pillars of society, namely medicine (unhealthy), religion (immoral), and law (human rights). It also precludes the monumental complexity of obesity, promotes an individualistic reductionist approach that locates the site of moral and social responsibility for losing weight, and avoiding the plethora of obesity-associated health risks in the individual (Gard & Wright, 2005; Greener, Douglas & Van Teijlingen, 2010; Maziak & Ward, 2009; Townend, 2009) despite the uphill battle (Rich & Evans. 2005; Monaghan et.al, 2010) and a “staggering 95% failure rate “ inherent in weight loss attempts (Aphramor, 2005, p.319). This sets obese individuals up for failure and worse yet, subjection to “moral censure” for failing (Throsby, 2007, p.1561). Failure to lose weight further reinforces the portrait of the obese individual as lazy, self-indulgent “out-of-control, asexual and unattractive” (Greener et.al, 2010), and leads to widespread experiences of bias, bigotry, and overall marginalization and social exclusion (Campos, 2004, Gard & Wright, 2005; Oliver, 2006; Townend, 2009). This may result in psychological ill health and eating disorders that further compound and sustain weight cycling in a vicious cycle (Bacon & Aphramor, 2011; Aphramor, 2005; Gard & Wright, 2005; Monaghan et.al 2000, Jutel, 2009a). Depression, anxiety, self-blame and isolation are known to result from the sense of failure associated with unrealized weight loss (Byrne, Cooper & Fairburn, Wang, Brownell & Wadden as cited in Greener et.al, 2010, Friendman, Reichman, Costanzo, Zelli, & Ashmore, 2005). The disease label, in this way adversely impacts a sense of self and self-efficacy, and can lead the ‘disease’ owner to

feel “forever flawed” and that she/he lacks the capability to transcend their problem (Smith, 2002, p.884). Thus, the ill-informed attempt to label obesity in this way has created unhealthy ‘side-effects’ for the individual. Sadly depression has recently been declared as the number one health issue globally. According to the WHO, depression is the “leading cause of disability worldwide,.....a major contributor to the global burden of disease”, affecting more women than men (WHO, 2012).

2.16 Framing Obesity – Media Complicity

On another level, framing obesity as not only an easily preventable disease but a massive economic problem that threatens the financial viability of national health care systems, situates obese persons as irresponsible social liabilities and imposes expectations that they will respond to a moral imperative to act to prevent individual and national health catastrophe for the collective good (Beausoleil & Ward, 2009; Clarke et.al, 2003; Gard & Wright, 2005). As a corollary, self discipline and individual governmentality became “the sine qua non of good citizenship” (Crawford; 2006, p.402) and the *raison d’etre* for the proactive relentless pursuit of BMI-defined ideal bodyweight, and by association the perfect health (Gard & Wright, 2005, Rich & Evans, 2005, Jutel, 2006, 2009a). Attempts by individuals to meet these responsibilities are made by accessing dominant obesity knowledges for the purpose of self- surveillance, assessment, micro management and prevention of risks (Clarke et.al, 2003, Gard & Wright, 2005, Jutel, 2009a, 2009b).

The mass media represents a significant source of both lay and biomedical obesity knowledges (Rich & Evans, 2005). As an industry, the media plays a role in the social construction of obesity as a problem. It draws heavily from the biomedical discourse

(Boero, 2007) to selectively report and sensationalize academic research findings in colourful, anxiety-provoking metaphors both textually and iconically (through television reality shows), as well as cyber media sites, thereby reinforcing dominant obesity knowledges and social understanding of obesity, widespread social stigma and marginalization (Oliver, 2006; Saguy & Ameling, 2008; Saguy & Riley, 2005). In a comedy of paradox, the same media that tout obese people for overeating and depict their struggles in televised reality shows (Monaghan et.al, 2010, Oliver, 2006; Saguy & Riley, 2005) vis a vis a “cultural celebration of thinness-in fashion, films and other media” (Lang & Rayner, 2005, p.311), generates revenue from running the food industry’s multi-billion dollar commercials and advertisements targeted at consumers (Colman, 2000).

With the widespread propagation of risks fueling fear of futuristic or probabilistic weight problems, it becomes virtually impossible not to feel at risk (Clarke et.al, 2003), and therefore “those at risk of becoming obese are as central to the epidemic as those who are actually obese” (Boero, 2007). Thus the divide between health and disease is “tenuous”, leading to anxieties that transform people into “ready subjects for health-related discourses, commodities, services, procedures and technologies” (Clarke et.al, 2003, p.172). It is important to note here that the word ‘risk’ in relation to discourse throughout this thesis, is used to denote the ‘truth effects’ of the dominant obesity discourse in its construction of responsibility, namely blame and fear instead of a focus on possibilities.

2.17 Risk Discourse and the Commodification of Obesity

Risk and surveillance, central pillars in the biomedicalization of obesity take on life form and are manifested and enacted in everyday living and health practices intended

to reduce, manage and prevent risk of disease and to conform to an “ideal” body weight (Gard & Wright, 2005; Jutel 2009; Monaghan et.al, 2010). This is reflected in ongoing surveillance, routine measurements at the population or individual level at home-through self diagnosis and self treatment with among others, scales, self-help books, diet books, and over the counter pharmaceutical products (Jutel 2009; Jutel 2006; Sorbal 1995). Health becomes more biomedicalized away from the medical space (doctor’s offices, health care settings), as the primary site of responsibility is reinforced in the individual who undertakes voluntarily to collaborate without direct prompting (Clarke et.al, 2003). Individual practices to avoid or manage risks are thus mediated through the consumption of weight loss goods and services, buttressed by an advanced technoscientific society that makes available innovative “corporeal possibilities” (Clarke, et.al 2003, p.162).

Finally, at the intersection of the individual and societal level therefore, the commodification of obesity represents what Halse (2009) describes as the assimilation of the external world (the socio-cultural and economic) into the internal world (psyche and body) of the individual. It becomes clear then, that a biomedical-based obesity discourse cannot be disassociated from developments in the larger neoliberal market economy (Beausoleil & Ward 2009; Colman, 2000; Jutel, 2009a, Monaghan et.al 2010; Oliver, 2006). In this market economy obesity is a multi-billion dollar industry (Colman, 2000; Jutel, 2009b; Lang & Rayner, 2005; Saguy & Riley, 2005; Oliver, 2006). The disease label is used by various stakeholders to actively lobby for and promote weight loss products and services (Jutel, 2001; Oliver, 2006; Sorbal, 1995), benefitting an array of industries (food and equipment, fitness clubs, gyms, weight loss clinics, self-help diet systems, cosmetics, pharmaceuticals) who all benefit extensively from promoting and

reinforcing the biomedical “epidemic” and “risk” discourse (Beausoleil & Ward, 2009; Gard & Wright, 2005; Jutel, 2009a; Monaghan et.al, 2010; Oliver, 2006; Sorbal, 1995).

In sum, historical accounts of biomedicine’s role in the obesity discourse, would seem to suggest an inertia particularly in terms of causation and solutions, the very discourse arenas in which biomedicine dominates. The chorus from ancient times has been about an energy imbalance requiring restoration through diets, physical activity, medications, and more recently surgery. Gard & Wright (2005) refer to this as an “obesity science (is) caught up in perpetual loop” in which data is recycled with “slight variations” (p.69), and attribute this need to hang on to the status quo to a reluctance to consider alternative perspectives that invite exploration of other possibilities. Hence, the foregoing historical and cultural account of obesity is necessary in order to situate the present, especially given that scientific truths and knowledges evolve from particular historical and cultural contexts/milieus that genealogically serve as the nexus between power and the truth claims and effects they spawn.

2.18 Obesity – Pregnant with Risks

Nonetheless, the hegemony of biomedicine notwithstanding, a new wave of scholars across disciplines are interrogating the science of obesity, posing different questions and considering alternative knowledges. Among these are feminists, who, although given medicine’s historical subscription to patriarchy and need to control women’s bodies, have weighed in on body weight issues for decades (Monaghan et.al, 2010; Robison, 1999). Historically, the feminine body has long been perceived as shrouded in mystery. It assumed an even more mystified and dangerous meaning in pregnancy, fraught with the depraving influence of maternal cravings that put at risk the

progeny of men and justify the medical regulation and management of women's bodies. Akin to notions of obesity, the impact of such historical assumptions extend to contemporary views of pregnancy as a condition of risk linked with maternal desires (Kukla, 2005), and consequently have implications for maternal obesity.

2.19 Maternal Obesity: A Biomedical Construction

As the prevalence of obesity escalates across all population segments, women are disproportionately affected (WHO, 2008b). At a global level, a higher prevalence of obesity is reported among women (Azarbad, 2010; Friedman & Fanning, 2004; Misra & Grason, 2006; Yogev & Catalano, 2009) in both Western industrialized, and developing countries (Mehta, 2008). For instance, in their analysis of the global trend in prevalence of overweight and obesity for the purpose of forecasting future trends, Kelly, Yang, Chen, Reynolds and He (2008) showed a “consistently higher [prevalence of obesity] among women compared with men in all world regions” (p. 1434). Approximately 62% of American women over age 20 are overweight, and 1 in 3 women are obese (Azarbad & Gonder-Frederick, 2010). Similar trends have been reported among Canadian women (Robinson, O'Connell, Joseph & McLeod, 2005). According to a recent clinical guideline document by the Society of Obstetricians and Gynecologists of Canada (SOGC, 2010), the number of overweight and obese Canadian women rose steadily from 34% in 1978 to 53% in 2004.

Concordantly, escalation in the prevalence of obesity among women is mirrored in the population of pregnant women, and more women are presenting with higher weights at their first prenatal visit (Azarbad & Gonder-Fredrick, 2010; Gunderson, 2009;

Kirk et. al, 2009; Krishnamoorthy & Schramm & Hill 2006; Mehta, 2008; Misra & Grason, 2006; Siega-Riz & Laraia, 2006; SOGC, 2010; Yogev & Catalano, 2009). An estimated 45% of American women enter into pregnancy overweight or obese, and approximately 43% of pregnant women gain weight in excess of what is recommended (Azarbad & Gonder-Frederick, 2010; Gunderson, 2009). On the Canadian front, Fell (2005) notes a similar surge in the prevalence of obese pregnant women, while the SOGC (2010) notes a corresponding rise in obese pregnant women but acknowledges a “paucity” of Canadian data on the prevalence of obesity in this population of women. Nonetheless Statistics Canada (as cited in SOGC, 2010) estimated 11-21% of women of reproductive age are obese suggesting a concordant rise in maternal obesity. In the Atlantic province of Nova Scotia for instance, the proportion of women who were obese entering pregnancy went up 10.7% from 4.1% over the course of a decade, while that of women who gained in excess of the recommended amount increased by 17% (Kirk et. al, 2010). Obesity therefore represents a significant issue for women (Cawley, 2007), with unique challenges that further pose additional risk for their health and wellbeing (Azarbad & Gonder-Frederick, 2010; Cawley, 2007).

In addition to the multi-organ comorbidities (respiratory, cardiovascular, musculoskeletal) generally experienced by obese individuals, obesity poses additional health risk specific to women (Azarbad & Gonder-Frederick, 2010, Gunderson, 2009; Morin & Reilly, 2007). Obese women have an increased risk of infertility, menstrual irregularities, polycystic ovarian syndrome, eating disorders (Azarbad & Gonder-Frederick, 2010; Misra & Grason, 2006), and increased incidence of endometrial, uterine and postmenopausal breast cancers (Azarbad & Gonder-Frederick, 2010; Cawley, 2007).

2.20 Maternal Obesity – An Array of Risks

While it is not outside the realm of possibility for an overweight, or obese woman to have a normal pregnancy with a good outcome (Gussler & Arensberg, 2011), maternal pre-pregnancy obesity represents the most significant high-risk obstetric condition with profound implications for a multitude of complications during pregnancy, childbirth and beyond, that increase the risk of maternal, fetal and neonatal morbidity and mortality (Birdsall, Vyas, Khazaezadeh & Oteng-Ntim, 2009; Catalano & Ehrenberg, 2006; DiLillo, Hendrix, O’Neil & Berghella, 2008; Friedman & Fanning, 2004; Gunderson, 2009; Krishnamoorthy, Schramm & Hill, 2006; Siega-Riz & Laraia, 2006).

Prenatally, maternal obesity (especially pre-pregnancy and first trimester obesity) is associated with an increased risk of pregnancy induced hypertension (PIH) and the associated condition of preeclampsia, a triad of symptoms of high blood pressure, edema/swelling and increased urine protein (Gussler & Arensberg, 2011; Azarbad & Gonder-Frederick, 2010; Catalano & Ehrenberg, 2006; Gunderson, 2009; Misra & Grason, 2006). Both conditions increase the risk of preterm delivery (DiLillo et.al 2006), and overall maternal and newborn morbidity and mortality (Gussler & Arensberg, 2011). Obese pregnant women are reported to have a two to three fold increased risk of preeclampsia (Catalano, 2003), and while the increased prevalence of maternal obesity has not been directly implicated, the incidence of preeclampsia is reported to have increased by 40% in the last decade (Gussler & Arensberg, 2011).

Another complication of pregnancy, gestational diabetes mellitus (GDM) is “perhaps one of the most significant” (Reece, 2008, p.24) maternal obesity-associated comorbidity (Reece, 2008; Sarwer, Allison, Gibbons, Marcowitz & Nelson, 2006), with

an estimated increased risk of 20% among pregnant women (Yogev & Catalano, 2009). An estimated 2-15% of pregnant women become gestational diabetics, and while other extraneous factors such as parity, familial history of diabetes and age are implicated, obesity is nonetheless independently associated with GDM (Yogev & Catalano, 2009). Paradoxically, pregnancy itself is an insulin resistant state (Reece, 2008), with a 40%-50% increase in insulin resistance during gestation (Catalano, 2003). Therefore, for obese women this exerts a double-edged sword effect as the state of obesity equally increases insulin resistance, accounting for the increased incidence of GDM in this population of women (Mehta, 2008). Left unmanaged, or poorly managed, GDM increases the risk of Caesarean section (CS) delivery, of large-for-gestational age (LGA), and macrosomic (fetal weight >4000 grammes) infants, and the associated intrapartum risk of shoulder dystocia and related birth injuries (Catalano & Ehrenberg 2006; DiLillo et.al, 2008; Gunderson 2009; Mehta, 2008; Reece, 2008; Sarwer et.al, 2006). Gestational diabetes is also linked to other adverse perinatal outcomes such as spontaneous abortion and stillbirths, as well as neonatal complications of hypoglycemia and respiratory distress syndrome (Reece, 2008). Additionally for obese women GDM increases the risk of remaining glucose intolerant, as well as future risk of developing type 2 diabetes by as much as 20%-50% (Reece, 2008; Sarwer et.al 2006).

2.21 Maternal Obesity – Endangering Safe Passage

Regardless of prior health status, obesity increases a woman's risk of intrapartum complications (Ehrenberg, Durnwald, Catalano & Mercer, 2004; Jensen, Damm, Sorensen, Molsted-Pedersen, Westergaard, Ovesen, et.al 2003). There is an extensive body of studies linking intrapartum (labour and delivery) complications and maternal

obesity (Krishnamoorthy, Schramm & Hill, 2006). An increased risk of CS secondary to prolonged/dysfunctional labour (Ehrenberg et. al, 2004; Jensen et.al, 2003), and an increased frequency of fetal macrosomia as well as comorbidities (preeclampsia and GDM) that necessitate delivery to be expedited (Krishnamoorthy, Schramm & Hill, 2006). In addition, CS deliveries pose significant risk of postpartum postoperative wound infection, and endometritis (DiLillo et.al, 2008; Krishnamoorthy, Schramm & Hill, 2006; Mehta, 2008). Obese pregnant women have higher rates of induction of labour (IOL) as well as higher rates of unsuccessful IOL secondary to fetal macrosomia and an unfavourable cervix (Mahlmeister, 2007) and unsuccessful vaginal birth after Caesarean sections (VBAC) (Krishnamoorthy et.al, 2006; Mahlmeister, 2007).

During labour and delivery other mechanical and practical difficulties present in the care of pregnant obese women including, difficulty monitoring fetal heart rate and assessing fetal presentation, increasing the potential for obstetric intervention and adverse neonatal outcomes (Krishnamoorthy et.al, 2006). Similarly anaesthetic challenges present difficulty achieving epidural or spinal placement/blocks, and in the case of general anaesthesia, risk of difficult or failed intubation and gastric aspirations (DiLillo et.al, 2008; Krishnamoorthy et.al 2006). Additional perinatal risks include thromboembolic disorders (deep venous thrombosis and pulmonary embolism) and postpartum haemorrhage (DiLillo, et.al 2009; Gunderson, 2009; Mahlmeister, 2007; Morin & Reilly, 2007). For the mother, beyond implications for pregnancy and childbirth outcomes, pre-pregnancy and gestational weight gain in excess of guidelines, increases the risk of weight retention and obesity in later life (Gunderson, 2009; Sarwer et.al, 2006; Yogev & Catalano, 2009) that can lead to negative self-image, and adversely impact mental and

overall quality of health (Krishnamoorthy et.al 2006). For the fetus in addition to the elevated risk of birth injuries and fetal/neonatal demise, maternal obesity has been linked to practical and mechanical difficulties such as the suboptimal ultrasonographic visualization of fetal anatomy. This prevents the timely detection of fetal/congenital anomalies, increasing a baby's chances of being born with anomalies including neural tube defects and heart defects (DiLillo et.al, 2008; Krishnamoorthy et.al, 2006).

2.22 Maternal Obesity – The ‘Culprit’ in Childhood Obesity

From a long term perspective, maternal obesity is increasingly being empirically implicated in another fast-emerging public health crisis, child obesity (Durand, Logan & Carruth, 2007; McNaughton, 2011; Oken, 2009). A large body of studies links large neonatal body size to obesity during childhood and adulthood (Oken, 2009). Macrosomic and LGA babies born to obese women have a nine-fold risk of becoming obese children and obese adults (Reece, 2008), thereby perpetuating a cyclical intergenerational effect, as obesity begets obesity (Catalano, 2003; Catalano & Ehrenberg, 2006; Mottola 2009).

2.23 Maternal Obesity and Breastfeeding – Damned if You Do Damned if You Don't

Similarly breastfeeding is another maternal-mediated pathway increasingly invoked and implicated as a predictive factor in long term maternal-and child body weight outcomes (Amir & Donath, 2007; Grummer-Strawn & Mei, 2004; Rasmussen & Kjolhede, 2004). Mothers who breastfeed have been shown to experience gains in weight loss and long-term cardiovascular health (Stuebe, Michels, Willet, Manson, Rexrode et.al, 2009) while breastfed babies, compared to their formula-fed counter parts, are shown to be less susceptible to childhood and adult obesity (GrummerStrawn & Mei,

2004). Yet, paradoxically while breastfeeding is shown to confer protection against obesity, maternal obesity is shown to affect a woman's ability to successfully engage in this WHO-endorsed infant feeding option (Rasmussen, 2007; WHO, 2004). Maternal obesity is associated with the lowest rate of intention to breastfeed (Amir & Donath, 2007), the lowest rates of breastfeeding initiation and a higher incidence of shorter duration (Rasmussen, 2007; Rasmussen & Kjolhede, 2004), and consequently overall low success rates with breastfeeding resulting in higher rates of formula feeding that compounds the risk of childhood obesity (Krishnamoorthy et.al, 2006). A biological basis for this association implicates a delay in lactogenesis and an endocrine-mediated effect on breast milk production wherein excess maternal adiposity leads to elevated progesterone levels which impedes prolactin secretion and in turn breast milk production (Amir & Donath, 2007; Rasmussen, 2007; Rasmussen & Kjolhede, 2004)

From another perspective mechanical difficulties in achieving proper positioning and latch (both so vital to successful breastfeeding) secondary to an obese mother's breast morphology (large breast and areolas, and flat nipples) have been cited (Hoover, 2008; Jewitt, Hernandez & Groer, 2007). In contrast other studies (Toschke et.al, Braegger, as cited in McNaughton, 2011, p.182) though considered to be based on limited findings (Gunderson, 2007) allude to the harmful effects of a diabetic mother's breast milk and contend that increased levels of glucose and insulin in the breast milk rather increase the infant's risk of childhood obesity. Therefore as McNaughton (2011) observes, against a backdrop of conflicting perspectives and discursive theorizing about the role of breastfeeding, obese mothers are dammed (emphasis on original, doomed) "if they do and" dammed "if they don't" (p.181). Less accounted for is the impact of the

subjective experience of obesity in a culture that has traditionally objectified female breasts as symbolic of feminine sexuality and sexual gratification (and continues to prescribe over where, when and in the presence of who a woman can bare her breast to breastfeed) (Baumslag & Michels, 1995; Palmer, 1993) vis a vis a Western cultural valorization of a slender, well-contained feminine body over an out-of-control, space occupying feminine body (Bordo, 1993; Orbach, 1988). Equally less accounted for is the possibility that obese women may feel embarrassed and uncomfortable to bare their body to the judgmental gaze of others (Richens, 2008) in probably the only culture where it is possible to construe the sight of a woman breastfeeding as ‘indecent exposure’ (Baumslag & Michels, 1995). Hence the extension of the notion of being doubly damned, adapted from McNaughton’s (2011, p.181) reference to these mothers being “doomed” whether they breastfeed or not, is indeed in order.

2.24 Maternal Obesity – ‘Responsibilizing’ Motherhood

The foregoing biomedical framing of maternal obesity within a risk discourse with consequences that extend beyond those that directly impact a woman’s health, to those that threaten the health of children, adults and by extension future generations, portrays obese pregnant women as a threat to the survival of humanity. Maternal obesity becomes a potent signifier for irresponsibility and recklessness. The framing of women as producing adverse health conditions in their children has always been a key plank in biomedical and public health approaches and is evident in the focus on pregnant women whose eating habits are increasingly being implicated in the body weight and future health outcomes of their offspring (Catalano & Ehrenberg, 2006). Consequently, an

unbridled biomedical focus on maternal obesity has created avenues for “the surveillance, regulation and disciplining of threatening (fat) female bodies while at the same time perpetuating a number of taken-for granted medico-moral assumptions about individuals and the causes of fatness” (McNaughton, 2011, p 180). Biomedical commentaries socially construct obese pregnant women as the cause of a global obesity epidemic as implied here: “Both the developed world and developing countries are experiencing a rapid increase in obesity. A key component of this dramatic increase is the cycle of obese parents (read women) producing offspring with a tendency for childhood obesity, who then become obese parents themselves” (Birdsall et. al, 2009, p.494). Not surprising therefore, medical rhetoric extends the causation thesis to the diet and lifestyle of pregnant women depicting them as lazy overeaters, as exemplified in Richen’s (2008) commentary: “Obesity which is evident prior to pregnancy is often due to an accumulation of excess body fat caused by the number of calories consumed exceeding the number of calories which are being utilized” (p.14) and concurrently by Mottola (2009): “ ---in addition to maintaining physical fitness, exercise may be beneficial to prevent or treat maternal fetal diseases ----all pregnant women with low risk pregnancies should exercise on most if not all days of the week” (p.306) thus insidiously implying all pregnant women are at risk. Often times such commentaries are made even while acknowledging the role of, and lack of appropriate resources or infrastructure for facilitating engagement in prescribed lifestyle activities, as this commentary suggests: “National Institute of Clinical Excellence (NICE) recommend informing women to join a group programme involving exercise rather than diet alone; however there are no national public schemes available to assist women in this” (Birdsall et.al, 2009, p.497). Maternal

culpability for fetal exposure to health risks is further invoked with declarations such as: “The evidence is clear and maternal obesity during pregnancy is associated with increased complications for both mother and baby” (Richens, 2008, p.15). The expectation is that obese pregnant women, in the interest of the fetus, will guard their weight and engage in prescribed interventions. Lifestyle interventions are thus justified: “To break the spiraling cycle of generation of unhealthy body weights and obesity-related health problems in adulthood, it is imperative to prevent excessive weight gain and to promote a healthy lifestyle during prenatal life for those women who are overweight and obese” (Mottola, 2009, p.311) and further: “The link between maternal lifestyle and the fetal environment reinforces the idea that the best solution for obesity prevention may begin with the promotion of a healthy lifestyle during pregnancy” (Mottola, 2009, p.312). In this epistemic context, it comes as no surprise when a “national commitment to solutions” is explained as doing “the obvious, which is to teach people to improve the quality of their diets by eating more fruits and vegetables and fewer fats and calories” and to “encourage health insurance to provide premium breaks to those who exercise regularly and lead a healthy lifestyle” (Reece, 2008, p.26). The implicit reference to personal responsibility and moralizing promotion of discrimination is apparent, and while a cursory reference to “the role of societal policies” is made, the article concludes with the need to “diligently uproot the source of these problems - obesity caused by the unhealthy habits of an industrialized and mechanized society” (Reece, 2008, p.28).

2.25 Maternal Obesity and Maternal Moral Responsibility

On another level of social construction, the media actively plays the role of vehicle for propagating and sensationalizing ‘scientific’ discourse on maternal obesity. Biomedical ‘truth claims’ in studies are recontextualized in the media to yield morally – steeped and dramatic headlines such as “Memo to mum, your children are what you eat”, “Mum’s diet key to fat adults” (Sunday Mail, as cited in Maher, Fraser & Wright, 2010, p.239); “Born to love fat, thanks to mom’s diet” (Taylor, Globe and Mail, as cited in McNaughton, 2011, p.190). Similarly, commentaries such as “we must look at the womb to understand what is producing today’s obesity” (Lebowitz as cited in McNaughton, 2011, p.179) locate the origin of obesity in the mother. Pregnancy is thus identified as a key time to target weight management strategies to curb the rapidly growing obesity epidemic. For instance, in a recent clinical practice guideline, the Society of Obstetricians and Gynaecologists of Canada (SOGC, 2010) alludes to “a sedentary lifestyle and poor nutrition” as the cause of maternal obesity and recommends that women be counseled and informed preconceptually “about the need to be as healthy as possible before becoming pregnant, which includes having a normal BMI, eating a balanced diet and participating in regular exercise”, further noting that exercise is inexpensive (p.171). It also calls for a “national strategy” to “*exploit* women’s interest in having as healthy a pregnancy as possible by giving them the information they need to become fit and have a normal BMI” (p.171). Pregnancy it further states, “is a good time to target health behavior change by using the extra motivation women tend to have at this time to maximize the health of their child” (p.171). All too evident among others, is the objectification of obese pregnant women, positioning them as having the ability to

control their weight, yet lacking agency and being *'exploitable'* on the basis of a culturally-ascribed gender role of nurturer, and the privileging of fetal health over maternal health. In contrast, Misra and Grason (2006) note that on the contrary, obesity is especially difficult to address prenatally compared to such behaviors as smoking, and contend that although there is a place for prenatal care, the traditional tendency to regard it as an "all-encompassing strategy" fundamental to positive maternal-fetal outcomes may have been oversold. They make a compelling argument that usually it is women most at risk and most in need of care who either have least access to care or hesitate to access care due to negative hegemonic experiences in healthcare settings. Additionally, they observe, given the role of distal or structural factors, changes in a woman's environment and resources may be more effective and timely than health care services during conception.

2.26 'A Ship Upon a Stormy Sea' – Privileging Fetal Health Over Maternal Health

The recurring allusion to personal responsibility in the discursive construction of maternal obesity has broader implications. Implicit in the notion of personal moral responsibility to health, is the expectation that the individual will engage responsibly in preventative activities or risk being "morally blamed" (Verweij, 1999, p.107). This 'moral thesis' is especially applicable to people whose health directly impacts another. Thus, a pregnant woman may have a 'prima facie' obligation to care for her health, because the health of the baby she carries depends on hers and can be at risk if she engages in 'unhealthy' lifestyle behaviours. Verweji (1999) further argues that "a special duty to care is part of our moral concept of being a parent", therefore along with the

decision to become pregnant is the “responsibility to care for her child”. However, notwithstanding the fact that most pregnancies are unplanned (Misra & Grason, 2006), throughout the lifespan women’s health is exposed to multiple societal/ structural pathways that converge eventually to negatively impact and determine women’s reproductive health. This begs the question, what then is society’s responsibility for ensuring maternal capacity for such a responsibility?

Overall, with a predominant focus on risk and pathology, biomedicine appears to privilege fetal health over maternal health and to discursively construct obese pregnant women as “irresponsible and dangerous to themselves, to their offspring and to society”, and therefore as “bad citizens” and “bad mothers” in need of “education and increased surveillance” (McNaughton, 2011, pp.185, 186). From a historical perspective, this approach is reminiscent of the centuries-old medical metaphor that likens a pregnant woman to “a ship upon a stormy sea full of white caps” that must be prudently navigated by “the good pilot who is in charge” (read physician/health care provider) if a “shipwreck” is to be prevented (Barker, 1998, p.1067).

As Hanson (2004) trenchantly observes, for all “the truths-claims attach(ed) to medical discourse, it remains necessary to stress the fact that the language of medical science, although it struggles for objectivity, cannot escape the fact that, as a language it is not value-free” (p.4). Yet as Venkatapuram and Marmot (2009) aptly and astutely note “it is commonplace to observe how ‘truths’ discovered by science become inputs into moral evaluations and actions” (p.80).

2.27 Managing Obesity – Micro Level Management of a Macro Issue

The biomedical risk-oriented focus plays out and dovetails into existing obesity guidelines (Lindsay, 2010) that inform strategies and approaches in obesity management. It is no surprise therefore that approaches in the management of obesity align with, and endorse the prevailing biomedical episteme by allotting priority to behavioral and lifestyle modification strategies that address “behaviors related to eating and physical activity in isolation from the broader social, physical, economic and policy context” (Huang & Glass, 2008, p.1811) thus relegating preventive strategies to the back burner. For nearly half a century guidelines have typically focused on micro-level strategies that focus in the main, on diet and physical activity (Nestle & Jacobson, 2000). Inherent in this approach is the all too simplistic presumption of knowledge deficit - that people lack the necessary knowledge to make healthy choices. Maziak and Ward (2009) refer to this strategy as “the mass marketing of behavior change based on a doctrine of personal responsibility and free choice, and the power of information to induce behavior change” (p.2136). Hence, health strategies for addressing and managing obesity while couched in a health promotion framework, are premised on biomedical principles and therefore deeply entrenched in a risk-oriented personal responsibility approach (Barry, Brescoll, Brownel & Schleisinger, 2009; Finegood, Karanfil & Matteson, 2008; Hobbs, 2008; Maziak & Ward, 2009). Interventions and programmes targeted at obesity are individualistic, reductionist and downstream (Maziak & Ward, 2009). They are delivered through a public health mantra about diet, physical activity, behavior & lifestyle modifications that require no political risk or will, and therefore while politically and economically convenient and feasible, have been consistently shown to be largely

ineffective and non-sustainable (Maziak & Ward, 2009; Hawe, 2009; Hobbs, 2008). More significantly, the preeminence of a biomedical, behaviorist episteme on obesity, and by extension practice guidelines that reflect and endorse this episteme, ultimately not only determine approaches to the management and care of obese individuals, but also the manner in which care or service is delivered.

2.28 Psychosocial Implications - Stigmatization

The discursive representation of obesity as an entirely preventable disease of overconsumption and physical inactivity and a ‘cost-burden’ to society, promotes a reading of obese individuals as immoral, lazy gluttons, makes it an issue of personal responsibility and underpins the widespread societal prejudice obese individuals encounter (Greener, Douglas & van Teijlingen, 2010; Maziak & Ward 2009; Saguy & Riley, 2005; Townend, 2009). Crandall and Biernat (1990, p.228) aptly observe that, “the main reason that the obese are so strongly disliked is that they are held responsible for their condition”. With its hypervisibility, obesity is one of the most widely stigmatized social conditions in the Western cultural hemisphere (Townend, 2009). So intense and vitriolic is the moralization about obesity that some people have been reported to say they would opt to die several years earlier or be blind than be considered obese (Schwartz et al., as cited in Brewis, Hruschka & Wutich, 2011). While physical disability and comorbid health problems associated with obesity can impact economic and occupational status, it is becoming increasingly clear that the psychosocial effects of systemic prejudice and stigmatization experienced by obese individuals can be profoundly devastating (Muenning, 2008). In their daily encounters and interactions with family members and friends, or publicly in institutions of health, education or employment,

obese individuals persistently experience advertent or inadvertent, subtle or overt psychological, emotional and physical acts of oppressive prejudice (Carr & Friedman, 2006; Townend, 2009). These experiences lead to feelings of shame, self-hatred, alienation, loss of self-esteem, self-recrimination, and overall assault on their human dignity and integrity (Rogge, Greenwald & Golden, 2004; Shortt, 2004, Townend, 2009). In addition to being affected by the discrediting and prejudicial attitudes of others, obese individuals internalize these negativities into their psyche (Schafer & Ferraro, 2011) and the stress of internalized stigma contributes to obesity-related morbidity (Brownell, Puhl, Schwartz & Rudd, 2005). Indeed, the collusion of healthcare providers, agencies and advocates in the prevailing prejudice against obese persons constitutes an unfortunate paradox (Rogge et. al 2004). By focusing and emphasizing the risk of disability and death associated with obesity, health advocacy groups as well as health professionals contribute significantly to societal understanding of obesity as unhealthy, deviant, abnormal, and reinforce the social construction of obesity as a disease, albeit one that is preventable and within the affected individual's volition (Rogge et.al 2004). Similarly the influence of a risk-oriented, hegemonic obesity discourse is manifested in the moralizing attitudes of health care professionals. Several studies show that health care professionals demonstrate prejudicial attitudes toward obese individuals (Brown, 2006; Brown, Stride, Psaro, Brewins & Thompson, 2007; Poon & Tarrant 2008).

2.29 Encounters In Healthcare – The Experience of Prejudice

Obese women's experiences of prejudice, discrimination and disrespect in healthcare settings are extensively documented (Carryer, 2001; Merrill, 2007; Wray & Deery, 2008). Concomitantly, obese pregnant women's experiences of stigmatization in

their encounters with healthcare professionals have been reported (Nyman, Prebensen & Flensner, 2010; Vireday, 2002; Wray & Deery, 2008). Vireday (2002) reports obese pregnant women's experiences of encounters during which they felt abused, harassed and humiliated by physicians or midwives who yelled at them; required them to give uninformed consent for CS; required them to diet during pregnancy and advised them to terminate the pregnancy given the risk entailed to the fetus. Women also reported negative remarks by friends and family. More recently, Nyman et. al (2010) report obese pregnant women's negative experiences in health care settings that left them feeling shamed, judged, discriminated against, and feeling personally responsible for their weight. Paradoxically, pregnancy is widely acknowledged to be a critical transitional period in a woman's life that is characterized by "heightened levels of emotion and anxiety" and thus a vital part of a woman-centered care is support and promotion of maternal psychological wellbeing to facilitate the psychosocial and emotional functioning needed to positively adapt to this key period (Fomeen & Martin, 2008 p.391). Yet, as Wray and Deery (2008) aptly observe, "hegemonic biomedical perspectives on fatness may influence healthcare professionals beliefs, values and practices" and result in "intolerance toward body shapes and sizes" that are deemed to be deviant (p.238), as well as a tendency to perceive obese pregnant women as "a statistic waiting to happen" (Vireday, 2002, p.31).

The state of being obese overrides all other forms of social and self- identity, and takes on a 'master status' especially for women (Brewis et. al, 2011). Given societal pressure to conform to a culturally prescribed slender feminine body ideal, women are more susceptible to obese-related stigma and discrimination (Azarbad & Gonder-

Frederick, 2010) and its impact on them is equally more pronounced (Roehling, 1999). Concurrently Lundgren (2004) notes that negative encounters with health care professionals profoundly impact the wellbeing of pregnant women. Furthermore, such experiences impact willingness to seek access to healthcare, (and yet they represent the very people who need it the most) and can also lead to or compound eating disorders and emotional stress that further exacerbate body weight issues (Bertakis & Azari, 2005; Carryer, 2001). A study by Puhl and Brownell (2001) found that obese women resorted to overeating and resistance to diet to cope with stigma-related stress, while Brownell et.al (2005) advance the thesis that experiences of bias in health care result in a cyclical effect in which a consequent avoidance of care compounds incapacity for self-care, ultimately leading to an exacerbation of obesity-related comorbidities.

Given the above, it may be that the caveat advanced by Castel (1991) about the iatrogenic effects of ‘prevention’ (as defined and promulgated by a risk-oriented, personal responsibility episteme) may very well have import here. Biomedical based approaches that promote moralizing and discriminatory attitudes against obese individuals may substantially be more harmful to health than the risk behavior they purport to want to manage or control.

2.30 Obesity Truism and the Preclusion of Context

A biomedical-inspired perspective automatically sets up a particular view of the obese pregnant woman and precludes (in the process of care or service provision) the contribution of contextual factors in the construction of obesity, even though as the literature consistently shows people cannot be separated from the political, socioeconomic and cultural contexts in which their lives are embedded (Raphael, 2010;

Wilkinson & Pickett, 2010). The literature notwithstanding, there remains a persistent tendency to perceive personal health behaviors as the strongest determinants of health and this is reflective of the main focus, the lifestyle approach to health professionals' practice (Hawe, 2009). Concurrently, the rise of an obesity epidemic has served to reinforce a dominant lifestyle approach to health promotion, even while this approach given its preclusion of the social context, is antithetical to the tenets of health promotion (Raphael, 2008). Notwithstanding its misplaced focus on health education/information giving and counseling, the practice of promoting health entails "both attitudes and actions" (Caelli, Downie & Caelli, 2003, p.171). Nursing actions can only be health promoting if they are undertaken within a milieu reflective of a willingness to listen, openness, and a participatory versus expert driven process, the intent of which is to among others raise awareness, promote self-esteem while acknowledging the role of structural and contextual factors (Caelli et.al 2003). In view of this, an enhanced awareness, deeper understanding and appreciation of the socioeconomic and political forces that construct and maintain obesity and the subjective experiences of those who live it (Aston et al., 2012; Hawe, 2009) will help recast and align health professionals' practice more with "the causes of the causes" of obesity (Hawe, 2009, p.292). For now, as Henderson (2007) emphatically asserts, while medical truisms of the adverse consequences of obesity abounds, less apparent is how issues of race, income, culture, class and gender converge to overshadow medical obesity truth claims.

2.31 Obesity – A Social Determinants of Health Perspective

While it is commonly acknowledged that healthy body weights are largely determined by healthy nutrition and physical activity, these are nonetheless predicated upon a confluence of socioeconomic, political and environmental factors (Dufty, 2005; Hobbs, 2008; Raphael, 2006; Townend, 2009; Wilkinson & Pickett, 2010). Collectively, these interrelated and highly interactive factors namely: “income and social status, social support networks, education, employment and working conditions, physical and social environments, biology and genetic endowment, personal health practices and coping skills, healthy child development, and health services” (Raphael, 2006 p.653), constitute the social determinants of health (SDOH) and represent a major defining guidepost of contemporary public health (Hawe, 2009; Raphael, 2006; Solar & Irwin, 2006). The SDH explain why some populations, societies, and nations are healthier than others, and why certain people within these entities are healthier than others (Raphael, 2006, 2010; Wilkinson & Pickett, 2010). Its emergence in contemporary society gave the impetus for several global health initiatives which sought to replace a predominantly disease-oriented biomedical health paradigm with a social-justice based population health approach (Raphael, 2010; Solar & Irwin, 2006), the goal of which was to facilitate a level play field in which all individuals have a fair chance to attain health to their maximum potential (Coburn, 2006; Raphael, 2010).

The recognition that health is a central resource of everyday living is based on studies that link people’s health to the context in which they are born, in which they grow, live and work (Graham, 2004; Hawe, 2009; Raphael, 2010) and that these contexts are in turn influenced by the value each society chooses to assign to an equitable

distribution of power, social and economic resources among its citizens (Marmot, 2006; Raphael & Bryant, 2006; Wilkinson & Pickett, 2010). As a central feature and grounding principle in an ambitious social reform agenda, the notion of SDOH is certainly not novel. Its evolution can be traced to the 1850s with the scholarly work of epidemiologists Frederick Engels and Rudolf Virchow (Raphael, 2010). Yet, as exemplified in the public health issue of obesity, it remains distanced from the sine qua non of health practice in North America and elsewhere, where neoliberal governance and market economies drive approaches that “are narrow, behavioural and say nothing about broader determinants of health or empowering citizens and communities” (Raphael, 2008, p.489).

Ironically, placed in historic context and much like the BMI, the original conception of the notion of lifestyle has evolved into a concept its founder never intended. The Weberian inspired concept of lifestyle has metamorphosed dramatically since it was conceived in 1922 (Frohlich, Corin & Potvin, 2001). For Max Weber, lifestyle broadly encapsulates income, occupation, education and status within a milieu of opportunity, “choices and chances”. He envisioned “life chances” as “opportunities that people encounter in life because of their social situation” and lifestyle as being socially determined (Frohlich et al. 2001 p.783). This aligns with the notion of SDH, and is far removed from the current pathologized, deterministic lifestyle discourse “often operationalized as habits of so-called ‘behaviours’, measured discretely and independently quantified as behavioural risk factors and ... targeted for strategic public health interventions” (Frohlich et al. 2001, p.783). With the emergence of an ‘obesity epidemic’, the hype and rhetoric of a lifestyles discourse, “by governments, the health

care and public health sectors, and the media” intensified (Raphael, 2008, p.488).

From a SDOH perspective, obesity is inversely related to socioeconomic status (SES) and downward social mobility (Colman, 2000; Drewnowski, 2009; Wilkinson & Pickett, 2010). The poor, and least educated have the highest rates of obesity (Drewnowski, 2009). Obesity is associated with a social gradient and is therefore more prevalent as one goes down the social ladder, and more common in unequal societies where income differences are wider, social distances greater and social stratification more important (Wilkinson & Pickett, 2010). With a rising prevalence in obesity correlated with a steepening social gradient, obesity is now seen as an affliction of the poor (Ciabattari, 2007; Wilkinson & Pickett, 2010). Poverty impacts every category of the SDH, including but not limited to, housing/shelter, transportation, physical activity and food security (Raphael 2008; 2010). Poverty and ill-health are intrinsically linked and highly interactive, with poverty leading to, or resulting from ill health, and ill-health maintaining poverty in a vicious cycle (Wagstaff, 2000; Stewart, Reutter, Makwarimba, Rootman, Williamson et. al, 2005) through the ravaging consequences of material deprivation compounded by marginalization, social alienation and exclusion (Messias, DeJong & McLoughlin, 2005).

2.32 Obesity and the Feminization of Poverty

Power is central to the process of social stratification (Thomas, 1994). Generally women are stratified in the lower echelon of society and are thus more likely to be economically disadvantaged, have fewer or no access to resources, goods, services and life opportunities, and tend to experience poorer and more stressful living conditions

(Spitzer, 2005; Thomas, 1994; Wuest, 2006; Wuest, Merrit-Gray, Berman & Ford-Gilboe, 2002). Incidentally, by most accounts women have a higher susceptibility to the deleterious effects of the SDH (Raphael, 2010; Sicchia & Maclean, 2006; Wilkinson & Pickett, 2010) and the social gradient in obesity is comparatively more consistent and steeper for women (Cawley, 2007; Slater et. al 2009, WHO, 2008; Wilkinson & Pickett, 2010) and among poorer women than their comparatively well-off counterparts (Slater et. al, 2009; WHO, 2008; Wilkinson & Pickett, 2010). Concurrently, socioeconomic deprivation and health inequalities are implicated as determinants of maternal obesity (Hestlehurst, Ells, Simpson, Battenham, Wilkinson et. al. 2007).

The higher propensity for obesity among women is linked to low educational and income status (Drewnowski & Specter 2004) with the former (low education) predictive only for women, and not men (Slater, et. al, 2005). The stronger association between SES, inequality and obesity among women suggests women's body weight issues are significantly influenced by economic and sociopolitical structures (Sicchia & Maclean, 2006; Spitzer, 2005; Wuest et. al, 2002).

The feminization of poverty thus has import for the feminization of obesity (Wilkinson & Pickett, 2010). Premised on the notion that gender disparities underpin women's poverty, the feminization of poverty is a global issue as women make up approximately 70% of the world's poor (Sicchia & Maclean, 2006). While women are poor for the same reasons that men are, two unique features of society – the gendered division of domestic labour and a gendered work force – put women at a much higher risk for poverty (Colman, 2000; Sicchia & Maclean, 2006; Spitzer, 2005). Similarly, women's multiple roles in society constrains educational and economic opportunities and

limit upward career mobility, and financial security (Colman, 2000; Sicchia & Maclean, 2006; Spitzer, 2005; Thomas, 1994). At a political and policy level, decreased health budgets and funding of social services in several countries, including Canada secondary to neoliberal-inspired globalized market economies (Raphael, 2006), disproportionately impacts women (Anderson, 2000; Spitzer, 2005). The consequent material deprivation leads to social deprivation, distress, low self esteem and overall psychological and emotional impoverishment (Colman, 2000; Spitzer, 2005; Wilkinson & Pickett, 2010) all of which through various pathways exacerbate body weight issues (Azarbad & Gonder - Frederick, 2010; Spitzer, 2005). The perinatal population is especially vulnerable to the influences and impact of socioeconomic deprivation especially in areas of lifestyle and health behaviours. This is most evident in maternal obesity, one of several but significant pathways by which socioeconomic disparities profoundly influence and determine perinatal outcomes (Joseph, Liston, Dodds, Dahlgren & Allen, 2007).

2.33 Obesity – The Food Insecurity Factor

Another consequence of material deprivation is food insecurity, and it is perhaps by far the most significant SES-related determinant that not only advances an alternative viewpoint, but packs a powerful challenge to the behaviourist lifestyle approach and hence the biomedical representation and reading of obese women as undisciplined overeaters. Food insecurity is a phenomenon wherein concern about the availability of resources to procure nutritionally adequate food at different times of the month influence the pattern, quality and amount of food consumption, resulting in initial consumption of ‘unhealthy’ foods early in the month, followed by a period of hunger at the end of the month when resources for food are depleted. The consequent cyclical effect of erratic

eating patterns has been linked with increased weight gain over time (Olsen, 2005; Phillips, 2009; Rideout, Riches, Ostry, Buckingham & McRae, 2007). This phenomenon is not exclusive to developing countries, but cuts across populations around the globe, wealthy nations inclusive, wherever poverty can be found (Rideout et. al, 2007). Food insecurity is directly related to income (Olsen, 2005; Phillips, 2009; Siega-Riz & Laraia, 2006). In their analysis of a community survey of overweight and obese Canadian adults, Slater et. al (2005) found food insecurity to be highly predictive of overweight and obesity in women but not in men. Other studies have yielded similar findings (Drewnowski & Specter, 2004; Siega-Riz & Laraia, 2006). Furthermore, it disproportionately affects low SES women (Attree, 2005; Mehta, 2008) who tend to be “held to a moral standard” in a society that does not provide the conditions or resources to nurture the capacity “to comply with these standards” (Mehta, 2008 p.414). These women resort to food banks, the official resource and response, where paradoxically the food obtained is energy-dense, of poor nutritional value and exacerbates weight gain (Slater et. al, 2005).

Yancy, Leslie and Abel (2006) observe that notwithstanding their increasing role in the workforce, women continue to retain and perform the gendered role of being largely responsible for the procurement and preparation of family meals. Concurrently, in examining the “nexus” between food insecurity and women’s health from a feminist perspective, Phillips (2009) notes that “women play a central role in food security” and hence experience “a double jeopardy” in the face of food insecurity. While their wellbeing is crucial to ensuring food security for their families, they are nonetheless “the first to stop eating” when food security is compromised, putting them “at greatest risk of

obesity” and other health problems (p.486). Olsen (2005) refers to this act of self-sacrifice as an “unhealthy trade-off” (p.321). Additionally, as a significant determinant of health “directly amenable to public policy”, food insecurity intersects with other SDH such as shelter, and creates the dilemma of whether to procure adequate quality food or pay the rent (Raphael, 2006) and thereby leads to the consumption of poor quality diets that increase or compound the risk of obesity (Raphael, 2010).

The impact food insecurity can have on women’s food choices and dietary habits, supports the argument that while poor diet occurs at the individual level, it is significantly predicated on socioeconomic, political and cultural environments (Raphael, 2008; Wilkinson & Pickett, 2010). In response to biomedicine’s discursive representation of obese pregnant women as among others, physically inactive overeaters (in need of expert scrutiny and self-surveillance to manage, control or lose weight) Wuest et. al (2006) advance the ensuing interrogation (albeit with reference to cardiovascular health but equally relevant for obesity) that lays bare the processes by which the SDH interact and intersect to constrain capacity, autonomy and resources for healthy diets and exercise: “Can women eat well when their income is used to pay for housing, when poor quality food is most readily available, when due to work and home responsibilities they have little time or energy to devote to cooking? Can women exercise when they have no time due to multiple roles, when the neighbourhoods where they live are not safe for walking, when there is little accessible, affordable recreation, when they have no childcare”? (p. 767).

Similarly, Affenito & Kerstetter (1999) postulate that “women’s health involves their emotional, social, cultural, spiritual and physical wellbeing” and is determined not only

by biology but also by the social, political and economic context of their lives (p.85). This implies that women's health cannot be divorced from the context of their daily living and the social forces that influence perception of these experiences, nor can there be much understanding of their lived experiences outside of these contexts. The incorporation of a SDH lens in a feminist approach to research has the potential to capture and advance into the limelight the multiple truths and realities embedded in pregnant women's experiences of obesity, thereby creating possibilities for the transformation of society's perception of and attitude towards this group of women. Additionally, it can promote understanding of the meaning they ascribe to their experience of obesity, and thereby put a face to, and give voice to the differing experiences hitherto silenced by hegemonic biomedical discourse. Not least of all, it will have the empowering effect of raising women's consciousness and awareness of alternative obesity narratives, and inspire the realization that external frames of reference are not and should not be constitutive of their lived reality. Yet, despite the magnitude of its relevance to women's health, Petite and Clow (2010) report a paucity of research on maternal obesity from a SDOH perspective.

2.34 Studies on Pregnant Women's Experiences of Embodiment

Most studies about pregnant women's experiences of embodiment undertaken in the last few decades have focused on issues of body image and yielded conflicting findings. Wiles (1994) undertook one of the earliest studies about pregnant women's experiences of obesity. Conducted in England, the two-phase qualitative study sought to

explore women's experiences of being 'fat' and how these experiences were impacted by pregnancy and childbirth. Thirty-seven pregnant women were interviewed at 30 weeks gestation and again at 6 weeks postpartum. Wiles found that a majority of women reported significant positive feelings about their body weight during pregnancy in comparison to the negative feelings held about their weight pre-conceptually, and reported positive encounters with their healthcare providers. They also reported feeling liberated from the social constraints and restrictions of their pre-pregnant weight. Wiles concluded that obese women's body image was positively impacted by a "greater social acceptability" (Wiles 1994, p.45) of obesity during pregnancy, and that pregnancy may be the only time when conformity to a cultural ideal of a slender feminine body and norms related to what constitutes feminine beauty and sexuality is waived because "being fat" is necessarily perceived as "part of being pregnant" (p.48). Concurrently, in that period, other studies that investigated the experience of women who were obese preconceptually yielded similar findings, reporting positive body image (William & Potter, 1999) compared to their non-obese counterparts (Fox & Yamaguchi; 1997).

William and Potter (1999) conducted a British study of 20 pregnant women to explore their feelings and perceptions about weight gain, body image and expert advice on eating behavior during pregnancy. Their findings not only support Wile's report that women felt liberated from the constraints of society's idealized slender female body, but is also suggestive of a 'social reconstruction' of the conventional slender ideal to a maternal ideal. This reconstructed ideal, with the expectation that pregnant women will consume more and be "rewarded for larger bodies" was found to be actively encouraged and mediated as much by family and friends as by health professionals, leading to the

observation: “it’s like they want you to get fat” (Potter, 1999, p.231). William and Potter also report agentic attempts by women to control their experiences of body weight by deciding that notwithstanding their body weight, in the interest of the baby, they were not going to diet until after the pregnancy, which ironically appears to be an attestation nonetheless to the power of the conventional socially-constructed slender ideal.

In contrast, almost a decade after Wile’s study, Earle (2003) explored women’s perception of obesity and body shape during pregnancy and “the extent to which their concerns reflect either resistance to the asexualization of the pregnant body or the continued oppression of women’s embodiment” (p.245), and found that pregnancy did not confer liberation from the constraints and pressure women feel about body weight. On the contrary, body weight and body image issues persisted throughout pregnancy. Nonetheless, amid concerns about body weight, most of the women “welcomed increases in breast size” (p.251). This led Earle to theorize that this meant either women felt the need to comply to the slender ideal and so did not see pregnancy as an opportunity to resist the ‘tyranny’ of slenderness, or the persistent concern with issues of obesity and appearance during pregnancy was indeed their way of resisting the asexual representation of pregnant women as little more than reproductive “incubators” (p.251). Thus pregnant women can be seen as resisters or compliant subjects to the ‘tyranny’ of slenderness depending on a particular theoretical or ideological bent. It is noteworthy that Earle’s participants were not identified as obese, in which case it is conceivable and arguable that they would feel and perceive body weight issues differently from obese women for whom pregnancy legitimates their weight and confers protection from societal pressures. Equally notable is the fact that in a decade, the social climate with regard to obesity has

changed and a surging prevalence of obesity has led to a more vigorous and salient focus on, and scrutiny of obese individuals and nobody is exempted, pregnant women inclusive. Against the backdrop of this literature review, Earle's findings are nonetheless significant to the extent that they underscore Gard & Wright's (2005, p.17) notion of an "everyone, everywhere" effect of the obesity epidemic 'risk' discourse which serves to beckon one and all, obese or not, to the project of self micro management and surveillance. Additionally from a poststructuralist perspective, the enthusiastic anticipation and welcome of "large breasts" denotes women's complicity and role in their own subjection (Butler, 1997) in relation to the cultural inscription of the female body as a sex object.

Using a mixed method approach that combined phenomenology and Foucauldian discourse analysis, Johnson, Burrows & Williamson (2004) investigated the experiences of 6 primigravidas (women with first pregnancy) between 33 and 39 weeks gestation, and explored their feelings about body weight, eating behavior as well as others' (health professionals inclusive) perception of them. Their findings, similar to Earle's, show that pregnancy itself is discursively constructed within a discourse of femininity that portrays women as being valued for their physical appearance and reproductive capability, and that the gendered discursive positioning of women was undertaken both by women and others. Women positioned themselves in relation to body weight and shape, as breaching dominant ideals for feminine beauty (evident in negative references to their pregnant body as "frumpy", "bloated" and "weird" and reports of other people's perception of them in a similar vein, Johnson et al, 2004, p.366); and breaching dominant ideals for feminine body (evident in concerns that they may be perceived as "fat" before they begin

to 'show', their expressions of relief when it became known, references to the body returning to 'normal' in the postpartum period, and expressions of pleasure at changes in breast size), but nonetheless felt pregnancy justified this breach as well as made it acceptable to eat more than usual. Johnson et.al concluded that women's experiences were shaped by "background practices, processes, and social structures" (p.371), and that women's positioning of themselves was disempowering, and underscores a need to replace gendered discourse with non-hegemonic "alternative representation" of women (p.371). The finding that pregnancy relaxes the pressure to conform to the slender ideal corroborates similar findings by Wiles (1994) and William & Potter (1999).

In a departure from the subject of body weight in relation to body image, a Swedish study by Nyman, Prebenson & Flensner (2008) examined pregnant women's experiences of encounters with health professionals during pregnancy and childbirth. Nyman et. al interviewed 10 women with a BMI greater than 30, four to six weeks postpartum. In addition to describing negative encounters with health professionals, participants also described what it meant to be obese and pregnant as, being constantly aware of one's body weight, its high visibility, and exposure and subjection to constant judgmental scrutiny. Although not discussed or examined, Nyman et.al report findings that point to women's internalization of the dominant discursive representation of obese pregnant women. They report that participants had some familiarity with the risks associated with obesity, and although they did not consider obesity to be a disease, some were greatly concerned by these risks. More significantly, they felt that they owned responsibility for being obese and felt their weight was a temporary state which they "could and intended to do something about" (p.427). They thus took up discursive

positioning of obese pregnant women as being personally responsible for embodying a pathologic condition which is entirely within their volition to control and avoid, and in so doing appear to be caught up in what Weedon (1997) refers to as a fictitious rendition of their own subjectivity and presumed control over it. Nyman et. al concluded that the high visibility of obesity renders obese pregnant women particularly “vulnerable” and called for a more respectful, non-judgmental approach to care that takes into consideration the perspective of these women.

In yet another British study, Furber & McGowan (2010) explored the experience of obesity in 19 women with a BMI greater than 35 through interviews during their third trimester of pregnancy and again between 3 and 9 weeks postpartum. Consistent with findings of other studies cited above, women reported negative experiences at both the institutional level (with health professionals) and at the interpersonal level (with friends, family and the general public) that left them feeling humiliated and stigmatized. They also reported distressful experiences of medicalization, given their presumed ‘high risk’ status, and a singular focus on the fetus especially with respect to ultrasonography where difficulties visualizing the fetus was not explained or communicated but merely glossed over. Furber and McGowan concluded that obese pregnant women are “sensitive” of their size and that negative interactions with health professionals further compound their distress. Similarly, Keenan and Stapleton (2010) analyzed data from longitudinal interviews of obese (“large bodied”) women, against a backdrop of growing medical and moral construction of obese pregnant bodies as pathological “subjects at risk” to themselves and their offspring. In support of findings by Wiles (1994) and William and Potter (1999), some women reported an overall positive body image and pregnancy

experience, and “feared and enjoyed” (p.380) pregnancy as a time free from the pressures of dieting and weight watching as well as subjection to the gaze and negative comments of others. Keenan and Stapleton also found that women were more inclined to feel more negatively about comments in the media and by family than by health professionals. This appeared to support the contention by Conrad, as cited in Keenan and Stapleton (2010) that the medicalization and moralization of obesity is not confined to the medical or health profession as other ‘social actors’ (family, friends, the media, interest groups and the obesity industry) play a significant role.

All but one of the studies cited above are British studies (with the one being Swedish). A literature search to date yielded no North American study. This appears to suggest a paucity of North American studies on the experience of obesity by pregnant women despite a reported higher prevalence of obesity in North America compared to the United Kingdom or Sweden (Wilkinson & Pickett, 2010). Additionally, while most of the studies address body weight as it pertains to feminine body image and aesthetics, they add to the wealth of information on maternal obesity. It is known that maternal obesity is on the rise, it is known that it is associated with a multitude of biopsychosocial comorbidities that significantly impact maternal and newborn health, it is known that while the associated fiscal cost is high, the human cost transcends quantification. These are known from sources other than those who live it. What remains largely silent and outstanding from discourse is the face and voice of the women who embody it. Maternal obesity needs to become clearly visible and needs to be heard loudly on the terms of the women who live it. No study could be found that has explored the prenatal experience of obesity by women in relation to how they take up, negotiate and resist the discursive

representation of obese pregnant women, nor has any study known, explored the interplay of these experiences with their lived social context. Such a study, undertaken from a feminist poststructuralist lens has the potential to yield and advance alternative viewpoints and narratives on the discourse on maternal obesity in ways that will enable the empowerment of obese pregnant women to recast themselves in other narratives and to “take(ing) up new ways of thinking and being” (Gannon & Davies, 2007, p.83). It also has the potential of empowering health professionals with rich insights to shift their moral horizon so as to enable respect, moral sensitivity, moral agency and advocacy in their encounters with obese pregnant women. At a macro level alternative narratives have the potential to reframe health risks and in the process send ripples across the court of public opinion and the landscape of policy making (Lawrence, 2004).

2.35 Feminist Perspectives On Obesity

Feminist scholarship on the body and its social significance, date back several decades (Gard & Wright, 2005). Feminists have consistently challenged pervasive patriarchal issues embedded in medical scientific knowledge, especially as it pertains to women’s bodies (Wray & Deery, 2008). As pioneers in embodiment scholarship, feminists were among the first to contest the conceptualization of the body as a mere biological object, in particular the female body as a site of reproduction, to be medically explored, and to challenge the discursive construction of obesity as a female problem, and thus played a role in unmasking the biomedical and cultural constructions of obesity (Gard & Wright, 2005); Wray & Deery, 2008; Yancy, Leslie & Abel, 2006).

2.36 Women's Obesity – A Consequence of Patriarchy

The allusion to the personal being political in the late sixties (Bordo, 1993) would come to define feminist thoughts about the body and constitute the premise upon which feminist based their interrogation of patriarchy. Similarly, it facilitated the realization “that even the most insignificant aspects of women’s existence and bodies were central to the construction and maintenance of oppressive feminine norms” (Bordo, Martin, Chermin as cited in Boero 2007, p.45). Accordingly, the focus and mainstay of early feminist embodiment scholarship in the sixties and seventies was the notion that women’s obesity was attributable to women’s oppression and exploitation by patriarchy and the cultural fixation on aesthetics of slenderness and beauty as a feminine ideal (Gard & Wright, 2005) as implied in Orbach’s (1978, p.22) contention that “fat is an adaptation to the oppression of women”. For instance, Orbach (1978) theorized that compulsive eating by obese women was an act of resistance to create a bastion between obese women and a repressive patriarchal society and hence female fat was seen as a protective shield against patriarchy’s exploitations. Furthermore, ‘fat’ became a barrier to fulfill traditional female sexual roles, as ‘fat’ was equated to sexual rejection and sex a realm only occupied by the normative slender female body. Thus fat was theorized as an avoidance of sexuality as the ‘fat’ female body was deemed asexual and undesirable (Orbach, 1978). In subscription to a patriarchal thesis, Rowe (1990, p.413) asserts that obesity/fatness “is an especially significant issue for women and perhaps patriarchy nowhere inscribes itself more insidiously and viciously on female bodies than in the cult of thinness”. In fact, obesity itself was not a problem, the pathologization of female obesity by the patriarchal medical establishment and the media constituted the problem, making “fat a feminist

issue” (Orbach, 1978) and anti-obesity sentiment a profoundly gendered issue, the varying perspectives and subject positions from which feminists theorized obesity notwithstanding, (Bordo, 1993; Chermin, 1981; Millman, 1980; Orbach, 1978; Spitzack, 1990; Wolf, 1991).

2.37 Obesity and Patriarchy – Fear of Fat is Fear of Female Power

Historically, women’s bodies have been subjected to a clinical scrutiny with medically sanctioned diet management aimed at altering body shape and size, (and a concomitant social devaluation of obesity) and depending on what the medical trend is at any point in time, women have been advised to fatten up or shed weight (Wray & Deery, 2008). Not surprisingly, women represented, especially in the sixties, the predominant subjects in obesity studies and therefore as McPhail (2008) cogently observes, “it was women’s bodies upon which medical knowledge of obesity was founded” (p.17). Furthermore, medicine’s “biological essential (ist)” (p.17) theorizing conflates body fat with female anatomy and physiology, especially in advancing that pregnancy is a fat-inducing condition during which women accumulate excess body fat toward use during lactation. Breastfeeding thus ensures the exit of excess fat from the body, but since contemporary women opt to feed their infants artificially, they in effect interrupt this ‘reproductive cycle’ and thus retain accumulated fat, making women more susceptible to obesity. With reference to the Canadian context, and with roots in the post-war period, McPhail (2008, p.24) further contends that this biological essentialism holds today, and advances the argument that obesity is largely “a cultural phenomenon grounded in social

structures and discourses mobilized to reproduce the status quo” in a society which continues to “re-inscribe oppressive gender relations that are inherently raced, classed and founded in hegemonic notions of normative (hetero) sexuality” (p.10). This, McPhail (2008) further submits, is ensured through a craftily constructed web of theorizing in typical Cartesian style that attributes women’s obesity to their “reproductive capabilities”, overeating and “over emotionalism” (p. 11), thus ‘psycho-pathologizing’ obese women to reassert the traditional gendered division of labour. Feminists have therefore contended that women’s bodies have been overly linked to their reproductive function and ‘capabilities’, their traditional gender role as nurturers and caregivers, and this has ultimately been the ideological premise for oppressive sexism (McPhail, 2008). It was therefore no coincidence that at a time when women were increasingly contravening established social norms by leaving their private, invisible, unrecompensed domestic work to take up publicly visible, paid work that conferred social power, the ideal female body size and weight underwent re-evaluation and was subjected to tighter restrictions, further fueling a cultural trend in the promotion of an unattainable slender feminine ideal and simultaneously rendering women who transgressed the ideal, vulnerable to social condemnation (Orbach, 1978; Wolf, 1991). For feminists, the anxiety and apprehension about women’s fat constituted in reality a fear of women’s social power, and the unattainable slender ideal juxtaposed against the abjection of female obesity was nothing but patriarchy’s defensive response and attempt to circumvent women’s foray into the public sphere and their quest for emancipation, greater independence and social equity (Bordo, 1993; Orbach, 1994; Wolf, 1991).

Traditional feminist scholarship therefore commonly situated obesity within an

aesthetic and moral milieu sourced to patriarchy. Such theorizing successfully challenged and troubled the totalizing discursive biomedical framing of body weight. Nonetheless, the conception of women's submission to the pressure to conform situated women as a homogenous group of docile, passive and duped subjects of patriarchy, and precluded the role women themselves play in the processes that shape their embodied experience (Bartky, 1990; 1997; Probyn, 2008; Williams & Germoy, 1999).

2.38 A Postmodern Turn – Acknowledging Women's Complicity

In contrast, third wave feminists, with a subscription to postmodern/poststructural theory, take the issue of body weight and obesity to a profoundly deeper level of analysis, emphasize the “inescapable relationship between embodiment, power and knowledge”, and employ French philosopher Michel Foucault's notion of “the discursive construction of bodies” as the platform “for a fully politicized analysis” of embodiment (Price & Shildrick, 1999, p.218). Feminist poststructuralists reject a focus on patriarchy as the oppressive culprit in women's embodied experiences, and question a stance that advances women as victims of patriarchal imperatives and subordination (Bartky 1990; Weedon 1987). They expand their lens further to interrogate how the body is constructed and shaped through social discourse, and how embodied meanings mediated through language and cultural images influence and impact women's perception and understanding of their bodies as imperfect objects that need altering to become socially acceptable and valued (Bordo, 1993; Butler, 1990; Smith, 1993; Ussher, 1997). Beyond being a medium of culture and surface upon which cultural norms are inscribed, the body is a site of social control achieved mostly through self-monitoring (Bordo, 1997). Feminist poststructuralists contend that women's bodies are discursively constructed

within and around dominant discourses and the power relations they produce, and so emphasize a focus on the impact of discourse on women's subjectivity and the role they play in its construction as central in facilitating a deeper understanding of their embodied experiences (Butler, 1990; Probyn, 1991; Weedon, 1987).

Rich (2011) observes that the Western society is deeply infused with a lifestyle mantra peddled under the rubric of health pedagogy in biomedicine, public health and mass media discourses which profoundly influence the way women think about their bodies and health. The insidious conflation of body weight and health through a lifestyle rhetoric is a form of social control (Rich, 2011) and functions to increase and rationalize surveillance and regulation of women's bodies through "the food/health/beauty triplex" (Lupton, 1996, p.137). While the slender ideal is reinforced in the promotion of healthy weight by various structural interests including the diet, fitness and fashion industries, women voluntarily aspire to this ideal and conform to cultural notions of femininity to avoid the stigma associated with obesity (Williams & Germov, 1999). Additionally, through a process of internalization of social discourse, women reinforce the power relations inherent in the cultural practices that objectify them and become participants in the regulation of their bodies (Bordo, 1999; Williams & Germov, 1999) and agents of their own oppression (Bartky, 1990). Feminist poststructuralists therefore acknowledge the voluntary reproduction of "normative feminine practices" mediated through self normalization of everyday practices "that train female bodies in docility and obedience to cultural demands while at the same time being experienced in terms of power and control" (Bordo, 1993, p.253). In this regard, Bartky (1990) contends that women's bodily discipline and practices are fraught with duplicity, and that "an adequate

understanding of women's oppression will require an appreciation of the extent to which not only women's lives but their very subjectivities are structured within an ensemble of systematically duplicitous practices" (p.76).

2.39 Women as 'Bearers of their Own Surveillance'

Bodily practices such as diet and exercise ensure women take up small space, and are engaged in, in order to alter body size and appearance. They therefore constitute performances engaged in to maintain and conform to an unattainable feminine ideal so far removed from most women's biological endowments that any semblance of it has to be artificially simulated through conscious and consistent effort, hence the allusion to duplicity (Bartky, 1990). Furthermore, these micro practices may function overtly to improve body appearance and be experienced as power, yet it also functions covertly to disempower women who obsessed with the pursuit of corporeal perfection may devote and deplete time and resources respectively, chasing a body ideal that is tantamount to a mirage (Bartky, 1990; Coward, 1985, Wolf, 1991). Bartky (1997, p.149) observes that "a woman may live much of her life with a pervasive feeling of bodily deficiency" while Bordo (1997) concurrently notes that a "centripetal (ly) focus (ed) on self-modification" ensures an embodied "memorization of imperfection" (p.91) and the social control mechanism of self-policing (Bordo, 1999).

Meaning and desire are therefore produced by prescribing what weight is and is not normal, and by conflating ideal weight with health, beauty, personal freedom and control. The ideal weight becomes constructed as a desirable commodity to be sought, particularly in a context where the value of women has always been linked with physical appearance and weight, wherein obesity signals a deviation from this ideal and in contrast

is symbolic of among others ill-health, hideosity, loss of control and sexual deviance punishable with stigmatization. Women internalize these prescriptions and undertake to self manage, monitor and control their body to avoid becoming blacklisted for not adhering to “a gendered political system that constructs the ideal weight” (McKinley, 1999, p.107). Through this process, social control is exerted without direct coercion as women who voluntarily submit to the pressure to conform “willingly take up less space both physically and symbolically”, becoming co-architects of their socially constructed embodied experiences and “bearers of their own surveillance” (McKinley, 1999, pp.108, 127).

2.40 Maternal Obesity – In Feminist Poststructural Context

Pregnancy represents a particular embodied period during which a woman has little jurisdiction over her body’s appearance, and thus belies the Western conviction that humans possess their own bodies and are able to mold them accordingly (Haynes, 2008). Akin to the irony of a long standing social duplicity that shrouds women’s embodiment issues (Bartky 1990; Smith, Hulsey & Goodnight, 2008), a discourse of essentialism that advances the pregnant body as performing a “function --- it’s meant to”, (Ussher, 2006, p.91) on the one hand operates to reconstruct a slender ideal into a maternal ideal that absolves women of responsibility for the embodied changes of pregnancy that allow them to “eat for two”, positions them as devoid of agency, and frees them from conforming to a slender ideal thus enabling a subject position wherein body weight ceases to be a priority (Ussher, 2006; Wiles, 1994; Williams & Porter, 1999). Yet on the other side of this paradox, social pressure is exerted on obese pregnant women to maintain a lean ‘healthy’ body weight as implicit, beyond biomedical theorizing, in mass media textual

and iconic messages (Rich, 2011) including depictions of nude pregnant Hollywood stars whose embodied pregnancies are nothing short of Utopian for the many women who struggle to maintain and manage gestational weight (Smith, Hulsey & Goodnight, 2008).

From a feminist poststructural perspective, attempts to socially control obese pregnant women are undertaken by among others, discursively situating the fetus as a public concern and privileging the subjectivity of the fetus in discourses of responsible motherhood that draw on the “metaphor of containment” which locates the woman as a “fleshy incubator” (Bordo, 1993), p.84). This metaphor resources a biomedical discourse which emphasizes and privileges pregnancy outcome and personal responsibility for the fetus over women’s subjective experience (Gross 2010, Ussher, 2006), hence alienating women from their own embodied experiences, justifying surveillance and monitoring of their body and lifestyle (Bordo, 1993), p.84), and placing them at the mercy of external forces and scrutiny, good intentions notwithstanding (Gross, 2010). Ussher (2006) concurrently asserts that in pregnancy, women are positioned as mere vessels which bear healthy babies, their subjectivity clearly relegated to the back burner, with dire warnings of health and fetal endangerment mediated through a risk discourse to those who might resist submission to the ‘medical gaze’, and public health lifestyle prescriptions. Obese pregnant women are further literally and metaphorically, discursively constructed as taking up more space than they should and violating “the boundaries of femininity” they are supposed to uphold through diet and exercise (Clarke, Gross & Rousham, 2004; Gross, 2010; Ussher, 2006; Williams & Potter, 1994). In addition to biomedical objectification of their bodies, obese pregnant women are also constructed by their social relations and themselves as embodying a condition in which they must manage their body

by controlling what they ingest, to avoid or minimize risk so as to ensure the wellbeing of the fetus, an overall healthy pregnancy and safe passage at delivery (Clarke, Gross & Rousham, 2004; Gross, 2010; Longhurst, 2005; Williams & Potter, 1999). They must also have the responsibility to “do more than passively submit” to the medical gaze (Ussher, 2006, p.89). They avail themselves to a proliferation of sources of information and advice about risks, from biomedical texts/research, official guidelines to self-help texts (magazines and books) and the media about nutrition, exercises, and how much weight to gain, that exhort obese pregnant women to be ‘responsible’ and undertake self-discipline and self-surveillance “to ensure a healthy pregnancy and baby” (Ussher, 2006, p.89).

A hegemonic culture of risk, compounded by a metaphor of ‘containment’ advanced in a dominant biomedical discourse, intensifies individual maternal responsibility for risk avoidance, rationalizes and endorses both personal and public surveillance and the role of expert others to attest to and validate the normality of the pregnancy (Lupton, 1999; Gross & Pattison, 2007). Pregnant women, especially those who are obese, are increasingly being monitored “largely as reproductively defined, instrumentally valuable vessels and vectors”, and surveillance of their bodies occurs everywhere, privately and publicly, where medicalized norms of “the responsible pregnancy” are used judgmentally to evaluate and criticize their behaviours (Morgan, 1998, p.95). Women have a vested interest in the outcome of their pregnancy, and thus take up a “medicalized subjectivity” (Morgan, 1998, p.95), engage willingly with the discourse of risk, and in a protective role take up self-surveillance and personal policing (Miller, 2005).

Thus through their bodies and mothering capacities, women “are the targets for both reform and manipulation, -----making them responsible for the epidemic” and they are also a vital bridge “between individuals and populations, making them a key entry point of intervention into the epidemic” and constructing them as such “serves to naturalize the language of epidemic as much as discourses of individual responsibility do” (Boero, 2007, p. 57).

Resisting a “medicalized subjectivity” is possible in circumstances in which genuine choice and access to alternate relevant discourse exist to facilitate a “democratization” and “demystification” of dominant biomedical knowledge and to neutralize the monopoly of experts to such knowledge (Morgan, p.95), and by reframing obesity from an “apolitical” social and “medically constructed” condition to one that is politicized and has the ability to subvert the dominant discourse that constructs it (LeBesco, 2001, p.75)

CHAPTER 3 Methodology

Paradoxically, given the preceding critique of biomedical discourse on maternal obesity, this chapter begins with an annotated view of postmodernism in a medical text in which Gray (1999, p.1550) likens postmodernism to an “elephant”, “easier to recognize than to define.” The term postmodernism famously defies definition, not least because it “does not represent a unified position” (Kirkevold & Foss, 2008) but rather as an umbrella term it encompasses several positions elucidated in diverse ways across diverse disciplines and fields of study (Cheek, 1999; 2000; Kirkevold & Foss, 2008). The plurality of approaches notwithstanding, collectively as a worldview they share a singular commitment to interrogate and subvert core Western modernist assumptions of absolute truths, reason, standardized and rationalized knowledge development (Aranda, 2006; Gannon & Davies; 2007), and a common suspicion of grand theories and metanarratives (Cheek, 1999; 2000). Additionally, the terms postmodernism and poststructuralism are often used indistinguishably and the conflation of the two has come to pass as legitimate. Cheek (2000) however observes that while they may share similar principles and assumptions, they diverge “in terms of focus and emphasis” (p.6). The term poststructuralism is used herein.

Historically, feminist researchers employed various theories to highlight and advance insights into gendered power relations and inequities in society. For instance, second wave feminists in the 1960s and 1970s were drawn to ‘social learning’, a popular theory at the time because it advanced a social versus biological explication of gender difference and theorized the individual as socially constructed. The theory nonetheless had limitations which included a representation of the individual as a fixed, coherent

subject but did not account for changing context, diversity in individual behavior in different situations, or possible resistance (Francis, 2000). Poststructuralism offered flexibility and transcended modernist limitations and as a result many feminists embraced it as an innovative way of thinking, and a methodology with relevance for feminists scholarship and research into gender, power and knowledge (Francis, 2000; Huntington & Gilmour, 2001).

3.1 Poststructuralism and Foucauldian Philosophy

While there are multiple perspectives of poststructuralism, the theoretical perspective associated with French historian and philosopher, Michel Foucault is considered “productive” for and of “interest” to feminists because it “addresses how social power is exercised and how relations of gender, class and race might be transformed” (Weedon, 1987 pp. 20,22). Therefore, a main focus and project of feminist poststructuralists is to explore and illuminate “how gender power relations are constituted, reproduced and contested” (Weedon, 1987, pvii) and how hegemonic social processes enable women to take up particular practices and “discursive positions”, and to behave in particular ways (Weedon, 1987, p.12). Feminists draw on Foucauldian philosophy to interrogate, illuminate and challenge hegemonic discourses that marginalize women politically, economically and socially (Arslanian-Engoren, 2002) as well as provide insight into why women are tolerant of and complicit in the very “social relations which subordinate their interest to those of men” (Weedon, 1987, p. 12).

3.2 Poststructuralism – Philosophical Assumptions

Foucauldian theory proposes the interrelationship between power, knowledge and subjectivity, and emphasizes that those elements are central to the process through which

individual identity and therefore human experience is constituted (Foucault, 1980) As with most theories, poststructuralism is underpinned by certain guiding philosophical assumptions (Weedon, 1987) that include the contentions that:

- there is no single approach to knowledge construction or development, hence the embrace of a plurality of truths and meanings (Weedon, 1987).
- power and knowledge are wedded – power “generates and is served by knowledge, and knowledge reinforces and supports existing power relations” (Doering, 1992, .26).
- knowledge is historically, politically and socially context-specific (Weedon, 1987), and is never neutral or value-free, rather it is “constructed, contested and incessantly perspectival and polyphonic” (Lather, 1991, p. XX).
- power is unstable and where it is exercised, there is potential for resistance, and therefore change or transformation is possible (Weedon, 1987).
- language is infused with social power and is central in the construction of meaning in life experiences (Weedon, 1987).
- subjectivity (with a feminist bent), is gendered, and embedded in sociopolitical and historical milieus (Weedon, 1997, Butler, 1997).

3.3 Guiding Concepts

Accordingly, the Foucauldian poststructuralist concepts of language, power and subjectivity have import for, and guide the conduct of the proposed study. These concepts are next further explicated.

3.4 Language

Poststructuralism's emphasis on language as a constitutive force is its hallmark, and hence its characterization as connoting a "linguistic turn" (Gannon & Davies, 2007, p.80). Poststructuralists argue that as a central and common factor in the analysis of social structures, social meanings and relations (Arslanian-Engoren, 2002; Doering, 1992), as well as individual consciousness, language is key to knowledge construction and "sustain(ing)s the social, historical and political manifestations that represent how individuals create and interpret their existence" (Lyotard, as cited in Murphy & Perez, 2002, p.67). Given its interpretive capacity, language is thus never neutral or value-free, but rather steeped in meaning-making (Cheek & Rudge, 1994; Cheek 2000), and meaning assigned and gleaned from language by the speaker and listener respectively, is context, historic and value specific, and thus constitutes particular realities (Abma 2002). Language not only "constructs", but also functions to "maintain" particular realities (Cheek & Rudge, 1994, p. 17) and social meanings, some of which become taken for granted as they become normative and assume the status of uncontested, objective 'truth' (Weedon, 1987). Hence language does not reflect, but creates understandings of reality and represents where individuals construct their sense of self and subjective understandings of the world "to which [they] have access" (Weedon, 1987, p.85). Individuals understanding of their sense of bodily self emanates from spoken and unspoken language that they receive from other people and popular images throughout their lives (Abma, 2002; Scott, 1994). Social meaning is therefore not constituted by the person who speaks, but by language which "enables [individuals] to think, speak and give meaning to their experiences" (Weedon, 1987, p.32). Accordingly, from a

poststructuralist perspective so powerful is the constitutive effect of language that there is no consciousness and no subject outside of language, and experience as no meaning outside of language (Butler, 1997; Davies et.al, 2006; Davies & Gannon, 2007; Weedon, 1987).

Feminist poststructuralists further consider language to be the medium through which gender is socially delineated and constructed, and the notion of femininity conceptualized, characterized and internalized (Scott, 1994), hence a recognition of discourses as valid sources of women's knowledge (Scott, 1994). As a constitutive force, language thus shapes knowledge in disciplinary discourses and thus plays a role in creating power relations in which certain knowledge is privileged over those of the subjects they inscribe, who, in submitting to the subjection of such knowledge, end up occupying marginalized positions wherein their voices are suppressed (Weedon, 1987). Thus "claims to knowledge" of a particular discourse are in fact "claims to power on the basis of expertise or ownership" of that discourse (Cheek & Rudge, 1994, p.17), and similarly with respect to issues of embodiment, it is partly through language in discourse that the human body transcends its biology to become the site of "social practices and the organization of power", making the body an entity "invested with relations of power and domination" (Doering, 1992, p. 25).

Nonetheless, despite its associated constraints, given that a sense of self is constructed through language, words can be a medium through which insight is gained about women's subjective experiences, and language can be used to give voice to experiences that are suppressed and excluded from dominant discourse (Arslanian-Engoren, 2002, Scott, 1994). Given the plurality of language, meanings conferred on

experience as constituted by language presents multiple ways of interpretation, and since meaning and its interpretation are discourse –specific, the essence of experience can be transformed “by bringing a different set of assumptions to bear on it” (Weedon, 1987, p.87). Therefore, as a site of meaning –making, language is also a site of potential resistance and can be used to influence perception of potential for change through alternative discourses and other “versions” or ways of constituting meaning (Weedon, 1987).

In the context of maternal obesity, the language and metaphors in discourse speak and inscribe obese pregnant women into particular ways of being, particular ways of knowing and understanding their world, particular ways of interpreting their experiences of obesity and related social relations and particular ways of communicating what it is they know or believe. While feminist poststructuralists contend that language in discourse constrains women by “framing and inscribing their lives”, they also acknowledge the opportunity language presents to use strategies of thinking the unthinkable and speaking the unspeakable to subvert and destabilize dominant voices (Weedon, 1987, p.22). The possibility of recognizing and interpreting the essence of oppressive life experiences as a product of social construction versus personal ineptitude and “deficiencies” is a necessary first step to consciousness raising and taking up resistant subject positions (Weedon, 1987).

3.5 Subjectivity

In contrast to the Cartesian/positivist subject encapsulated in fixed, binary constructions such as mind/body, male/female categories, Foucault (1980) posits a social production of human consciousness in which the self is not a fixed, coherent entity but is

instead positioned and positions in multiple shifting discourses, and as such changes overtime in tandem with the social power structures which produce it. The Foucauldian subject is therefore fluid, unstable and mutable, and can be passively or actively constituted (Winch, 2005). Foucault (as cited in Winch, 2005) further explicates what the word “subject” implies - “subject to someone else by control and dependence, or tied to (being subject to) one’s own identity by consciousness or self-knowledge” (Winch, 2005, p.178). Active constitution of the subject therefore occurs when “practices of the self” can be sourced to cultural or social imperatives. For Foucault, individuals are not born unto the world fully constituted but are constituted through power-imbued social relations (Allen, 2002).

Subjectivity and the discursive process by which individuals “become gendered subjects” is a key issue for feminist poststructuralist who reject traditional universal essentialism applied to women’s embodied experiences and hence subjectivities (Gannon & Davies, 2007, p.82). Feminists have long recognized the importance of conceptions of the subject and have been interested in “how women are formed and informed by social, economic and political conditions, how the female subject gains particular life experiences, vision and voice from a disadvantaged social status”, yet needed to be able to reframe the subject in a way that derails “Cartesian logic” and related binary conceptualizations that tend to marginalize women (Leavy, 2007, p.94). An opportunity to merge feminist and postmodern principles enabled feminists to declare the traditional subject ‘dead’ and to incorporate gender into the postmodern conceptualization of the subject. Butler (1993) in this respect contends that gender identity is a product of discourse wherein femininity assumes an “idealized presence” (p.232). Furthermore, with

a nod to Foucault, feminist poststructuralists consider the subject as “largely constituted” rather than “constituting” (Leavy, 2007, p.94) without precluding agency (Butler, 1993; Davies & Gannon, 2007). In concurrence with Foucault, and giving precedence to the role of social discourse in subject formation, Butler (1993) observes that experience as shaped by discourse, produces subjects in a process wherein individuals are called into being by taking up discursively-produced subject positions which precede them. Therefore social forces influence the perception of self and the acquisition of gendered subjectivities. Similarly, Weedon (1987) delineates subjectivity as the “conscious and unconscious thoughts and emotions” that facilitate an individual’s sense of self and understanding of the world (p.32), while Doering (1992) posits it as “a process of self-formation in which individuals internalize social power relations” (p.25). The process of subjectification is also seen to be perpetual and continuous, in which individuals are inscribed and reinscribed in a discourse they did not produce (Davies et. al, 2006), are “both subjected to available regimes of truth and regulatory frameworks” and simultaneously become actively “complicit” in their “own subjection, seeking (both) submission and mastery” (Butler, as cited in Gannon & Davies, 2007, p.83).

Nonetheless, as a product of social discourse, subjectivity also represents “a site of permanent openness and resignifiability” (Butler, 1993, p.50). Therefore the discursive constitution of the individual/subject is not tantamount to a discursive determination of the subject, but rather represents “the very precondition of its agency” (Butler, 1993, pp. 45, 46). Butler further theorizes that since the subject is constituted in and through language-based discourse, the subject can resist by exercising linguistic and performative agency to ‘resignify’ or reframe the contextual meaning in discourse and instead infuse it

with new, less oppressive meaning. In her analysis of corporeality, Butler (1993) further suggest that people who are different because they do not conform to prevailing social values and canons, are equated with deficiency, pathologized and moralized as such. Therefore resistance and challenge to such hegemony can be in the form of “rearticulate(ing) -----what qualifies as bodies that matter” (p.16). Since the subject is always inside the language, changing the language changes the effect and therefore through performative resistance, the subject can transform the conditions of discourse (Butler, 1993; Weedon, 1987). Resistance and change therefore entail “prising apart the meanings and assumptions fused together in the way we understand ourselves in order to see them as historically specific products, rather than as timeless incontrovertible given facts” (Henriques et. al. as cited in Davies et al, 2006, p.91) and by doing so, exposing hither to “silent habits of thought” and replacing them with “new ways of thinking and being” (Davis et. al, 2006, p.89). Butler (1993) however cautions that the transforming subject is not immune to emerging or new dominant discourse, and thus the naivety of the old subject might recur occasionally, nonetheless, the subject/individual “becomes the one whom” she/he “can no longer imaginably be” (p.188). Similarly, Davis et. al (2006) sound the caveat that the process of transformation is a “messy” endeavor in which the subject is always cognizant of “its own vulnerability” to the process because it stands within the very discourse it attempts to tear down, and that in doing so, specific values and beliefs are at play and hence certain positions will be privileged over others (p. 90). Additionally, transformation transcends “a play of words” and a mere, conscious, rational decision “to be someone or something else, it requires reworking the “material body”, reframing old technologies to create a new self, because the “constitutive effect resides”

both in the language of discourse and “the affect of the material body” (p.90)

For the subject, the goal of a poststructuralist metamorphosis is to be able to visualize what it currently is, and in opening up to this epiphany, to break free of oppressive forces and pave the way for a new less marginalized subject (Davies et. al, 2006; Weedon, 1987).

3.6 Power

As a pivotal subject in his theory, power was the guiding concept, and arguably the tour de force of Foucault’s work that yielded in particular his notions about the “productivity of power and the constitution of subjectivity through power relations” (Gordon, 1997, p.xix). Foucault maintains that phenomena should be theorized in the context of time or period and the dynamics of power and resistance in effect (White, 1988). In sharp contrast to bourgeois conceptualization of power as centralized and hierarchical, Foucault (1977, 1980) describes power as capillary and productive. In a departure from traditional renditions of sovereign/state/hierarchical power, Foucault conceives of power in terms of who, and how it is exercised as well as how it produces knowledge (Foucault, 1980). To Foucault, power packs more control and has more to do with “the pronouncements of expert discourse, organized in what he calls ‘regimes of truth’ which legitimate particular social attitudes and practices” than with economic and administrative powers (Cameron, Frazer, Harvey, Rampton & Richardson, 2006, p.132).

The major defining characteristics of Foucault’s concept of power are its capillary and productive actions. Power, according to Foucault (1980) is capillary, diffuse and pervasive. It is not fixed or localized in any one person or group, or owned and wielded by one person, or group over others. Individuals, therefore do not have power, they

exercise power. Foucault (1977, 1980) further theorizes power as a decentralized network of relations, resident everywhere, inter alia, within individuals, within roles and disciplines. Power is exercised in a net-like fashion in which individuals can be both bearers/sources of and victims/recipients of power and its effects, becoming “not only its inert or consenting target---- (but) also the elements of its articulation” (Foucault, 1980, p.98).

Of the productive capacity of power, Foucault (1980) observes that: “what makes power hold good, what makes it accepted, is that it doesn’t weigh on us as a force that says no, but it traverses and produces things, it induces pleasure, forms knowledge, produces discourse” (p.98). According to Foucault (1977, 1980) power and knowledge are intertwined. Power generates/produces knowledge and knowledge initiates power, and is used to choose and implement mechanisms of power to maintain established power relations and to sustain existing mechanisms of power to maintain established power relations, and to sustain existing social, political and economic structures. Thus power and knowledge are interdependent, each makes the other possible (Foucault, 1980). In this respect, Doering (1992) observes that knowledge reinforces and supports truth claims, and power generates and shifts with changes in knowledge. Polifroni (2010) concurrently notes that power is exercised through the production of truth and cannot be exercised, as Foucault (1980) observes, without truth or knowledge, therefore truth and knowledge represent the backbone of power. Referring to power and knowledge as two sides of the same coin, Freshwater & Rolfe (2001) add that knowers (those with knowledge) assume positions of power, and those with power define and regulate what qualifies as legitimate knowledge in a self-perpetuating cycle, as evident in dominant

discourses. Power thus mediates the constitution of subjects in discourse. The ability of discourse to produce subjects and objects in particular ways emanates from the power of knowledge and ‘truth claims’ embedded in them (Foucault, 1980). It is this power that enables some discourses to be dominant and privileged over others, and which functions to perpetuate norms that stipulate and regulate who or what is normal and simultaneously promote the social exclusion, marginalization and stigmatization of those who do not fit the norm or dare to be different. In the context of obesity, the pathologization and stigmatization of obese women is inter alia a function of the subtle expert power of health professionals, and strategies of surveillance that reinforce hegemonic conceptions of body weight and health. Thus Foucault (1980) observes that power and knowledge have mutual goals - control and domination.

3.7 Self Surveillance – The Power of Panoptism

In his analysis of power, Foucault identified various forms of power including biopower, governmentality and disciplinary power, the latter being the “most accessible account of power” (Roberts, 2005 p. 34) with import for the proposed study, and exemplified in Foucault’s (1979) Panoptic metaphor. Constructed by 18th century architect, Jeremy Bentham, the Panopticon (all seeing place) was a prison structure with a guard located in a central tower encircled by cells whose occupants, even though could not see the guard, had a sense of being under constant surveillance and therefore undertook to control their behaviour and conform through self-policing behaviour (Foucault 1979). The Panoptic effect therefore produces and maintains a power relation, an awareness of being under constant watch and that indiscretions will lead to consequences invokes self-regulation devoid of direct coercion (Roberts, 2005), as

Foucault (1977) explains there is “no need for arms, physical violence, material constraints. Just a gaze ---which each individual under its weight” internalizes to the extent that she/he becomes her/his own police (p.155). Power thus prevails in many forms of selfhood and subjectivity, not necessarily through force but through self-surveillance. The Panoptic effect “assures the automatic functioning of power” (Foucault, 1979, p.201) and highlights the anonymous and strategic elements of power (Bartky, 1990). Like the inmates, obese women internalize the powerful panoptic gaze of social and cultural forces, aim it at themselves and engage in body micro-management and self-surveillance. Hence the power of the gaze is everywhere and yet nowhere, in everyone and yet no one as Bartky (1990) muses: “Where are and who are the disciplinarians? The disciplinary power that inscribes” the female body with an unattainable feminine ideal “is everywhere and nowhere, the disciplinarian is everyone and yet no one in particular” (p.74). Hence through the mechanism of “a highly invisible disembodied authority” (p.74) women come to believe that their bodily practices and standards are necessarily individual and personal and therefore assume responsibility, while the influence, power and responsibility of social forces (the gaze) in how women relate to their bodies remain largely incognito (Bartky, 1990, Spitzack 1990; Wolf, 1991). The Panoptic power makes subjects out of individuals, (Roberts, 2005) and the “body Panopticon” has been used to refer to women’s self-monitoring bodily practices (Germov & Williams, 1999, p.126). Panopticism functions invisibly in various arenas in society including insitutions of health and education, in dominant discourses and the media. The insidious conflation of body weight and health through a lifestyle rhetoric is a Panoptic mechanism and a form of social control (Bartky, 1990; Duncan, 1994; Wolf, 1991.)

3.8 Power – Opportunity for Resistance

Similar to his conceptualization of language, Foucault (1980) contends that where there is power, there is possibility for resistance. Power produces knowledge as a result of resistance to power. Resistance occurs when an individual realizes and acknowledges what is being forbidden by power. Such acknowledgement leads to new knowledge and insight.

Feminist poststructuralists draw on Foucault's concept of power and acknowledge that the social construction of knowledge and the power /knowledge interplay implies that the meaning or essence of experience and the individual's understanding of experience are regulated by macro forces of social discourses and practices. Power is believed to function at the level of everyday living, encompassing the physical, embodied and material aspects, and draws individuals into particular ways of knowing, behaving and being, engendering self-governing practices that maintain individual subjectivity and sustain the power status quo (Roberts, 2005, White, 1988). Yet there is poetic justice in the sense that just as power is "repressive" and "constraining" it is also "enabling" (Allen, 2002, p.134) thus the power of discourse to subjugate the subject it constitutes can be deployed in a discursive expose to yield new ways of thinking and possibilities for transformation and thereby neutralize the power discourse exercises over the subject. The reinscription of dominant discourses to facilitate the discovery of alternate meanings will subvert and destabilize the power embedded in them, and displace hitherto contrived and oppressive meanings (Arslanian-Engoren, 2002; Weedon, 1987). As Foucault (as cited in Cheek, 2004, p.1143) aptly declared "discourse is the power which is to be seized".

Nonetheless as Bordo (1999) cautions, and Germov & William (1999) concur, the

subject's agency notwithstanding, the role-played by material interests and identifiable holds of power should never be ignored. Foucault's explication of power does not necessarily preclude the existence of "dominant positions, social structures or ideologies emerging from play of forces". The notion that power is not exclusively held or possessed by any individual or group does not imply equal power by all. There remains a need to acknowledge differential power positions, for while there may be no sole control of "the rules of the game, not all players are equal" (Bordo, 1999, p.253). Similarly, it is necessary to consider beyond social norms and how the subject is socially constructed, the socioeconomic milieu from which subjectivities arise. Accordingly, Butler (as cited in Magnus, 2006, p.93-94), observes that responsibility or agency does not necessarily imply "blame", and "the first goal of ethics should be the critical engagement with the social conditions that produce subjects who may or may not be free". She further acknowledges that the inability of the subject to "fully account for" herself "also makes it necessary to conceive of responsibility in social terms and demands instead that actions be viewed as the complex result of the interaction between subjects and the social circumstances that delineate their possibilities" (Magnus, 2006, p.93). Weedon (1987), similarly alludes to this when she observes that although "in principle the individual is open to all forms of subjectivity in reality----- access to" a broad array of subjectivity is determined by "social factors and forms of power at work" (p.95), while with a nod to Hannah Arendt, Beauvoir (1989) asserts that freedom requires both the agentic 'I will' and the contextual reality of 'I can'. Arendt (as cited in Zerilli, 2005, p.11) observes that 'I can' "points to the worldly conditions that enable one to do what one wills". The subject must have capacity for agency. Foucault's notion of transformation as an exercise

of the self on the self would on the surface appear to be suggestive of an 'I will' to the preclusion of an 'I can' (Allen, 2002; Zerilli, 2005). Changes in subjectivity must of necessity go with changes in the social structures that enable the constitution of subjectivity. With specific reference to (maternal) obesity, Zerilli (2005) aptly points out for example, that unequal distribution of healthy diets translate to an absence of freedom to exercise healthy preference. This requires both agentic and material capacity, hence the need to wed a Foucauldian-inspired feminist poststructural lens to the framework of the SDH in seeking insight into pregnant women's experiences of obesity and the contribution of socioeconomic inequities to their experiences.

With this consideration, a feminist poststructuralist perspective, informed by Foucauldian concepts of language, subjectivity and power provides insight into the process through which discourse on maternal obesity functions to regulate and influence social meanings by which obese pregnant women come to know themselves and their bodies, adopt particular health attitudes, practices or behaviours, as well as how they come to accept, resist or negotiate discursive representation and positioning of obese pregnant women.

3.9 Methods

In qualitative research, the term methods is generally used to refer to established guidelines or principles according to which a study can or should proceed (Cresswell, 2007). As a poststructural "qualitative analytical" approach, discourse analysis (DA), characteristic of its philosophical underpinnings, it defies homogeneity, it "is not a unified, unitary approach" (Cheek, 2004, p.1144). In fact, DA thrives on challenging "other research trends and assumptions" and resists traditional or conventional methods,

its “power” located in “its explanatory and critical depth” (Jaworski & Coupland, 2006, p.31). While there are no established postmodern research ‘methods’ (Cheek, 1999; 2000; 2004; Parker, 1992; Potter & Wetherell, 1987), DA avails itself to traditional ways of data collection “to generate text” for discursive analysis (Cheek, 2004,p.1149). As a research approach informed by poststructural theory, DA critically analyzes language in texts or interview data that are located contextually in their cultural, historic, social and political milieus “to uncover the unspoken, unstated assumptions implicit within them” (Cheek, 2004, p.1144).

3.10 Discourse Analysis

There are two main approaches to DA but while both approaches are rooted in social constructionism, as their ‘label’ imply, the level of focus and emphasis on key concepts of discourse differ (Stevenson, 2004). A social constructionist DA as explicated by Potter & Wetherell (1992) focuses on the subject’s textual language and its constitution of truth and knowledge, and as Campbell & Arnold (2004) observe, precludes a focus on power issues. A second approach, a Foucauldian DA, acknowledge but does not focus exclusively on linguistic practices but extends its analytic lens to include discursive practices and power relations that constitute subject positions (Stevenson, 2004).

Parker (2002) observes that discourse is made up of sets of statements that call social objects into being, and words and phrases in language convey systemic and institutionalized meanings also referred to as ‘discursive practices’ that position individuals as subjects in power relations, which constitute their interpretation of the essence of experiences and hence makes them who they are. Discourse analysis, he

maintains, functions to illuminate the interplay and nexus between power/knowledge and meaning. Four steps or stages are posited in DA (Cheek, 2000). In the first stage, the study is introduced and placed in context in terms of delineating the research issue or questions and a review and critique of related literature and research; in the second stage, methodology is addressed but appears to address issues of ‘methods’ as it calls for explication of choice of (and rationale for) text and details of how data or text will be gathered (interviews, articles or documents); thirdly, data is analyzed through coding of transcripts and identification of discursive frames, focusing on ways of speaking and thinking about the reality in question that are present or not and why” (Cheek, 2000, p.52); in the fourth and final stage, a discussion is undertaken and linked to pertinent and related literature “to draw out points of discussion about the substantive area” understudy (p.52) and the researcher engages in a reflection of the research process, and (where data is collected via interviews) the researcher’s positionality and role as co-creator of the process (Parker, as cited in Cheek, 2000). Parker (1992) points out that the stages do not represent a ‘method’ as there is none, and the DA approach does not differ from qualitative approaches, in concurrence with an observation by Jaworski & Coupland (2006) that DA is a committedly qualitative orientation. Accordingly, Parker (1992) suggests, where called for, to incorporate or utilize some of the stages proposed by Potter & Wetherell (1987).

3.11 Sampling

A purposive sampling strategy was employed in which the researcher made a judgment about the individuals to include in the sample, based on identified criteria relevant to the study issue, willingness to participate, and who will contribute to data

appropriate and relevant to the study. This type of sampling aims to describe a phenomenon under study, not its distribution in the population (Cresswell, 2007, Patton, 2002). The study sought insight into the experience of obese pregnant women, therefore the intentional search for women who were able to articulate the everyday experiences of obese pregnant women and who could best inform the subject of inquiry, was justified. Overall given its qualitative approach, purposive sampling was appropriate (Cresswell, 2007).

3.12 Inclusion Criteria

Inclusion criteria was low-income (under \$25,000 annually) women aged 18 years or older, who were 20-40 weeks pregnant, self-identified as obese, who speak, read and write English and who were willing to give their consent and agree to sign a consent form.

Women were excluded if they were not pregnant, did not speak, read or write English and who did not consent to participation and hence did not sign a consent form.

3.13 Sample

A sample of 2-4 participants were proposed for the study. Potter and Wetherell (1987) caution that the analytic process of DA can be time consuming and laborious given the transcription, coding and perpetual “reading and rereading” (p.161) of large amount of data. Additionally, where the focus is in language use and discursive practices “rather than the people generating” them, “the success of the study is not in the least dependent on sample size” and therefore a small sample size and few interviews are acceptable and recommended (Potter & Wetherell, 1987, p.161). In concurrence, Kilduff and Mehra (1997) observe that postmodernist researchers are interested in rich “detailed

understanding of the particular for local knowledge” not in “statistical trends” and therefore tend to limit sample size to “one or a few cases” (p466).

3.14 Setting

The setting was an outpatient prenatal clinic located in a hospital in the Annapolis Valley, Nova Scotia, established in recognition of the importance of timely access to preconceptual and early prenatal care by women. Services included routine prenatal care and screening, needs assessments, community resource referrals, and consults to mental health and diabetic clinic, and notably health education about diet and exercise among others. Services were provided twice weekly from 0900 hours to 1600 hours, and the clinic staff was comprised of an obstetric nurse, a clerk, and a rotating obstetrician/gynaecologist.

3.15 Recruitment

Access and recruitment process were discussed in consultation with the manager of the prenatal program. To gain access to participants, the clinic nurse was given an information sheet with details of the study, its purpose, method, potential risks and benefits, duration, measures to assure self-determination and confidentiality, and a request made for her to introduce and invite women who met the inclusion criteria to participate in the study. In addition recruitment posters were placed at the clinic to enhance recruitment. The researcher was on hand at the site of recruitment to answer questions, and to provide further details about the study when required. Nonetheless there were initial unanticipated challenges encountered recruiting participants. As a result of a lengthy local ethics process, the cohort of obese pregnant women who would have met the initial inclusion criteria had advanced beyond the set gestational period (20-24 weeks)

in my original ethics application, necessitating an application for an amendment to revise the original eligibility criteria to facilitate an increase in the pool of potential participants. This notwithstanding other challenges emerged following approval of the amendment including but not limited to participants who agreed to enroll in the study, but called to cancel scheduled interviews due to family emergencies or other matters that required their attention. In the end two interested participants enrolled in the study, and interviews were arranged to take place in a small conference room in the hospital where the clinic was located. Participants were given the option of location and time and opted to have the conversational interviews after a scheduled visit to the clinic because they found it to be convenient in terms of travel and time.

3.16 Interviews

From a qualitative research perspective, studies undertaken with a goal to gain insight into the human experience and related meaning from the perspective of those who live it are best achieved through interviews (Kvale, 1996). The ultimate goal of qualitative research interviews is to access participants' world to gain insight into their everyday subjective life experiences (Fossey, 2000). Research interviews yield relevant data that are specific to the research question, and philosophical underpinnings of the research study influence the type and conduct of the interview (Kvale, 1996).

Potter and Wetherell, (1987, p.163) note that interviews allow for "greater comparability in responses, and increased simplicity in initial coding" (p.163) because they afford the researcher an ability to address the same issues with a sample of participants.

The usual conduct of traditional qualitative interviews was adapted to

accommodate features that are specific and necessary to elicit relevant data for the purposes of the study. In DA, diversity in response from participants is essential, and as important as consistent responses. In addition to yielding highly informative data about the diverse discursive resources participants access to construct “meaning of their social world”, a variety of responses also illuminate how participants mediate their construction of meaning (Potter & Wetherell, 1987, p.164). As a strategy to facilitate such diversity in data, Potter and Wetherell suggest the use of open-ended questions.

One in-depth audio-recorded (with participant’s consent), semi-structured personal interview lasting 60 minutes was used to collect each participant’s narrative of her experience of obesity. All interviews were conducted by the researcher, using an interview guide (Appendix A) made up of open-ended questions about their everyday experiences of being and living with obesity.

An opening, non-sensitive question about health in general was followed by more specific questions about participants’ experiences, perceptions and related feelings about body weight, health (diet, physical activity) and relationships. Follow-up questions were used to probe, clarify or validate responses (Patton, 2002). From a DA perspective, the use of follow-up questions serves to elicit from participants “alternative problematic views”, the goal of which is to actively engage with participants to enable them to explore the discursive resources they access to interpret experiential meaning to the fullest. Follow-up and probing questions are used maximally in DA interviews and function to make the interview more “interventionist”, a distinguishing characteristic from the traditional interview, necessary to generate “interpretive contexts” (Potter & Wetherell, 1987, p.164). Potter and Wetherell further suggest the use of an interview

guide, which in addition to the questions to be asked, anticipates probing and follow-up questions, ensuring that each participant is asked the same questions. Notwithstanding the use of an interview guide to give structure and enable the collection of relevant data, the researcher used emerging questions in response to cues from participants' descriptions of experiences. Field notes were taken immediately following each interview to capture inaudible aspects of the interview, such as gestures intonations, observations about the interviews, as well as notes about key points made during the interview (Kvale, 1996). At the close of each interview the researcher summarized experiences described and provided participants an opportunity to clarify, validate or add further thoughts. The audio-taped conversational interviews were immediately reviewed and listened to for an initial general gleaning of issues. The tape conversational interviews were subsequently transcribed verbatim into written texts by a transcriptionist, then reviewed and analyzed by the researcher. In DA, the interview constitutes a natural and informal conversation in which the researcher is an active participant. The interview was thus co-created by both the researcher and participants and is acknowledged as such (Potter & Wetherell, 1987). A post interview analysis was undertaken as recommended by Patton (2002) during which details about the interview process such as participants' behavior, distractions and quality of information gathered among others were reflected upon. Such reflection enhances and sustains the researcher's conscious awareness of her/his role in the creation of narrative accounts, and thus locates her/him solidly within the interview (Cooper & Burnett, 2006). The researcher's approach and conduct during the interview and entire research process was ethically and morally grounded.

Grounding the study in Foucauldian and feminist philosophy and principles

required doubly that power issues be attended to through researcher self-awareness and reflexivity throughout the research process. The research interview is an ethical enterprise infused with ethical issues, and in which the ethical and moral conduct of the researcher transcends ethical knowledge and encompasses the researcher's "sensitivity and commitment to moral issues and action" (Kvale, 1996, p.117). In Foucauldian terms, power is omnipresent in all human interactions and transactions. The research study is therefore an 'institutionalized' site of power and to be critically reflexive implied attending to issues of power during the research process (Parker, 1992). Concurrently, Nunkoosing (2005) likens the qualitative research interview to a "dance of forms of power" (p.699) and opines that "it is in the use of the self, of relationship building, of acute awareness of the flow of conversations, of a sensitive awareness of the interviewer's theoretical and professional position, and of his or her research question that qualitative data of high quality are constructed in the interview" (p.698).

Similarly, the pursuit of researcher reflexivity and self awareness is in keeping with a poststructuralist perspective and needs to be engaged in from a recognition among others that the social positioning of both the researcher and the participant influences the research process and outcomes (Buckner, 2005). The establishment of a good dialogue is first and foremost the responsibility of the researcher and requires an open mind and heart. Thus the use of strategies and behaviours that impart non-judgmental respect and sensitivity for participants and the stories they shared was imperative, and a priority throughout the research process. It was also acknowledged that the researcher's respect for participants and the narratives they share is always crucial to the emancipatory goal of research (Lather, 1991). Rapport entailed making a connection, communicating empathy

and understanding by being courteous, and listening attentively (Clarke, 2006). Attentive reflexive listening necessitated owning up to the “ignorance of one’s own privilege” (Devault & Gross, 2007, p.183) and opening up space to hear what was being said, listening for silences, gaps and pauses in speech as they had potential to hold meanings beyond what was spoken. Active listening validates women’s narratives, prevents marginalization of their voices (Butler, Ford & Tregaski, 2007), and is reflective of a countenance that acknowledges research for, and with rather than about participants (Devault & Gross, 2007).

It is hoped participation in the research provided an opportunity to be heard, gave voice to participants’ experiences and countered prior experience of oppressive silence, enhanced self-knowledge, and brought to consciousness strengths, enhanced capability for action, that can be cathartic and empowering (Clark, 2006, Kvale, 1996; Merrill & Williams, 1995; Rogers, 2008). From a Foucauldian perspective, the DA interview enabled participants to identify dominant power relations, and to gain new insights about themselves and their practices, and thus hopefully emerged from the conversational interview possibly thinking differently about themselves (Parker, 1992; Potter & Wetherell, 1987). The findings of this research can be a rich source of understanding, consciousness-raising and practical knowledge for health care professionals who read the final report and as a consequence transform their approach to care of obese pregnant women to one that is non-judgmental and empowering. Conversely, it was acknowledged that participation could evoke repressed feelings and emotions that could lead to emotional and psychological distress (Kvale, 1996; Rogers, 2008). In recognition of this attention was paid at all times to both verbal and nonverbal cues indicative of distress to

ensure appropriate action to provide options to change topics, continue or stop the interview, and arrangements were made for referral to appropriate professional resources if necessary.

3.17 Data Analysis

The analytical process began with the transcription of audio-taped interviews into text. Transcription provides the opportunity to “closely read a body of discourse” and transcends merely writing down words on paper (Potter & Wetherell, 1987, p. 165). Transcription is a time consuming “constructive and conventional activity” in which the transcriber decides what was actually said and represents them in text. While transcription by the researcher confers the advantage of a head start in analyzing meaning, (Kvale & Brinkman, 2009), the services of a transcriber was utilized due to time constraints of academic requirements.

Transcribed narratives were then read and reread several times to get acquainted with the narratives and to get a general sense of discursive issues and subjects that popped up and notations made within the transcripts to that effect. After multiple readings, the transcribed narratives were reread closely and critically with feminist poststructural attunement and sensitivities to discern and capture their general essence, which were next coded under different discourse headings (Cheek, 2000). Coding entailed linking fragments of data with the use of keywords into categories of statements that share common elements, and served to simplify, condense and organize the narrative data into manageable forms (Kvale & Brinkmann, 2009). It is also a “pragmatic”, “preliminary analytic” to pave the way for the “much more intensive study of the material culled through the selective coding process” (Potter & Wetherell, 1987, p.164).

In DA, all data are included for coding – this includes entries in the researcher’s reflective journal relating to thoughts about the interviews, questions and issues about the research process that arose during discussions with the researcher’s thesis supervisor. Initial coding categories of beliefs, values pertaining to health, pregnancy, body weight and health practices (healthy eating, physical activity) identified in articulated narratives were discussed with my thesis supervisor.

The coded data is next analyzed to identify themes and discursive frames. The narratives were subjected to further multiple readings and interrogation to uncover the assumptions and expectations that belie the beliefs and values, specifically experiential values and beliefs that related to participants’ experience of health and their particular world; their relational values and beliefs that expressed their perception of their relations with self, health professionals, social network and the public; the extent to which the beliefs and values were acted upon (health practices) accommodated negotiated or resisted; and how they functioned to legitimize, privilege or conversely suppress and exclude particular discourses; or yet still how these in turn served to privilege or exclude particular ways of understanding experience or reality and thus self. A further close and critical reading of transcribed narratives was undertaken to glean articulations constitutive of subjectivity, selfhood and power relations with respect to their subject positioning within dominant or alternative discourses, with a keen analytic exploration of the language used to articulate how they experienced their multiple subjectivities (as among others low income, pregnant, obese women), their body, pregnancy, and sense of self (as for example, guilty, culpable, acknowledged or not, excluded, surveilled); in what ways their subject positioning constitutes their relation with self, health professionals,

and others in their social world, were they experienced as enabling or constraining, and whose reality was being privileged, promoted or marginalized. Again with the attunement of a feminist poststructuralist, I engaged with the narratives interrogatively, listening for tensions, ambivalences and contradictions in binary oppositions that were emblematic of multiple interpretations of experience, as well as the presupposition of alternate discourses within the dominant discourse and hence the potential of subversion and resistance. Such re-readings and contemplation led to the gleaning of instances of simultaneous uptake and subversion of the same discourse through linguistic articulations suggestive of critical reflection and questioning, or direct expressions rejecting particular practices or assumptions, leading to appropriation of a discourse and a simultaneous refusal to construct self in compliance with it. Similarly, the narratives were read multiple times to critically interrogate and bring to the fore not just what was unsaid, but what they said that they were not saying (implicit allusions). Overall the analysis focused on how language accessible from available discourses and used in the narratives constituted the meaning ascribed to their experience of health, body, pregnancy and self, and how these either served to reify and uphold, or disrupt and subvert the status quo of the dominant discursive construction of obese pregnant women. Themes were next analyzed to identify and extrapolate meanings attributed to discursive frames and the SDOH. The sub-themes in each narrative data were analyzed in relation to the literature on maternal obesity. A further reading was undertaken to compare, refine and glean from the sub-themes in both cases, three overarching themes which were further subjected to analysis with respect to their intersection with other neoliberal discourses and their broad-based ramifications.

There is no set way of doing analysis to establish interpretation (Potter, 1992; Potter & Wetherell, 1987). Potter and Wetherell liken the analysis of discourse to “riding a bicycle” in comparison to analyzing survey data that is straightforward like “baking cakes from a recipe” (p.168). Analytic skills are action-oriented and they “develop” as the researcher strives to understand and “identify the organizational features” of transcripts. The only certainty is that the analytic process in DA involves reading and rereading data multiple times in cycles (Potter & Wetherell, 1987, p.168) reminiscent of the endless circular process of the hermeneutic circle (Ortiz, 2009). The data in this study was repeatedly read with scrutiny for details to make sense of data and glean discursive patterns that show both differences and consistencies in narratives (Potter & Wetherell, 1987). Quotes from the transcribed data are organized in categories according to themes, as new themes emerge, quotes were re-categorized until saturation was achieved, and no new themes emerged, and all quotes had been categorized under one or more headings/categories.

Throughout the analytic process, I endeavoured to glean and present the multiple ways the two participants positioned themselves in the accounts they gave, how particular discourses were constructed, for what purposes, for whom, and how these constituted their reality. Major themes in participants’ narrative accounts, values, beliefs and ideologies from which they drew their storied narratives, as well as the power relations that influenced their construction, instances of negotiation with or resistance to discourse, their related effect (whether they legitimized or subverted) and related subject positions were examined and discussed against the backdrop and context of the literature on maternal obesity. The art of listening to understand extended to the analytic stage (Power;

2004). Therefore in the analytic work of reading and rereading, data was listened to attentively and with poststructural sensitivities to enable me “to look beyond, between, and underneath” participants words and phrases to better understand their narratives and the discursive meanings they yielded (Power, 2004, p. 860). Validation of my analysis was sought from my thesis supervisor and committee members who are exceptionally familiar with feminist poststructuralism. Thematic findings are presented within discursive frames to illuminate intelligibly and vibrantly the otherwise hidden, common and varied meanings these women append to their everyday experiences. Findings were further analyzed and critiqued using a SDOH lens against the backdrop of related literature to acknowledge, illuminate and uncover the role played by socio-political, economic and environmental forces in shaping participants’ experiences and/or constraining and limiting possibilities for equitable access to resources for health – where ‘I can’ constrains ‘I will’. The final report was prepared using adequate excerpts/quotes from interviews as evidence and depiction of participants’ voices to enable readers to evaluate and validate interpretations.

3.18 Ethical Considerations

In accordance with protocol, a research proposal for the study was submitted to the Dalhousie University ethics board and the Annapolis Valley Health ethics committee for review and was approved. Ensuring the safety of participants during the research process required adherence to ethical principles related to the research process and safeguarding participants’ rights (Creswell, 2007; Kvale, 1996; Lowes & Prowse, 2001; Nunkoosing, 2005). The ethical principles of autonomy, confidentiality, beneficence, honesty and researcher sensitivity was adhered to throughout the research process. It was

acknowledged that implicit in the method used to gain access was a potential for power imbalance (Miller & Bell, 2002) wherein participants could feel intimidated, given the role of the clinic nurse, to participate. Therefore, to mitigate this, I (the researcher) was on hand to elaborate and answer questions participants may have had and to further assure them of the non-judgmental conduct of the study. In addition to information given about the study and voluntary nature of participation at the time of recruitment, participants were given a telephone number to contact the researcher (or alternatively provide a number they could be reached at if they chose to) if after consideration they were still willing to participate, thus exercising their right to self-determination. Those who chose to participate were assured their participation and the information they share will be held in strict confidence, and will not be disclosed to anyone, the clinic nurse inclusive. With respect to data collection, the purpose, process and potential benefits and risks of the research were adequately and clearly communicated to participants to ensure voluntary consent was informed.

It was acknowledged that at all times the safety and wellbeing of participants was preeminent and transcended knowledge production. Information about counseling and psychological resources and support was made available. A written consent form outlining research purpose, procedures, risks, benefits, voluntary nature of participation, right to disengage anytime, measures to ensure confidentiality as well as a request for permission to audio-tape interviews and use quotes from interviews were reviewed and participants were given an opportunity to ask questions prior to signing consent. Participants were reminded of their right to withdraw by being asked to verbally consent to participate, and were also assured of confidentiality with respect to participation and

information shared prior to the interview. Participants' identity was protected through the use of pseudonyms ensuring only participants recognize themselves in the report. Audio tapes were destroyed after data analysis was completed. All study data were kept under lock at all times in a secure place and access to computer files secured with a password. Access to study information was limited to the researcher, her thesis supervisor and members of her research committee. All study information will be destroyed five years following publication of the study report.

At an individual level, reflexivity "is a self-critical" activity, at a "communal level" it demands that the researcher attend to and consider the influence of power issues and multiple environmental contexts of the researcher and the participant on the conduct and outcome of the research (Hesse-Biber & Piatelli, 2007, p. 497). Reflexivity deconstructs power, minimizes power imbalance, and promotes an ethical relational engagement with participants based on shared knowledge throughout the research process (Hesse-Biber & Piatelli, 2007). In view of this, the site of recruitment, the clinic, represents a site of Panopticism, associated with the clinical gaze and pathologizing power that subjugates clients into compliance. Giving participants the opportunity to opt for a less 'oppressive' site, and pick a time of their convenience for the interview was done with the intention of imbuing a sense of locus of control, safety and freedom to talk without feeling pressured to, or inhibited (Clarke, 2006). As mentioned previously both participants felt it was more convenient for them to have the interview after their clinic appointment, at the hospital. Nonetheless I must acknowledge that my identity as a graduate student, albeit equally occupying a subject position as a nurse had potential to create a power imbalance and may have created a social desirability bias given the fact

that while I used the terms ‘health professionals’ and ‘nurses’ interchangeably I could not help but notice that participants either used ‘the doctor’ or ‘they’ even though it was implicit ‘they’ alluded to both physicians and nurses. However the meticulous care I took to convey my unqualified respect for them mitigated, I hope, this power imbalance – evidence of this was the fact that while Jane intimated in her narrative that she never discusses obesity with anyone and tries to avoid such discussions, she was very forthcoming with me, privileging me with her inner thoughts and feelings.

Maintaining transparency of personal beliefs, values and preconceptions to facilitate ongoing reflexivity and cultivation of self-awareness throughout the research process was a priority. Therefore in concurrence with Roger’s (2008) observation that emerging ethical issues cannot be entirely anticipated, I employed the use of a research journal to facilitate ongoing researcher reflexivity, an ability to identify and address ethical quandaries, and ensure that ethical considerations remained at the forefront of all decision-making throughout the research process. All steps of the research process as explicated in this thesis were adhered to ethically and in the spirit of feminist poststructuralism from the study question, through to data collection and analysis.

Foucault (1990, p.9) invites agency in “thinking differently rather than legitimating what is already known”. It is hoped that participation in this study will continue to inspire in both women agency in thinking about themselves differently, give them access to new insights that empower them to identify and challenge constraining, oppressive power relations that seek to directly or indirectly subjugate them. This study in some small measure, gave participants an opportunity to make their voices rise resoundingly to be heard, and their stories and themselves written into text as local

narratives, yet nonetheless as the Davids among the Goliaths of metanarrative and grand theories.

3.19 Trustworthiness

Given its purely qualitative nature, and markedly different theoretical assumptions, DA is not amenable to conventional trust-grounding strategies of reliability and validity employed to assure a study's integrity (Madill, Jordan & Shirley, 2000; Potter, 1996). Therefore, discourse analysts have established various alternative criteria for determining trustworthiness of DA, and these include: coherence, participant's understanding, fruitfulness (Potter & Wetherell, 1987), deviant case analysis, and reader evaluation (Potter, 1996). These criteria are not necessarily all incorporated in all DA studies, and in poststructuralist *modus operandi* they are not 'infallible' nor do they 'singly' or collectively assure the integrity of any analysis (Potter, 1996; Potter & Wetherell, 1987). In addition, feminist poststructuralists extend the notion of validity to encompass aspects of postmodern relational ethics that include voice and reflexivity (Alex & Hammerstrom, 2007; Hesse-Biber & Brooks, 2007; Lincoln & Guba, 2003; Parsons, 1995).

In this study, DA criteria of participant's understanding, reader's evaluation and fruitfulness, as well as feminist poststructural-specific criteria of reflexivity and voice are employed to assure integrity of the study's interpretation. It is noteworthy that some of these criteria overlap. For instance, assuring reader evaluation rests on utilizing and allowing participant's voices to come alive resoundingly in the text, through the use of excerpts or verbatim quotes, thus imbuing their representation with authenticity.

Similar to the traditional qualitative strategy of member checking, participants' understanding implies that the researcher ensures participants recognize the study's interpretations as meaningful. This promotes trust and confidence in the study, while the absence of such recognition threatens it (Stevenson, 2004). As a strategy, to ensure accurate representation of participants' storied accounts and transparency of their perception of experiences, clarifications were sought frequently, to validate participants' narratives during interviews, and a recap/summary of main points of storied accounts was undertaken to provide opportunity for participants to validate, agree, disagree or add thoughts at the close of each interview. Validating particular accounts is crucial, as embedded in details are "the powerful and symbolic meanings of events that are eclipsed by conventional accounts with socially attributed meanings" (Butler, Ford & Tregaski, 2007, p. 295).

The purposeful sampling strategy and open format of the interviews led to a small scale, but thick, rich and detailed description (Cresswell, 2007; Lincoln & Guba, 1985) of participants' narrative accounts of their experiences, and the incorporation of verbatim quotes serves to authenticate and instill participant's voices into the text, and enhance the accurate representations of their perception of experiences. Additionally, the feminist practice of sharing interpretive power with participants (by offering participants a lay summary of study findings) (Devault & Gross, 2007) was presented as an option to, but declined by participants as reflected on their signed consent forms. This offer was made as part of the consent process and at the conclusion of the conversational interview. It is difficult, and may be presumptuous to speculate about the reasons participants may have had for opting not to receive study findings. For feminists, from an ethico-political

standpoint, member checks imply more than just “getting it right”, it also implies “the politics of representation” (Devault & Gross, 2007, p. 189). Nonetheless, while the notion of member checks is widely acknowledged as indicative of respect for, and value of participants, that ethic of respect and value also implies the researcher’s obligation to uphold the “autonomous choice” or right of participants to opt not to receive study findings (MacNeil & Fernandez, 2006, p.50). Thus the need for the researcher to demonstrate a ‘politics of representation’ cannot supersede respect for participants’ informed choice.

As an important feature of the entire research process, reflexivity plays a multifunctional and multipurpose role. Lather (1991, p. 128) opines that reflexivity “mean(s) those stories which bring the teller of the tale back into the narrative” while Hesse-Biber & Brooks (2007, p. 423) emphatically observe that “personal experience becomes a source of authenticity rather than a contaminant and by honestly acknowledging her situated perspective, a researcher increases the validity and legitimacy of her research project”. Thus the researcher’s engagement in reflexivity does more than enable “flashes of insight and growth in self-awareness” (Cutcliffe as cited in Alex & Hammerstrom, 2008, p. 170). Alex and Hammerstrom observe that it also ‘enhances’ the study’s grounding by “taking into account the researcher’s values, beliefs, knowledge and biases”, and additionally, the use of reflexive “discursive strategies” in the interview establishes “quality in the qualitative research (Alex & Hammerstrom, 2008, p. 170). Similarly, Benner (1994) and Koch (1994) observe that the credibility of the research study extends beyond the procedures used to generate and analyze data to include researcher self-scrutiny, documentation and acknowledgment of their repertoire of values

and beliefs and their possible effect on the research process. Ongoing reflexivity and cultivation of self-awareness throughout the research process is both a qualitative research principle and a feminist imperative. In addition to reflective accounts about the research process, a research journal was used to explicate and reflect upon my values and beliefs, especially as they pertain to knowledge and experience in maternal nursing practice vis a vis the conduct and process of the research as it unfolded. Making explicit my subject positions also opens up the research process to readers' scrutiny and renders transparent my influences and contribution to the interpretive process, thereby enhancing trustworthiness (Benner, 1994; Koch, 1994).

From a DA perspective, the criterion of evaluation also entails "providing the readers with enough raw data to assess the adequacy of an analysis" (Madill, Jordan & Shirley, 2000, p. 14) and addresses how the study contributes to readers' understanding as well as new insights into the subject under inquiry. Addressing the transformative action and contributions of the study, also encompasses the criterion of fruitfulness, identified by Potter and Wetherell (1986) as "the most powerful criterion of validity" (p. 181). Potter (1996) further observes that the use of rich data is a "distinctive feature in the validation of discourse work" that enables readers to assess the study's interpretation vis-à-vis the raw data (p.135). In this study, the use of verbatim quotes supported by relevant theoretical references provides readers with raw data to facilitate their understanding of the interpretation. Additionally, auditability of a research study represents a key indicator (Koch; 1994) and a hallmark of trustworthiness (Lincoln & Guba, 1985), and relates to the DA validity criterion of reader evaluation. An audit trail opens the study up for reader assessment. Therefore, to facilitate a discernable trail allowing readers to follow the

pathway that led to interpretations (Cresswell, 2007; Koch, 1994; Lincoln & Guba, 1985), the reflective journal was also employed to document ethical, methodological and analytic decisions made, as well as actions taken (with related rationale) throughout the research process. This is done while mindful of the Foucauldian poststructuralist stance that no reality can ever be captured in total, and there is no omnipotent podium from which to posit an absolute truth. Therefore, in DA there is no universal interpretation (Madill et. al, 2000). Each reader's understanding and interpretation is contingent upon their particular worldview, experiences and situatedness. Thus differences in understanding and interpretation are considered inevitable (Whitehead, 2004). Each reader brings with them "a different perspective" and their interpretations and evaluations "will hold sway (within) the different contexts in which it is read" (Madill et. al, 2000, p. 14). There is therefore no one right interpretation, only a different kind of understanding. The intent of the study is not to prove or disprove, hence no empirical correctness is assumed (Crusius, 1991). Rather it is to inspire a moment of profound insight, an 'aha' hermeneutical moment wherein the subject of inquiry, pregnant women's experiences of obesity, "receives its unique whatness", meaning and value (Anderson, 1998, p. 179). It is also to inspire thought about the mystery of what is (Chang & Horrocks, 2008) and the possibility of innovative vistas of understanding (both on the part of health professionals who care for pregnant women, and obese pregnant women themselves) that reflect on, and critically interrogate the status quo, the power relations and presumptions of the whatness of the experience of maternal obesity. Herein lies the fruitfulness of this study.

CHAPTER 4 Conversational Interview 1

Jane (self-chosen pseudonym for participant A) is a 23 year-old Caucasian woman who self-identifies as obese, and is 28 weeks pregnant with her first child. This is an unplanned but nonetheless accepted pregnancy. She has high school education, currently works part-time at the local KFC fast food restaurant and reports an annual income of under \$10,000. She is in a common-law relationship and her partner, with whom she lives is a seasonal worker who is currently unemployed and on social assistance after he exhausted his unemployment insurance.

Her narrative of her experience of obesity as a pregnant woman opens with an account of persistent experience of nausea and vomiting and a perception that she is losing weight consequent to an inability to retain consumed foods. The ambivalence of this understanding of self given her identification as obese by her own admission, soon becomes evident as her beliefs, values and practices come across in a messy, complex and often contradictory narrative in which she positions self in the ensuing multiple discourses (both dominant and subjugated) which she appropriates at different points under different contexts to inform her understanding of self and experiences of health as a self-identified pregnant woman.

4.1 Bodyweight as Marker of Maternal and Fetal Health

Her opening narrative in response to an invitation to share her experience of pregnancy thus far, is an account of her subjugated experience of pregnancy which nonetheless conflates bodyweight with health:

“Hell, I was puking every morning.... Well, not every morning. Every morning and night.

It's like all day long. I get sick....Oh, I can't keep nothing down. I'm pregnant and I am losing weight so....[laughs]. It's unhealthy, it should not be happening”.

Jane alludes to the perception that weight loss during pregnancy is not a normal occurrence and is hence unhealthy. This appears to imply that pregnancy justifies weight gain and/or that it confers liberation from cultural feminine standards of the slender ideal. As noted in the review of the literature, similar views by pregnant women have been reported in studies about pregnant women's experiences of embodiment (Fox & Yamaguchi, 1997; Wiles, 1994; William & Potter, 1999). While this would suggest that Jane does not experience her body as 'obese' and in fact appears to not covet weight loss, the contrary soon becomes evident as her narrative becomes emblematic of appropriation of dominant discursive obesity truths. For instance in response to a question as to whether she feels external pressure to manage her bodyweight, she says:

“I really....I've really never been pestered about my weight (*an assertion she contradicts elsewhere in her narrative*) But I know it's a problem. I know I'm overweight. I know I need to get it under control. But I'm 248 pounds. It ain't healthy”

In stark contradiction to her opening narrative, Jane's positioning in the dominant discourse emerges from implicit dominant discursive beliefs in her narrative that to be obese (while Jane self-identifies as obese she uses the term overweight instead) is problematic and tantamount to being unhealthy in apposition to a normal weight/slender body that imbues health, and relatedly that bodyweight is manageable at the individual level. She also reifies the master narrative's portrayal of obese individuals as out of control. Equally of significance, she appropriates the dominant obesity truths as self-authored (*I know, I know*), alluding to a self-determining, self-knowing subject who

consciously and naturally knows what constitutes a normal healthy body and what does not. Yet, this is a discursive façade and as Danaher, Schirato and Webb (2001) point out, on the contrary, individuals take the cue from scripts written for them by discourse/social forces. Not least of all, Jane also inadvertently legitimates the dominant discourse's assignation of responsibility for obesity on the individual by announcing that she needs to get her weight 'under control', an implicit acceptance of individual/ maternal accountability for body weight and health, thereby absolving state responsibility for ensuring conducive conditions for health and colluding with her own subjugation. Crucially, in owning the problem she also accepts responsibility for its solution and concomitantly any failures encountered in efforts at its management. Nonetheless this positioning subsequently undergoes a shift, as will become evident as her narrative takes on a counter discursive turn.

Jane also alludes to a history of weight cycling, noting that while her body weight has "generally stayed around 200 ----- (it) has been a little lower ----- (and) also been a little higher", and she appropriates master obesity truths to inform her current understanding of her experience of her pregnant obese body as pathological, dysfunctional and physiologically incapacitating. Her own desire to embody a normal weight coincides with the truths and standards of embodiment espoused by the dominant discourse, and render her an active participant in the constitution of her subjectivity as an obese pregnant woman, as the following narrative excerpt intimates:

"If I could drop down to 150 pounds, I could be a lot more active and my breathing would probably be a million times better probably. Yeah it would make a big difference

in the way my life is. Not like career-wise or anything, just my health in general. I like to be healthy and not weigh too much where it's unhealthy and I can't run from point A to point B".

That Jane is a ready subject of the dominant obesity discourse is manifestly evident. The power of the said discourse to shape Jane's perception of self and reality pertaining to body and health is sharply in focus. Equally palpably explicit is the understanding of obesity as a flawed or deficient, and unhealthy state of being. Less evident, but nonetheless implicit is the allusion to moral and hegemonic binaries that encapsulate slender/thin and obese bodies respectively as normative versus pathological, healthy versus diseased, functional versus dysfunctional and good versus bad, and thus provides the *carte blanche* for social exclusion and stigmatization of those whose bodies fail to measure or live up to mainstream expectations and standards. Not surprisingly then, and of significance, while she points out that her desire for a normative weight is premised on a desire to be healthy (not "career-wise"), her profound belief that it would lead to "a big difference --- in --- my life" (implying a normative weight is a means to a transformed life) belies this assertion, and this becomes apparent later in her narrative when she articulates her preferred vision/goal for her future. Nonetheless, on the surface (and explicitly) it communicates a desire to be able to move or go "from point A to point B" and a belief that it would make a difference if she had less weight as her breathing might be easier.

While she laments her body's inability to endure physical activity and frames it, through the biomedical lens, as a consequence of corporeal pathology, she takes great exception

to the general presumption in society that pregnant women who are obese are necessarily so because they engage in unhealthy lifestyle practices and observes that:

“They’re ridiculous. Every one tries to be healthy, every one tries to eat health. You know I’ve been big my entire life. I played soccer from the time I was 4 until I was 18, summer and winter. You can’t tell me I wasn’t active. I just was a bigger person. It’s not easy to lose all that weight and be the scrawny little thing everyone thinks every one should be. So it’s impossible!”

Of significance, Jane simultaneously upholds and subverts the dominant discourse. She attempts to employ the logic of biological essentialism to explain her corporeal appearance as being “big” versus obese and therefore not related to her diet or activity level but simultaneously serves up an admission to a non-normative body weight by alluding to the fact that “it is not easy to lose all that weight”. Her description of the conversely slender female as ‘scrawny’ imputes unattractiveness and unhealthiness, and thus challenges the normative view of what constitutes a healthy female body and the pervasive discursive binary of thin/slender as healthy and attractive, and obese as unhealthy and unattractive. She resignifies what is normal. She thus redefines the significance of aesthetics and decentres the rigid and reductive standards by which the dominant discourse allots aesthetic value to slender bodies, and refuses to concede to the slender ‘other’ the biomedical and cultural discursive privileged status of desirability/attractiveness/health. As a subject of discourse, Jane is always inside language and it is ultimately language that imbues meaning to her experiences (Abma,

2002; Butler, 1997; Davies et. al, 2006; Davies & Gannon, 2007; Weedon, 1997), therefore changing the language changes the effect (Butler, 1993) by bringing to the surface thoughts previously silenced and making room for alternate ways of thinking about and understanding self (Davies et. al, 2006). Thus, in employing the term ‘scrawny’ Jane disrupts her negative sense of corporeal self that arises from dominant discursive and cultural portrayals of obese individuals (as unhealthy and unattractive) through spoken and unspoken language (Abma, 2002; Scott, 1994). In doing so, she turns the dominant discourse unto itself through the use of what Butler (1993, p.16) describes as linguistic and performative agency to destabilize and resignify “.....what qualifies as bodies that matter”. Concurrently, Cressida (2007) observes that the act of changing language and applying alternate meanings to categories can be freeing. Accordingly, Feder (2011, p.64) contends that a reversal, “an effort in other words, to recast normalcy” counts, for “even as there are clear standards of health of all kinds, it still makes sense for us to talk about what is healthy ‘for me’”.

Similarly her declaration: “ I don’t care what anyone thinks of me. I am who I am”, made shortly after stating she will like to “drop down to 150 pounds”, serves to assert or emphasize that this wish is purely for health versus aesthetic reasons, and is consistent with the foregoing resisting subject position. That she does not care about her non-normative appearance and public reading of it, interrogates the legitimacy of, and subverts the dominant discursive objectification and judgmental reading of obese pregnant bodies. Jane refuses to submit to a reading of who she is or is not, based on her corporeal presentation, and this would seem to imply that she is concerned about the way society views obesity. She refuses to be captive to the “ontological” portrait of self that

is embedded in an understanding of self as human or not courtesy of external forces (Cressida, 2007, p.18). She is who she is, not what someone else thinks she is, resonates with Cressida's (2007, p.17) contention that "the idea that our embodied deviances or conformities are or should be expressions of an inner self isa mechanism of docility we should resist" and equally Foucault's exhortation that we refuse imposed identities (Foucault, 1982).

Conversely, when asked how life might be different for her than other pregnant women who weigh less, she declines to speak in comparative terms about other pregnant women. She nonetheless cites an example of a friend who weighs less than she does but equally struggled to maintain a healthy diet during pregnancy, and alludes to the need to consider context and to avoid judging individuals based on their body weight:

"Really it all depends on their own situations, you know. I've never judged anybody by how big or small they are, you know. It's just ...like my friend weighs maybe 100 pounds less weight. And when she was pregnant she went through basically the same thing I'm going through, trying to feed herself, trying to eat healthy, working a shit job. So everyone struggles in their own way".

This understanding of self in relation to other pregnant women serves to disrupt the commonly held belief (paradoxically one she implicitly upholds herself, albeit on and off in her narrative) that obese individuals are necessarily so because they maintain unhealthy diets/lifestyles and bolsters the argument for a pluralistic /multiperspective versus a monistic/reductionist approach to obesity. She subsequently agrees however that she would have more concerns about her unborn baby than they would:

“Maybe. Because you know, I have the overweight and it’s not as easy to exercise as it would be for someone who’s a little bit smaller and is more flexible and more able to do more things without having to worry about their whole body crashing down on them.

[laughs]

Jane serves up another contradictory rendition of self-understanding and evidence of conflicted subjectivity. She reifies the categorization of obese bodies as sloppy, dysfunctional and out of control, and normative/slender bodies as functional and contained. Similarly her deprecatory reference to her body “crashing down” suggests she is uncomfortable with it, even possibly embarrassed by it.

4.2 Maternal Responsibility for Fetal Health

In addition to conflating body weight with health, Jane acknowledges her health to be linked to the health of her unborn baby in an explanation of what her health means to her:

“ My health? Everything. It’s the baby, it’s me. A healthy baby”.

Implicitly, Jane believes and understands her unborn baby’s health to be dependent on hers, suggesting her practices and actions affect her unborn baby and therefore assumes an unspoken maternal responsibility for fetal health. Interestingly she expresses her desire to have a healthy baby, but qualifies it as follows:

“ Yeah. I don’t have to but it’s a good thing to have a healthy baby. Yeah.”

Unspoken, yet implied is Jane’s understanding that she does not have to but she chooses to because good mothers strive to have healthy babies. The presumed discursive and cultural moral imperative for a mother’s obligation to fetal health and outcome is implicit, and so is her reification of the dominant discursive constitution of particular

maternal identities and subjectivities – good versus bad, responsible versus irresponsible mothers. Nonetheless Jane frames it as a self-authored, unconstrained choice when in fact as a function and effect of her positioning in the dominant discourse, it is necessarily regulated or sanctioned and therefore a constrained discursive choice premised on the truths of maternal responsibility for fetal health which she now speaks into existence as part of the frame that informs her understanding of self as an obese pregnant woman. However, while this illusion of autonomy is a consequence of the invisible nature of power relations that creates the impression of an agentic self-constituting subject, as Butler (1995, p.116) submits, it is also a concurrent function of a sense of being in control and submitting to power relations or an external force “and it is this paradoxical simultaneity that constitutes the ambivalence of subjection” and represents “the condition of possibility for the subject itself”.

Given this sense of maternal responsibility, her inability to sustain a healthy diet and its potential implications for fetal health and outcome troubles her:

“I’m worried that I’, not going to be able to eat the right foods I’m supposed to eat, that my baby is not going to be healthy when it’s born. It worries me. It does. But I can only do the best I can do. I can’t do any better.”

Her acknowledgement of the role her lifestyle practices may play in determining her unborn baby’s health notwithstanding, her reference to an ability to do ‘only the best she can’ and no more than that alludes to a struggle to negotiate her maternal subjectivity to accommodate fetal subjectivity.

4.3 Practices And Resistances

Relatedly, having accessed obesity truths, Jane understands self to be responsible for managing her body weight to assure both maternal and fetal health, and consequently believes one can have a healthy baby by:

“Eating right, having the right medications you’re supposed to have. Exercise right. Do the best you can.” Nonetheless her day-to-day life experiences present challenges:

“Where I have to work every day and I have a messed up ankle, I can barely go for walks. I can’t exercise really. I can’t do much of anything besides go to work and come home and lay on the couch. I worry I cannot always eat properly. I don’t have money to buy the food that I am required to eat when I’m pregnant. Yeah.”

Jane’s appropriation of the dominant discourse is again evident as she identifies diet and physical activity (technologies of the self -TOS) as central to weight management and thus legitimates the discursive representation of obesity as a consequence of the individual’s poor lifestyle choices and thus easily corrected by the ‘right’ choice of food and engagement in exercise. Dietary practice during pregnancy represents a key-defining touchstone in the cultivation of maternal moral identity and sense of self (Lupton, 1996). Hence Jane’s allusion to healthy eating as “eat(ing) right” has moral undertones and conjures up the binary of “right” as in “good” food and conversely “wrong” as in “bad” food indicative of maternal moral integrity and maternal moral laxity respectively (Lupton, 1996, p.27) and neatly intersects with neoliberal-driven biomedical discourse of personal/maternal responsibility. Thus it represents an acknowledgement that given the adoption of appropriate/normative lifestyle choices, maternal obesity can be transcended

and concomitantly justifies the responsibility placed on obese pregnant women to individually manage their body weight and health. Yet by Jane's own acknowledgement, paradoxically within the same narrative syntax, beyond individual factors, broader socioeconomic factors determine an individual's ability to successfully take up and sustain these practices. Therefore while she stories and attests to the influences of social factors she does not deploy it in this particular excerpt to interrogate or subvert the dominant discourse. Gard and Wright (2005, p.124) take up the issue of social determinants and make the observation that the biomedical obesity discourse conveniently overlooks "the reasons why people might organize their lives differently around priorities other than exercise and diet," and this is especially true of women (Wuest et. al, 2006). Other scholars have echoed similar viewpoints (Lupton, 1999; Raphael, 2008, Wilkinson & Pickett, 2010). Consequently, the perennial approach to obesity management premised on the presumption of individual knowledge deficit and therefore, as Maziak and Ward (2009) note, a misguided focus on individual responsibility and the presumed power of health information essentially leads to a cul-de-sac.

Jane also appropriates the biomedical recommendation to embrace physical activity but insists she has always been, and loves to be active but currently her ability to engage in exercise is compromised by inter alia her ankle injury, lack of material resources as well as her geographic location:

"They don't have it so people in these rural areas have accessibility to things like that. I'm not going to go out and walk down in the middle of the highway. There's no side walks for you to go walk down. I've the dirt on one side of the #1 that I can go walk

down. Which is not going to happen. I'm not going to go risk getting hit by a car".

Nonetheless, Jane's physical inactivity typically incurs a dominant discursive sanction that labels her as indolent and lacking the will to pursue self-health and by extension fetal health. Yet as noted in her narrative and equally supported in the literature (Jette, 2006; Raphael, 2008; Wilkinson & Pickett, 2010; Wuest et. al, 2006), this also conveniently disregards contextual structural factors that in Jane's case, includes the built environment (no side walks or recreational facilities where she lives), affordability and time constraint. This notwithstanding, Jane also attributes her inability to engage in physical activity to her malfunctioning body, and legitimizes its discursive construction as unhealthy, as suggested by the ensuing narrative excerpt:

"I'd love to be able to run again, but I haven't been able to run in like four years. I used to be able to run for an hour. Now I'm lucky if I can run across the road without losing my breath".

Overall, Jane understands weight management in the name of health to be a project that one undertakes on the body through diet and exercise, nonetheless it is a project she cannot afford and in the following excerpt alludes to the role she perceives health professionals can play in this regard:

"I wish they would be able to give you more information on places you could go to lose the weight. Someone that could help you, you know, lose weight and where it's not going to cost you an arm and a leg to get a personal trainer at a gym or something. You know? Like more places where you could go and have like free access to a weight room or whatever, or exercise machines, you know. So where you are able to go and work out and able to go try to lose the weight".

Jane takes up the position of the non-expert neoliberal citizen who values and wishes to access a fitness facility for the purposes of losing weight and seeks expert guidance in this regard. Jane thus takes up the values and beliefs of the dominant discourse but is not able to afford enacting them. She positions self within the dominant discourse and assumes what Rose (1993) describes as the ethos of a consumerist subject in a quest for expert information and guidance to gain access to resources that will enable enactment of TOS. Similarly she unwittingly legitimizes the commodification of obesity, a corollary of biomedicine's twin discourse of risk and individualism, by subscribing to its values and assuming the ethos of a "consumer(s) and enterprising individual(s), two virtues of neoliberal(ism) ---- market fundamentalism" (Ayo, 2012, p.102) that serve to feed a multi-billion dollar obesity industry (Jutel, 2009b; Lang & Rayner, 2005; Saguy & Riley, 2005). Relatedly as a subject of the master obesity discourse, to inform self about normative lifestyle practices, Jane accesses and identifies sources of obesity truths as: "The Canada Food Guide, the information the doctors give me of what you are supposed to eat, what you're not supposed eat, the prenatal books. You know, things like that where it tells you're supposed to eat lots of fruits, lots of vegetables, drink lots of milk.TV, newspapers, just people talking on the street. I am a cashier at a fast food joint. People come in and talk to me about everything" (attesting to the ubiquity of obesity discourse).

Despite the omnipresence of obesity talk, Jane on the one hand denies feeling pressured to manage her weight noting she has "really never been pestered about my weight"; "my family doesn't really get at me"; and that she never discusses her weight with family, friends or other pregnant women, in fact she emphasizes "I don't really discuss my

weight with people” and in response to whether there is a reason for that: “No, it just never comes up”. On the other hand, she responds in the affirmative to a direct question as to whether she feels pressured by society to eat healthily or be active because she is pregnant and says:

“Well, I feel like... Well, my friends and family think I should eat healthy and I should be exercising *and this and that* (emphasis to note vexation and allusion to feeling pressured). And I try to eat healthy”, subsequently adding: “My mother occasionally tells me I need to lose weight. But that’s just she wants me to be healthy”.

Evidently with respect to the role and influence of social relations in her understanding of self and experiences of her pregnant body, Jane privileges her mother as a much more legitimate source because she believes she (mother) has her best interest at heart.

She also acknowledges that she was counseled prior to pregnancy to lose weight:

“ Well the doctor when I was up in the city, he told me that I needed to lose weight before I **even** got pregnant because I was starting to become overweight. And I had to start eating healthier and everything. Yeah.”

Jane values and trusts expert medical counseling and guidance, (notably in as far as it will lead her to the resources she needs to manage her weight) and attempts to comply with their imperatives preconceptually but is simply unable to afford, and therefore sustain the recommended lifestyle practices. She consequently questions their judgment when it comes to the expectations they have of her and communicates her inability to live up to those standards of living:

“I can only do the best I can do. I can’t do more than....I can’t do everything that they’re expecting me. And I tell them that, and I tell them that I can only afford so much. Like

100 bucks every two weeks in groceries don't go very far, if I can afford that. Like between my power bill and my rent and water and everything else you've got. Cell phones, whatever. You know? You need...Like I need a phone”.

Although her need of a phone was acknowledged, she felt a need to emphasize and explain it further:

“You need to have a phone. A phone one way or another. You've got to have a cell phone. I pay \$25 a month for it. That's \$25 I can have for something else. But that's life. I've got bills.”

Jane challenges (implicitly of course) the elitist mentality that holds in contempt attempts by marginalized individuals to engage in practices or possess items that pass as everyday basic necessities in their privileged world, dismissing them as misguided indulgences in luxury they can ill-afford at the expense of attending to externally promulgated and imposed priorities such as procuring healthy foods. In a related observation, Lupton (2012, p. 333) notes that hegemonic directives for corporeal management may raise no objection from more privileged women because they coincide with their elitist values (*and they have the resources to enact them – my emphasis*) but “for less privileged women, however, the imperatives of body control may be experienced as punitive and overly controlling in a context in which they have less control over their life circumstances.”

Jane also draws from her subjugated/local experiences of material deprivation to interrogate the expediency of the dominant discourse in relation to what she understands to be the realities or local truths of her life and reflexively decides, notwithstanding access to obesity truths she is only as capable of their enactment as her particular life

context permits her to. The reiterated ‘and I tell them that, and I tell them that’ alludes to a persistent attempt to make her case and not being listened to. Regardless, this subtle problematization of the discourse “enables problematization of one’s (*her*) conduct” (Danaher, Schirato & Webb, 2000, p.44) and represents rumblings of emerging resistance as her subsequent confrontation with the dominant discourse proves. Fundamentally, contrary to a defining premise of the biomedical discourse, access to information about healthy diets and physical activity does not necessarily make the resolution of obesity a *fait á compli*.

Having accessed obesity truths, Jane understands her body to be outside of normal and self to be responsible for managing her abnormal body weight and compromised health, and by extension the health risks it could potentially confer to her unborn baby and that these are resolvable through healthy diets and exercise. She therefore desires the corporeal transformation promised by disciplinary power but is incapacitated by the local truths of her life, and thus even though enactment of obesity truths is a condition for accessing them, she is unable to embrace in totality technologies of the self. Her motivation for embracing a healthy diet stands in stark contrast to the diet she actually consumes, as her narrative of what constitutes a typical daily diet suggests:

“I eat probably a piece of toast in the morning. And then I go to work. And around 2 (read 2pm), I’ll eat a piece of chicken and some fries. (And adds defensively) I work at KFC. So I eat KFC (the unspoken read as, what do you expect?). And then I’ll come home and sometimes it will be Kraft Dinner, sometimes it will be rice. On the rare occasion, (implied treat) I get to go out to the corner store and buy some sausages or something. But most of the times it’s rice or potatoes or French fries with gravy.

Something cheap and easy”.

For Jane, affordability determines choice of food:

“It’s how much I can get for as little amount of money in my pocket. The more I can get for my money. The best value”.

Therefore she tries to eat as healthily as her circumstances make possible and to negotiate between dominant dietary stipulations and the realities of material deprivation to accommodate to the best of her ability the dominant discourse:

“Yeah, I try to do everything I possibly can. I try to go to the Food Bank every month because they will give me food. I try to buy as much healthy food as I can possibly afford. But as I said, it’s expensive”.

Therefore as part of her strategy to accommodate the dominant discourse, Jane accesses the Food Bank every month for food she perceives qualifies as healthy nutrition, comparatively of course to KFC (I return to the use of Food Bank in my discussion).

Altogether the magnitude of material deprivation and its associated debilitating impact on Jane’s ability to consistently model the lifestyle canons stipulated by the dominant discourse is captured vividly in the ensuing multiple excerpts from her narrative:

“I can’t eat fruits and vegetables all the time. It’s cheaper to buy a bag of chips than it is to buy a bag of apples, you know. I go to the Valley for food, the prices of food if it’s cheaper..... I’ll buy that over top of something that’s healthy that costs a lot more because I ain’t got the **money to** afford something that costs more. Yeah.

Well, when milk is \$6 a jug, I’m not going to go pay \$6 for a jug of milk when I can go buy something else a hell of a lot cheaper, like.

I shouldn’t but I eat a lot of food at my work because I have a 50% discount. I pay \$2 or

\$3 for a meal compared to going to the grocery store and paying \$5 or \$6. You know? But fast food ain't the healthiest thing. It makes me gain weight. [laughs]

I have to bus to like... I have to bus to Greenwood to go to Sobeys or the mall and go to Walmart. Or I can go to Foodland or Save Easy. Those are my only... Like those are the only 3 grocery stores I'd be able to go to. Yeah. And it has to be by bus. Like I don't have a vehicle. Which makes it real difficult. Transportation is always an issue no matter what I'm doing."

Evidently, Jane understands her experience as a self-identified obese pregnant woman as a constant struggle to make ends meet as well as live up to hegemonic health and corporeal standards that preclude the real dynamics of material deprivation that pervades her every day existence. These include but are not limited to:

The impracticality of eating fresh fruits and vegetables and in general healthy foods that she finds expensive relative to the cheaper priced foods denounced as junk and unhealthy, yet work well for her budget; or easily accessed food at work which are equally classified as unhealthy but nonetheless from a pragmatic perspective represents food for survival; the reality of issues of access that necessarily come with living in a geographic location devoid of supermarkets and therefore limits access to fresh foods, conversely promoting reliance on non-perishable yet unhealthy alternatives; and all of the above compounded by the issue of lack of transportation.

As a consequence of such indigence and its interaction with the pressure to live otherwise or risk "end(ing) up on the scaffold" (Foucault, 2003a, p.34), Jane experiences stress

which she readily and boldly acknowledges she smokes and eats to relieve:

“I have financial stress. When I get stressed out, I smoke more. [laughs] Stress causes me to go into food and smoke my brains out”. Yet when she thinks about the health risk smoking entails for her unborn baby:

“ It makes me feel I shouldn’t but I can’t quit. But I can’t do anything to try to quit because if I try to quit, it puts too much stress on me, it puts too much stress on the baby. But I can’t take anything to even try to quit, to decrease that stress because I’m pregnant and there’s nothing out there for me to take. You know?”

Substance use represents perhaps the ultimate deviance during pregnancy because the moral outrage directed towards pregnant women who smoke arises out of a concern and need to protect the defenceless fetus a woman is carrying (than necessarily about the latter’s health) based on, again, a *prima facie* obligation a pregnant woman has to protect her unborn baby. Thus the privileging of fetal interest over maternal needs, manifests strongly here and nets these women heavy social censure or a trip to the ‘scaffold’ as Foucault would say, because in the public eye if there was ever a motivation to quit smoking, pregnancy should be it. Health care providers equally entertain the expectation that pregnancy represents an ideal or opportune time for women to give up smoking and other unhealthy habits (SOGC, 2011). Yet as Lupton (2011) observes, several studies have shown that despite their awareness of social condemnation, the stress of material and social deprivation makes it challenging for marginalized women to abandon habits such as smoking. This may explain (in response to a question that asked what represents the biggest obstacle to her health) Jane’s own grading of “tobacco” as the biggest impediment to her health and by extension the health of her unborn baby, even though

her entire narrative focuses on her experience of health and self in relation to diet and physical activity. Nonetheless, from a feminist poststructuralist perspective my role in shaping/co-constituting these narratives cannot be overlooked.

While this form of resistance is deemed as not serving maternal or fetal interest for that matter, it however puts into sharp focus the iatrogenic consequences of the biomedical obesity discourse and its potential to exacerbate the very condition it seeks to eradicate. In concurrence, Offer et. al (2010) note that “economic insecurity”, a consequence of neoliberalism creates chronic stress associated with food insecurity and social inequity which in turn “drives higher levels of obesity” (p.297), while Blaine (2008) implicates the lure of junk food, anxiety and stress in the obesity debacle. Therefore as Lupton (1995) observes, given the absence of a level play field, subjects are not equally set up to individually control or manage their health. Yet as Rose (1999) observes, structural impediments or encumbrances notwithstanding, contemporary neoliberal subjects are expected to be capable of rational choice. I argue however that in this respect ‘rational’ becomes a subjective notion, rational to and for whom? In Jane’s context she understands her ‘choices’, (if it can indeed be viewed as such, - Levin, 2003, p.380 posits, “choice distinguished by the lack of choice is unchoice”) to be rational. Therefore where external others, removed from her context view it differently, perhaps as irresponsible and therefore irrational, she simply understands it as a need to reorient her priorities to meet basic needs. Jane eats what is accessible to her. Nonetheless according to the master discourse by eating junk food she not only risks her health but the “precious cargo” she is carrying (Lupton, 2012). Hence by separating self-survival (she has to eat something) from fetal interest she is guilty of transgressing the prima facie obligation of any good

mother to privilege fetal interest over hers. Or conversely and more commonsensically, if her particular social and material context were acknowledged, it could be said that in assuring self-survival within her means, at the very minimum, she assures fetal survival unless of course starvation is seen as an option in which case both mother and fetus become the ultimate casualties. I make this argument to highlight in a minuscule way the biomedical discourse's oversimplification and embellishment of the highly complex issue of maternal obesity and the related issue of maternal responsibility for fetal health in total preclusion of social determinants, along with its all encompassing yet fallacious conception of what constitutes 'rational' choice. The crux of my argument is further captured in Levin's (2003, p.380) take on rational choice:

"The unhealthy choices people make are not irrational choices. We have to see them as constrained rationality, making the best of a bad situation. Most of the apparently unwise decisions people make have a relative rationality to them when their circumstance is taken into account, so it is unlikely their behaviour will change simply by lecturing to them. You have to change the context within which choice is made".

One could also argue that in Jane's case she is smart in that she makes use of a resource available to her – the food bank – and use of affordable, 'cheap' food at KFC, and that she knows how to survive under her circumstances.

On a different note Jane's allusion to an attempt to quit smoking leading to further stress on her and her unborn baby further upholds the intrinsic connection of the maternal/fetal dyad. Significantly it represents an allusion to stress not being good for their health either, an appropriation of a biomedical truth (ironically biomedical

injunctions do caution pregnant women against experiencing stress and anxiety – Cain, 2013) to subvert and turn discourse unto itself, as is her claim that she cannot take anything to help her quit smoking or eliminate stress because she is pregnant, as she implicitly alludes to the inadvisability and lack of consensus on the use of pharmacotherapy for tobacco cessation in pregnant women (Osadchy, Kazmin & Koren, 2009) and in general the caution around medication use during pregnancy.

Yet paradoxically, a disregard of biomedical imperatives (eating junk food and smoking) inadvertently reaffirms the dominant discursive construction and profiling of obese pregnant women as irresponsible, indulgent overeaters. Hence power relations do not cease to be because one fails to abide by the rules in toto, on the contrary central to power relations “and constantly provoking it, are the recalcitrance of the will and the intransigence of freedom” (Foucault, 1982, p.790). The function of freedom is dependent on free subjects and therefore freedom is power’s “point of reference” (Cook, 1993, p.113). We are always in power relations, there is no stepping out of or escaping relations of power, however as Danaher et al. (2000, p.131) suggest “we can identify themand identify our own practices of the self ... and from the basis of this knowledge, formulate tactics by which we can live in the world”. Ultimately what matters is that we cultivate a reflexive awareness of power and its effects, tempering one’s role as a player with a healthy dose of skepticism, selectively, using power to our advantage and in our best interest so as to escape the constraints of its consuming and damning identity-shaping effects.

4.4 Tensions –The Path To Resistance

It is necessary to briefly address at this time, the contradictions and tensions that constitute so many of the threads that make up the fabric of Jane's local narrative as these collectively and necessarily give rise to her resistances.

While Jane expresses a dissatisfaction with her "overweight" body and desires a lower body weight (ideally, 150 pounds, coincidentally as Jenna which leads to a presupposition that this was medically recommended), there is a tension in her simultaneous resistance of the dominant discourse's privileging and promotion of a slender ideal, her own corporeal discontent, and deprecation of her body for deviating from that ideal. There is also a tension in her perception and understanding of self (as unhealthy and functionally defective) and her outrage at the suggestion that the public holds similar views. Similarly, while she de-emphasizes the importance of corporeal appearance and public opinion of her based on her external presentation, she is nonetheless aware of, and possibly affected by, the role it plays in the public's appraisal of obese pregnant women and the social (dis)value attached to bodies as evidenced by her use of the descriptor 'scrawny' to subvert the biomedical/feminine cultural privileging of slender bodies as attractive and healthy. Jane tries to negotiate this possible effect on her by avoiding, or steering away from talk about obesity and pregnancy. Yet by her own admission, "people talk to her about everything" and given the public nature of her work place:

"Maybe I heard customers talk to each other about it and things like that. But not to me, no. I stay away from conversations like that".

And while she may not actively participate she cannot help but overhear them say: “That it sucks. [laughs] How it’s harder to get through the pregnancy. You have a rougher go at it. You... You know, more worries of blood pressure, high sugars. There’s more chance of... What’s that thing where you stab yourself with a needle every day? Diabetes, yeah. You have a higher chance of diabetes. You know, there are more risks of being overweight while having a baby than it is to be smaller. But it’s what life dealt you”.

Although she sources these biomedical truths to others, it is quite conceivable that given her access to various literature and media coverage about maternal obesity, these represent her own appropriation of the dominant discourse. This becomes all the more apparent when later in response to a direct question as to whether she thinks about the risks to self and baby she says:

“Oh yeah, I know the risks and I try to avoid them, yes”.

This complex and messy, albeit clearly fragile subjectivity becomes difficult to make sense of. Yet Goffman’s (1967, p.65) notion of “differential avoidance” whereby the individual intentionally and painstakingly avoids “discussion (of) matters that might be painful, embarrassing or humiliating” may offer some clarity. Regardless, her desire to dissociate self from social discursive messages and obesity talk is clear. This leads to a reading that it is possible she may be more affected by the dominant discourse than she lets on. Hence, her avoidance may represent a strategy to protect self from experiencing stigmatization, real or anticipated. However from a power perspective, this passive strategy can serve to bolster mainstream society’s ability to define what social/public

spaces obese individuals can or cannot patronize. Weedon (1997, p.32) observes that “the individual is always a site of conflicting forms of subjectivity” and posits that this “precarious, contradictory” characteristic of subjectivity is what renders possible, access to alternate discourses and multiple truths, leading to tensions which manifest in the subject speaking from contradictory podiums. Therefore the disharmonies and incoherencies in contradictory subject positions, necessarily goad resistance and lead to apertures of opportunity for contemplating possibilities (as for instance Jane’s resignification of her experiences as externally/socially enabled versus personally created) (Medina, 2011; Weedon, 1997). Medina (2011) further explains that when discourses collide, some ascend into dominance while others descend into subjugation, thus contradictions serve to make visible discourses previously hidden and inaccessible to the subject. Jane’s local experiences of deprivation which shape her existence (albeit unacknowledged by the master discourse) as an obese pregnant woman, constitute her subjugated knowledges and truths of her life which are discounted and shoved to the periphery, “and rendered unqualified and unworthy of epistemic respect” or acknowledgement by the dominant obesity discourse (Medina, 2011, p.13). On the other hand, the truths of her life coincide with the alternate discourse of social determinants and tentatively serve to undermine the absolutism of obesity truths that she comes to understand as bordering on the oppressive. Consequently, the disharmonies produce “a counter-perspective that resists and invalidates the normative expectations of the imposed dominant ideology” (Medina, 2011, p.15). This enables the subaltern to, even if in the interim, step “out of the shadows” (Foucault, 2003b, p.70) of the abyss of deprivation and marginalization to speak the local discourse of the marginalized.

4.5 Mobilizing Social Determinants Discourse

As a resisting subject, Jane thoughtfully considers the socioeconomic factors that impact her daily existence, and understands them to be much more than constraints on her ability to have capacity for health. She sources obesity to structural factors and understands her inability to live up to stipulated lifestyle standards as a function of social factors and not a personal failure. Her vexation with the audacity of external forces to make unrealistic demands of her comes across as her storied narrative takes an interrogational and confrontational turn as the following excerpts reveal:

“And I wish that healthy food wasn’t more expensive than unhealthy food. It should be the complete other way around. You should be paying more for the food that tastes good but unhealthy for you compared to the food that you need every day. Why is it that milk is more expensive than pop? Why can’t pop be the price that milk is, and milk be a lot cheaper? Why am I paying \$4 for a bag of apples and a buck 99 for a bag of chips? You know?”

“They should just make healthy food more available to people in general instead of charging them an arm and a leg for it”.

Jane has posed these questions to health care professionals but she observes “they don’t really know the answers either”. She has posed them to politicians who come to her door canvassing for votes during election year and concludes:

“It’s the government that should have the answers to those questions. And they don’t. So... But yes, I’ve asked people (you know, the electees that go around door to door trying to get you to vote, them people) that come to my door, why is it that junk food is cheaper than good food? And they never have answers. They’re like, “So that’s the way it

works.”

While his earlier work highlighted the exercise of power through the production of truth, Foucault’s later oeuvre acknowledged the “threat to capacities where an agent’s potential to perform a range of actions is reduced.how the process of government operated against a backdrop of human freedom”, where an individual’s capacity to choose or act is constrained and “the operation of governmental power.....significantly alter the extent to which an individual is the author of his or her own life” (Moss, 1998, p.156).

Jane’s micro political resistance is an exercise of agency, wherein her “essential subjective will express(es) itself and (is) not silenced, subordinated or enslaved” (Rose, 1991, p.1) by external forces. She attempts to overcome her sense of powerlessness through a performance of her subjectivity in relation to context, “not to the institutions and discourses that give (her) subjectivity form and substance” (Tobias, 2005, p.79), albeit through acts of transgression that distance her practices from hegemonic external opprobrium’s that exclude her particular social location, and hence local narrative. Her articulation and deployment of the counter narrative of social determinants however exposes and brings to the surface the normalizing dominant discourse for what it is, an external force that is incompatible with the truth of her life and thus fractures the absolutism of dominant obesity truths, thus provisionally rendering her local narrative no longer marginalized or discounted. It also allows her to justify vacillating between healthy and unhealthy practices, her accommodation of the dominant discourse when she can, and to deflect sole personal/maternal responsibility for self and fetal health, resignifying it as society’s responsibility too. She provisionally rejects the totalizing and

normalizing truths of the dominant discourse that grounds her understanding of self as being culpable of her body weight as the disparity between such positioning and the force of the local narrative of the truth of her life collide and yield a dissonance. McLaren (2002, p.67) reminds us that truth and reality are products of one's particular social location thus the production of Jane's "truth about" self necessarily "takes place within (her) social context". According to May (2011), familiarization with the power relations within which we stand or that drives us, what they are, what they do, how they do it and for what purpose enables us to loosen the constraining grip of power, while McLaren (2002, p.96) observes that "as a subject under surveillance" Jane's "own power lies in the continual surveillance of power itself".

Against this backdrop, Jane's interrogation of the dominant discourse emanates from a realization of, what Foucault posits as, her gnostic self, the self that becomes aware of, and hence reckons with the discrepancy between her "life practices, and actions and what she understands to be true about herself" (Foucault, cited in Anderson & Wong, 2005, p.427) or for that matter the truth of her life context. Therefore this becomes the premise upon which she makes her 'choices' and enacts her practices. Self-truth then is truth that is posited within not "outside of one's own specific life" (Anderson & Wong, 2005, p.430) and is hence local and authentic to self versus normalizing in accordance to a collective context or external force that is removed from, and hence incompatible with the reality of one's own life context. Crucially, contrary to the neoliberal exhortations and claims of the biomedical obesity discourse, free will and individual 'choice' must necessarily entail a function of one's particular social context.

4.6 Situating Power In Further Perspective

While Jane recurrently assumes a resigned ethos in her narrative as her use of catch-phrases – “It’s life”, “It is what it is” suggests, she nonetheless still has “hope and faith” and envisions a better future for self and baby. She also believes weight loss will transform her life although she points out not “career-wise” but health-wise. However her articulation of her aspirations belie this:

“I’m working to get myself out of it. My hopes are that we’ll be able to afford all of it.

That we’ll be able to afford the cost of raising a child, especially these days in this economy. I see myself in a lot better place than I am now.

Yeah. That I am going to be able to. It will all work out in the end. And I’ll be able to go to my school, I’ll be able to get my schooling, and I’ll be able to be able to afford everything I need for this child.

Yes. Everything comes to money. The world revolves around it.”

In declaring her aspirations, Jane constructs self as having the ability to manage her life circumstances and as a resilient mother-to-be actively working at transcending material deprivation. While she attributes her inability to enact healthy lifestyle practices to structural factors and alludes to social and collective responsibility, her aspirations construct self as individually capable of transcending the very obstacles she sources to society. She therefore inadvertently suggests that while her marginalized existence is systemically-enabled, it can be transcended through individual entrepreneurial work ethics, and positions self as both the problem and the solution, diluting the SDOH stance. This narrative of aspired initiative and self-reliance upholds the neoliberal value of

individualism and its conceptual sibling, the proverbial Horatio Alger myth that implies anyone can raise themselves and move up the social strata through individual hard work and discipline vis a vis the pervasive view of obesity as indicative of a lack of discipline necessary for “achieve(ing) upward mobility” (Bordo, 1993, p.195). Nonetheless from a SDOH perspective, bootstrapping may have worked in the age of Keynesian welfarism where social policies were averse to foreclosing opportunities for individual advancement or exacerbating poverty in the name of commodified health and free markets, an approach (that is or was more in tune with the philosophy and intent of the Ottawa Charter of Health Promotion) that still operates to some limited extent in social democratic Scandinavian countries that subscribe to egalitarian principles of equality and collective social responsibility(Rose, 2007).

Bordo (1993) argues that women’s quest for the ideal feminine body is associated with the fact that it is symbolic of a higher social status and upward mobility, two key neoliberal values. The ability to fit in and advance in other sectors of society requires capability for self-management and self control. It is no coincidence that the physical state of the external body is emblematic of this capability. An obese, out of control body negates and deprives an individual of this opportunity for social approval and/or recognition. Hence constraints in body space translate into constraints in social space and as Schilling (2003) observes, it is this ability of corporeal exteriority to determine social position and upward mobility that inspires cultivation of the body as a project. Hence the need to manage her body and desire for an ideal “150-pound” body is as much Jane’s need for control and recognition as it is for her health. This self-constitution coincides with the agenda of Western neoliberal economies and the neoliberal rationale that

informs and sustains the dominant biomedical discourse. Thus on a broader scale, with respect to neoliberal goals of grand scale “production and the accumulation of wealth ‘good health’ is that condition which is least disruptive of production. A healthy person is able to take part, to the best of his or her physical ability, in contributing to the nation’s prosperity” (Peterson & Lupton, 1996, p.67). Concurrently, Danaher et al. (2000) observe that while the apparent goal is that technologies of the self (TOS) are in the best health “interests” of subjects (p.68), the unofficial sub rosa goal is to “mould people in order to make them more serviceable for the state” (p.70). Therefore individual responsibility, the sine qua non of self-surveillance is a form of social control in increasingly risk averse post-Keynesian neoliberal societies where citizens are exhorted to aspire to perfection, not just in corporeal terms but in all aspects of life. In this regard, Rose (2001, p.17), further observes that biomedical “values” have become “entangled with the aspirations of ‘the people’ themselves – especially the poor, the disadvantaged, the working class”, wherein health transcends a disease-free state or longevity, and extends to “overall wellbeing – beauty, success, happiness, sexuality” thereby commercializing health in the process.

Jane’s aspirations can thus be read as the point of intersection between multiple and broader discourses of the body, health, risk and neoliberalism wherein anticipated long term investment in self and health ensures that one will be a productive citizen in society and thereby reap the rewards of recognition and entitlement to other social privileges. Nonetheless in the context of individual micro politics, this again implies resistance is not escape from power, but freedom from the constraining effects of particular power relations that are currently in play, because the subject can never be outside power but

can move from one power relation into another or others (Allen, 1996; Butler, 1997). May (2011, p.80) suggest that a Foucauldian “freedom is a matter of experimentation ...not to figure out who we might be and then go there; it is to try out different possibilities for our lives....to create a life from within a space of uncertainty”, knowing now what we have been made to think we are, but in doing so, remaining skeptical, vigilant and always ready to break free from constraining power relations. Similarly, Butler (1997, p1) points out that power is not “.... simply what we oppose but also, in a strong sense, what we depend on for our existence and what we harbor and preserve in the beings that we are”. Power is hence not bad tout court but represents ‘games of strategy’ (Foucault, 1997, p.280). Jane aspires to power that enables rather than constrains. In advocating that we “refuse what we are” Foucault (1997, p.336) also insists “we have to imagine and build up what we could be”. Accordingly, Jane momentarily attends to her life truth and considers that what currently is, does not have to be.

4.7 Summary- Conversational Interview 1

Summarily, Jane’s narrative suggests a normative discontent with her pregnant body. Yet while her health and her unborn baby’s health are more explicitly at the epicentre of her uptake of the dominant obesity discourse, her concern with her feminine appearance are less obvious and hence more implicit in her local narrative of her experiences of health and pregnancy as a self identified obese pregnant woman.

Jane’s appropriation of the dominant discourse is underpinned by her desire for a healthy, functional body, worry about the potential health risks her unhealthy non-

normative practices and body weight pose to self and unborn baby, and overall belief that an ideal normative bodyweight would be a ticket to a better life. She positions self in the dominant obesity discourse by accessing (through external others and the media) obesity truths/beliefs and values about what constitutes a healthy maternal body and moral maternal identity. She buys into the master discursive truth that bodyweight is both controllable and malleable through individual uptake and enactment of technologies of self (TOS) - lifestyle practices of healthy eating and physical activity. She nonetheless struggles to commensurately embrace these normalizing practices of the self (TOS) due to maternal and structural constraints that surpass her individual control. Her particular life context constitutes a radical departure from the privileged elitist standards, values and moral opprobrium of the dominant discourse. She therefore intermittently rejects the master notion that such lifestyle is necessarily possible or achievable at the individual maternal level and thus implicates society as equally responsible for making the resources and tools necessary for such a lifestyle inaccessible to the individual. Thus Jane understands her experience of powerlessness with respect to weight management to be attributable to her particular socioeconomic context. Her inability to conform to dominant discursive/normative diet and fitness practices in the name of health for self and unborn baby is punctuated with feelings of worry and frustration vis a vis a sense of clear and omnipresent powerlessness of being limited to doing only what “I can” which she understands as not good enough but nonetheless, for a moment, resigns self to a fatalistic *c’est la vie* ethos.

Jane hovers between the illusion of feeling a sense of control endowed by access and possession of knowledge and conversely feeling her control slip away in the face of

structural constraints that render the enactment of accessed truths/knowledges impossible, and leads to an understanding of her everyday experience as a self-identified obese woman, as stressful.

Thus, irrespective of accessed obesity truths, the incongruence between normative lifestyle prescriptions and the truth of her everyday lifestyle experiences of deprivation, the related feeling of stress and sense of futility that together manifest as contradictions and tensions in her narrative, open a path of resistance against the imposition of impractical standards and expectations on her day to day existence as a self-identified obese pregnant woman. She defiantly resists the dominant discourse by taking up non-normative practices of overeating junk food (and smoking), the very practice she paradoxically wishes she had the tools and resources (access to affordable healthy foods, fitness facilities and trainers) to avoid. However as a strategy of resistance, her outright rejection of norms is not without risks. She inadvertently feeds into the dominant discursive portrait of obese pregnant women as overindulgent and irresponsible mothers who by their unhealthy practices put their unborn babies at risk. Jane nonetheless further subverts the dominant discourse by reasoning that this is how she copes with stress which incidentally is neither good for her health or her unborn baby's health, noting further her limited options (an allusion to pharmacotherapy) given her gestational status. Hence rather than "escape knowledge (dominant truths) altogether" Jane unwittingly but conveniently "mobilizes" some truths against others and turns the dominant discourse onto itself (Medina, 2011, p.13).

Nonetheless while from the Cartesian lens of the dominant discourse such resistance may be construed as irrational, for Jane, located on the margins of society, these practices are not only rational but enable her to successfully negotiate and manage her day to day existence, and gives back some sense of control where realistically the normative brand of control is elusive and simply unattainable. As Lupton (1995) observes, at the “micro-level people may not conform to health promotional advice because of, among others “a conscious sense of frustration, resentment or anger or because they derive greater pleasure from other practices of self” (p.133), while Sayer (2005) reminds us that “experiences influence the reception of norms, and people who negatively experience social inequality can develop ethical positions that lead to anti-normative lifestyles” (p, 152). Relatedly Gilliom (2001) in an account of the marginalized and oppressive experiences of low-income women observes that for the poor, simple acts of day to day resistances and the related explanations given for them represent “forms of politics that hew closely to the tangible needs, the opportunities, the experiences and the limited resources” so endemic to life on the periphery of society (p. 108). Crucially regardless of the nature of Jane’s resistance, if it does nothing else, it makes visible local subjugated knowledges and forces a rethink of marginalized experiences that are devalued, discounted, socially excluded and “rendered unqualified and unworthy of epistemic respect by prevailing and hegemonic discourses” (Medina, 2011, p.11) of obesity.

Overall Jane’s multiple, often conflicting and simultaneous positioning within dominant and alternative discourses, is consonant with the fluid and dynamic nature of

subjectivity. She vacillates between the acquiescent docile subject of the dominant obesity narrative with desires and aspirations for normative or ideal body weight who embraces TOS (healthy eating and physical activity) as best as her circumstances allow, and a defiant, resistant subject who draws from alternate discourses to agentically indulge in what is most readily accessible and affordable and interrogates the audacity of the dominant narrative to make such unrealistic lifestyle demands of her. However, while she fiercely employs the alternative narrative of social determinants to frame and source her non-normative lifestyle practices and by extension her bodyweight in systemic terms, she paradoxically frames the solution in individual terms as well by accommodating a significant ideological premise of the dominant narrative – individualism, in aspiring to individually transcend her current constrained situation. This, perhaps, is attestation to the coercive allure of the master narrative, which, while not encompassing in toto is nonetheless deeply embedded, in corporeal desires and aspirations (for a 150-pound bodyweight and belief that it represents a ticket to the telos - goal of practice - of a transformed body and hence life) that coincide with dominant values and truths. This notwithstanding, Jane's provisional retrieval of her local/subjugated truths of her life as a basis for resistance may, or may not eventually coalesce into alternate, non-constraining ways of relating to the power of the dominant obesity discourse.

For now, while she stands in the eye of power, Jane selectively and inconsistently accommodates the norms and canons of the dominant discourse and draws from her local force of truth to provisionally resist its internalized gaze. Insisting she is who she is, she attempts to refuse an identity premised on her bodyweight, and to distance self from the mirror that reflects back the image of a spoiled identity, the consequence of acts of

prejudice and stigmatization sanctioned by the dominant discourse and society writ large. In so doing, Jane endeavors to assimilate without getting assimilated and raises her subaltern voice to be heard from the abyss of material deprivation.

CHAPTER 5– Conversational Interview 2

Jenna (pseudonym chosen by participant B for the purposes of this study) is a 19-year old Caucasian woman who identifies self as obese, and is 36 weeks pregnant with her first child. Although she would have preferred to lose some weight before becoming pregnant, she has come to accept and welcomes this pregnancy. Jenna has high school education, is currently unemployed, on social assistance and reports an annual income under Canadian \$10,000. She describes self as single. Both she and her boyfriend who currently works as a farm help, live with her mother.

In her narrative of her experience of obesity as a pregnant woman, Jenna appropriates and positions herself in the following multiple discourses (both dominant and alternative subjugated/ embodied) about pregnancy and health to navigate, negotiate and make sense of her experiences as a self-identified obese pregnant woman.

5.1 Bodyweight As Marker Of Maternal And Fetal Health

Jenna believes weight is a marker of health and she has always valued being healthy. This is evidentiary in her narrative about what comes to mind when she thinks about health:

“I think for me, to be in a good, ...in a good weight range. Because I had been in a good weight range prior. That used to be something that was important to me. I used to be in... like healthy and a good weight and stuff. So I would put that definitely in there” .

She aligns self with the prevailing dominant discursive conflation of weight with health and the meaning of this sense of self is further punctuated when she invokes the dominant binary of “skinny” (slenderness) as normative and “chubby”(fat/obese) as “different”, a state associated with a negative sense of wellbeing as illustrated in the following excerpt:

“I’ve never been really skinny but I’ve been like, I want to say my lowest weight was 150 (*not specified in pounds or kilos, but assumed in pounds*). So still chubby [laughs]. I was never skinny. But I think that a good weight for me that I’d like to be would be 150, around there. That’s when I felt good. ---And I think you definitely notice. Like if you were big your whole life, you wouldn’t notice as much, the feelings. But I have noticed that I do feel different now that I am big as opposed to when I was smaller. Like I feel I don’t have as much energy and I am tired more, and stuff. Like you notice more when you put the weight on”.

5.2 Risk Discourse-Maternal Obesity A Perilous Affair

Her long held beliefs and values about health and weight are at play and equally inform her sense of self and understanding as a pregnant woman who self identifies as obese and is indeed a recurrent theme throughout her narrative. For instance she buys into the caveat that obese women should consider losing weight preconceptually :

“---When I found out, (*that she was pregnant*) I was really worried. Obviously it wasn’t a planned event. So yeah.”.

She subsequently explains:

“ So I was in the process of trying to lose weight so in the future, I could have children and everything would be good. Because I knew it wasn’t, it’s not ideal to be overweight and get pregnant”.

Jenna also believes her weight to be of more paramount concern now that she is pregnant: “It’s now ...It’s definitely more of an issue....Like I was never on the scale all the time to notice. But I didn’t notice until I started getting weighed here (*the clinic*). And I was like,

‘Wow, that’s quite a bit of weight’ Because I think it was I had gained 100 pounds in only about like a little over a year. So that’s pretty substantial!’ .

Additionally, although not overtly put out there, there is an implied understanding in the immediate preceding excerpt that weight, maternal health and fetal health have an intrinsic connection and therefore:

“Definitely, it’s a lot more of a concern than it had been.....before I was pregnant, I was trying to lose weight . And that was the purpose because I knew it wasn’t good to be big and try to have a baby”.

Being “a good weight” will ensure good health and by extension a healthy pregnancy. Her construction of her health (maternal health) as enmeshed with the health of her unborn baby (fetal health) becomes more evident as her narrative unfolds:

“It’s definitely more of a concern when you are pregnant because it’s not just you anymore [laughs]. You have to think about like the baby and stuff”.

Her concern about her weight in relation to her unborn baby transcends the concern she had about her weight in relation to self. Jenna thus positions herself within another dominant discourse – privileging fetal health over maternal health and with it she is further appropriates the dominant risk discourse and discourse of maternal /personal responsibility for self and fetal health. She appropriates and inadvertently upholds the discursive representation of normal, or in her term ‘good’ maternal weight with a normal pregnancy and good outcome in juxtaposition with the representation of maternal weight outside of “a good range” with the potential of risks to the mother and the unborn baby.

This comes across when she says:

“And then you hear all the horror stories of there’s a bigger rate of miscarriages with

bigger women, and like all this, all the different things that go with being a plus size. ... So that scared me [laughs]. That was the biggest thing in the beginning. But...like when you get past a certain point, they say you're in the clear pretty much. So once I got past that, I was a little bit better".

This discourse informs her previously identified understanding for the need for a woman to have a normal weight (good weight range) prior to having babies and hence her initial decision:

"...to wait a few years . So I definitely wasn't planning ...*(to get pregnant)* I had known before, prior to getting pregnant, that there were risks for bigger women" .

Jenna's internalization of the risk discourse is bolstered and reinforced by alternative familial (specifically her mother's) discourse – her mother's history and personal experience of pregnancy reflected in the following excerpt:

"...there can be risks with the baby. Like you can get gestational diabetes and stuff. My mother had that with both of her babies. And I ended up being 14 pounds when I was born because she was bigger and she got gestational. So I had known about the risks because she had went through that. And she had a vaginal birth but they had to like break bones. Like they had to break my arms and stuff to get me out because 14 pounds is a big baby".

Within this narrative, is also the allusion to the dominant conceptualization of obesity begetting obesity/intergenerational (she was born big because her mother was "bigger"). Her mother has always had weight issues and she has "a lot of bigger women in my family" who unlike her mother constitute their subjectivity as big women differently and offer counter discourses that trouble her positioning causing her to resist by dismissing

them as less credible sources:

“.... They kind of just brush it off. They didn’t take it as seriously as I thought. Do you know what I mean? So I didn’t really have any good sources because they were all like,
 “oh, it’s the same. It doesn’t matter how big you are”.

In the same vein her boyfriend, with whom she is “definitely comfortable talking about it” (weight) offers the dissenting discourse of fat acceptance because “he says he likes big girls” [laughs] . Although Jenna laughs as she shares this, her narrative communicates a resistance to such liberating discourse which appears to contradict her beliefs and ideas (appropriated from the dominant discourse) about pregnancy and how it ought to be experienced by an obese woman.

5.3 Maternal Responsibility For Fetal Health

Access to counter liberating discourses notwithstanding, Jenna believes in the conflation of body weight and health and by extension a healthy pregnancy and safe delivery of a healthy baby. She therefore succumbs to the more oppressive discursive readings and dominant hegemonic imperative that position obese pregnant women as ‘unhealthy’ and a risk to their unborn babies and thus locates in them the responsibility for heeding and avoiding the potential risks and negative consequences associated with maternal obesity. For Jenna that sense of responsibility starts with buying into the risk discourse and cultivating awareness that her body weight merits a heightened concern and attention now that she is pregnant:

“It’s always been an issue, just being bigger in general” but then with pregnancy it:

“Definitely it’s a lot more of a concern than it had been” because she has to “think about

the baby and stuff”, and she does not “want people to feel that I don’t care about the baby. Do you know what I mean?” .

Further into her narrative that sense of maternal responsibility comes across more clearly:

“Because I’m not caring about my health and stuff. Because I feel like I was kind of already in that boat before I got pregnant. You know what I mean? Like I was already bigger. And I almost feel irresponsible. Do you know what I mean?”

Self-indictment, the perception and sense of self as blameworthy for being “bigger” is further pronounced in her mea culpa: “And then I feel guilty” because she is aware it is not “recommend(ed)” you be obese or overweight and pregnant . She also inadvertently upholds and reifies the dominant discourse that attributes obesity to overconsumption and sedentary lifestyle by assuming responsibility for her lifestyle choices:

“ I know that I’ve got to the weight I am because I don’t, I’m not very active . I do tend to eat not very good either” and while she does not have gestational diabetes, her “baby is in the 80th percentile. So he is bigger.... And I feel like it probably is about my weight. Do you know what I mean?”

She alludes to the normative notion of a good and responsible mother as one who ensures the health of her unborn baby by managing her weight and lifestyle to avoid/ minimize risks to the unborn baby. Jenna therefore appropriates (and in so doing legitimizes) authoritative biomedical knowledges/discourse on maternal obesity to constitute her subjectivity, and engages in biomedical practices of corporeal self-care and self-discipline to negotiate and self-manage her experiences of pregnancy as an obese woman. In consonance with her normative positioning and concern about her weight, Jenna’s initial action upon finding out that she was pregnant was to take it upon herself to

proactively seek out medical/health information:

“ I like to research and stuff and learn about (it). So that’s the first thing that I did, was to look that up.”

She identifies the media, specifically the Internet which has “a ton of stuff” as her primary source of health information. She prides herself in taking personal responsibility for accessing information with which to manage her life:

“.....I do that with everything. Like when I buy anything new, oh I’ve got to look it up on the internet and see what it says” and this is primarily how she has come to know what she does - that obese women risk experiencing unhealthy pregnancies – and, as her narratives later show, how such knowledge fits and informs her particular pregnancy experiences and practices:

“Because I have done research and I know that they don’t recommend you be obese or overweight and be pregnant.I’ve read a lot of things....and the ways it can be harmful”.

Jenna thus positions herself as the responsible consumer of health information who stands within the mainstream discourse that upholds preconceptual self-care and awareness as responsabilizing and proactive good mothering who made an informed decision (based on her biomedically sourced knowledge of risks) to defer having children until she had lost some weight to ensure a healthy and safe pregnancy. She never intended to be irresponsible by getting pregnant while embodying her current weight and it matters to her, and she worries that is the way she is judged but ironically feels exactly that way as this previously referred excerpt implies:

“...I don’t want people to feel that I don’t care about the baby , about my health and

stuff. Because I feel like I was kind of already in that boat (was big) before I got pregnant.....I almost feel irresponsible.”

She also inadvertently takes up the discourse of good citizenship and enlightens her less informed, equally ‘big’ friends who are contemplating pregnancy about the risks she has read about, and cautions them not to get pregnant while they embody ‘unhealthy’ weights:

“....And I tell them, like I said ideally I wouldn’t be trying to get pregnant when I am this big because a few of them want to have babies. And I do say, I say ideally, it’s not ideal to be big. And I tell them there is things”.

She therefore tries to impress upon them the need to heed these warnings, encourages them to lose weight prior to conception and asserts that: “if I could go back and be a healthy weight, I’d rather do it that way obviously....I feel like I had a lot of worry because of that when I got pregnant. So I don’t want them to get into it and then find out later when they’re already into it that it’s not an ideal situation. You know what I mean?”

Such an assertion conjures up Jenna’s reading and constitution of self as less than ‘ideal’, and an understanding of her pregnancy experience as an imperiled condition courtesy of a not so ‘ideal’/ pathological (unhealthy) bodyweight (in fact not surprisingly the use of the word ‘ideal’, synonymous with perfection is recurrent throughout her narrative). The internalization of deviance, her location of self outside or on the periphery of the normative realm is thus evident.

Similarly, Jenna accepts and assumes the status of non-expert and seeks expert endorsement of the biomedical knowledges she has already acquired from the media and her own mother’s experiential narrative. Branding the internet as “confusing” and hence

less trustworthy, she privileges the authoritative and expert voice of health professionals, (with specific reference to doctors) who she trusts more and from whom she expects not only acknowledgement and validation of her weight-related concerns in relation to her pregnancy, but also guidance and counseling as to how to conduct her pregnant body in alignment with mainstream/normative prenatal imperatives. She is however surprised at what she experiences in healthcare because she “didn’t hear anything from the *actual* doctors that I went to see” The emphasis in italics is to underscore the allusion to the socially sanctioned bona fide status of information from medical experts or the notion of ‘doctor knows best’ and the nuances of underpinning power dynamics that privilege biomedicine’s ability to set the normative standard about health during pregnancy and how it ought to be conducted or experienced. This becomes palpably evident several narrative syntaxes/lines later. She had “read a lot” about weight and pregnancy health yet the only reference they made to her weight was:

“...it would be ideal if I could remain the same weight or just gain a little bit of weight and not gain, like definitely not gain as much as..... It was more or less what they said was not to gain a bunch of weight. They didn’t go into the details of anything that I had read.” She makes it clear she would “feel better knowing the information... if they would have said some of the things that I had heard, like there is risks and you need to be careful. Because I knew that and some people might not” (a clear reference to her uninformed ‘bigger friends’ and big women in general); “if they tell you the issue, like the concerns with being big. If they let you know the information”; and while she “feel(s) like it’s something that they almost dance around” because “they don’t want to offend bigger people, not saying anything can be detrimental too”. In response to the question

of whether she ever directly communicates this concern to health professionals she assumes a reflective demeanour and emphatically asserts:

“I do. I do bring it up because I feel like it’s definitely something that should be addressed. So I say, like recently I gained, I think I gained a few pounds. And I said, now, is there anything that I should be doing about that? Should I be exercising more? Should I be like changing the diet up more?I do ask because it is important to know.”

The foregoing is indicative of the invisible, albeit productive effects of panopticism, wherein no overt sanctions are required to drive and entrench Jenna’s faith in and commitment to beliefs, values and practices that uphold normative injunctions about how an obese woman ought to experience her body and pregnancy. The Panoptic effect thus enables the “automatic functioning of power” (Foucault, 1979, p.201) which facilitates the internalization and folding back unto self, the invisible disciplinary gaze of social and cultural forces that is everywhere and yet nowhere, in everyone and yet in no one causing Jenna to wonder in frustration – to use Bartky’s (1990) words – ‘where and who the disciplinarians are’ (p.74). Her indignation at health care professionals’ failure or inability to acknowledge and address the subject of her weight and provide guidance for her related practices creates tension in her subjectivity. Looking at this further through the lens of power, it transcends a mere challenge of the dominant discourse that undergirds her molding of self/subjectivity. It represents a moment of reflective awareness wherein she reclaims her agentic voice to interrogate both her habits of thought and her uncritical acceptance of the dominant discourse. Faced with unanswered questions about her perceived weight increase and whether or not she should be upping the ante on her prenatal diet practices, Jenna is objecting to disciplinary power not living

up to/or standing up for its own imperatives or proclamations and is troubled by the fact that she has to continue to look elsewhere (the internet) and remain in perpetual uncertainty given that such sources are in her estimation less credible and authoritative. This silence, not addressing the issue, robs her of the opportunity to not only present, or better yet give voice to her local narrative (her particular life context in relation to her weight) but also insidiously robs her of the opportunity to authentically collaborate in her care in a manner that is meaningful to her. On the one hand this implies privileging, appropriation and complicity with the normative/dominant discourse, but on the other hand her uncertainty is actually the subtle makings of skepticism about the discourse upon which she has constituted her pregnant subjectivity which almost, momentarily at least, takes on a fragile quality in danger of crumbling as evident in the ensuing excerpt:

“ Like I feel like if the doctors were more straightforward and stuff. Because then you almost think it’s ok when they don’t say anything. Do you know what I mean? You almost, it’s almost like, oh well, if they’re not addressing it and it’s not a big deal to them, maybe I shouldn’t be worried either. Do you know what I mean?”

Jenna, it appears, is simultaneously positioned within and subverting the dominant discourse, thus destabilizing a hitherto seemingly stable boundary between her docile subjectivity and agentic self. In effect she assumes the status of a compliant subject in juxtaposition to one attempting to disassociate from the very power dynamics and processes that constitute it. This is central to the Foucauldian notion that resistance does not necessarily reside in or lead to self discovery but a refusal of what we are (Danaher, Schirato & Webb, 2000), although I would argue that it is a refusal of who we have been made to think we are – in this case a refusal of who she has been made to think she is

This becomes a recurrent and central issue of tension in the breadth of her narrative as she repeatedly takes on and interrogates the dominant discourse about obesity and related risks in pregnancy, at times reflectively and at others accusatorily. For instance she attributes her transgression and slippage in diet practices to the seemingly laissez-faire attitude of health care professionals and in so doing deflects personal/maternal responsibility:

“And that’s the thing because that’s, I have trouble with it because I’m definitely worried and am concerned. But I feel like if they would have been more straightforward the times when I did, you know, have a bad day where I ate junk food and stuff... Do you know what I mean?.....Like if I felt like if I had more information from them, I would have done a little better with the healthy eating during the pregnancy.”

She also wonders why she was not counseled about her diet or physical activity even after measurements indicate she is carrying a “bigger” baby in the wake of blood work that ruled out gestational diabetes:

“And that’s the thing because even now I don’t have gestational but the baby is in the 80th percentile (appropriation of biomedical knowledge as self-authored). So he is bigger. But even then, they don’t say, you know, like maybe you could cut back a little more, exercise a little more. They don’t. You know, it’s never about my weight. All they have said was because my mother had a big baby that I should assume (read as she should assume she will too). And I feel like it probably is about my weight.”

“.....they mentioned if the baby got too big that there might be a C-section thing. But they’ve never mentioned anything other than gestational. They were worried about gestational. But as soon as the blood work was done, they never mentioned anything

about anything else. That was the only thing that they mentioned about my weight.”

Clearly evidentiary of a conflicted subject – they are making it about her mother, but this is about her, it is about her weight or is it (after all there seems to be no concern about her diet or exercise practices)? Yes she is obese, but she does not embody the ‘normal’ conditions associated with it. Jenna’s personal/subjugated experiences are in dissonance with those professed/intended by the dominant discourse within which she is (albeit precariously) positioned. Thus conflicted by the contradictory ways in which she perceives, understands and engages with her pregnant body, the truths of the normative discourse cease to be absolute and incontrovertible, and so she problematizes her self-regulating practices undertaken in the name of maternal and fetal health and declares: “...I really don’t know if there’s anything that I could be doing.” She is both frustrated and bewildered, and considers it unthinkable that her concerns about her weight are not overtly acknowledged or addressed. It is arguably her inability to explain or make sense of this experience in relation to her positioning within the master obesity narrative that leads to a disruptive uncertainty and hence a fragmented/split subjectivity. These periods of uncertainty are also ‘aha’ moments in which she appears to start to critically contemplate longstanding taken-for-granted assumptions (habits of thought) about her sense of self. While it may not be an outright rejection of the dominant discourse, as an act of thought, problematization of her currently held beliefs/values and self-regulating practices has potential to pave the way to transcend constraints associated with them. To this effect Foucault’s exploration and articulation of ‘thought’ as a desideratum in the constitution of subjectivity/one’s sense of self has import here. Foucault (as cited in O’Leary, 2010, p.176) posits thought as:

“that which institutes, in diverse possible forms, the game of truth and falsehood and which, consequently, constitutes the human being as a subject of knowledge; that which founds the acceptance or refusal of the rule and constitutes the human being as a social and juridical subject; that which institutes the relation to self and others, and constitutes the human being as ethical subject”.

Accordingly, as ‘a tool for ethical behaviour’, thought is what gives one pause, enables one to retreat, even if momentarily, from one’s conduct/practices to contemplate how they came to be and what consequences they yield; “thought is freedom in relation to what one does” because it enables problematization of one’s conduct (Danaher, Schirato & Webb, 2000, p.44). It can be argued then, that Jenna’s ability to confront and put the dominant discourse under critical and reflexive scrutiny and interrogation is an exercise of agency no matter how ephemeral. In concurrence with Foucault, Weedon (1997) contends that the ability to contemplate or question one’s subject position opens space for agency.

5.4 Normalizing Practices

As a productive effect of her positioning within the dominant obesity discourse, Jenna turns to self-regulating practices to control and normalize what she understands to be her deviant/abnormal pregnant body in an effort to negotiate her pregnancy experiences and to manage self in ways that are socially acceptable (as in exuding the image of the responsabilized mother-to-be) and personally satisfying and rewarding (as in attaining the ‘ideal’ ‘healthy’, pregnant body). She endeavours to normalize her experience of

pregnancy and to self-manage and control her weight by taking up normative practices of dieting, healthy eating and to a lesser degree physical activity intended to improve her health and by extension to protect her unborn baby from obesity-related risks.

Nonetheless Jenna's engagement with, to use the Foucauldian term, technologies of self antecedes her gestational and immediate preconceptual subjectivities as her narrative suggests:

“ Well mostly like when I was younger, I didn't really know the nutrition stuff but I would count calories and different things like that, and try to lose weight. And my mother has always had like weight issues, so she's always been like dieting. That's always been a big thing that I grew up around. But I have always stayed chubby pretty much (laughs). And different things I've tried. I tried the food guide, but then I started gaining weight when I tried to do the Canada Food Guide.”

Given her long standing pursuit of an ideal body, Jenna appears to simultaneously position self within separate, but morally and ideologically intersecting discourse of obesity and the pervasive Western cultural discourse of femininity and hence while concern for her health and unborn baby's wellbeing are paramount, a quest for an aesthetic body also underpins her self care ethics and investment in controlling her diet. Her narrative suggests a longstanding access to, and appropriation of the discursive frame that constitutes slenderness as an aesthetic feminine ideal. Pregnant women preexist in a society that upholds and privileges slenderness as a marker for both health and feminine aesthetics and therefore assimilation and appropriation of such social and cultural values and related practices have the potential to intensify during pregnancy. The pressure to conform to the Western slender ideal has always been greater for women who, growing

up come to associate slenderness with corporeal perfection and social rewards/approval and the converse, overweight/obese bodies with social deprecation and hence strive to achieve and maintain the former through dieting from early on in life, no matter how elusive (Bordo, 2003; Hesse-Biber, 2007; Leavy, Gnonng & Sardi-Ross, 2009). In Jenna's case corporeal dissatisfaction and hence the pursuit of the ideal body extends into pregnancy, negating the notion that pregnancy legitimates body weight and confers protection from societal pressures.

Jenna's pervasive preoccupation with dieting, aversion for her 'big' body, as well as her appropriation and subtle subversion of official recommendations in the Canada Food Guide (a nutrition norm subscribed to prior to pregnancy) – comes across in the following narrative in which she questions the utility of the official national guide for healthy eating:

“So then I got scared when I was dieting, I had been on like a 1200 calorie diet. So then when you go to actual, to like the food guide, you put on a little weight because you are eating more calories and stuff.”

She also alludes to engaging in ongoing dieting practices in her narrative about her social relations with her “bigger” friends: “And we still like diet together, and try like different little things”. Her dieting practices are about as much a quest for normal, risk-free pregnancy as it is about her desire for an ideal feminine body.

Relatedly, in response to an inquiry about what her opinion is on the prevailing tendency for the public and society at large to attribute maternal obesity to unhealthy eating habits and physical inactivity, Jenna concurs and assumes and locates responsibility for her body weight in her lifestyle choices and in so doing perpetuates the construction of obese

pregnant women as responsible by dint of their indolence and poor food choices:

“I definitely...I know that I’ve got to the weight I am because I’m not very active. I do tend to eat not very good either. What I have done in pregnancy wasn’t ideal. So I do. I do think that is fair in most cases. And not all, because I do exercise. Like I have always exercised. But it’s eating the junk food and stuff where I definitely fall short. “

Through her self-regulatory practices, she inadvertently reifies and upholds the discursive representation of obesity as an entirely preventable condition of overconsumption and physical inactivity and an issue of individual/ personal responsibility for lifestyle choices. Jenna also alludes to an understanding of self as deficient (“fall short”) by dint of eating ‘junk food’. In her narrative she admits to lapses/transgressions (“slip ups”), moments of indulging in something sweet, like a “a granola bar” or “cookie” and confesses to feeling culpable for giving into embodied cravings, for transgressing the normative imperative to eat healthy foods:

“Definitely...I feel sometimes, because I do feel guilty when I slip up. And obviously that’s going to happen if you’re...if you’ve been big and eating a certain way, you are going to slip up. But I do feel guilty now because now it’s not just me.”

Her accommodation of the discursive reading of obese individuals as lacking will power is apparent. Equally evident is the pressure to eat healthily in the interest of her unborn baby and the challenge involved in negotiating between the dominant imperatives and subjugated desires:

“Well now that I’m pregnant, it’s different. You know what I mean? Before I was pregnant, it was whatever I wanted at the time...But it’s definitely different now that I’m pregnant.”

“...like every time I eat, I’m like is this good for the baby.”

Jenna therefore privileges fetal subjectivity and endeavours to consciously seek out and incorporate into her diet healthy foods:

“...Cereal for breakfast usually. The oatmeal is what I like....And then dinner I do like a meat and vegetables, and then like some sort of bread or like potato... And then the same for supper....for snacks I do fruits and vegetables but it depends because sometimes I’m just like I want something a little bit sweet. And then .. I usually have a granola bar. I like those. (laughs) yeah..”

Having thus internalized ubiquitous biomedical desiderata, Jenna accepts and assumes maternal responsibility for the health of her unborn baby by endeavouring to consider the potential harm/benefit the food she eats will confer to her unborn baby before consuming it. She also tries to maintain a healthy diet and physical activity [walking] purported to confer desirable weight control and by extension maternal and fetal health, as well as safe passage at delivery. Nonetheless, she “slips” from her positioning within the normative discourse towards her more subjugated experiences and in the process, resists inter alia discourses of maternal moral responsibility and self-control, and the privileging of fetal subjectivity over her subjugated needs and experiences (i.e. cravings). Hence she does not submit to or accommodate dominant voices in toto, but responds to her own subjugated/embodied experiences at the risk of moral opprobrium inherent in hegemonic and stigmatizing obesity discourses which she paradoxically self-inflicts (guilt feelings devoid of external censure). This notwithstanding, Jenna negotiates her multiple but complex maternal and feminine subjectivities within the dominant discourse to balance and accommodate both her needs (feminine desire for a normal body weight she can feel

good about, but also the need to reserve the right to occasionally indulge herself - eat what she desires/craves) and those of her unborn baby thus circumventing conflict between maternal subjectivity and fetal subjectivity. She does this by taking up practices to control and normalize her self-identified abject, deviant pregnant body (negotiating to incorporate more healthy versus junk foods in her diet), to negotiate her prenatal experiences and manage self in ways that are both socially acceptable and personally satisfying.

5.5 Counter But Related Discourses

In relation to her eating habits, Jenna cites her “emotions” as a “definitely big” obstacle to her ability to engage in healthy eating, and adds that emotional eating is her coping mechanism:

“I just think that is always how, how I was brought up to deal with emotions. Because my mother, that’s how she dealt with her emotions. So I think that was just what I was raised to know. And whenever we have like big like family gatherings, it’s the food...Do you know what I mean. Like it is an emotional thing definitely.”

She says she has been more “emotional” during her pregnancy due to “worry” she eats when she “feel(s) down” or “upset” and as her pregnancy draws to a close she is “like oh well...I’m getting emotional, ‘oh a cookie would be good’” She admits “it’s hard” but fortunately she lives with her mother who “keeps me in check because she was in the same position. So it is easier when you have somebody to keep you accountable”. It is a complex constitution of self that culminates in her understanding of self as “a very sensitive, like emotionally sensitive person.”

Thus in this narrative Jenna simultaneously resists and positions herself in the multiple, albeit overlapping discourses of genetic determinism and intergenerational obesity, and biological essentialism. Her narrative about a family history of 'big women' and emotional eating allude to a familial predisposition to obesity. Jenna thus appropriates the logic of obesity gene discourse to deflect and shirk (individual) maternal moral blame/responsibility and failing. She has dieted most of her life, but as she euphemistically puts it, she has always remained "chubby pretty much." Hence given her familial history, she has no control and cannot be held morally accountable. Yet au contraire, as other scholars have noted, the gene hypothesis does not confer absolution from moral culpability in toto as it remains "the failure to do something about their weight which becomes the site of moral closure" (Throsby, 2007, p.1565). Nonetheless and paradoxically, like a double-edged sword, while such positioning may function to mitigate culpability, she inadvertently positions self in, and reifies the discourse of biological essentialism that McPhail (2008) observes psycho-pathologizes obese women by attributing their deviant bodies to over eating and 'over-emotionalism'. Similarly she inadvertently appropriates and legitimizes the biomedical discourse that associates pregnant bodies with "raging hormones" and proclaims the supposed unstable emotional conditions of pregnant women (Ussher, 2006, p.89), which serves to marginalize and locate in them an inability to function "objectively and dispassionately" in the public sphere (Longhurst, 1999, p.79) underlining the gendered ideological and moral agendas that serve the interests of particular political economies. Such positioning also gives legitimacy to the discourse about intergenerational obesity that conveniently implicates obese pregnant women in the obesity epidemic, sourcing the womb as the origin of

obesity with moralistic choruses such as “blame your mother if you’re overweight” (Warin, Zivkovic, Moore & Davies, 2012, p.367) and fuelling stigmatization against obese pregnant women. Similarly, while taking up a gene discursive positioning may mitigate the simplistic presumption that obesity is controllable largely by individual disciplinary enterprise/initiative, it nonetheless also dilutes the role of structural forces in the obesity debacle and subverts politicization of obesity (Aphramor, 2005).

Jenna’s understanding of self as abnormal is also embedded in her comparison of self, and her experiences to those of mainstream pregnant women who weigh less. She alludes to pregnant women in general giving some thought to what they eat but observes that pregnant women who embody ‘healthy weight(s)’ do not have to be as hard on themselves in terms of their diet practices, suggesting they are comparatively not under as much, if any, duress to self-regulate or self-monitor their pregnant bodies as she avers in the following excerpt from her narrative:

“I think they definitely don’t have to worry as much. Because like every time I eat, I’m like is this good for the baby?.....And not that they wouldn’t. They obviously do too. But I mean they can be a little bit more lenient with what they are doing during their pregnancy because..... if they are at a healthy weight, I don’t think it’s as much of an issue to them because they’re..... like they can be a little bit more lenient with the diet and stuff” (p.18).

She gives an example of her equally pregnant friend who “eats whatever she wants. And it’s not as much of a concern because she’s at a healthy weight, and she has her....she has everything under control in that department.”

Such understanding of self and experience emanates from her taking up hegemonic and

normalizing truths about body weight that employ a logic of binaries to assign bodies as either abnormal and therefore unhealthy, or normal and hence healthy. Jenna also appropriates the discursive neoliberal construction of obese pregnant women as lacking restraint in contrast with their slender counterparts who are considered to be in control and credited with will power. Appropriating the dominant discourse that constructs maternal obesity as, *inter alia*, a consequence of uncontrolled maternal appetites Jenna admits to “definitely fall (ing) short” when it comes to “eating junk food”. She also understands and interprets her experience of her body as out of control, and experience of self as ‘other’ (different). Foucault submits that knowledge of normality arises from knowledge of abnormality. Hence the category of abnormal serves as a template from which the normal is delineated. He also posits that the categorization of normality *vis à vis* abnormality is an identity-forming strategy that also serves to confer status and social privileges to deserving ‘normal’ citizens and conversely withhold it from undeserving ‘deviant’ citizens, thus ensuring the pursuit of self-regulating practices purported to transform deviant bodies and to achieve the status of normal, and thus underpins power relations in society (Danaher, Schirato & Webb, 2001). Having internalized the label of abnormality, Jenna monitors and manages self in alignment with normative standards, and in so doing serves the goals of the very discourse that both constitutes her and seeks to exclude and locate her outside the norm. Nonetheless, she again takes a reflective pause and engages in self-introspection, in an attempt to make sense of her experiences and understanding of self:

“.....I think it’s just different because I think I’m just definitely more paranoid about every little thing because I am big, that I put that into everything about my pregnancy.

...I feel like everybody is worried when they're pregnant. But I think there's more worry and stress to somebody who's bigger because they've worried themselves about it. Do you know what I mean?"

She attempts to counter her positioning within the dominant discourse/narrative by dismissing her concerns over her weight as irrational and histrionic, and chiding herself for allowing her perception of self as 'big' to pervade her experience of pregnancy and by so doing becomes a subject who calls itself and its situation into question. This form of resistance evinces the Foucauldian strategy of reflexively reappraising the taken-for-granted by problematizing or interrogating it, which in turn opens up possibility for self-redefinition.

5.6 Maternal Obesity - Living In The Public Eye

Positioning self as she does, as abject in comparison to other pregnant women deemed normal by mainstream obesity canons causes Jenna to experience feelings of "embarrassment", of being different, caught in the paradox of being simultaneously positioned within the dominant discourse and yet located/standing on the outside of the mainstream circle. Against a backdrop of a mute, invisible but nonetheless potentially productive clinical gaze (in the context of not being acknowledged by health professionals), Jenna is aware and feels her body's hyper-visibility and its associated stigmatizing effects. This is evidentiary in her narrative response to an invitation to share her experiences in healthcare.

Although "everybody's been nice" she feels "embarrassed because (I feel) it's (obese body) definitely not a good thing. It's just, well people obviously notice. You know, like

it's not something that you just have that like other things that people may have. Like smoking, like you don't notice that on their body when you look at them." She adds this leads to her "worrying about myself, thinking that people are thinking things" and while she has not experienced any rudeness about her body weight, "I know myself that it's not good so I feel like I feel embarrassed and I feel like people are thinking things. Do you know what I mean?"

Jenna is thus aware and alludes to mainstream society's tendency to make presumptions about the health of obese individuals based on their physical appearance. She, to some degree resists the mainstream narrative when using a smoker as an example, she alludes that one's appearance is not necessarily a marker of one's health behaviour. Nonetheless given the ascendancy of the mainstream obesity discourse in her positioning, and consistent with the state of felt stigma, she internalizes feelings of humiliation. This observation is supported in the literature. Saguy and Riley (2005) note that unlike smoking and drinking, the hypervisibility of obesity renders it more open to public scrutiny and moralizing. Additionally the stigma of obesity is grounded in the high currency attached to physical appearance in the Western hemisphere (Warin et. al 2012) and creates "a culture of negative collective 'knowingness'" about obese individuals (Murray, 2005, p.154). For women especially the mere vision of self as overweight educes feelings of shame and guilt (Lupton, 1999). Pregnant women are constantly monitored as 'vessels' for the propagation of human progeny and are hence, especially for those who are obese, subject to both private and public voyeurism and moralistic appraisal (Morgan, 1998). They are also doubly damned for being doubly deviant, by dint of their bodyweight which contravenes conventional /normative feminine beauty and

health imperatives – Lupton, 1999. The discursive conflation of body weight with health implies the latter can be easily discerned by the naked eye. Furthermore given the prevailing tendency to denounce obese individuals as among others, irresponsible, amoral and lazy, the obese body thus becomes evidentiary of the individual's moral integrity and character. In a sense the body becomes a marker of identity (Chrysanthou, 2002; Gronning, Scambler & Tjora, 2012) and self-identity merely a mirrored reflection of who mainstream society at any point in time presumes one to be (Goffman, 1963). The hypervisibility of the obese pregnant body nets prompt disrepute and leads to what Goffman (1963) coined a 'spoiled identity', and provides a carte blanche for social control and exclusion of bodies considered 'out of bounds' (Warin, Turner, Moore & Davies, 2008). Negative attributes have a stigmatizing effect as they position obese individuals as different – in a bad way – from those otherwise constituted contrariwise, and leads to feelings of shame and self-blame [Scambler, 1998; 2009]. At an ontological level, stigma signals the state of imperfection and elicits shame while deviance, associated with stigma, signals moral deficiency and elicits moral culpability. Of three types of stigma – enacted (as in overt acts of discrimination against those considered inferior or unacceptable); felt (assimilation of shame and fear of potential discrimination); projected (efforts to avoid or fight enacted stigma) – felt stigma which encapsulates Jenna's particular experience is by far more damaging (Scambler, 2009). Overall stigma has significant adverse ramifications on the psychosocial health of its victims (Puhl & Brownell, 2004; Sorbal, 2004). Paradoxically psychosocial wellbeing is a critical component of women's health during pregnancy (Fomeen & Martin, 2008). Jenna's experience of constant worry, feelings of inadequacy, otherness, shame and guilt

is also testament to Foucault's assertion that the lucidity/rationale of a power that enables a constituted subject to sit in judgment and cast in condemnation its own thoughts, actions and desires based on historically generated/produced normalising truths, is to make the soul, not the body agonize (Foucault, 1979). Similarly, with a bow to Foucault, Weedon (1997, p.105) posits that discourses go beyond meaning-making, they colonize "the unconscious and conscious mind and emotional life of the subjects they seek to govern". This inherent feature of the dominant discourse of obesity is of necessity what needs politicizing and subverting. It can therefore be suggested that central to resistance is the ability to disallow colonization of the human psychic.

Additionally, in line with her biomedically-sourced belief that health implies "taking care of yourself just in general, like exercising", Jenna accommodates "a half hour walk every day or other day or so" and admits she is "definitely not somebody at the gym, like hard exercise" but she likes "little things like walking" and thus appropriates the discourse that promotes and advocates physical activity (albeit to a lesser degree compared to her engagement in diet practices) as a vital component of weight management in the interest of maternal and fetal health yet cautions against strenuous exercise during pregnancy. Nonetheless her accommodation of this TOS is telling in the sense that she contradicts herself. Early on in her narrative she alludes to exercise not being a routine pre-pregnancy but later contradicts this within the same narrative thread when she shares her thoughts about mainstream presumptions of obese pregnant women as inactive and consumers of unhealthy foods:

"I know I have gotten to the weight I am because...I'm not very active. I do exercise. Like I have always exercised", and much later in response to a question that asked

directly if she engaged in exercise prior to or during pregnancy, she asserts: “I was exercising before” and qualifies it as “walking” not “go to the gym and stuff like that.....I’m definitely not somebody at the gym, like hard exercise”.

On the surface, it is difficult to reconcile these contradictory ways of self-understanding in relation to a fitness practice to which she subjects herself in the name of maternal/fetal health. However her subsequent narrative about her subjugated experiences of physical activity within the context of her particular social/environmental reality illuminates these contradictions in telling ways. Jenna alludes to a lack of (threats to) safety and exposure to verbal harassment when she goes walking in the neighbourhood, and is forced to negotiate her accommodation of physical activity by devoting time and effort to driving with her mother, to a trail for walks:

“We go to a trail because just we have neighbours that are....that will yell and stuff and just...I don’t really feel safe in the neighbourhood”.

Taken together, her enduring feelings of embarrassment, guilt, worry about the image her ‘big’ abject body reflects, her contradictory ways of self-understanding in this respect belie a dread of subjecting her body to public scrutiny and she endeavours to negotiate and control that as well as ensure self-preservation by avoiding public spaces (neighbourhood streets, gyms which also entail costs) where, at any rate, she experiences denial of space (given she is presumed to have over-appropriated space) and exclusion. By virtue of such constraints, engagement in physical activity purported to bestow health is not autonomous or pleasurable given that it is sourced to social control and undertaken to discipline the deviant pregnant body in accordance with hegemonic discursive frames that in typical neoliberal fashion calculatngly preclude the role systemic and

environmental factors play in determining health. It can therefore be argued that for all its claims, the dominant obesity discourse negates the very flagship that supposedly underpins its enterprise – health.

5.7 Mobilizing Social Determinants Discourse

Jenna recognizes and draws on the counter-discourse of social factors that constrain her efforts to practice and maintain healthy eating. Despite her effort to be vigilant about her food choices and to include as best as she can all the food groups in her daily diet, Jenna acknowledges that her food choices are largely determined by her budget which simply cannot consistently support the practice of healthy eating. Hence she purchases “what’s cheap” and thinks the cost of “good (read healthy) food” is prohibitive:

“ Well, I think sometimes the good food is too expensive. Like strawberries this summer was like \$5 a box. Like I can’t pay that much. I don’t have that right now (laughs). “

She however strategizes and negotiates around this reality by opting to buy substitute foods that are “good” but within her means and by “stock(ing) up” on foods that go on sale, and still at other times it is what it is when she cannot afford it:

“But I try to get the cheaper things that are good for you too, like beans. I do beans and stuff like that. And like when meat is on sale, we stock up on different things...When I’m doing well, I buy food like the fruits and vegetables that I probably couldn’t afford at other times. And then sometimes I just can’t afford it”.

While availability of food is occasionally a problem, it was a lot worse prior to her pregnancy as finances were tight then, and her partner was not fully employed. Her pregnancy somehow confers relief from the experience of food insecurity:

“ But definitely before I was pregnant, it (food availability) was more of an issue. Now that I’m pregnant, you know, people are more ... (laughs) more helpful (laughs).

.....They’re more concerned. Because my mother definitely worries because she had same issues, that she wants to make sure that I’m taking care of myself and stuff”.

Thus in a counter narrative, Jenna presents her experiences of structurally-imposed deprivation as inconveniences impeding access to healthy foods but does not implicate them in her understanding of self as an obese pregnant woman, nor does she appropriate this alternative discourse to destabilize, rewrite and thus resignify her embodiment within the master obesity discourse. From a Foucauldian/poststructuralist standpoint the social determinants narrative is eclipsed by her strong positioning within the dominant narrative in which she accepts personal responsibility for both her health and that of her unborn baby’s and thus sees and understands self as both the problem and solution where her weight, her health and the health of her unborn baby are concerned. The biomedical/lifestyle discourse which embraces and is embraced by Jenna, gains ‘ascendency’ over the less powerful social determinants discourse and neutralizes the latter’s ability to bear out alternate positions, thereby constraining a politics of resistance. Jenna’s internalization of maternal responsibility for healthy diet serves the biomedical and lifestyle rhetoric of individualism which conveniently precludes the role of structural determinants in her particular social context. On a broader level, the moral assignation of maternal culpability and expectation of maternal capability by the dominant obesity discourse precludes consideration that maternal health behaviour and practices indelibly intersect with the wider cultural and sociopolitical terrain and may be more a function of socioeconomic standing and social privileging than a function of moral character. Despite

access to biomedical knowledges that exhort diet and physical activity as the overriding gateway to a 'normal', 'healthy' body and pregnancy, Jenna is nonetheless incapacitated, and her engagement in TOS rendered ineffective in the face of the realities of her socioeconomic and environmental context, which she is incapable of transcending individually. This underscores the irony of the illusion of control conferred by knowledge vis à vis powerlessness by virtue of material incapacity created by social forces, and effectively negates the lifestyle discourse premised on a presumption of ignorance about what constitutes healthy foods.

5.8 Summary-Conversational Interview 2

Summarily, from a feminist poststructural perspective Jenna participates in her own surveillance by taking up the master discourse of maternal obesity that conflates maternal health with body weight and constitutes obese pregnant women as among others abnormal, a risk to themselves and their fetuses and a liability to society by virtue of the role they are presumed to play in the obesity epidemic. As a consequence of feeling obese and having accessed and internalized biomedical imperatives that categorize healthy/unhealthy, normal/abnormal maternal bodies, (making them synonymous with maternal moral worth) and neoliberal notions of individualism that locate responsibility for lifestyle choices in self, she endeavours to normalize her experience of pregnancy and self by privileging and undertaking normalizing practices of diet and physical activity (the latter to a lesser extent) to control and manage her weight, and thus reifies the social control and biomedical objectification of maternal bodies. Therefore while Jenna's practices are undertaken in the name of maternal and fetal health, they are also intended

to curb maternal appetite and discipline a body subject to the feminine ‘tyranny of slenderness’ (Chermin, 1981). It is engagement in these practices of self-surveillance that foregrounds the production and regulation of her understanding of self and embodied experiences of pregnancy as an obese woman. These self-policing practices also serve to subject her to “a state of conscious and permanent visibility that assures the automatic functioning of power” akin to the power relations inherent in the Panopticon (Foucault, 1979, p.201). As a self-identified obese pregnant woman, Jenna experiences self as living in anxiety and worry, living in shame and guilt, more aptly and collectively described by Bartky (1990, p.7) as “the internalization of pervasive intimations of inferiority”, and living in the eye of public censure. She speaks from contradictory subject positions but overall positions self in the master obesity discourse and becomes subject to its normalizing truths and power. She serves the goals of power by taking up the normalizing practices of the dominant discourse to govern her reading of self and to self-manage her pregnant body in the hope of transforming it into a ‘normal’, healthy and socially-acceptable body. A quest for the ‘normal’ and ‘healthy’ becomes a quest for a body she desires, and can ‘feel good about’, a quest for acceptance and recognition within mainstream society and which necessitate her use of techniques made available to her by the prevailing obesity truths she aligns with. As a form of biopower, disciplinary power thrives on the subject’s own desires for transformation of the body which it promises (Foucault, 1979) but sadly hardly delivers. Jenna is therefore both a product of the dominant obesity discourse and complicit in the production of her own identity as an obese pregnant woman. Thus at the epicentre of “taking care of the self, applying techniques of the self, is the relation between freedom and power” (Danaher,

Schirato & Webb, 2000, p.163).

While power as a relation is evident when one submits to the myriad ways external others seek to delimit available options, the individual is never totally at the mercy of power and is able to respond in any one of several ways to refuse “the type of individuality that has been imposed on” them (Foucault, 1982, p.190). In other words the individual is capable of resistance, the exercise of which constitutes an agentic subject capable of controlling the way power affects her. It is therefore the constraining effect the dominant discourse has over the pregnant obese woman that needs to be interrogated/politicized. Thus while resistance does not do away with the power relation, it neutralizes its ability to dominate and constrain, the sine qua non and life source of power that endows it with an insidious ability to influence and mold moral identity. Jenna’s vacillations between multiple, yet at times contradictory subjectivities are consistent with poststructuralist view of subjectivity as fluid, constantly in flux, allowing the subject to align with or challenge accessed discourse, “casting some aside, incorporating others” (Butler, 1992, p.9). Contradictory subject positions open up space for resistance, enable Jenna move from docile to a speaking and reflexive subject who attempts to rewrite her subjectivity within the master obesity narrative and to reflexively problematize previously taken-for-granted “discursive relations which constitute her” (Weedon, 1997, p.121). Thus for Jenna, resistance was in the form of the tools of self-scrutiny and reflexive skepticism to reclaim her agentic voice, and to activate the Foucauldian “self that has to render itself visible to itself, so that it becomes capable of knowing itself both as it is and as it might be” (Foucault, 2000, pp.300-301). In effect, this in turn opens up the possibility of cultivating and embracing alternate practices or habits of thought that empower her with the ability “to play these

games of power” (the truth games of the obesity discourse) while incurring “as little domination (and its associated stress) as possible” (Foucault, 2000, p.298).

Rose (2001) rightly contends that ‘contemporary biopolitics’ is risk politics given the pervasiveness of a risk culture and its associated obsession with TOS in post-Keynesian neoliberal societies. Additionally, while these TOS often fail to deliver their purported goal - transformed bodies – they nonetheless transform the consciousness of the ethical self purely on ‘corporeal terms’ akin to a somatization of selfhood/identity as engagement in TOS “reshape(ing) experiences...re-organizing it in new way(s) and according to new values about who (one is), what (one) must do and what (one) can hope for” (Rose, 2001, p.19). In the same vein in relation to subjectivity, Foucault (2005, p.190) raises the question about the “price” one must “pay for access to the truth” and suggests that the “price” is indeed located in the subject herself in the form of the TOS (work on self) she must undertake. Thus access to obesity truths require self-conversion as “one cannot have access to the truth if one does not change one’s mode of being” (Foucault, 2005, p.190)). Yet within such truths and practices lurk the ultimate agenda of disciplinary power, the colonization of thought and selfhood as “the body becomes central to the question of who the self is”(Danaher, Schirato & Webb, 2000, p.124). Resistance to power, the colonization of thought therefore lies in transcending the tendency to take up discourse without question. I would contend that from a feminist poststructural perspective the political end (authentic emancipation), and thus central to Foucault’s theorizing about subjectivity and power relations is the need for the subject to hold all discourse in skepticism, to judiciously sift through discourse using what one must to one’s advantage without subjecting self to undue constraints of trying to meet externally-assigned elusive

standards of who one should be. With a bow to Butler (1992) it should always be about something one does, never who or what one is. For Jenna this entails stepping away from the mirror that reflects a discursively/socially-constructed self.

CHAPTER 6 Discussion

This final chapter starts with an overview of the findings in this study, as captured in 3 emergent themes, and in relation to the questions that guided the study. It also takes up further two issues at the forefront of these findings, food insecurity and stigmatization. It concludes with implication and recommendations for nursing practice and future research and an overview of the utility of a Foucauldian feminist poststructuralism for this study and for nursing in general.

In accordance with the guiding questions posed in Chapter 1, this study sought to explore how 2 self-identified obese pregnant women understood their embodied experience of obesity in their everyday life and encounters with health care providers, and how those experiences came to be, that is, how they have been discursively constituted by the prevailing dominant discourse on obesity.

From the preceding data analyses, 3 overarching themes encapsulate the two women's understanding of self and daily experiences as self-identified obese pregnant women based on obesity truths accessed variously through the media (the internet and television) circulating prenatal literature, their interactions with health care professionals, social relations, and the public. For these women, the prenatal experience of obesity was perceived and understood as: a) doing the best I can do, b) living in the public eye under public censure and c) not being listened to. These themes are next addressed individually.

6.1 Theme 1-Doing The Best I Can Do

Access to, and appropriation of dominant obesity truths, positions both women in the dominant obesity discourse and causes them to interpret and understand their experiences

of obesity and their sense of self through this discursive lens. Their understanding of what constitutes normal/abnormal, healthy/unhealthy, responsible/irresponsible ways of experiencing pregnancy as obese pregnant women is informed and driven by those truths. Hence this discursive lens also informs their prenatal practices. As part of these truths, a normal, healthy pregnant body is one that is non-obese and this ideal is easily attainable by eating healthy foods and engaging in regular exercise. A normative pregnant body guarantees health for self and provides a safe haven for the developing fetus, and is thus indicative of moral and responsible maternal integrity. Given their non-normative maternal bodies therefore, they experience and understand selves as abnormal, unhealthy and uncontrollable and concomitantly assumed maternal moral accountability for fetal health along with the negative identities such positioning yields. A sense of maternal obligation and desire for a normative natural body leads to endeavours to eat as healthy as they possibly could. They both struggle to maintain healthy eating habits, vacillating between adherence to eating foods discursively classified as healthy and heeding the subjugated call of cravings, or succumbing to the reality of their materially-deprived daily existence that necessitates negotiation and strategizing to buy healthy foods when they are on sale; reliance on food banks, or simply procuring and eating what is readily affordable and accessible (as for example in Jane's case through her work place) – “cheap”, “unhealthy” junk food. Thus these women have to be acknowledged and credited for their resilience, skillful strategizing, and navigation of the system to ensure survival under such dire material circumstances. On another level, the reality of structural impediments also foreclosed opportunities to engage in regular exercise. Beyond the preclusion of the role of social factors and material deprivation, the dominant discourse,

as the narratives of both women indicate, also fails to acknowledge the impact of environmental factors on individual behaviour around physical activity. Yet the importance of structurally healthy sustainable communities that address issues of the built environment such as access to recreational facilities, parks, walkways, lighted neighbourhoods, convenient transportation infrastructure, accessible supermarkets versus convenience stores for access to fresh, healthy foods has been cited as key to the prevention of obesity, without (conducive environments) which lifestyle pedagogies stand little chance of yielding effective outcomes (Ewing, Schmid, Killingsworth & Zlot, 2003; Papas et. al, 2007). Fundamentally however, their lifestyle decisions and choices, the extent to which they take up, negotiate, accommodate or resist dominant lifestyle imperatives is premised on material capacity. The lack of material resources required to maintain healthy eating creates the perception and understanding of selves as “doing the best one can do”.

These women can be said to be in a proverbial Catch-22 situation. They are sandwiched between two realms of constraints. On the one hand there is the constraint arising from their positioning within a discourse that exhorts them to take up autonomous lifestyle practices that are in complete dissonance with their social location, and on the other, the constraints associated with having to cope on a daily basis with an existence of material deprivation that allows them to only do what they can given their circumstances, yet risk public censure. They are damned if they do not play by the rules (uphold unaffordable mainstream dietary standards) at the expense of other basic needs, and they are damned if they try to negotiate to make the rules flexible so as to allow them to concurrently attend to other basic needs. Yet in trying so hard to comply, they risk

exacerbating an already stressful existence on the margins of society. Hence they cannot be who they are expected to be nor are they allowed (unless they resist, which they ultimately do) to be who the truth of their lives dictates that they be.

Therefore, contrary to the perennial simplistic and fallacious assumptions that obese pregnant woman engage in poor lifestyle and behavioral practices because they lack knowledge about what constitutes healthy choices (a premise for current health promotion and prenatal care approaches steeped in lifestyle behavioural pedagogy) these women do think about their health and the health of their unborn baby, have knowledge of what healthy foods are, acknowledge and accept the role of physical activity in overall wellbeing and in their own different ways desire to have healthy babies. They strive to attend to all of these albeit inconsistently due to structural obstacles for which they had little or no control even though external forces construct and tell them otherwise.

6.2 Theme 2-Living In The Public Eye, Under Public Censure

Given the foregoing, in the context of constrained capacity, maternal moral culpability in the obesity debacle is beyond the pale. Yet the consequences of material incapacity paradoxically set them up for medical and public surveillance (their own colluding self-surveillance notwithstanding, albeit undertaken because failure to police themselves in accordance with obesity truths incurs social censure, [Heyes, 2007]) and condemnation. The biomedical approach that informs the dominant obesity discourse is based on moral and universal assumptions (insidiously propagated as advancing the interest of maternal and fetal health and by extension population health) that influence society writ large and obese pregnant women themselves to link maternal bodies to

maternal identities, self-worth and integrity. Beyond its health rhetoric, the dominant biomedical discourse imputes moral valuations on obese pregnant bodies (Lundgren, 2004, McNaughton, 2011, Vireday, 2002, Wray & Deery, 2008).

In taking up the categories or labels (unhealthy, irresponsible, abnormal, overeaters, lacking control) discursively assigned to them, and by undertaking to self-monitor and govern their maternal bodies in conformity with the discourse to among others avoid the scrutinizing eyes of external others, Jane and Jenna define who they are relative to their practices around food and physical activity (the discursively-determined causal factors for their deviant maternal bodies) in juxtaposition to the practices of women who inhabit normative maternal bodies, and thus assume thoughts about self that “legitimate(ing) what is already known” (Foucault 1990 p.9) or discursively scripted. They therefore stand in the shadow of a reflected other, cast by both their own, and the surveilling gaze of external others. Their self-governing corporeal practices are intended to confer control and an ability to escape scrutiny and so for both women, failure as in when they transgressed dietary imperatives leads to explicitly expressed and implicitly alluded feelings of powerlessness to do better, guilt and self-recrimination premised on an equally explicit and implicit understanding of selves, as irresponsible amoral mothers-to-be judged as such and under constant surveillance. While this serves as an effect of discourse, it also goads them to desire a normative body because it has the power to confer social recognition and approval. Hence paradoxically their actions are both produced and constrained by the perception of surveillance and the fact that its function is taken for granted, readily accepted and incorporated in everyday living as legitimate and normative because, even as it exercises moral authority over them (determining their

identities in the process) it also formulates life problems and proposes life solutions leading to a false notion of altruism - serving the best health interest of deviant maternal bodies under surveillance. Yet on the contrary, the hegemonic moral underpinnings of biomedicine's classification and construction of obese bodies "shape how obese people are perceived, represented, treated and positioned on hierarchies of moral worth and systems of symbolic exchange" (Monaghan & Hardy, 2011 p.70). The narratives of the women in this study suggest an acute awareness (albeit one of them, Jane tried to cope by attempting to distance self from that awareness) of a public reading of disapproval and moral censure directed at their perceived pathological and abnormal maternal bodies and this threatened their sense of self and maternal identity expressed as worry that by inhabiting an obese body they may (as in Jenna's case) be (mis)construed as "not car(ing) about the baby, my health and stuff" or in Jane's case the allusion that she has no choice but to strive to have a healthy baby because this is what any good mother would do. Both women expended time and emotional energy that should have been invested in enjoying their pregnancy in worrying, nurturing feelings of anxiety, guilt, embarrassment and frustration. Their narratives suggest a perception of being under scrutiny, surveilled everywhere by no one in particular in their private and public world. They feel the gaze of external forces trained on them everywhere, emblematic of the invisible function of panopticism. This sense of surveillance controls their practice, their own self-monitoring of acts of compliance and conversely acts of non-compliance and deviance leading to exacerbation of feelings of guilt, vexation and powerlessness. Thus, an over emphasis on the biophysiologic risks of obesity precludes the greater harm inflicted by the psychosocial consequences of stigmatization, a corollary of the biomedical discourse of

obesity. This felt denigration of human worth and integrity as a consequence of the systemic character assassination of obese individuals mimics in them a sense of negative self worth, guilt and shame (Ogden & Clementi, 2010; Rogge et.al. 2004) and has been reported in studies of obese pregnant women (Amador et.al 2008; LaCoursiere et.al. 2006; LaCoursiere, Hutton & Varner 2007; Nyman, Prebensen & Flensner, 2008; Smith & Lavender, as cited in Bernier & Hanson, 2012). Stigmatization serves to further disempower marginalized individuals (Link & Phelan 2006) thus exacerbating classism and social inequality (Wilkinson & Pickett, 2010). Guttman and Ressler (2001, p.122) invoke biomedicine's do no harm clause to problematize and put into ethical perspective this consequence of the dominant biomedical discourse on obesity as follows:

“Is it ethical to add to individuals' suffering by implying they are at fault for their suffering? Is it ethical to tell people that they should adopt certain health practices when they cannot readily do so because they are restricted by social circumstances? Would this only lead them to frustration and guilt? Such questions underscore the ethical issue of whether the onus of responsibility should be placed on the individual--- exempting dominant social institutions and those in power from responsibility”.

Thus current approaches that invite these women to step up and take up self-autonomy and self-governance in decision making about their health (and that of their unborn baby) through active engagement in practices intended to manage their maternal bodies regardless of material incapacity to do so, and then actively blame them for such incapacity becomes morally and ethically suspect. Failure to successfully self-govern their maternal bodies in accordance with mainstream standards earns them chastising labels that brand them as amoral, irresponsible economic liabilities culpable of subjecting

their unborn babies to unnecessary yet avoidable health risks that include childhood and adulthood obesity, thereby further exacerbating the global obesity epidemic. Their pregnant bodies therefore become pathways by which upright neoliberal citizenship is either conferred or revoked, and more significantly the conduit for social control of maternal bodies wherein maternal bodies are enmeshed with maternal identities and women are expected to shoulder the weight of the universe and yet forbidden to bear evidence of it on their bodies.

Therefore through biomedicine, normative notions of femininity and gendered hegemonic and moralistic notions of what constitutes or conversely does not constitute a responsible and nurturing maternal identity coalesce to find expression in a neoliberal-based obesity trope that functions to uphold the prevailing status quo of social inequality. It is in this respect that biomedicine intersects with the sub rosa agenda of neoliberalism to promote “the management of the individual and social body, as a vital national resource” through lifestyle practices all in the name of health (Rose, 1993, p.285), without necessarily expending the effort to invest in the resources and social capital required to achieve this ostensible health goal. This way, women like Jane and Jenna remain incognito, neither seen nor heard in ways that matter to them. Hence in a paradox that defies comprehension, they are visible where they seek invisibility, and invisible where they seek transparency, acknowledgement and recognition. What they wish will be made visible and given public airing - their local narratives, their voices - are silenced, declared epistemically unworthy, marginalized and muffled by the omnipresence and loud din of a biomedical discourse that simultaneously functions to hypervisibilize their maternal bodies and invisibilize the very institutional and societal conditions that

pervasively contribute to their subjectivities as low income obese pregnant women.

6.3 Theme 3-Not Being Listened To

If hypervisibility of their bodies earned them social censure and discredit, their perception of a reluctance on the part of health professionals to engage with them in a discussion of body weight issues and related concerns in a manner they deemed adequate or significant, rendered them feeling unacknowledged.

Both women regarded health professionals as experts who could provide them reliable guidance as well as validate information accessed from less trusted sources. A direct discussion about body weight was deemed important, as well as the opportunity to tell their story and have health care professionals listen to and acknowledge their concerns. Nonetheless, at the forefront of their narratives is the experience of a lack of information of the kind that mattered to them, an inability by health professionals to clarify or explain adequately information given beyond a confusing recommendation to “remain the same weight, or just gain a little bit of weight and not gain as much” (as in Jenna’s case) leading to an understanding that they were “danc(ing) around” issues and not being “straightforward”. Equally, a tendency to focus on the biophysiological aspects of care, and to persistently frame counseling about body management around the consumption of healthy foods to the total preclusion of engaging in discussions about the obstacles they (women) encounter adhering to those recommendations (as in Jane’s case) is experienced as frustrating, vexing and disempowering. The persistence in prescribing lifestyle standards that are unrealistic and in dissonance with the realities of everyday experiences of material deprivation is further compounded by a reluctance to listen when attempts are made to communicate this reality to them.

Thus their local narratives are further denied an airing at the point of care, denied epistemic value or authority, apprehended within a master discourse far removed from their location on the margins of society, effectively foreclosing an opportunity for their local knowledges and truths to be incorporated in the plan of care and maintaining an unequal/unbalanced power relations with health care professionals. Similarly it invalidates their local truths as equally valuable in the quest for solutions for overcoming obesity, denies them an opportunity to authentically collaborate or participate in their own care, compounding further, their exclusion and marginalization.

The inability to have their stories told (as in Jane's case) and to rely on the expertise of health care professionals they trust to help them unravel information in a way that makes sense to their particular experiences (as in Jenna's case) led to indignation, and exacerbated their feelings of worry, anxiety, frustration and powerlessness.

It is necessary to note a caveat that this is a small exploratory study and in no way meant to be reflective of or generalizable to the experiences of other obese pregnant women. Nonetheless it is equally noteworthy that this experience of angst about the therapeutic nature of encounters with health professionals is not novel. Other studies have reported similar findings (about the perception of concerns not being adequately addressed) among obese individuals in general (Kirk et al., 2014), among obese women in general (Carryer, 2001) and among pregnant women (Dahlen, Mills & Schmied, 2011; Furber & McGowan, 2011; Heslehurst et. al., 2011; Nyman et al., 2010). In support of Jenna's observation, Furber and McGowan (2011) suggest that the difficulty health professionals have in engaging in discussions about obesity may be due to the sensitive nature of the issue, while Keenan and Stapleton (2010) observe that an awareness of a

lack of the necessary resources required for weight management contributes to health professionals' disinclination to engage in discussions. In their study about the management of obesity in health care, Kirk et al. (2014) explored policy makers' perspectives, obese individuals experiences and perceptions of health care encounters, as well as health professionals' perceptions of these encounters and they report an interesting finding. Notwithstanding their commonly accepted expert status, health professionals were similarly frustrated with the challenges they experience in supporting obese individuals' management of this complex health issue, and cited among others, their inability to provide answers when they lacked solutions themselves, their ambivalence about micro-level versus macro-level approaches and a sense that they were not "equipped" to manage the issue.

Hence it would appear that the angst and tension about prevailing approaches to obesity management is a phenomenon experienced, albeit for different reasons and in different ways, by all stakeholders.

Nonetheless for the women in this study, their feelings of frustration, worry and indignation aroused skepticism of the dominant obesity truths conveyed by the very discourse upon which health care professionals ground their expert knowledge and would hence play a role in their resistance to their subjectivity within such relations of power.

Despite these interpretations of their experiences as captured in the foregoing themes, Jane and Jenna muster the alternate lens of social determinants from which to view and mount counter narratives in an attempt to resignify their understanding of self and experiences other than what the dominant discourse sets them up to perceive. Thus while they collude, reify and legitimate the dominant discourse in various ways by

appropriating its truths to serve, inter alia, their desires for a normative female/maternal body, social approval and recognition, the power of the dominant discourse was not all encompassing. A dissonance between their local reality and an externally imposed reality enables them to clue in to the contingent nature of these norms and normative ways of being, facilitating realization of a self not accounted for in the master narrative. In doing so, they both, in their different ways reject the moral identity slapped on them by dint of their obese maternal bodies, becoming provisionally, subjects who “know(s) self both as it is and as it might be” (Foucault, 2000, p.300), thus envisioning possibilities that were previously foreclosed.

On a different note, embedded in the three major themes are two foremost issues in this study which were taken up in an unpublished paper (Abudulai, 2013) as part of (and now incorporated into) this thesis - food insecurity, which necessarily stems from material deprivation, and stigmatization. These issues are pertinent not least because the former, food insecurity, highlights the need for a multiperspective approach in the management of obesity, while the latter spotlights the iatrogenic consequences of the singular and stubborn focus on biomedical grand truths and interpretations of what it means to be obese which I contend may well contribute to fuelling a vicious cycle of an “epidemic” for which it (biomedicine) can take credit for discursively enabling, individual collusion notwithstanding.

6.4 Food Insecurity in Political Perspective

Food is a political issue. It is both social and personal and as Lupton (1996, p.1) observes “it is central to our subjectivity and sense of self”. In fact the power of food is evidentiary in the intersecting issues of obesity and food insecurity and as such the assertion that food

access and consumption represent a function of power relations is indeed valid (Counihan, 1999) as is the observation that food plays a vital role in assuring freedom (Sen, 1984). Counihan (1999) further captures the significance of food in delineating it as “a product and mirror of the organization of society on both the broadest and most intimate levels” (p.6). As a desideratum for survival the power of food is evident in the role it plays in the constitution of bodies, identities and gender roles (Counihan, 1999; Kilbourne, 1994; Witt, 1999) especially in the case of obese women (Drewnoski & Specter, 2004; Lupton 1996; Mehta, 2008; Olsen 2005; Phillips, 2009; Siega-Riz & Laraia, 2006; Slater et. al, 2005; Wuest et. al, 2006).

To put food insecurity into further political perspective, as a critical indicator of food insecurity, food banks are a consequence of welfare retrenchment (Raphael, Diaski, Pilkington et al., 2012; Riches, 2002). Food banks have been in existence in the United States since the late 1960s, subscribing paradoxically to the philosophy that it exists to wed the ‘interest’ of a flourishing over-endowed “food industry---with those of grassroots poverty organizations”(DBFB as cited in Riches, 2002, p.651). The first of its kind emerged in Alberta, Canada in 1981 as a temporary response and solution to the consequences of high unemployment in the wake of an economic recession caused by an oil crisis (Riches, 2002), but have since grown exponentially vis a vis “stagnating wages, declining social assistance benefits and rising housing costs” (Raphael, Daiski et. al, 2012, p132) enabling governments to shun responsibility for the “nutritional health and wellbeing “ of citizens (Riches, 2002, p. 648). A 2001 Hunger Count Survey by the Canadian Association of Food Banks reported that 718,334 Canadians accessed 632 food banks and 2,123 affiliates Canada-wide for food in March of that year alone, indicating

an overall rise in “food bank use’ by 90 percent in a little over a decade (Riches, 2002). In its most recent 2013 report, Food Banks Canada reports the existence of over 3,000 charitable “food-related” agencies across Canada accessed for food by more than 800,000 Canadians each month. Ironically, flashed across the cover page of the report are the words: “low wages, poverty, exclusion, unemployment, unaffordable housing, layoffs, food insecurity, family break-up, health problems” (Food Banks Canada, 2013), a recipe for and attestation to bad social policy. In a United Nations inquiry that sought to determine whether the use of food banks by a wealthy nation such as Canada constitutes a contravention of an international covenant (of which Canada is a signatory) which stipulates the “fundamental right of everyone to be free from hunger”, Alberta and Quebec very tellingly justified their use as a “valuable ----means of resource distribution” while the federal government and other provinces opted not to respond (Riches, 2002). Therefore the act of denying marginalized obese individuals access to the very resource (healthy foods) touted to imbue health, and then through pecuniary neoliberal market economies make the converse (junk foods) readily accessible as the only option, and then have the audacity to blame them for submitting to this option for survival, and in the process subject their human spirit and integrity to a moral assault is inscrutable. It can also be argued that while neoliberal nations, through biomedical discourse decry the cost burden of obesity and exhort citizens to individually own and employ hegemonically prescribed behavioural lifestyle approaches of diet and physical activity, they also proactively create conditions that ensure a vicious cycle and a road to nowhere but what currently is – the status quo which upholds social inequality and inequity. This approach also ensures that the SDOH agenda remains a policy mirage, and flies in the face of the

commonsensical reality that human capability (the exercise of agency) requires capacity (access to resources and social capital). In this respect, interrogating the inequity of food deprivation with specific reference to India (but equally applicable in this case), Sen (1984) observes that “a sense of legitimacy and order, and one of naturalness, make inequities entrenched and hard to dislodge” (p.87) and ponders how any “just society (can) be built on so much delusion” (p.89).

6.5 Stigmatization In Further Perspective

It is crucial to further explicate the issue of stigmatization as it is a direct consequence of the dominant obesity narrative, and constitutes by far what needs to be relentlessly and unreservedly interrogated and subverted. Stigmatization does not have to be overtly experienced by obese individuals, its mere anticipation “can challenge core social identities” (Brewis & Wutich, 2012, p.332). I suggest that a singular, tunnel-vision biomedical approach inevitably renders the women’s (in this study) existence of deprivation omnipresent in their day to day efforts and struggles to survive, embattled with a vicious cycle of the stress of worry, anxiety, guilt, embarrassment, shame, frustration and powerlessness, the cumulative physiological and psychological effects of which defeats the ostensible ‘health promoting’ intentions of the discourse. The felt or anticipated experience of stigmatization is at once debasing, demoralizing, dehumanizing, emotionally draining, psychically incapacitating and disempowering tout court. It has to be asked, by what scientific, humanistic or moral logic does such corrosive state of existence, advertently or inadvertently enabled by hegemonic imperatives to achieve corporeal perfection constitute or imbue health and wellness? Such interrogation is in

order given that the psychosocial pathway of stress resulting from feelings of low self esteem, anxiety, shame and a sense of lack of recognition associated with low income and low social status (Wilkinson & Pickett, 2010) have been shown to play a role in exacerbating obesity irrespective of biomedicine's energy consumed/energy expended theory (Aphramor & Gingras, 2011; McGibbon, 2012). Hence it can be argued that social gradients translate into health gradients.

Unfortunately the multiple effects of stigmatization and discrimination on an individual's "internal sense of self" and by extension their external material resources and ability to participate in their health are often underestimated and overlooked. Yet for the eradication of health and social inequities to occur, the impact of injurious acts and attitudes of oppressive stigmatization and discrimination within power relations at macro level institutions and social structures, as well as micro level interpersonal encounters and caring relationships need to be recognized (Dill & Zambrana, 2009; Weber, 2006).

In an insightful explication of stigma, Courtwright (2009) maintains that stigma represents an unacknowledged determinant of health. As a major cause of health inequities, it demonstrates that the drivers of health inequities transcend unequal distribution of resources and includes "factors that do not so comfortably fall within the traditional domain of distributive justice" (p. 90). Stigma, Courtwright insists, entails the act of "branding" a person or group of people based on an "identified characteristic" that is judged to be "undesirable". He contends further in explicating the concept stigma, that it is necessary to address the "unique disvaluing" that takes place and which distinguishes it from sister "concepts like prejudice, discrimination, bias and bigotry" (p. 91). Courtwright expands on this, noting that the goal of stigmatizing another goes beyond a

facile need to “respond to a trait” that is deemed to be “undesirable”. It includes the intent to ‘brand’ another in “a way that they find the trait undesirable” and associate it with “shame and self-loathing”. Hence “when we stigmatize the obese, the disabled or the poor, we are not only judging that it is undesirable to have these characteristics but that anyone who has these traits should feel deeply ashamed” and should hide from the rest of the world (p.91). It is this dimension of stigmatization - “the demand that the stigmatized share the judgment of the stigmatizer” that differentiates stigmatization from, and places it out of the league of the aforementioned sister concepts (Courtwright, 2009), although it does result in widespread discrimination and exclusion at all levels of society (Courtwright, 2009; Townend, 2009), as well as a “self-perpetuating” cycle in which the stigmatized, stigmatize that feature in others “so they feel the same shame”. Stigmatization “turns a person on herself” and it is this self-alienation that makes it more injurious than its sister concepts, and deals “potentially its most devastating” adverse consequences on health (p.91). The stigma of obesity and resultant prejudice and discrimination in public, in the media, in areas of employment, education and health, for many, lead to feelings of devaluation, powerlessness, internalized negative self-concept, low self-esteem, self-loathing, depression and chronic stress (Brewis, Hruschka, & Wutich, 2011; Saguy & Riley, 2005; Townend, 2009) all of which singly or collectively impact ability and or desire to seek health-optimizing goods and resources. Chronic stress has been identified as a pathway for health inequities, given its impact on several SDH such as income and education (Townend, 2009; Wilkinson & Pickett, 2010). The self-fulfilling effect of an internalized view of self premised on the “external assessment of their value” hampers the pursuit of capabilities inherent in education, income and other

resources to enhance health and overall wellbeing, activating a phenomenon referred to by economists as “adaptive preferences”, wherein the individual adjusts her/his expectations, dreams and desires to coincide with her/his devalued social position, and opts to settle for less, thus triggering a vicious cycle of self-fulfilling prophecy (Courtwright, 2009, p. 94). For instance it can be inferred that Jane’s declaration that weight loss will transform her life (for the better), but haste to qualify this dream as “not like career-wise or anything, just my health” is indeed reminiscent of an “adaptive preference” ethos. Thus the constitutive and pervasive effects of the language of biomedicine’s framing of obesity is infused with moral meanings that not only determine a current sense of self and worth but attempts to also influence endeavours at envisioning possibilities about the kind of agential subject one aspires to be.

Clearly then, the moralizations inherent in the biomedical discourse of obesity “reinforce(s) injustice, ---- as it fails to provide a basis for analyzing and addressing its structural determinants, thus denying the (social, my emphasis) responsibility of a solution to those who need it the most: the poor and materially deprived” (Townend, 2009, p. 177), and it also impedes and renders any progress in healthy public policy comatose (Morone, 2002) as it simultaneously thwarts the effective management of obesity at the micro political level. Indeed so widespread and pervasive is the stigma of obesity at all levels of society, that Stunkard & Sorenson (1993) dubbed it “the last socially acceptable form of prejudice” (p. 1037).

The preposterousness of conflating bodyweight with moral worth or integrity is captured in Stone’s (2011, p.156) observation that in the contemporary tradition of making New Year resolutions that typically include goal-setting that are “medical(ly)”

premised, such as to lose weight “or cut(ting) out junk food, and so on” one does not append to that resolve to “become a morally better person” or for that matter, to become a good, responsible mother by losing weight. The point here is that there is no intention to undermine the importance of the pursuit of health (which means different things to different people depending on the period and context). It is however, to assert that we engage with obese individuals with the understanding that there are multiple truths, not least of which is the local truths of the individuals we purport to assist or support and that we cannot, should not base our practice in toto on a discourse that results in the denigration of human integrity and spirit in the name of health promotion. It is the discursive effect of imposing labels on the moral character and identity of obese pregnant women and by extension obese individuals in general that must be challenged and subverted.

Ultimately therefore, given its profound impact on health, the stigma of obesity is indeed, on its own a major, albeit avoidable determinant of health, and given its impact on ability and opportunity to access and enjoy the “goods” of life, it is “morally suspect” (Courtwright, 2009, p.93) and very much an issue of social justice. Social justice is about human interrelationship at the interpersonal, community and national levels, and “basic human rights” (Barnes, 2005, p. 15), including the right to human dignity (so often violated and infringed upon by injurious acts of marginalization) that ground these intersubjectivities.

Against this backdrop, it is evident that in grounding their approach in the management of obesity in the biomedical discourse, nurses may be colluding in the creation of the very social inequities they seek to eradicate, and may also very well be

negating their efforts to advocate for, and promote the common good at both the micro-political and macro-political level. The question becomes, to adopt Courtwright's words (p. 95) how can nurses "foster a set of attitudes among the stigmatized that would allow them to resist the effects of stigmatization, thus reducing the impact it has on their health"?

6.6 So What? – Implication For Nursing Practice

Historically, nurses have advanced justice, like caring, as a nursing imperative to promote the health, wellbeing and social conditions of individuals rendered vulnerable secondary to their location at the periphery of society (Bekemeier & Butterfield, 2005; Boutain, 2005; Falk-Rafael, 2005). Over the last two decades, feminist, critical theory and postcolonial nurse researchers' use of a social justice lens has helped advance a social justice agenda in nursing "from consciousness raising" to policy advocacy and development, the goal of which has been to transform "how nurses teach, research and practice" (Boutain, 2005, p. 21). Indeed as a concept compatible with nursing's philosophical roots, social justice is promoted as a moral mandate in various professional position papers, code of ethics and upheld by the International Council of Nurses (ICN) (Reutter & Kushner, 2010). As part of that moral agency, nurses are required to be cognizant of the impact of the social determinants of health (SDOH), systemic factors and poverty on health and wellbeing, and how these limit choices and options for some people. Similarly, for decades the concept of social justice has been advanced and explicated in nursing as a central professional value (Johnstone, 2009), yet following a review that examined its conceptualization in the nursing literature, Boutain (2005)

reported that social justice was poorly and inconsistently articulated, was more often delineated as a “concern for the equitable distribution of benefits and burdens in society and less often as changing social relationships and institutions to promote equitable relationships” (p.44). More recently however, the moral basis of nursing practice is increasingly being explored through the lens of poststructural and postmodern relational theories that emphasize and have as a central focus, the interrogation of power relations within social and institutional power structures and their impact on social justice at the individual and wider human community /population level (Woods, 2012). Nonetheless relational-based practice approaches have been criticized, as have poststructural approaches to inquiry, presumably for their tendency to be individualistic, and attending less to the wider social context (Woods, 2012). Yet it is almost impossible for a relational ethic to stand outside a social ethic, for as Woods (2012, p. 61) inquires: “how could a nurse care for an individual or a group of individuals in one sense (i.e relational) but ignore the sociocultural and political contexts that were affecting their overall social welfare at the same time”? The philosophical foundations of nursing practice have been shifting for decades and with it the evolution of emancipatory approaches and concepts such as holistic care, family-centred care, capacity-building, community development, etc., and yet the Cartesian worldview persists. Purkis (in Doane & Varcoe, 2005, p. 231) concurrently points out that “the rhetoric of health promotion has not really affected a shift in practice. Rather, the expert-driven model of practice is more difficult to recognize”, while Hatrick (1997, p.61) suggests that what needs transforming are “the values and assumptions that serve as the foundation for our practices”.

With respect to Courtwright’s (2009) question, a strengths-based approach that

seeks to discover and enhance a client's capacities versus a problem-based approach that objectifies the client and relegates him/her to a mere recipient of health care is widely endorsed in the literature (Dunst & Trivette, 1994; Hatrick, 1997; McAllister, 2003; Jonsdottir, Litchfield & Pharris, 2004). Echoing this viewpoint, McAllister (2003, p.53) suggests the adoption of a relational stance that is respectful and non-judgmental and strives to do less telling and more listening – to know the person not the label”; and further notes that in addition to understanding, valuing and maximizing the client's existing capacities and ability to strategize, a strengths-based approach privileges the client's voice and perspective in a partnership, while a problem-based approach upholds a “power differential” in that it assumes an expert nurse role, privileges the nurse's voice and is thus “ill fitting – inherently reactive – at best inefficient and short-sighted and at worst amoral” (McAllister, 2003 p. 530). Tapp (2000, p.241) observes that a problem-focused approach renders “clients as problems to be corrected rather than mysteries to behold and attend to”, while Doane and Varcoe (2005) caution that a focus on problems blinds us to the strengths of the client, leading us to practice in relational oblivion. The essence of relational practice is underpinned by the emancipatory principles of respect, compassion, empathy, social justice and equity and is not driven by a need to fix things but by a need to truly get to know the client so as to enable a connection with them in the quest or effort to support, promote health and nurture capacity within the context of their lives (Doane & Varcoe, 2005). Not surprisingly therefore, strategies that uphold these principles are strengths-based and entail following the client's lead (they are the experts of their lives), forging useful alliances and partnerships, being open to limitless possibilities, engaging in dialogue that supersedes conversation and focuses on listening

to facilitate a deeper understanding (Doane & Varcoe, 2005).

Gadow (1999) proposes a strengths and empowering-based postmodern relational narrative approach in a 3-tiered dialectic framework in which the first, a premodern ethical approach advances an “unreflective and uncritical certainty about the good” (p.59), and the second, a modern approach premised on codes of ethics and principles advances rational objectivity and universalism, while the third, a postmodern break or turn away from positivist-based universalism advances an approach in which the moral values that guide the relationship in pursuit of the good, do not stand outside but are created and hence stand within the relationship.

The first approach, the premodern/subjective immersion, advances a certainty about the good that is being sought, and is sourced to entities that transcend the individual – culture, religion, and the professional “ethos” (Gadow, 1999, p.59). Its strength is in the unified front it presents, in that the nurse and client adhere to “an unquestioned view of the good and are united in their attempt to attain that good” (Gadow, 1999, p.60), and it is this unison in viewpoint that grounds certainty. Naturally therefore, this certainty is threatened when the individual/client attempts to assert an opposing viewpoint, and is met with “shame or exclusion” to promote compliance. This approach is akin to historic nursing practice underpinned by the paternalistic values of general narratives that submerge the client’s story while privileging a ‘communitarian’ ethic and narrative (Gadow, 1996; Gadow, 1999, p.60).

The second approach, modern detachment/ethical universalism, is grounded in universal “principles that are categorical and unconditional” (Gadow, 1999 p.61), allowing the nurse to employ the external objectivity of universal moral principles to

ground certainty. Although this approach advances equal respect for individuals, the unconditional and universal application of principles does not attend to individual uniqueness and diversity of experience, and therefore a power differential is created in which the nurse's views are reflective of those advanced by dominant societal structures and discourses. In many ways this is reflective of the lifestyle approach to health promotion in which practice guidelines that inform management of obesity align with, and endorse a prevailing biomedical episteme that allots priority to behavioural and lifestyle modification strategies (preclusive of individual context), based on the discursive framing of obesity as a consequence of individual moral failure secondary to overconsumption, poor lifestyle and behavioural choices (Gard & Wright, 2009; Maziak & Ward, 2009). A consequence of framing obesity as an individual moral issue and responsibility, is the ensuing moral panic that underpins obesity stigmatization and its attendant injustices (Townend, 2009).

Jeffery & Kitto (2006) postulate that despite nursing's ontological roots, nurses are caught between opposing discourses (nursing, biomedicine, and neoliberal) and are often subsumed by powerful forces of a ubiquitous biomedical discourse and prevailing pervasive neoliberal governance in healthcare. Additionally in an earlier study that explored nurses' perception of ethical and moral practice, Rodney et. al, (2002) found that in "navigating towards a moral horizon", nurses were often confronted with conflicting priorities and values and had to work "within a shifting moral context --- and 'in between' their own values and interests and those of others, and 'in between' competing values and interests" (p.80). Examined in this context, the pre-eminence of a modernist biomedical/behaviourist episteme on obesity and by extension practice

guidelines that reflect and endorse such discourse, ultimately not only contribute in determining nursing approaches to the management and care of obese individuals but also the manner in which care or service is delivered. Similarly nurses' individual repertoire of values and beliefs not only shape their worldview but impacts how they selectively interpret knowledge (from theory to practice), as well as influence their perception of and response to their clients. To this effect, MacDonald (2006) states that when values and perspectives conflict, mutual respect, a principle of relational practice becomes key in an approach that embraces dialogue, mediation and collaboration to establish a common ground.

From a postmodern perspective, individuals are situated as unique, "existential" and "intrinsically relational" (Gadow 1999, p.62) and a relational approach demands an ability to transcend the presumption of "a universal view to no where" in order to embrace, "imagine and appreciate" the diversity of individual particularities. Postmodern engagement/relational narrative, Gadow's (1999) third ethical approach, embraces intersubjective engagement and is thus antithetical to the emotionless 'ethical objectivity' characteristic of the modernist approach. It invokes a nurse-client relationship anchored "in the ambiguity of their being at once encumbered and free, situated and transcendent", and thus supersedes by far the therapeutic and transformational potential of ethical codes and principles, which although stipulate moral conduct, nonetheless lack the "authority" to sanction such quintessential, participatory and empowering human intersubjective engagement (Gadow 1999, p.63). Akin to the seriousness with which Courtwright (2009) views stigma, Gadow (1999) refers to the injurious acts of "modern oppression" that shape equally oppressive experiential meanings as "hermeneutic terrorism in which

experience is held hostage to authority” (Gadow, 1999 p.63). Accordingly, the goal of the postmodern relational encounter is to subvert and ‘destabilize’ the power of such framing by challenging, resisting and rendering oppressive meanings as socially constructed and contingent, and facilitating their transformation into emancipatory meanings. Thus a postmodern turn in relationship strives to “embrace(ing) contingency, refuse(ing) certainties and resist(ing) the modern drive for unity, order, and foundations” (Bauman & Tester, as cited in Gadow, 1999, p.63). The narrative space in which this occurs becomes “the homeland” for the nurse and client, where they mutually “compose” a storied account of the client’s interpretation of experiences (Gadow, 1999 p.64), and in which the nurse remains cognizant of the power of language to shape the client’s reality and also what is known about them. To this end, an unstructured and informal interaction characterized by power with versus power over, enables one to be unconditionally attuned to the client, and communicates a genuine interest in her/his story as well as a willingness to go wherever they choose to go with the dialogue. Jonsdottir, Litchfield & Pharris (2004), observe that in a partnership interaction is spontaneous and non-directive, and “the nurse is fully present to the patient --- having no prescriptive agenda other than attending to what is going on for the patient, --- embraces whatever emerges and goes with the conversational flow as new meaning unfolds.the focus is on expanding understanding” (p.243). Similarly, Hall, Stevens & Meleis (1994) note that the inclusive approach of a narrative-based interaction empowers marginalized individuals and lends “an ear to their experiences and an eye to their struggles” (p.38). Concurrently, Fenwick, Barclay & Schmied (2001) observe that interaction devoid of rigid formality promotes rapport and a sense of partnership that appears to be particularly relevant in bolstering

self-concept and self-esteem in marginalized individuals. Partnership invites client participation and can help decrease feelings of alienation and powerlessness associated with marginalization. Thus within an empowering relational narrative space, in which respect for all ‘aspects of humanness’ is upheld, emancipatory opportunities are provided for clients “to know the good they seek---through their own accounts, their personal ethical narratives” (Gadow, 1999, p.65).

As a human principle, and moral value addressed in all codes of ethics and areas of nursing (Tarlier, 2004), respect and its role in the nurse-client relationship has received considerable airing in the literature. Browne (1995, p.96) posits respect as “the central moral attitude from which all other moral principles are explained”, and further observes that respect is underpinned by the acceptance and treatment of others as “inherently worthy and equal” and a genuine willingness to listen to and understand the other’s situation. Concurrently, Tarlier (2004) notes that “respect for self as well as others is arguably the most fundamental moral value” through which other basic values such as trust and mutuality are developed (p.237), and ostensibly the most challenging (be it as in behaviour or personal life location or situation) individuals are the ones nurses must endeavour to make the greatest effort to respect and connect with (Halls, 1999). While respect is a principle embraced in both the modernist and postmodern ethical approaches espoused by Gadow (1999), the nature of respect in each is different in terms of their respective ideological/philosophical basis. In the modernist approach, respect is premised on the conception of the individual as a rational, autonomous being, “an end” unto herself/himself, and this respect presumably prevents coercion, oppression and discrimination among others. Nonetheless, rational principles are subject to

misinterpretation, not least because their interpretation is dependent on and therefore influenced by another's personal repertoire of values and beliefs. This potential for different interpretations contradicts and invalidates the premise of universalism and certainty. Additionally, given the diversity of humans and their lived context, a universal principle can only be applied "blindly". Within these inconsistencies, respect is premised on a "dualist metaphysics" which privileges "reason" over human emotionality and embodiment as the "essence of humanness" and "values persons as transcendent, (while) it devalues those experiences, already marginalized by dualism, that are not fully controllable", and a rhetoric of equality stands within the context of a "moral high ground of rationality ---- synonymous with privilege and power" (Gadow, 1999, p.62). In contrast, respect as advanced in a postmodern engagement/relational narrative is "dialectic" and "nondualist". Individuals are valued in all aspects of their 'humanness', as "irreducibly ambiguous, particular and universal, embodied and intellectual, emotional and rational" (Gadow, 1999, p.62). Additionally, respect for the 'existential' other, goes beyond a mere acknowledgement of her/his autonomy, to include valuing her/his unique situatedness by being genuinely and deeply attuned, and profoundly responsive to the other (Gadow, 1999).

The postmodern ethic of valuing and act of conferring a genuinely profound respect (by most accounts the mother of all moral values) for the individual as a whole, is perhaps by far the single most important empowering attitude to adopt in the ambitious project of promoting social justice for marginalized individuals. Indeed, the issue of respect as a human ethic and moral value is the subject of much discussion in the general literature (Fraser & Honneth, 2003; Honneth, 1995; 2001; 2003). In his theory of

recognition, Honneth (1995; 2003) concurs with the postmodern notion that humans are by nature 'intersubjective', and their need to relate is facilitated by recognition nurtured by attitudes of love and care, and contends that the development of a positive or negative self-regard is influenced and determined by intersubjective pathways of recognition and misrecognition. Honneth (2001, p.45) delineates recognition within a discourse of ethics as the "reciprocal respect for both the unique and equal status of all others" and advances it as "the fundamental moral category" (Honneth 1995, p.10), similar to a postmodern account of respect. He further asserts that self-regard and recognition does not exist in a vacuum but is dependent on regard and recognition by others, "as the only way in which individuals are constituted as persons is by learning to refer to themselves from the perspective of an approving and encouraging other, as being with certain positive traits and abilities" (1995, p.173). He also advances a healthy positive self-regard as a precondition for self-empowerment (1995; 2003). Rooted in Hegelian phenomenology of consciousness, the politics of recognition is by no means novel, and historically among Greeks, spoke to the process wherein those whose conduct or looks coincided with the approval of the 'polis' were recognized as deserving of the good life (Honneth, 1995). From a justice perspective, respect, and in particular self-respect is considered a primary good. To be respected/recognized is to be treated justly, to be disrespected/misrecognized is an injustice, and experience becomes a key referent for injustice as the latter is experienced as an avoidable, socially-mediated "psychic" suffering injurious "to one's integrity, honour, or dignity" (2003, p.131). Honneth therefore proposes that a "withdrawal of social recognition" mediated by injurious acts of "humiliation and disrespect" be located at the "core of all experiences of injustice" (2003, p.134), and

suggests that it would require a “symbolic change” – a “revaluing” of previously disrespected and marginalized individuals and groups through “the wholesale transformation of societal patterns of representation, interpretation and communication” inherent in dominant discourse to redress this abstract, but hugely significant feature of social justice (1995, p.7). Correspondingly, Courtwright (2009), points out that stigmatization leads to loss of self-respect secondary to “become(ing) beholden to the evaluation of others”(p.94). He suggests that “foster(ing) self-respect” may have the empowering effect of nurturing and mobilizing resistance to stigmatization. Self-respect endows one with a self-appraisal ability, and through self-appraisal and reflexivity the ability to be “crucially the final arbiter of (one’s) relative (dis)value” (Didion, as cited in Courtwright, 2009, p.94).

Facilitating and imbuing a sense and feeling of being respected and valued in obese individuals, is a quintessential goal of a therapeutic nurse-client relationship that invites us among others, to first and foremost see the client as a human being with a tapestry of life experiences intricately interwoven in time, relationships and unique social, cultural and political structures and environments, who has the ability, given the resources and an imbued sense of empowerment to resist the status quo and to transform her/his world in her/his own terms. The human characteristic of self-respect, so vital to a sense of human dignity and integrity is so often robbed from those who exist on the margins of society, through injurious acts and attitudes of stigmatization, discrimination and prejudice. Nurses can redress this by disengaging from a biomedical focus and taking a postmodern turn in which a focus on sharing power in the mutual pursuit of a good is undertaken within a milieu grounded in caring respect and recognition, conditions

necessary for enabling self-empowerment. While respect represents a primary good, it cannot be appropriated from those who have an excess of it and redistributed to those who have less, but it can be nurtured and experienced. It is acknowledged that this represents practice at an individual, micro level, but to the extent that it enables interrogation of marginalized subjectivities, fosters insight into previously silenced alternative narratives and unleashes the power of self-transformation, it constitutes an endeavour in social justice, albeit at a relational level, crafted in empowering and insightful stories and narratives, the kind only a postmodern relational space can accommodate and facilitate.

6.7 Implication For Practice At The Macro Political Level

Beyond the foregoing implications for nurses' micro-political practice, the macro-political arterial role of nurses cannot be emphasized enough. Humans cannot be understood in abstraction of their sociocultural context, any attempt to address the situatedness of humans must necessarily be done in relation to the broader socio-political and cultural context (Campbell, 2001). This resonates with the notion that the social determinants of health are not self-determined and cannot be addressed outside the milieu of family, community, traditions and values and the wider sociopolitical and economic establishment. As noted by the Canadian Public Health Association (CPHA, 1996) in its Statement for Health Promotion, "policies shape how money, power and material resources flow through society and therefore affect the determinants of health" and therefore nursing advocacy for healthy public policies is imperative. To this effect, the nursing literature is replete with calls on nurses to engage in macro-level social justice activities and political advocacy at national and global levels vis-à-vis reports that

suggest a paucity of sociopolitical activism by nurses (Berkemeier & Butterfield, 2005; Browne & Tarlier, 2008; Carnegie & Kiger, 2009; Crigger, Brannigan & Baird, 2006; Crigger, 2008; Falk-Rafael, 2005; Lowery, 2010; May, Phillips, Ferketich & Verran, 2003; Messias, DeJong & McLoughlin, 2005; Reutter & Kushner, 2010; Rice & Wicks, 2007; Siström & Hale, 2006). Advanced practice nurses (APNs) are particularly strategically situated to take on a political role. Falk-Rafael (2005, p.222) postulates that nurses who practice at the crossroads of “public policy and personal lives” are ideally placed to politically advocate for changes to policies (*such as those that direct and stipulate current dominant approaches to the management of obesity – my emphasis*) that uphold social and health inequities. Browne & Tarlier (2008) similarly contend that in the interest of sustainable role development for APNs, it is vital to intersect the biomedical approach of advanced practice with a critical social justice perspective. They explain that just as changes in the landscape of healthcare and society gave rise to the need for APNs/nurse practitioners, escalating social disparities across societies provides the impetus for the development of new, dynamic, politically-adept and socially-responsive nursing roles that expand a focus beyond individualist approach to include a macro-political advocacy role that addresses the genesis of health and illness. McGinnis, Russo & Knickman (2002) note that a critical component of advocating for public policy change is leadership that motivates and informs change in a manner that acknowledges that the most important allies for prevention are those that benefit most from it – the public. It is imperative therefore to begin the process of transforming current approaches by first raising public awareness about the power of the SDOH to prevent disease and enhance the quality of life, and the belief that measures to improve social conditions are achievable. Similarly Raphael, Curry-Stevens & Bryant (2008) advance three leadership strategies that nurses as well as other health professionals can mobilize at the meso and

macro level to advance and promote social and political support and action on the SDOH as education, motivation and activation.

A key initial leadership strategy therefore entails informing and actively publicizing alternate messaging about the SDOH to counter current biomedical messaging about healthy lifestyle (Raphael, 2010; Raphael et. al, 2008). This can be done through presentations, town hall meetings, letters and articles to the media. It can also be done by engaging and mobilizing people to spread the messaging about the SDOH and what it means for health by word of mouth through friends, family, colleagues and neighbours. The primary messaging should be that living conditions determine health and that the policies government makes shape the quality of those conditions. Another strategy would be to advocate for, and insist that public health structures feature prominently in their million-dollar communication strategies, terms like ‘unhealthy/insecure living conditions’, ‘food insecurity’, ‘unemployment’ in place of ‘unhealthy diets’ and ‘physical inactivity’ (Raphael, 2010). The value of developing alliances with key stakeholders – politicians, social scientists, (Falk-Rafael, 2005) community groups such as antipoverty and women’s advocacy groups etc., and seeking membership in key committees or groups for example welfare boards (Cohen & Reutter, 2007) is a key political activity. Raphael (2010) also suggests engaging other key stakeholders such as the Heart and Stroke Association and the Canadian Diabetes Association in the conversation and adoption of a SDOH approach, as their traditional messaging precludes the direct role played by the SDOH and more importantly how healthy choices are predicated upon the SDOH. Motivation also entails inspiring and influencing a shift from a focus by the public, media and policy makers on dominant biomedical discourse to a SDOH lens by rhetorically invoking a human spirit through rich narratives, testimonies or

stories about the havoc social determinants such as food insecurity, unaffordable housing and low income inflict on people's health and wellbeing. Evidence suggests the media and some policy makers have responded to such testimonies (Raphael, 2010). Similarly, motivation is engaged through advocating for more transformational research that provide an avenue for previously silenced and marginalized voices to provide their perspective about society and oppressive power structures, to enable their voices to rise and assert their concerns thus empowering them to be politically active in pushing for policy changes (Getzlaf & Osborne, 2010).

A third strategy, activation is the most challenging strategy and calls for "supporting political action in support of health" (Raphael et. al, 2008, p.231) and building and mobilizing key political alliances to influence and solidify political support for public policies based on the SDOH (for example those that facilitate affordable housing, and the subsidy of agriculture to make healthy foods affordable and accessible, etc.). Equally important is the need to advocate for supportive social assistance policies that do not further constrain the health of low income/marginalized women (Rice & Wicks, 2007). This implies lobbying or advocating for an increase in minimum wage that reflects and is compatible with current market and cost of living to enable above subsistence living and decrease dependence on food banks.

These entail the use of direct strategies such as emailing, calling or writing to politicians and key people in power, arranging and meeting with key influential people socially and professionally, submitting petitions and resolutions to key organizations and stakeholders, joining in campaigns of politicians who support SDOH etc. and are best pursued when a window of opportunity presents, such as an election year. A less commonly explored strategy is media advocacy. As observed in the literature review, the

media has usually been castigated on the one hand for its role in promoting sedentary lifestyles that contribute to obesity, and on the other hand for its role in creating a moral panic about obesity and among others its moralizing representation of obese individuals, thus compounding stigmatization of obese people (Boyce, 2008). Indeed, Boyce observes that “many moral panics of the last century laid blame squarely at the door of the media” (p.201). Yet as a former journalist, I concur with some scholars’ (Boyce, 2008; Rabinowitz, 2010; Wallack & Dorfman, 1996) observation that the media can make a powerful ally in policy advocacy. What society deems to be of value, fair or just indelibly intersects with every significant public health issue (Wallack & Dorfman, 1996). The pursuit of a society in which all people can be healthy entails the “contentious process of blending science, politics, and activism in the context of social values and interests” as well as “navigating along the nerve centers of society”, with the metaphor ‘nerves’ representing “those basic values regarding the balance between personal responsibility and social obligations in battles” fought along political and behavioural fronts (Wallack & Dorfman, 1996, p293). In the course of such activities, ‘mediated’ stories and information can reinforce the status quo or advance policy goals for social transformation. Depending on the approach, the media can be used to advance the promotion and development of healthy public policies that ensure equity in society. Therefore as Wallack & Dorfman (1996) note, the mass media is influential in advancing and framing policy discourse.

It is commonly acknowledged that while the media does not tell the public what to think, it can tell the public what to think about. It is this ability that endows the media with its capacity to “effectively set the public agenda for discussion of an issue and (to) establish --- the boundaries of that discussion” (Wallack & Dorfman, 1996, p.294). Hence it is important to cultivate a relationship with the media, and to use “media advocacy as a

policy-oriented” (Wallack & Dorfman, 1996, p.294) strategy to advance and raise awareness about SDH and related issues. The mass media has the capacity to “amplify “ silent voices so that policymakers cannot ignore them in the “din of policy debate”(Wallack & Dorfman, 1996, p.294). Therefore in place of traditional, tried, tested and failed lifestyle approaches, a media strategy consistent with current sociopolitical understanding of the SDH would embrace citizen participation and intersectoral collaboration. Where the traditional approach uses the media to “package and deliver” lifestyle information and leaves people with a health message (Wallack & Dorfman, 1996) a postmodern media advocacy approach enables population/public empowerment and capacity building, and leaves people with alternative narratives and the power to transform social conditions and environments that construct ill health. In this respect, Falk-Rafael (2005) notes that an enlightened public makes a powerful ally while Raphael (2012) observes that macro-political activities that seek to align public values with those of the SDOH may pressure politicians and policy makers to view the SDOH as a cause worthy of political focus, pursuit and investment. While such macro-political strategies were advocated decades ago, they are nonetheless even more relevant in an era of neoliberalism wherein the SDOH agenda represents a threat to various interests that uphold and sustain corporate hegemony and along with it, the commodification of health. Therefore the daunting, and yet quite conceivably surmountable sociopolitical and economic quagmire within which the public health issue of obesity is deeply submerged demands that nurses become custodians of social justice. Implicit in this role is a commitment that combines micro-level individualist strategies with upstream macro-level population strategies that in synergy (not exclusive of each other) offer the best, and perhaps the only hope for curbing the cascading tide of obesity and its associated assault on the human body and spirit.

Yet a lack of political acumen has been implicated as an impediment to nurses' ability to participate at a political level (Browne & Tarlier, 2008; Falk-Rafael, 2005). With regard to this, Dufty (2005, p.115) opines that an appreciation of the "political roots of economic deprivation" and the "fundamental political and psychosocial cultures that power behavior" is necessary to effectively engage in macro level upstream strategies (that simultaneously uproot the structural causes of obesity as well as facilitate the necessary resources and opportunities require) to make a healthy lifestyle accessible, affordable and feasible. Thus, the realization of transformational nursing roles and practice imply the need for nursing education and curricula to shift away from the traditional, institutional and apolitical socialization of nurses in favour of academic and clinical preparation that incorporates critical social justice courses (Falk-Raphael, 2005; Reutter et al, 2004) to turn the tide against the prevailing tendency to shy away from sociopolitical activity. Additionally, given that health is intrinsically political, courses in politics, in particular health politics, and health policy need to be incorporated both at the undergraduate and graduate levels as required versus elective courses. Familiarity with the political landscape, the political ideologies within which particular health care systems are immersed, and therefore the ideas, values and interests that drive them is key to developing the political savoir faire needed for political advocacy (Browne & Tarlier, 2008, Reutter & Kushner, 2010). It will also serve to dispel concerns nurses tend to have about power and resistance as necessarily negative and therefore counter to their altruistic image. Inter-faculty collaboration between nursing and political science will be key to such curriculum design and development.

6.8 Implication For Interdisciplinary Practice

Beyond nursing, there are also implications for medicine and other allied health professionals' practice, education and learning with respect to the need to develop greater awareness and sensitivity about how they produce, replicate, take up and translate obesity knowledges and the discursive effect and impact on obese individuals. The need for a multi-perspective approach in the management of obesity, demands dialogue and collaboration across health disciplines and recognition of a mutual mission to improve the health and wellbeing of individuals and populations within a milieu that emphasizes the collective social accountability and social responsibilities of all health professionals. This requires innovative interdisciplinary approaches at all levels of health care – the micro-individual level, the meso-institutional level and the macro-policy or governmental level. For example, promoting interactive or shared socialization of nursing, medical and other allied health students to interdisciplinary practice through interdisciplinary academic and clinical learning experiences, and later at a professional continuing education level, may mitigate or eliminate hierarchical relations of power that perpetuate fragmented practices based on different professional values and interests. In an era of increasing complexity and fiscal constraints in health care, team work and collaboration is key and interprofessional learning and socialization is considered a means for facilitating this (Larson, 2012; Mickan, Hoffman & Nasmith, 2010; Schuetz, Mann & Everett, 2010). Such an approach has promise for advancing a multi-lens approach to obesity as it will help make visible for consideration areas of commonalities and dissonance in the various perspectives among health disciplines, promoting the former while finding mutual and respectful ways of transcending the latter in the interest of a

common vision for health for all in an equitable society. It is necessary to reiterate therefore, that while this study interrogates the effects of the dominant discourse on obesity there is no intention to perpetuate polarization but to inspire critical reflection and insightful discussions about ways in which health professionals can ‘work within and through various discourses’ in their education and learning, practice and research to embrace and advance a multi-perspective approach to addressing obesity that acknowledges the role played by the wider sociopolitical, economic, cultural and environmental milieu. It makes sense to look at obesity from a multi-perspective lens that does more than just explore or examine causation and the onus of responsibility as the only point of reference for finding solutions.

6.9 Utility of Feminist Poststructuralism For This Study

This study is part of an academic work undertaken to explore among others, how the use of a feminist poststructural approach to inquiry can illuminate and advance a better understanding of the experiences of pregnant women living with obesity.

The use of a Foucauldian-inspired feminist poststructural (FP) approach enabled the exploration of study participants’ lived experiences of obesity beyond the meaning and interpretations ascribed to these experiences to more significantly how they came to be understood as such, what external forces, values and beliefs (ideologies) in the form of discourses to which they have access, give rise to and sustain their intrinsic perspective of those experiences. An insight into how, why, for what purposes and in whose interest, for whose benefit or not the discourse of obesity has been constructed or problematized offers in general “a better understanding” of the multi-factorial, multi-contextual issue of

obesity (Aston et. al, 2011, p.1190). Beyond facilitating an understanding of how they negotiated and positioned themselves within and between discourses, it enabled insight into their unwitting complicity in their own subjugation, and thereby their own inadvertent collusion in upholding and sustaining the constraining meaning they have come to associate with their experience of self, body and pregnancy. Thus the FP lens guided this study, not in the direction of unearthing some truth but to the more emancipatory project of interrogating how particular maternal obesity truths came to be, by whose narrative and doing, for what purposes and in whose interest. Such interrogation is only possible when the focus of inquiry or its point of reference is how particular knowledges come to inform and constitute particular experiences and practices. It therefore enabled an analysis of these experiences in a manner that takes up feminist and power issues, allowing an expose' and unpacking of the relations of power inherent in what counts as truth and what does not, and therefore what is marginalized and excluded and by what means. By bringing to the surface the every day taken-for-granted assumptions of maternal obesity based on the uncritical uptake of biomedical truths, it enables the politicization of the complex issue of obesity and the associated social injustices that result from a hegemonic discourse that promotes a facile but injurious characterization of obese pregnant women based on their corporeal or external appearance. Overall the use of a feminist poststructural lens allowed an analysis of the issue of maternal obesity as present in the experiential narratives of the two women in a manner that rendered its kaleidoscope of historical, political cultural and social contexts as well as the underpinning power relations that drive it open for contestation. Above all, it facilitated a process of inquiry that, in a small way, enabled the women to experience

‘aha’ moments that motivated them to lift their voices in attempt to resignify their experiences in less constraining ways.

In light of the above, I concur with Aston et. al’s (2011) recommendation that nurses endeavour to become cognizant of the power relations that both constitute them and inform their practice, and that feminist poststructural provides the avenue for engaging in critical contemplation and interrogation of the epistemic and ideological basis of nursing practice.

Embracing a feminist poststructural lens will enable nurses to reflexively examine their own values and beliefs. This will in turn lead to realization of the deleterious consequences of prevailing biomedical-based approaches, compel a rethink of such approaches, and conversely motivate commitment to practice that nurtures agency in obese individuals and enable them to micro-politically resist the constraining affects of dominant discourse. In this respect, feminist poststructuralism allows for practice that takes a multiperspective approach to the issue of obesity, factoring in the influence of power relations that are in play. It can also lead to an awareness of obesity as a complex phenomenon versus its simplistic portrayal by the dominant biomedical discourse as an easily preventable and therefore individually created problem, resulting in a way of looking at, talking about and caring for obese individuals in a more empowering or ‘non-conformist-to-the-prevailing-ideology’ fashion. In addition, as a consequence of such awareness, nurses will be inspired to interrogate the stigmatization perpetuated by the dominant discourse.

The pursuit of social justice nonetheless requires a multifocal approach that also recognizes the role macro forces play in constituting some as privileged and others as

marginalized, and in creating conditions of social inequities that impact health, and hence the need to act at a political level in the interest of social transformation. A multifocal nursing social agenda calls for a role in macro-level, upstream advocacy.

6.10 Utility of Feminist Poststructuralism For Nursing Research

Feminist poststructuralism has much to offer in advancing nurses' pursuit of social justice, and offers the opportunity for emancipatory research that subverts the status quo, thereby spotlighting issues that need to be reconceptualized in the interest of social equity. It therefore presents an opportunity to transcend traditional politically appropriate approaches to envisioning and doing research to embracing more egalitarian, multivocal and multiperspective approaches to inquiry.

With respect to research, I unequivocally believe that feminist poststructuralism has, to adopt Tobias' (2005, p.68) words, "the emancipatory potential of analytic critique and vigilance" required to push forward nursing's social justice agenda and to address the ethical imperative of scholarship which is "to give new impetus, as far and wide as possible, to the undefined work of freedom" (Foucault, 2003d, p.54). I therefore argue for the continued use of feminist poststructuralism as a lens to interrogate and politicize obesity truths that essentialize and universalize obese individuals' ways of being and understanding self, foreclosing alternate truths and thus apprehending their sense of self worth and human integrity. I recommend that nurses undertake more studies that employ a feminist poststructural lens in tandem with a social determinants or health equity lens to explore the experiences of obese pregnant women, given the mounting evidence that this population of women constitute women who are more apt to live on the periphery of

society and hence more susceptible to the havoc of material deprivation, as well as the corrosive effects of stigmatization based on the simple fact that they inhabit the bodies they do and are located on the lower echelons of the social ladder. More studies using this lens have the capacity to make transparent the not so obvious promotion of stigmatization that is a direct consequence of the neoliberal-premised dominant biomedical discourse of obesity. More significantly, an abundance of such studies will ensure a multiplicity of empowering and emancipatory translation of obesity knowledges that upon dissemination may have the capacity of transforming both public opinion and health professionals' beliefs and assumptions about obesity. Such studies will thus make the case for democratization of perspectives, and promote alternate, more liberating approaches that acknowledge the local truths of obese pregnant women as equally valuable and deserving of an audience that truly listens to hear and commit to alternate ways of understanding obese pregnant women. Studies using a feminist poststructural lens will compel a reflection of current practices; a critical appraisal of health professionals' values and beliefs; and a resultant commitment to reformulate current oppressive practices to open space for authentic relational practices that engage women in conversations that promote their ability to empower self to resist or at least control the effect constraining power relations have on them. In this respect, such studies also have the potential to collectively explore various resistive strategies that can be accessed and deployed by marginalized obese pregnant women to counter and resist the stigmatizing effects of the dominant discourse, while resignifying their experiences in less constraining, and more empowering ways. Equally significant, in addition to their ability to promote greater awareness and understanding of obesity, such studies can draw attention to and lead to

“the provision of” the necessary “supports” (Kirk et. al., 2014, p.10) and resources required to make empowering approaches a reality.

As mentioned earlier, for decades nursing has advanced social justice as a central professional value and as a fundamental desideratum necessary for the advancement and sustenance of human survival (Taylor, 2006; Sluka, 2006). Not surprisingly, the impetus for the evolution of the nursing profession was the pursuit of social justice and the fundamental right of every human being to dignity regardless of race, creed, colour, gender or class (and for that matter body size) was the platform from which nursing promoted work in the service of the marginalized and disenfranchised (Barnes, 2005). I argue that as a worldview, feminist poststructuralism has congruence and is therefore highly compatible with nursing’s quest for social justice and the elimination of social inequities as it advances and provides the opportunity to, inter alia, adopt an ethico-moral relational practice that emphasizes respectful, empathetic and empowering interactions with marginalized clients in tandem with macro-political action, thereby creating individual micro-political ripples and paths to macro-political waves of collective social transformation. With this in mind it is important to point out that the original design of this study did not include a follow up interview. From a feminist perspective, in the interest of a politics of representation, it is recommended that future studies could include a second interview to add another layer of interpretation. This may also afford the women an opportunity to discuss the interpretation (if they so wish) as well as how their participation in the study affected their own understanding of obesity and pregnancy.

6.11 Feminist Poststructuralism-Addressing Reservations

It is necessary at this point to mention some of the criticisms leveled by liberal feminists against feminist poststructuralism, specifically at the Foucauldian notions that ground it. Foucault's analytic of power as a relation and disavowal of grand theories and truths has been lambasted for supposedly being, among others, nihilistic, relativistic, antithetical to traditional notions of politics, an impediment in the political landscape because it immobilizes political transformation, stymies rather than advances resistance especially at the macro-political level as there is no one truth to dismantle; his conception of the capillary nature of power essentially leaves no villain (dominator) to blame and no victim (dominated) to free or empower and hence it lacks a cause to fight (Anderson & Wong, 2013; McLaren, 2002; Smart, 1998; Tobias, 2005); branded useless for feminism and "a dangerous approach for any marginalized group to adopt" (Hartsock, as cited in McLaren, 2002, p.24). McLaren's (2002) book, *Feminism, Foucault and Embodied Subjectivity* delivers an insightful master defence of Foucault's utility for feminism and philosophy in general. For the purposes herein, I take up one of the criticisms that has particular import for my oeuvre. Given the criticism leveled against the utility of Foucault in advancing macro-politics which necessarily includes social and state action on the social determinants of health, it becomes necessary to consider the contrariness of this (mis) reading by considering his notion of limit-experience. In this respect, I draw heavily from Tobias' (2005) explication of this notion in his overview of Foucault on freedom and capabilities. Foucault delineates limit- experience as " an experience that undermines the subject ---- because it transgresses the limits of coherent subjectivity as it functions in everyday life, indeed threatens the very possibility of life" (Foucault, as cited

in Tobias, 2005, p. 78). Central to this notion is that “certain point of life” renders experience “unlivable” (Tobias, 2005, p.74). Admittedly, the negative experiences of Jenna and Jane and presumably (it is hoped, at least) many women in similar situations of material deprivation may not constitute, literally of course, a threat to life. Nonetheless, Foucault’s delineation of ‘limit’ experience acknowledges the powerlessness associated with material or economic deprivation can delimit and compromise a subject’s capability for effective agency due to a “sustained inability to bring about real changes in one’s own life situation” (Tobias, 2005, p.79) leading to a goal not of resistance but survival. This in effect renders a compromised “knowing subject” (p.78) incapable of self-action to facilitate “understanding and action whereby a meaningful relation to self can be conceived and enacted” in power relations (Tobias, 2005, p.79). This may be reminiscent of Jane’s allusion to extreme transgression – “smoke my brains out”. For after all, “capacity for action on the self” (Tobias, 2005, p.78) is a desideratum for the pursuit of self ethics which in turn implies the application of “a politics of freedom---- only to a subject sufficiently integrated into existing circuits of knowledge and power” such that they are “empowered” rather than “constrained” by them (Tobias, 2005, p.81). In short, a viable exercise of resistance and agency requires the capacity of resources to do so. By his own admission among others, through his political activism (which attests to the significance he assigned relational intersubjectivity and collective action) Foucault does acknowledge that the powerlessness of material and political deprivation may indeed warrant external action (social policy) to turn around (McLaren, 2002; Tobias, 2005). In addition his conception of parrhesia, the moral and ethical notion of truth-telling as self-practice that mobilizes the assistance of others, “listener(s) in a political context”

(McLaren, 2002, p.154) is further testimony in this regard. Tobias (2005, p.82) puts this further in focus when he notes that for Foucault “a reluctance to endorse even a minimum threshold of public provision risks ‘leaving people in the slums thinking they can exercise their rights there’”. The wisdom of this is captured elsewhere in a related context in the words of a poor Latino woman: “I don’t care about your revolution if I can’t get rice and beans” (cited in Hall, 1999, p.91) and is concomitantly echoed in a researcher’s observation that “the goal of the moradores (residents) of the Alto- Cruzeiro is not resistance but simply existence” (Scheper-Hughes, as cited in Tobias, 2005, p.80). This makes the commonsensical argument, in the name of our common humanity, for tempering and balancing personal responsibility with a social responsibility for health for as Foucault further asserts the project of self-care is “not an exercise in solitude, but a true social practice” (Foucault, as cited in Anderson & Wong, 2013, p.425). This in no way devalues the importance of individual micro-politics. Individual resistances are vital because resistances in and of themselves “are all the more real and effective because they are formed right at the point where relations of power are exercised” (Foucault, 1986, p.142). Hence, paradoxically, “I don’t care about your revolution, if I can’t get rice and beans” is indeed an individual micro-political act of resistance in the sense that the subaltern sounds her voice and gets a resounding audience because she can be quoted and read by many who might be inspired to rethink their stance or practice, or sound their own voice in resistance. Therefore, contrary to being an antithesis to collective politicization, Foucault intended for local narratives to expose and ultimately transform how discursive truths come to be and how they function, hence his observation that “the swarms of points of resistance traverses social stratifications and individual unities. And

it is doubtless the strategic codification of these points of resistance that makes a revolution possible” (Foucault, 1980, p.96). Besides, I argue that if targeting individual bodies for discipline is the path to regulating populations, then it stands to reason that resistance should emanate from the individual micro-political level from whence it will disseminate to the macro-political level. I cite for example the fact that the civil rights movement began with one random act of individual resistance on a city bus that led to a 381-day collective boycott of buses by other marginalized individuals, undermining and sabotaging the economic and social power of the dominant group, and crucially culminating in a resounding constitutional defeat. That individual, a working class seamstress, Rosa Parks refused to give up her seat to one who had been discursively constructed and privileged as a superior human being on the basis of skin colour, because she was simply “tired of giving in” (Parks, 1992, p.116). This micro-political individual act of resistance, a consequence of a refusal to be who she had been made to think she was, sent ripples across the wider socio-political waters of civil rights. Referring to the power of such resistances and following Foucault, Birrell & Theberge (1994, p.363) aptly note that they “mount up causing inconvenience and disruption to the system and those it serves” and thus while social transformation is the goal, individual micro-political resistances can be viewed as the path to such transformation.

Hence, as history reminds us, social forces undoubtedly have the potential to cause political action overtime. Yet the power of public awareness and social consciousness to define the manoeuvring latitude available to effect macro-political upstream structural and policy changes necessarily emanates from individual awareness and raised consciousness. The question to critics of feminist poststructuralism then

becomes, assuming there is a consensus that individuals make up a collective, how does any individual engage fully and effectively in collective macro-political activity when they remain psychically colonized? As McLaren (2002, p.116) so eloquently sums it up individual bodies cannot be discounted because they form the social and collective body for:

“It is my body that marches in demonstrations, my body that goes to the polls, my body that attends rallies, my body that boycotts, my body that strikes, my body that participates in work slow downs, my body that engages in civil disobedience”.

Without a doubt therefore, it is individuals who take up macro-political resistant actions. There can be no collective action without individual participation, and the individuals required for collective social action are those whose skepticism has led to a raised consciousness, those who have become cognizant of truth games and have decided to assert their agency in order to have a say in how it is played; it is ultimately those who have come to know who they are and refuse to be what others say they are and therefore true to their moral, ethical selves speak truth to power.

CHAPTER 7 Conclusion

It is no coincidence that the significance of maternal obesity extends beyond its implication for the health of the mother-baby dyad to its impact on the general population. As a health issue that has garnered immense global attention, obesity is a relevant research issue if only because of the effect this attention has had in the creation of a moral panic about, and the discursive social construction of obese pregnant women which positions and enables them to position themselves in ways that repress and constrain personal, political, economic and social possibilities. As a marker of population health and a 'barometer' of the state of the healthcare system, maternal health is key to the overall health and development of any society or nation (McDonagh & Goodman, 2001). Safe Motherhood, an advocacy initiative that evolved in the late 1980s in response to maternal morbidity and mortality in developing countries, now has import for developed countries where maternal obesity is currently considered the most common obstetric risk factor associated with multiple co-morbidities (Bennet & Adams, 2002; Wilcox, 2002). Ensuring safe motherhood for obese pregnant women implies ensuring that they receive the appropriate relevant care they require to be safe and healthy, both physically and psychosocially throughout pregnancy, childbirth and beyond. This requires a responsive, proactive, timely and sensitive approach to care of obese pregnant women, within a practice milieu that acknowledges the influence and impact of power structures and relations on maternal obesity. More significantly, that such caring incorporates a postmodern ethic of relational practice and reflexivity in which respectful, empathetic and empowering interactions with obese pregnant women moves from the margins to centre stage. While such transformation may be at a micro level, as Zerwekh

(2000, p.60) notes, “by strengthening individual clients, we enhance the possibility of their acting as empowered communities.”

The crux of my interrogation is not to reject knowledge, but to reject its uncritical uptake as the only truth that counts. It is also to interrogate the truth effects of a singular approach to obesity management that leads to the colonization and commodification of identity. To embrace Rogers’ (1991, p.10) words I did not set out to “tell it like it is” but to extend an invitation to pause for a moment and “look at it this way” through alternative prisms. I nonetheless confess that I consciously set out to subvert the totalizing and unequivocal certainty with which obese pregnant women are read and understood, causing them to in turn read and understand themselves from a dominant biomedical prism that labels and excludes them as Other. To this end, this study hopes to invite and incite nurses to pause, read between the lines of discourse, discard presumptions, give the time of day to what is taken for granted, and to envision possibilities of caring approaches grounded in principles of relational ethics and social justice in their everyday encounters with obese pregnant women.

Remaining true to the spirit of feminist poststructuralism, I acknowledge that women are not a monolithic collection of humans and that their experiences exist in diverse contexts, they are inter alia raced, classed, sexed, historically, culturally, socially and politically specific and contingent. This was a small exploratory study of white, heterosexual, low income, rurally-located, self-identified obese women experiencing their first pregnancy. The findings are not meant to represent the experiences of obese pregnant women in toto. Nonetheless, there were nuances of these two women’s narratives of experience that cohere with those of other obese pregnant women explored

in other studies as pointed out in the literature review and noted elsewhere in this document. Thus the findings can be acknowledged as a minuscule contribution to the pool of local narratives that have already been given airing and a salute to the many more that simply beg to be afforded the same emancipatory opportunity.

I also acknowledge the inevitability of a different reading of this work by a different set of eyes, undertaken at a different point in time, period or context. Remaining true to the spirit of the methodology I have employed I subscribe to a plurality of truths and perspectives and acknowledge that there is “no point of view that could give us access to any complete and definitive knowledge” (Foucault as cited in Anderson & Wong, 2013, p.430). Equally of significance, deferring to diversity and “difference” entails being open to the ongoing process of meaning making, and avoiding the presumption of a “fixed” meaning and thereby foreclosing possibilities, for meaning much like subjectivity “is constantly subject to dispersal” (Weedon, 1997, p.96). Given time, in another place or context, my own reading of these narratives may be different in light of new experiences and access to other innovative discourses. For now, I am both morally and ethically obliged to acknowledge the polysemic nature of my oeuvre.

Therefore with one final bow to Foucault (2003c, p.247), there is no intention here to “lay(ing) claims to totality. I don’t try to universalize what I say; conversely what I don’t say isn’t meant to be thereby disqualified as being of no importance,” hence this work is meant to incite more inquiry on the issue of maternal obesity along similar lines; so “try it out, and then if it doesn’t work, try again somewhere else”. Crucially, this is a toast to remaining perpetually uncertain and skeptical, for therein lies the motivation to keep treading the paths less travelled in quest of ‘aha’ moments that free us and others to

refuse what and who we have been made to think we are and to aspire to endless possibilities.

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Appendix A

Interview Guide

I would like to thank you for taking the time to participate in this study. This is an exploratory study and there are no right or wrong answers. I want to hear your story, and what it is like for you to experience obesity and pregnancy. I will start with broad questions and let you do most of the talking.

1. Tell me what it is like living with obesity.

Probes:

What is obesity for you? How do you feel about obesity?

Is obesity a concern for you? Why/Why not?

2. Tell me what it is like to be your weight and pregnant.

Probes:

Do you feel pressure to be a certain weight because you are pregnant? How so? Do you feel in control of your weight?

Why or Why not? What makes you feel in control or not in control?

3. Tell me about your experiences of health care as an obese pregnant woman.

Probes:

What would you like to see happen in your encounters with health care professionals? What do you wish health care professionals knew or understood about your weight issues?

Is there anything we have not talked about today? Is there anything you wish to add, elaborate or correct? Thank you very much for your time.

Appendix B

Demographic Questions

I need some background information about you to assist me with my study report. You do not have to answer any if you prefer not to. As with all study information, the information you provide here will be held in the strictest confidentiality and any identifying information will be excluded in the study, study report or presentation.

What is your age? -----

How many weeks pregnant are you? -----

Is this your first pregnancy? Yes ----- No -----

If not, how many children do you have? -----

What is your marital status? Married/Common law ----- Single/Separated -----

What is your level of education? High School ----- College ----- University ----- Other -----

What is your employment status? Employed: Full time ----- Part time----- Unemployed -----

Please indicate what closely represents your approximate yearly income.

Under \$10,000 ----- \$10,000 - \$20,000 ----- \$20,000 - \$24,900 -----

What is your ethnicity?

African/ African Canadian ----- Asian/Asian Canadian ----- Caucasian -----

Hispanic/Hispanic Canadian ----- Native Canadian ----- Other -----

Appendix C

Letter of Invitation to Participate in a Research Study.
Study Title: Pregnant Women's Experience of Obesity.

Dear Potential Participant,

My name is Evelyn Abudulai. I am a maternal child health nurse and currently a student in the Master of Nursing programme at Dalhousie University. As part of the requirement of this programme, I am doing a research study about pregnant women's experiences of obesity and would like to formally invite you to participate. I believe what is currently known about this issue can never be complete or effectively serve women's self-identified health and wellness interests unless their stories are given voice. I also believe you have an important story to tell that must be heard.

Please inform the clinic nurse if you are interested in participating. I will be present at the clinic to enroll interested participants in the study, and will be happy to answer any questions you may have about the study, and or provide you with further information. On the other hand, if you prefer to, I can contact you, or I can be contacted at (902) 678-7381, extension 3050 or at (902) xxx - xxxx (home). Participation is completely voluntary, will be held in the strictest confidence and involve one 60-90 minute conversational interview with me, at a time and place convenient to you.

Thank you in advance for your consideration of this invitation.

Sincerely,

Evelyn Abudulai

Appendix D
Statement of Informed Consent

Study Title: The Experience of Obesity: Perspectives of Pregnant Women,
Exploring a Path Less Travelled.

Simplified Study Title: Pregnant Women's Experience of Obesity

Researcher:

Evelyn Abudulai, BComm, BScN, RN
Graduate Student
Master of Nursing Programme
School of Nursing
Dalhousie University
Halifax, Nova Scotia
(902) xxx-xxxx

Research Supervisor:

Dr. Megan Aston
Professor, School of Nursing
Dalhousie University
5869 University Avenue
Halifax, Nova Scotia
B3H 4R2
(902) 494-6376

Funding Source: None.

Introduction: You are being asked to participate in the above study. It is important that you understand why the study is being done, what it involves and what is expected of you. Please take time to review the following information carefully to decide whether you want to agree to take part in this study.

Purpose of the study: The purpose of this study is to explore and describe the meaning pregnant women assign to their experiences of obesity within the context of their everyday life, and in their encounters with health care providers. The researcher is conducting this study to complete the requirements of a Master of Nursing programme at Dalhousie University.

Are there any conflicts of interest? There are no conflicts of interest on the part of the researcher or the research supervisor. The researcher is not being paid to conduct this study.

Participation in the study: Participation is completely voluntary, and is your decision. You do not have to participate if you do not want to. If you do decide to participate, you also have the right to and can withdraw from the study at anytime if you so wish. You are

eligible to participate in the study if you are 20-24 weeks pregnant, have an annual income under \$25,000, self-identify as obese, speak, read and write English, give consent to participate and agree to sign a consent form.

What will I be asked to do?

Participation, if you agree, will involve one 60-90 minute conversational interview with the researcher, at a time and place convenient to yourself and the researcher such as a private room at the clinic or your home. The conversation will be in English and will be about your experiences, knowledge, feelings, values and opinions about health, pregnancy and obesity, where you get your ideas and information about these issues and the meaning these hold for you. You do not have to answer any questions you are not comfortable answering. The conversational interview will be audio-taped to help reflect and represent as accurately as possible the stories you share. The audio-taped interview will be transferred and written on paper word for word. A portion or portions of your interviews will be cited in the study report without revealing your identity.

How will my privacy be protected? Participation is confidential. Any information you share will be held strictly confidential. Your identity and privacy will be protected throughout the study as your real name and any identifying information will not be used in the study or written report. To guarantee confidentiality, you will be assigned or you can choose a pseudonym (fake name) to be used in the study, study report and /or presentations. All study information will be kept under lock at all times during and after the study in a secure place and access to computer files secured with a password. Access to study information will be limited to the researcher, her supervisor and her research committee of two university professors for the purpose of completing the study. An ethics audit committee may also need access for auditing purposes. All study information will be destroyed after a period of five years following publication of the study report.

What are the risks of participation? Anticipated risks from participation are minimal. Feelings of emotional discomfort may arise during the conversational interview, given the personal nature of the subject under discussion. You are not required to respond to any question that you may find emotionally upsetting or distressful. You are free to bypass any question that causes you to feel uncomfortable. You are free to stop the interview at anytime. Should the narration of an experience cause you any emotional or psychological distress, you may contact one of the professional resources that will be provided to you at the end of the interview.

What are the benefits of participation? Participation may provide an opportunity for personal reflection, and may inspire thoughts about possibilities and new ways of self-understanding. The interview may not benefit you, however, the stories you share may help health care professionals understand better what shapes the life and experiences of obese pregnant women and may inform the development of more sensitive, responsive and supportive relevant care and policies that take into account these unique experiences.

Results of the Study: The results of the study will be published in a report to complete the requirements of the Master of Nursing programme. They may also be used in articles

or presentations. In all instances, the anonymity of participants and the confidentiality pledged will be preserved and upheld at all times. A lay copy of the study results will be provided to you at the completion of the study if you request it.

Contact Information: If you have questions or concerns, or need more information about the study, please contact: the researcher, Evelyn Abudulai at (902) 678 -7381, extension 3050 (work) or at (902) xxx -xxxx (home) or the research supervisor, Dr. Megan Aston at (902) 494 -6376.

If you have any difficulties with, or wish to voice concern about any aspect of your participation in this study, you may contact Catherine Connors, Director, Research Ethics, Dalhousie University for assistance at (902) 494-1462, ethics@dal.ca.

Appendix E

Letter of Introduction to the Manager, Maternal Child Health,
Annapolis Valley District Health Authority.

Study Title: The Experience of Obesity: Perspectives of Pregnant Women
Exploring a Path Less Travelled.

Dear Ms. _____,

As you are aware I am enrolled in the Master of Nursing programme at Dalhousie University and currently undertaking thesis work towards partial fulfillment of the programme's requirements.

This letter is to formally introduce to you the research study I propose to undertake and towards which you have kindly agreed to allow me access to your prenatal clinic for the purposes of recruiting study participants.

While there exists an extensive discourse on the science of maternal obesity, less documented are the voices of pregnant women on their human experience of it. Accordingly the purpose of the study I propose is to explore and describe pregnant women's experiences of obesity, how these experiences came to be and what meaning they ascribe to them in the context of their everyday life, and in their encounters with health care professionals. It is hoped the study will illuminate the processes by which obese pregnant women take up, negotiate and or navigate the various available dominant and often conflicting discourses on body weight and health. Such insight may help reconceptualize the horizon of understanding maternal obesity (both on the part of obese pregnant women and the health care professionals who care for them), as well as inform the development of relevant guidelines that promote non-judgmental and empowering interactions and approaches in the nursing care of these women.

The study would require the participation of 2 – 4 women who are 20 – 24 weeks pregnant, have an annual income under \$25,000, who self-identify as obese, speak, read and write English and who give their consent to participate and sign a consent form. I will need, and have requested the assistance of the clinic nurse in recruiting potential study participants. Participation in the study will entail one 60-90 minute audio-taped conversational interview, at a time and place of participants' convenience. Participants will be asked questions about their experience, knowledge, feelings, values and opinions of health, pregnancy and obesity.

Once again thank you for your support and assistance in this undertaking. Please find enclosed, for your information, appendices that were sent to the Dalhousie University Graduate Ethics Committee.

Sincerely,
Evelyn Abudulai

Appendix F

Letter of Introduction to Prenatal Clinic Nurse.

Study Title: The Experience of Obesity: Perspectives of Pregnant Women
Exploring a Path Less Travelled.

Dear Colleague,

My name is Evelyn Abudulai and I am enrolled in the Master of Nursing programme at Dalhousie University, and currently undertaking research work toward partial fulfillment of the programme's requirement.

This letter is to formally introduce, and to request your assistance in recruiting participants for my research study. While the science of maternal obesity is extensively documented, rarely is the human experience of the pregnant women who live it given voice. Therefore the objective of the study I propose is to explore and describe pregnant women's experiences of being obese, how these experiences came to be, and what meaning they hold for them in the context of their everyday life, and in their encounters with health care professionals. The goal is to gain some insight into how obese pregnant women take up, negotiate and or navigate the various dominant and often conflicting discourses available to them on body weight and health. This will in turn enable a reconceptualized horizon of understanding maternal obesity (both by obese pregnant women and health care professionals who care for them), as well as inform the development of relevant guidelines that promote responsive, non-judgmental, empowering interactions and approaches in the nursing care of these women. The study will require 2 - 4 women who are 20-24 weeks pregnant, have an annual income under \$25,000, who self-identify as obese, speak, read and write English and who give their consent to participate and agree to sign a consent form.

I am requesting your assistance in the recruitment of participants because I believe you are strategically positioned in the community and are in direct contact with potential participants on a daily basis. Your role would involve introducing the study to potential participants (based on the inclusion criteria and letter introducing and explaining the nature of the study) and inviting them to participate if they are interested. Recruitment flyers will be posted at the clinic to enhance recruitment. I will be on hand to answer any questions and to provide any further information potential participants may request, and to enroll interested participants who meet the inclusion criteria in the study.

For participants, the study will involve one 60-90 minute audio-taped conversational interview, at a time and place of their convenience. Participants will be asked questions about their experiences, knowledge, feelings, values and opinions of health, pregnancy and obesity. They will be provided with and requested to sign a written consent form with information about the study purpose, procedures, risks, benefits, voluntary nature of participation, the right to withdraw at anytime, measures to ensure confidentiality and a request to record the interview and to use direct quotes in the final report.

I thank you for your time and consideration and look forward to your response. If you require any further information, I can be contacted at (902) 678 7381, extension 3050.

Sincerely,
Evelyn Abudulai

Appendix G

Recruitment Poster

Research Study

Pregnant Women's Experience Of Obesity

If you are 18 years or older, 20-40 weeks pregnant self-identify as obese and have an annual income under \$25,000, you are invited to participate in a study that examines pregnant women's views and experiences of obesity.

The research study is interested in hearing your voice and your story about what it means to experience health and everyday life as an obese pregnant woman.

The goal of this study is to document your perspective to enable a better understanding of what shapes your experiences.

New and different ways of understanding obesity can promote more respectful and empowering ways of interacting with obese pregnant women and overall more positive health care experiences.

If you are interested in participating please contact:
Evelyn Abudulai at
(902) 678 7381 Ext. 3050

Participation involves one interview in which you will be asked questions about what you know, your views, and feelings about health and body weight.

This study is part of the researcher's work toward a Master of Nursing degree at Dalhousie University.