

# **‘Gaining the Right Amount for my Baby’: Young Pregnant Women’s Discursive Constructions of Health**

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*Received 6 November 2010 Accepted 11 September 2011*

## **Abstract**

*In Canada, obesity is increasingly emphasised as a “risk” to the health of mother and foetus. At a time when pregnant women are under greater pressure to personally uphold the health of their foetus, understanding the impact of the discourse surrounding obesity and health on young pregnant women is critical. Using a feminist poststructuralist discourse analysis, we explore how pregnant young women construct their subjectivities either within dominant discourse on health and obesity or possibly resistant discourses. Open-ended interviews were conducted with 15 pregnant women between the ages of 18 and 28, coming from various socioeconomic and educational backgrounds in the Ottawa region. The analysis reveals that these women constitute themselves as complex, fragmented subjects who at times construct themselves within alternative and resistant discourses but generally reproduce dominant discourses of obesity, of individual and moral responsibility for health, and of maternal responsibility for foetal health. Implications for health promotion and policy strategies are discussed.*

**Keywords:** Women; pregnancy; health; obesity; discourse, poststructuralism

## **Introduction**

Over the past two decades, we have witnessed an increasing concern over an ‘obesity epidemic’. Individuals have been exposed to a huge amount of ‘scientific’ information regarding obesity and health imbricated to public media messages emphasising the negative effects of obesity and the individual responsibility for these effects. This has led some scholars to identify a dominant ‘obesity discourse’ in Western societies wherein health is equated with slenderness, and weight and shape are thought to be controlled through individual lifestyle and actions on the body (Boero, 2007; Evans et al., 2004; Gard & Wright, 2005; MacNeill & Rail, 2010; Oliver, 2005; Orbach, 2006; Rail, 2009; Rail et al., 2010; Rail & Lafrance, 2009). Within this obesity discourse, many scholars have also identified moral and normalising undertones leading to the stigmatisation of ‘overweight’ and ‘obese’ individuals (Campos et al., 2006; Gard & Wright, 2005; Murray, 2007; Oliver, 2005; Saguy & Almeling, 2008).

More recently, a number of biomedical studies have focused on the ‘risks’ associated with ‘excess’ weight gain during pregnancy (Jovanovic, 2001; Smith et al., 2008). The dominant obesity discourse has likewise transformed to now include references to the necessity of weight control during pregnancy. Exact guidelines regarding appropriate weight gain have surfaced along with recommendations for nutrition and exercise to control weight gain (Kuhlmann et al., 2008; NICE, 2010; Polley et al., 2002; Rasmussen & Yaktine, 2009; SOGC, 2010; Weissgerber et al., 2006).

Feminist scholars have long criticised the medicalisation and pathologisation of pregnancy as well as the fact that women’s bodies are increasingly controlled through medical and public surveillance (Bordo, 1993; Lane, 2008; Longhurst, 2001; Lupton, 1999; Martin, 1987; Mitchinson, 2002; Weir, 2006). Firstly, many feminist scholars have argued that the advice and interventions that pregnant women receive are most importantly aimed at protecting the health of their foetus, and that pregnant women lose their autonomy and personhood during pregnancy since the health of the foetus is considered paramount (Bordo, 1993; Chavkin, 1992; Longhurst, 2001; Lupton, 1999; Martin, 1987; Weir, 2006; Young, 1990). Secondly, many scholars have noted that despite important social determinants of health, the pregnant woman is increasingly viewed as the sole individual responsible for the health of the foetus (Bordo, 1993; Chavkin, 1992; Lane, 2008; Lazarus, 1994; Lupton, 1999; Ruhl, 1999). The pregnant woman is expected

to do everything she can to reduce risks to foetal health in order to deliver the 'perfect' baby. The dominant obesity discourse mirrors a growing emphasis on the pregnant woman to self-regulate her body and health in order to reduce possible risks to the foetus while simultaneously being increasingly surveyed by the medical and lay communities.

Various researchers have looked at the ways in which pregnant women construct their health and health practices (Bondas & Eriksson, 2001; Lazarus, 1994; Markens & Browner, 1997; Martin, 1987; Rudolfstottir, 2000). Devine, et al. (2000) have asserted that pregnancy may be a time when many women change their health practices and beliefs. They stress that "life transitions such as childbearing have been conceptualised as times of change in personal health attitudes and practices due to changes in social networks, health concerns, or resources" (Devine, et al., 2000, p. 568). Therefore, pregnant women's increased exposure to medical discourse at their new 'life stage' may create a change in lifestyle. Markens and Browner (1997) have discussed the internalisation of prenatal norms surrounding diet. They have argued that pregnant women are willing to accommodate the discourse surrounding maternal diet, thus upholding the view that women are personally responsible for the health of their foetus. Bondas and Eriksson (2001, p. 828) have also commented on the motivation that women feel to improve their health in order to "safeguard the health of the wished-for baby". The women in their study were also worried that the health of their child would be affected by their unhealthy habits. In sum, many scholars have noted that women do internalise the medical discourse upholding the health of the foetus as paramount and the idea of the mother's responsibility for its health as opposed to ideas associated to structural determinants of health of both mother and foetus.

Other authors have looked at women's constructions of pregnancy experiences and have argued that they often differ from those presented as 'normal' within dominant biomedical discourses (Markens & Browner, 1997; Mitchinson, 2002). In that regard, Root and Browner (2001, p. 218) have suggested that biomedicine has a "homogenising potential ... to normalise women's pregnancy experiences along its own disciplinary lines" but that, within women's accounts, there persists an "ever-present and potent individual agency". The women in their study draw on dominant (i.e., medical), but also subjugated knowledges (i.e., those practices and experiences of pregnancy that do not rely on medical expertise, for example, embodied feelings) in decisions concerning their health practices.

Past literature indicates that pregnant women make decisions about health in complicated and conflicting ways, turning to both medical expertise and their own needs and experiences. However, within the current context of a very dominant obesity discourse and given the recent interest in, and guidelines associated to, purported 'risks' of 'excess' weight gain during pregnancy (SOGC, 2010), pregnant women's discursive constructions of health remain unclear. The purpose of our study was thus, to contribute a better understanding of young pregnant women's constructions of health in such context. We thought it was important to unpack how the dominant obesity discourse and other health discourses (e.g., maternal responsibility for foetal health) impact, if at all, on the ways in which women discursively construct their health during pregnancy, and whether these women are interpellated by other (e.g., alternative) discourses related to pregnancy or the pregnant body. Lastly, given the various and often contradictory subject positions available to women, we thought that understanding how they construct their subjectivity within alternative and/or resistant discourses could be a crucial step in disrupting the current medicalised and pathologised constructions of pregnancy. In the next section, we present the theoretical and methodological choices we have made to conduct this study.

### **Feminist poststructuralist perspective: Theoretical and methodological considerations**

Many scholars discuss the value of feminist poststructuralist thought in understanding how power produces individual actions and beliefs in society (Butler, 1997; Rail, 2009; Sawicki, 1991; Weedon, 1997). We have opted for this perspective for our study and this implies a number of important concepts. With regards to *power*, our poststructuralist stance means that we understand it as not wielded over individuals, but rather exercised from innumerable points (Foucault, 1976). Feminist poststructuralists also posit that power is exercised from a male perspective where socially-constructed biological differences are stressed in a way that upholds women's inferiority (Weedon, 1997). Furthermore, concepts such as the '*gaze*', whereby the subject becomes intimately aware of herself and her actions, helps to explain how patriarchal power functions to discipline and subjugate women, creating '*docile*

*bodies*'. Docile bodies are those that "may be subjected, used, transformed, and improved" (Foucault, 1975, p. 136). Bartky (2003) has described Foucault's concept of the docile body to define the feminine docile body as one that upholds her subjugation through the very actions that create her as a woman. Women regulate their bodies to uphold a feminine standard, and through this perpetual regulation, become docile feminine bodies. Foucault (1976) also posits *biopower* as a form of productive power that acts to control populations and manage the production of life. Recently, biopower has come to mean the circulation of a discourse of personal responsibility for health and wellbeing. Foucault (2003) has linked this to the emergence of liberalism, whereby individuals no longer need to be governed by the state, but must take personal responsibility for their own life. Therefore, biopower works to create docile bodies that participate in their own surveillance, upholding the management of their life processes.

Foucault (1975) argues that power produces the subject through *interpellation* by certain discourses. Discourses produce our reality and thus create the individual, for instance, one's *subjectivity* as a woman, a pregnant woman, and a future mother. However, subjectivity is not stable or fixed, but rather fluid, emergent, multiplicitous, and performative, through actions already socially established (Butler, 1997). From this perspective, subjectivity is constituted within and between contradictory discourses, opening up the possibilities for resistant positions. Women also have the capability to reflect on their subject positions (i.e., their positioning with particular discourses and social structures), creating the possibility for *agency* (Weedon, 1997).

Our selected perspective allows us to better understand how young pregnant women are interpellated by certain (dominant or alternative) discourses, notably those related to obesity and health. Concepts such as the 'gaze', the 'docile body' and 'biopower' help to identify why and how women may act to uphold their own subjugation within patriarchal power relations, and the poststructuralist perspective also considers the active constitution of subjectivities, thus allowing for an understanding of dominant and/or subversive constructions of health during pregnancy.

Our theoretical stance has methodological repercussions and we adopted a feminist poststructuralist discourse analysis method for our qualitative study. Feminist scholars assert that the purpose of research is to advance the interests of the participants and create social change. They argue for this change by challenging women's oppression, questioning taken for granted notions about social order and relations, and practically improving the conditions of women's lives through their research (Sprague, 2005). In addition, poststructuralist thought rejects the view of meta-narratives and the idea that meaning and truth are pre-existing and can be found (Kvale & Brinkmann, 2009). Therefore, a feminist poststructuralist stance stresses the act of research as a joint process with the participant wherein meaning and knowledge are created rather than found through interaction. We took such considerations to heart.

Participants were recruited purposively through snowball sampling and contacting local prenatal programs in the Ottawa area. The sample included 15 young pregnant women between the ages of 18 and 28. We looked to Kvale and Brinkmann (2009) for the use of informal conversations and an exchange of views or 'interViews' as a way to collect our qualitative materials. In this way, we considered narratives created during the interViews not as 'truths' to be found buried in a participant, but rather as constructed, specific and contextual events and understandings that are created through interaction with this participant. Such narratives are intimately affected by both the researchers' and participants' lived experiences (Sawicki, 1991; Weedon, 1997). Both individuals construct their own meanings together through their interaction and influence on each other.

After receiving ethical approval of our study from the University of Ottawa Human Research Ethics Committee, interViews were set up at times and locations of the women's choice. The women freely consented to the study and were able to drop out from it at anytime. InterViews were tape-recorded and lasted between one and two hours. While we used an interViews guide, participants were encouraged to open up the conversation within the main themes of health, obesity, pregnancy, and the body. The interViews were then transcribed verbatim, organised with the use of the NVIVO qualitative data software, and then submitted to a thematic analysis followed by a feminist poststructuralist discourse analysis.

The thematic analysis focused on WHAT the participants had to say. The analysis allowed for the

identification of themes according to semantic affinity. This was done by thematically grouping the related text fragments of all individual participants and then comparing and refining the emergent themes across participants. The latter strategy allowed us to better understand how young pregnant women's situational contexts interacted with their experiences and constructions of pregnancy and health.

To explore HOW participants said things, we submitted the narratives to a closer reading and conducted a feminist poststructuralist discourse analysis (Rail, 2009; Weedon, 1997; Wright, 1995). Particular attention was given to the ways in which the women constructed their meanings of health as well as their subjectivities within the available discourses on health, obesity, and pregnancy, and whether they positioned themselves within dominant or alternative discourses. We then looked to whether these constructions recreated the status quo regarding dominant discourses of 'risks' associated with 'excess weight' and other medicalised health discourses during pregnancy or, in contrast, disrupted current power structures and provided alternative discourses. This part of our analysis means that we were particularly interested in how narratives work to actively shape and/or reflect power relations in society (Lupton, 1992).

In order to ensure that our interpretations most closely reflected the participants' reality, we summarised the results of the study in the format of a story involving a hypothetical young pregnant woman and we sent it electronically to the participants. The participants were then asked to read the brief story and to send feedback on it, asking, among other things, whether the story was an accurate representation of their reality or the reality of a pregnant woman they know. To ensure anonymity, self-chosen or assigned pseudonyms were used and these are also the ones found in this article.

### **Constructions of health: 'Controlling my health for the health of my baby'**

The contextual backdrops that frame our participants' lives are important to acknowledge in understanding their constructions of health. The women are all white but come from a variety of socioeconomic and educational backgrounds. Four have completed or are currently in high school, four have college diplomas, and seven have completed or are currently in university. About half the women work full-time and three are single. They are in various trimesters of pregnancy, two in first, five in second, and eight in the third trimester. One woman is on her second pregnancy, one her third, and two have had previous abortions. These participants also have diverse medical care during their pregnancies (e.g., obstetricians, gynaecologists, general practitioners, midwives, nurses, naturopaths) and most draw pregnancy information from more than one source. While three identify themselves as 'underweight' in relation to recommended medical guidelines, three acknowledge having gained more than medically recommended. Lastly, two of the women consider themselves as 'obese' or 'fat'.

As part of the interViews, participants were asked "what is health" in general. A number of themes emerge from the analysis of their narratives. The theme of body control is by far the most common and it is associated with narratives around diet, physical activity, controlling weight, and abstaining or decreasing consumption of drugs and alcohol. Other common themes or meanings of health are that health is having a well-functioning bodily system (lack of sickness, lack of disease, having 'working' internal organs) or functional ability (e.g., being able to walk up a flight of stairs). Health is also described as a state of being, for instance, when participants equate health to psychological and emotional wellbeing or when they see it as a personal feeling (e.g., "health is when I feel healthy").

While there is quite a bit of overlap with the general health themes, when women speak of "health during pregnancy", their narratives suggest that their constructions of health are impacted by the pregnancy status: the existence of the foetus becomes forefront in their mind. For them, health during pregnancy is constructed as: (a) something secondary to and intimately connected with foetal health; (b) body control through lifestyle factors; (c) something requiring an active search for expert knowledge/appraisal; and (d) a personal feeling influenced by embodied experiences. In relation to the first theme, all the women are most concerned with their foetus' health and many speak about how they place foetal health above their own. This is well illustrated in the following excerpts:

*You can't help a lot of the things, but if I can help it, I will. I want to do everything I can in my power to make this the best environment for a little growing being that I can. (Jessica)*

*Sometimes I do worry about my health, but again my health is secondary right now. (Jaime)*

The women's narratives generally demonstrate the priority that they place on foetal wellbeing over their own. In addition, their health is understood as intimately linked to the health of the foetus. Markens and Browner (1997) found that most prenatal programs and literature emphasize the close relationship between maternal intake (i.e., diet) and foetal health, leading most women to reproduce this belief. Similarly, our participants construct their health as intricately linked to that of their foetus. Two participants express this link in an explicit way:

*Any health problems that they could have, I could be potentially the cause so I usually try to stay pretty aware of my stress level and what I'm eating. (Tara)*

*Your health is their health. If you're healthy, they're going to be healthy. I mean, if you're not healthy, there's a chance they're still healthy, but you're risking it more. (Ruth)*

For the second theme, if health directly affects foetal health, then it makes sense to the women that the latter is most directly controlled through lifestyle. The women discuss a myriad of personal changes they are making to improve their health and thus foetal health. This includes diet and moderate exercise, abstaining from drugs and alcohol, avoiding or decreasing exposure to cigarette smoke, avoiding chemicals (e.g., cleaners, dyes, nail polish), increasing sleep, and decreasing/avoiding stress and stressful situations. By far the most discussed lifestyle changes are related to diet and exercise. Additionally, while most women believe that weight gain is natural and expected during pregnancy, they conceptualise exercise and diet as important factors in controlling weight. When asked about health during pregnancy, the women emphasise bodily control. For instance, Ruth mentions "I take prenatals and I'm staying fit, I keep walking, and I'm not just sitting on a couch eating away" and Michelle notes that, "it's natural [to gain weight], yeah, as long as you try to stay as healthy as possible. To keep eating healthy, keep exercising. You're supposed to gain weight."

In relation to the third theme, the participants also discuss increased reliance on experts in decisions about health during pregnancy. This includes their health care practitioner, but more often the Internet, books, and other media as these two participants suggest:

*Like, especially all the reading I'm doing now, in my books I bought, like What to Expect When You're Expecting books, and you know, I would never do any of that reading before. (Vanessa)*

*You know, because it's my first baby, I've never experienced this before, so, like, [for] every little thing [that happens to me], I Google or call my doctor. (Jaime)*

Health is constructed as a personal issue, where one takes action upon oneself to be 'healthy', but also as something that requires expert surveillance and recommendation. Thus, the women discuss in great detail the personal changes they make to their lives during pregnancy to reduce 'risks' and control their health.

Connected to the fourth theme is the idea that despite their efforts and those of experts to control their body, the participants understand pregnancy as something uncontrollable, as it involves physical experiences such as cravings, aches, heartburn, and nausea, which vary greatly in intensity between women. Most participants agree that individual experiences lead some women to experience very 'difficult' pregnancies and others to seemingly have very little control over exercise, food and weight gain. This understanding of the pregnant body has a direct impact on the control they feel they can exert over their health. Lauren confides that "because your hormones come into play, I mean, there's so much that you can't... You can't control it when you're pregnant." Jaime's narrative echoes such notion: "I'm not gaining weight because I'm unhealthy. I'm gaining weight because it's what happens. Each woman is different, their body works differently." Health and weight gain are simultaneously constructed as controllable (through exercise, nutrition, and medical surveillance) and uncontrollable and specific to each individual.

### **Dominant and alternative discourses on health and obesity**

Turning to the results of our feminist poststructuralist discourse analysis, we find that the participants are interpellated by both dominant and alternative discourses. In order to emphasise the multiplicity, complexity and ‘messiness’ of our participants’ narratives, we follow the footsteps of other scholars (Fortin, et al., 2005; Richardson, 1992) and utilise a different typeface to depict discordant discourses. Where the women recite dominant discourses, the font is in italic typeface and where they locate themselves within a resistant or alternative discourse, the typeface is italics with underlining. Participants draw simultaneously on dominant (often medical and popular) and subjugated (often personal and embodied) discourses and navigate these in very telling ways. Thus, we have included excerpts that speak directly to the women’s conflict and emotions in order to clearly display the multiple and often conflicting discourses within which the participants position themselves in their discursive constructions of health during pregnancy.

### ***Discourse of maternal responsibility for foetal health***

Many scholars have discussed the increasing emphasis on personal responsibility for health and the need for consumption of products and knowledge to fulfill this responsibility (Clarke, et al., 2003; Evans, et al., 2004; Jette, 2006; Markens & Browner, 1997; Rail, 2009). Clarke, et al. (2003, p. 162) write that “health itself and the proper management of chronic illnesses are becoming individual moral responsibilities to be fulfilled through improved access to knowledge, self-surveillance, prevention, risk assessment, the treatment of risk, and the consumption of appropriate self-help/biomedical goods and services”. Pregnant women have even more pressure given that they are expected to uphold not only their own health, but that of their unborn child as well (Lupton, 1999). In our study, we find that the participants are also interpellated by the dominant discourse of maternal responsibility for foetal health. They discuss their increased consumption of information through the Internet, books, videos, prenatal groups, and medical specialists, and they speak of their motivation to take it upon themselves to prevent or lower health risks through individual lifestyle factors. Amid reproduction of the discourse of maternal responsibility for foetal health, the participants also recite alternative discourses. Some of the women discuss their partner’s involvement in the health of their foetus. This is counter to a dominant discourse of maternal responsibility that largely ignores the role that fathers play in the health of the foetus (Bordo, 1993; Pollitt, 2008). In the following example, Beth draws on alternative discourse (demonstrated in italics and underlining) as she discusses her partner’s role in the foetus’ health:

*I felt maybe he shouldn’t come home drinking or maybe he shouldn’t have weed in his pocket for me to take [laughs]. Really it is my choice, but it is his kid too so ... Alright, but don’t bring it around me, right.*

Beth’s narrative points to her partner’s involvement, but also suggests that ultimately foetal health is her responsibility and hinges on her ‘choices’ thus, reproducing the dominant discourse of maternal responsibility for foetal health. Some of the women, like Beth, point to negative aspects of their partner’s involvement although more generally, partners are constructed as a helping factor to achieving health (e.g., cooking healthy meals, helping around, providing motivation to be healthier during pregnancy).

The women’s feeling of personal responsibility seems directly connected to discourses available to them, which they appropriate as their own (Weedon, 1997). To elaborate on the productive possibilities of disciplinary power, Haber (1996, p. 141) emphasises that, “women act in collusion with patriarchal power because they are constituted within discourses that give ‘women’ meaning as subjects of the male gaze”. In the case of our participants, their subjecthood rests on their actions as ‘mothers’, more specifically as ‘good mothers’ discursively constructed through the medical and social gaze. Our participants thus strive for this status even while it may mean upholding their subjugation. The women do discuss outside pressure to be ‘good mothers’ and to ‘be healthy’ but have largely internalised this pressure. The following excerpt from Karen’s narrative speaks to this:

*Myself. I mean, I’d like to say society because, I mean, based on who we are, it’s affected by society, how we were raised, and how we were brought up, and how we were taught. But I think I would be more inclined to say that it comes mostly from me because it’s the pressure of ... You want to make sure that you’re doing everything possible to ensure that your baby is healthy. So, I think, I think it’s totally pressure*

from myself [laughs].

The words in italics and underlined display Karen's awareness of the societal pressure to be healthy during pregnancy; however, she internalises this pressure appropriating the discourse of maternal responsibility for foetal health. Most of the other participants view this as a positive pressure that helps them to become healthier, by following nutritional recommendations, exercising more, and controlling weight gain.

### **Obesity discourse and gaining the 'right' amount**

The dominant obesity discourse stresses weight maintenance as a defining characteristic of health (Gard & Wright, 2005; Rail et al., 2010). Currently, this includes weight control during pregnancy. Clinical guidelines provide exact weight stipulations for pregnant women, stressing that being inside the recommended weight category is part of pregnancy health (NICE, 2010; Rasmussen & Yaktine, 2009; SOGC, 2010). Almost all the women discuss their awareness of weight recommendations, and many see this weight as part of being healthy, positioning themselves within the dominant obesity discourse. Vanessa, who has been told she is 'underweight', accommodates to the clinical weight guidelines. She positions herself simultaneously within two discordant discourses as she negotiates between 'modern' medical discourse and an alternative discourse (less modern, more traditional discourse of bigger is better and healthier):

*Yeah, I think I would never worry about it if I wasn't reading the information, right? And again, if I was in a different culture, probably nobody would care how much I weighed, you know what I mean? But I think because the information is written black on white that, at this point, at 28 weeks, I'm supposed to be anywhere between 16 and 24 lbs, and I'm at 12 [lbs ...] Am I doing something wrong? Is the baby going to be too small at birth, you know, is it going to affect her health? Almost probably because I'm thinking that if I'm not following the guideline then I'm not at my optimal pregnancy health. Do you know what I mean? It's almost like a link that you make in your mind whereas it's probably not true.*

Vanessa, like other women who are deemed 'underweight', believes she is probably healthy, but because of the growing expectation to be a certain weight in Western culture, feels anxious and worried. Despite her resistance to the clinical guidelines' view of pregnancy health ("it's probably not true"), Vanessa still feels uncomfortable about being outside the guidelines for a 'normal and healthy' pregnancy. The same is true for participants who are diagnosed as 'overweight' during pregnancy: they adopt multiple subject positions within the discursive formation related to pregnancy and weight. For instance, Jaime first rearticulates a dominant discourse on health expertise, trusting her doctor and nurses the most:

*I trust my doctors the most for sure and the nurses, just because they've had all this experience and, like, they're not perfect but they know a lot more than I do when it comes to certain things. So I definitely trust the doctors.*

Simultaneously though, Jaime emphasises other women's experiences as well as her own understanding of her body when she disregards medical weight gain recommendations and looks to her mother for guidance and reassurance. Notably, she discusses her confrontation with a nurse over gaining more weight than recommended:

*And I'm just, like: "Are you serious? You're telling me I'm too fat and I'm pregnant. Are you actually saying this?" And I felt really bad, and then I called my mom because she never had this when she was pregnant with me, and she's just like: "Don't listen to the b-i-t-c-h... Don't even pay attention to that because each woman gains differently..." It's just... They look at weight as, like: "You should only be gaining this much," you know, like, "that's the healthiest." But: "Who are you to say what's healthy for me when it comes to that?" I'm not going out eating McDonald's every night. The fact that she asked me: "Do you eat a lot of junk food?" That's judging me right there, on 50 lbs you know. "I'm freaking pregnant!"*

In the above excerpt, Jaime resists the dominant pregnancy and obesity discourses that stress "excess" weight as a threat to her foetus' health. She turns instead to her own experience and that of her mother as a basis to locate herself within resistant discourses that carry alternative ways of understanding health

during pregnancy. Like Jaime, some women do not support the view that they need to be a certain weight, however all agree that lifestyle factors such as nutrition and exercise are determinant of health and foetal health.

### ***Discourse of 'mother blame'***

The understanding that exercise, diet, and weight control are an individual choice and responsibility leads to the moral stigmatisation of those who do not conform to dominant 'health' ideals (Evans, et al., 2004). During pregnancy this is exacerbated, as women are considered personally responsible for the health of the foetus and culpable for any health problems during pregnancy, supporting a moral discourse of 'mother blame' (Pollitt, 2008). Jette (2006) has discussed the concept of biopower as it relates to the pregnant body. She explains that pregnant women may internalise bodily health practices, thus upholding themselves as personally responsible for foetal health and thus the health of the nation through their actions. Therefore, those who do not uphold recommended health practices (e.g., nutritional and exercise guidelines) are seen to be moral failures as (future) mothers. Some of the women in our study reproduce the moral discourse of 'mother blame'. For instance, the meaning of 'eating for two' has shifted for many of the women: no longer an accepted indulgence during pregnancy, many consider it within a discourse of moral failure, since dominant medical discourse emphasises calorie control during pregnancy. Additionally, the participants discuss laziness and gaining 'excess' weight as features associated with an irresponsible pregnant woman. Some of the women discuss cultural differences surrounding weight gain, displaying their awareness of alternative discourses reconciling fat and pregnancy. However, most accommodate to Western norms and some go on to condemn and blame those women who do not uphold such norms. Both discursive positions are sometimes adopted by the same participant, as can be seen in the following fragment of interViews with Vanessa:

*I would hate to see anyone be pregnant and smoke and drink and eat burgers all day ... I just, for some reason, have the image that a pregnant woman should, I guess, be more conscious of her health and should, you know, make more efforts to be healthy to make sure her baby will be healthy ... I wanted to make sure that I wouldn't be one of those who gained, you know, 70 lbs. I don't want to be someone who wakes up at 3am and wants egg rolls [laughs]. Because I just don't think that that's a good idea for me, for my perception of pregnancy health ... It's [this way of looking at pregnancy] certainly a medical approach, I mean you're followed closely, you have guidelines for everything: how much weight you're supposed to gain, how many calories you're supposed to have ... So it's a lot more of a medical and a lot more restrictive approach ... So it's interesting but because I live here and this is the environment that I'm in, and because this is the information that I have access to, I follow it. I just find it interesting to know that elsewhere in the world, you put on 70 lbs, wonderful, you're a healthy pregnant woman.*

Vanessa shows awareness of alternative cultural discourses of pregnancy but, like many participants, accommodates to the clinical guidelines and perpetuates the idea of moral failure among women who do not uphold them.

### ***Contradicting the dominant pregnancy discourse: Embodied and individual experiences***

From our analysis of the participants' narratives, we conclude that they are interpellated by dominant (often medical) discourses surrounding pregnancy. They recite discourses of maternal, individual and moral responsibility for health, and consider lifestyle factors as simple controls for weight and health. In parallel though, the participants often discuss the ways in which they experience a lack of control and feelings of powerlessness in the face of increased expectations. Much of this lack of control stems from their embodied experiences (e.g., cravings, aches, tiredness, nausea). For example, many of the women discuss the need to 'give into cravings'. They deeply feel these embodied urges at the same time as they are interpellated by dominant obesity and pregnancy discourses surrounding the importance of resisting 'bad' foods and controlling calories. Some of the women express guilt after eating more than what they feel is recommended and two participants even go as far as to describe behaviours involving bulimic-like features. In the following excerpt, for example, Cherry describes embodied cravings as well as an action that seem to counter (thus the italics) her position as a subject of dominant discourses surrounding calorie control and food intake for the sake of the foetus' health:

*Because once in a while, I eat, you know, you just can't help it, you're pregnant, and you're like: "I need*



*the chips!" But the best way to do it is, if you want it, chew it and then spit it out in a bag. Just don't let anybody else around you when they see it because they're going to be like: "Eww! What are you doing?" And I'll be like: "Avoiding weight gain." And then I'll eat something healthy after so that way I had the taste in my mouth, I'm good to go, and now I'll have an orange, and I'll actually swallow it... Well, because that way, the baby's not getting any of the trans fats and I still get to taste [the chips], so... I know, it's probably really disgusting [laughs]. I never did that in my life, eh, that's just nuts!*

Cherry is interpellated by dominant bodily discourses and goes to great lengths to control weight gain and follow nutritional recommendations, even while her embodiedness would demand that she disregard such discourses. Medical discourse surrounding pregnancy also stresses the importance of exercise for maternal and foetal health and for controlling weight gain (Weissgerber et al., 2006). The participants are quite clearly appropriating this discourse, but simultaneously express difficulty following the guidelines given their embodied feelings. This tension is apparent in the following statement:

*Feeling sick all the time, I think, is making a difference. And I don't necessarily feel that it's a valid excuse [for not exercising]. Starting a new job, and moving, and being pregnant, [this] was all kind of a lot of stuff to adjust to, and I think just feeling more now than I was before, like, more busy and that there's no time. I think there's always time. I mean, I could get up earlier and I could work out before dinner, and so I think that's partly me being lazy and partly I think it's a large part of the pregnancy. And so feeling really tired and really nauseous and that kind of [thing] prevents me from feeling, like: "Yeah, I'm going to go for a run or a long walk or a bike ride." Because I just feel sick, I have no desire to actually run around, Basically, I want to like lie down all the time. So I think that kind of prevents me. (Amanda)*

Amanda's embodied experiences play a large part in the control she deems to exert over her exercise level. For other participants, embodied feelings and personal experiences similarly and regularly lead to worry, anxiety, and doubt about their own health and that of their foetus as such feelings and experiences seem so far removed from the ideal norms present in dominant pregnancy and obesity discourses.

### **The fragmented subject: Impact and implications**

As subjects, participants in our study present a self that is not unitary, simple or static. These women's self and subjectivity are made up of the various discourses and structures that shape society and their experiences within it. In that respect, their subjectivity is multiple, complex and fragmented. It is at the intersection of discordant and at times conflicting discourses. On the one hand, the women position themselves as subjects within dominant discourses of maternal responsibility, personal control over weight and health, and condemnation of those women who do not uphold health ideals. Such positioning constitutes them (and leads to their misrecognition) as individual, autonomous, coherent, self-authored subjects. On the other hand, the same participants demonstrate moments of awareness and even resistance to maternal and health norms, drawing on alternative discourses, embodied feelings, personal understandings of their body, and other cultures or women's experiences of pregnancy to trouble the hegemony of dominant bodily discourses. For most participants, this oscillation between constructing themselves as (modern) subjects of dominant discourses and as more reflexive and resistant subjects seems to point to the fluidity, multiplicity and fragmentation of their subjectivity.

The dominant discourse surrounding pregnancy, health and obesity is very present in the narratives and seems extremely powerful in interpellating the participants. Despite moments of resistance, these participants reproduce or, at best, accommodate this discourse and, in so doing, participate in maintaining patriarchal power relations. Indeed, to the extent that they internalize and disseminate the notion of foetal health as paramount as well as the idea of maternal and moral responsibility for foetal health, medical dominance remains intact and the current social, gender, and political order go unchallenged. On a broader social level, upholding the hegemony of the dominant pregnancy discourse has discursive effects in that it contributes to the neoliberal order that blames individuals who make the "wrong" lifestyle choices and/or fail to maintain health while deemphasising the social determinants of health (Raphael, 2003). Additionally, it ignores the de-responsibilisation of neoliberal governments *vis-à-vis* health and their failure to provide work/family policies or programs aimed at helping women (and possible partners) raise a healthy family. Finally, casting pregnant women as personally and morally responsible for foetal health leads to other aspects of their lives (e.g., work) to be associated with health

complications during pregnancy. This leads to mother blame and can effectively relegate women back to the private sphere (Pollitt, 2008).

Coming back to the participants, we believe that the dominant discourses of pregnancy, health and obesity have a negative impact on them as they find it hard to reconcile such discourses with external factors and embodied experiences. At a time when their pregnancy status should allow them to feel feelings of power, strength, joy, and pride, many participants discuss their anxieties around not doing everything they should for their unborn baby, and confide their frequent feelings of doubt, frustration, worry, powerlessness, and guilt. Some even express anger with a dominant medical discourse that ignores their own experiences during pregnancy.

Given such results, we would recommend that those in the health care sector pay particular attention to women's individual contexts rather than normalised and medicalised understandings of pregnancy (e.g., regimented calorie intake and weight control) that tend to blame women for their own "obesity" and for "risks" to the foetus. The women's frustration and confusion surrounding pregnancy recommendations could be greatly reduced if the diversity of pregnant women's experiences would be recognized and validated. Additionally, shifting policy and program focus to other factors that greatly affect pregnant women and foetal health (e.g., pregnant women's socioeconomic status and related life conditions, working conditions, social and physical environments, social support, paternal health and support, attitudes toward and representations of pregnant women) may decrease some of the pressure that pregnant women feel and the self-blame associated with pregnancy experiences (e.g., weight gain, cravings) and pregnancy-related health risks or problems.

### **Final thoughts**

In this article, we have documented how a small group of women discursively construct their health during pregnancy in the context of the obesity discourse. The women's constructions of pregnancy health emphasise foetal health and the pregnant woman's responsibility for and control over health, while constructions of embodied and personal experiences contradict this control. Through a poststructuralist discourse analysis we found that the women recite dominant discourses of pregnancy, health and obesity emphasising lifestyle factors as well as maternal and moral responsibility for the foetus. Finally we have shown how these women adopt complex and at times conflicted subject positions as they simultaneously reproduce alternative (cultural, their own and other women's experiences) and dominant discourses surrounding pregnancy. It is important to emphasise that the women we spoke with consider themselves healthy and in relatively 'risk free' pregnancies. They are also able-bodied, white, heterosexual women. Given that health and obesity are racialised, ableist and heterosexist constructs, especially as they pertain to women (Rail, 2009; Rail & LaFrance, 2009; Saguy & Almeling, 2008), it would be important that future studies focus on women of differing races, ethnicities, abilities and gender orientations, and on those women with higher risk pregnancies. In locating the potential for resistance, we agree with Sawicki (1991, p. 87) that we should continue to explore the "different ways in which women are being affected ... the material conditions of their lives, their own descriptions of their needs, and of their experiences of pregnancy and childbirth". It is from these subjugated positions that disruption of the intersecting and dominant obesity and pregnancy discourses become possible.

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