Weight stigma and perinatal care: Perspectives of women with high BMI and dietitians

by

Lindsey Mazur

A Thesis submitted to the Faculty of Graduate Studies of

The University of Manitoba

in partial fulfilment of the requirements of the degree of

MASTER OF SCIENCE

Department of Community Health Sciences

University of Manitoba

Winnipeg

Copyright © 2021 by Lindsey Mazur

Table of Contents

Table of Contents ii
Abstract iv
Acknowledgements v
Dedication vi
Preface vii
Introduction 1
Thesis Map 3
Literature Review 5
Dominant Perspectives 5
Dominant Perspectives: Pre-Conception 7
Dominant Perspectives: Pregnancy 8
Dominant Perspectives: Postpartum Period 11
Dominant Perspectives: Indigenous People With High BMI 13
Critical Perspectives 14
Critical Perspectives: Pre-Conception 19
Critical Perspectives: Pregnancy 20
Critical Perspectives: Postpartum Period 22
Critical Perspectives: Indigenous People With High BMI 23
Critical Perspectives: Critical Dietetics 24
Chapter 1: Methods, Methodology and Ethics 26
Research Design and Procedure 26
Research Questions 27
Study Sample 28
Data Collection 32
Data Analysis 35
Ethical Considerations 36
Personal Critical Reflexive Statement 38
Chapter 2: Good, Vanilla, Bad: Fat Women's Experiences of Perinatal Dietetic Care 42
Good Experiences 43
Vanilla Experiences 54
Bad Experiences 65
Chapter 2 Conclusion 71

Chapter 3: What to do, What not to do: Recommendations for Improved Perinatal Care for Women with a High BMI 73
Introduction 73
Summary of Findings 73
Chapter 3 Conclusion 97
Thesis Conclusion 98
Contributions to Knowledge 98
Strengths and Limitations of the Study 100
Study Significance and Impacts 101
Areas of Future Research 102
Concluding Thoughts 104
Appendix A: Sample Interview Guide –Women with High BMI 105
Appendix B: Sample Interview Guide – Dietitians 107
Appendix C: Consent Form – Women with High BMI 109
Appendix D: Consent Form – Dietitians 113
References 117
Endnotes 145

Abstract

Existing research has explored the experiences of weight discrimination among clients with a high body mass index (BMI) and physician perceptions of these clients. Of those with high BMI, a sub-population garnering additional academic attention are women with high BMI seeking reproductive care. Literature is beginning to show that these women face discrimination and inequity within healthcare, ranging from mild weight stigma to outright denial of care. Missing from the research, is a focus on client experiences with allied health professionals, with no research on perinatal dietetic care from the perspective of *both* clients with high BMI and dietitians providing this care. To fill this research gap, this thesis uses a fat studies methodology with a specific focus on critical dietetics to explore weight stigma from the perspective of women with high BMI who have sought perinatal dietetic care and the perspective of dietitians who provide this care Manitoba, Canada. For this qualitative study, 90-minute interviews were completed with 10 women with high BMI and 10 dietitians. Most of the women with high BMI described "good" perinatal dietetic care experiences, which included a focus on health not weight, were empowering, and were tailored to the clients' lives. Other participants described "vanilla" care experiences, which did not consider clients' unique circumstances and were sometimes ultimately harmful. Finally, two participants described "bad" care experiences, which were described as "harsh," "traumatizing," and weight stigmatizing. All of the women with high BMI and most of the dietitian participants advocated for a "health not weight" approach in perinatal dietetic care and made recommendations for how health care providers can move toward such an approach. As this research provides rich insight into the lived experiences of women with high BMI during the perinatal period, and includes the voices of dietitians, it can contribute to informing best practice guidelines for weight-inclusive perinatal dietetic care, that focuses on health not weight and is more compassionate, nurturing, and nourishing. Further, as voices of those with high BMI are limited in the literature, this research may support transferability to inform best practice guidelines for weight-inclusive care more broadly.

Acknowledgements

Thank you to the study participants for your bravery to share your stories. Special thank you to the dietitians who supported recruitment.

Thank you to my committee of Dr. Deborah McPhail, Dr. Christine Kelly, and Dr. Jacqui Gingras. Special thanks to Dr. Deborah McPhail for going above in beyond in providing me support and for also offering me a job as a research assistant.

Students are not successful without support, and I owe much of my success to my support system. Thank you to the supports at the Department of Community Health Sciences, with special mention of Administrative Assistant, extraordinaire, Theresa Kennedy. As a Métis student, I was also a part of the Ongomiizwin Education and appreciative of the safe and comfortable place for studying and connecting with other Indigenous students and the ability to use the office supplies and printer. As a student struggling with mental health issues and a learning disability, I could not have been as successful as I have been without the accommodations and support provided through Student Accessibility Services.

Thank you to friends, family, chosen family, and partners (past and present) for being there for me over the past five years. While I had what I thought were insurmountable personal challenges coinciding with this degree, your support has helped guided me through. Thank you also to my health care team that included therapists, physical therapists, my family doctor, and my psychiatrist. Being a graduate student is challenging in regular times, but the COVID-19 pandemic brought additional and unique challenges. Special thanks to those who did virtual co-working sessions with me to help keep me on task.

I was honoured with scholarships throughout my degree. I would not have been successful in those applications without the generosity of the many referees who wrote letters on my behalf. Special thanks to my committee members as well as Dr. Jon Gerrard, a tireless advocate for ending weight discrimination. Finally, thank you for the financial contributions to this research: from the Manitoba Training Program for Health Services Research, Research Manitoba, the Women's Health Research Foundation of Canada, and the Prairie Indigenous Knowledge Exchange Network.

Dedication

To all the rad fatties, radical dietitians and dietetic students, and everyone working to eliminate discrimination based on weight, height, and physical appearance

Preface

Before beginning in earnest, it is important to discuss the tensions surrounding the language used in this thesis. This study explores weight stigma in health care, and it is important to note that a plethora of research acknowledges the language used to discuss body weight can be problematic and can lead to clients feeling discriminated against (Lydecker et al., 2016; Swift et al., 2013; Volger et al., 2012; Wadden & Didie, 2003). When discussing weight with clients, clients prefer to have their weight addressed simply as "weight" or "BMI" (Body Mass Index[i]) (Volger et al., 2012). Words such as "fatness," "excess fat," "large size," and "obesity" are less desirable (Volger et al., 2012).

Fat studies and critical weight studies highlight ways in which the word "obesity" serves to medicalize and pathologize those who have a higher body weight and are healthy (Aphramor & Gingras, 2011; Ellison et al., 2016; McPhail & Mazur, 2019). Medicalization[ii] is the process of making common life occurrences into medical problems requiring treatment (Bell, 2016). Fat studies and critical weight studies view body weight differences as part of the normal diversity of body size and reject the medicalization of body size (Saguy, 2013). Scholars and activists are reclaiming the word "fat" as a simple descriptor of this natural diversity of bodies, analogous to tall, thin, short, and so on (Lupton, 2013), although for many people, being labeled as "fat" is still considered an insult (Saguy, 2013).

People who are marginalized based on socioeconomic status, race, sex, and sexuality face inequities in health care such as receiving suboptimal care (Bell, 2016). People with high body weights often receive suboptimal health care as well. For marginalized women, their bodies are often regarded as a "problem" or "abnormal" (Bell, 2016), and People of Colour, working class/working poor people, Indigenous people, and queer communities are often over-identified as having "obesity" (Ellison et al., 2016). Targeting these groups based on the medicalization of obesity serves to further marginalize these already marginalized groups, which creates worsened health care and therefore further health inequities (McPhail & Mazur, 2019).

Scholars and health care professionals working in the field of obesity have shifted from "identity first" language in favour of "person first language" with the rationale that clients support this shift in language as more inclusive and non-stigmatizing (Nutter, et al, 2018). Nutter et al. (2018) recommend the phrase "person with obesity" instead of "obese person" and

compare this to similar language shifts in diabetes care, to describe a "person with diabetes" instead of a "diabetic person." Fat studies scholars recognize the meaning of the root of the word obesity – which is essentially "to have eaten oneself fat" and assumes that everyone who is fat is fat due to overeating – as an inherently stigmatizing word (Lupton, 2013; Saguy, 2013). With negative connotations attached to this word and the problems associated with the medicalization of body size as described above, fat studies scholars argue for rejecting the word "obesity" all together (Ellison et al., 2016; Lupton, 2013; Saguy, 2013).

For these above reasons, this thesis uses a variety of words to describe higher body weight. This thesis may be read by obesity scholars, fat studies scholars, and perhaps clients as well. These groups will recognize their preferred language of body weight throughout this thesis. Because of my positionality as a fat studies activist who rejects the use of the word obesity as well as the medicalization of body size, when the words "obese" or "obesity" are used, it is in the context of summarizing the literature. The words "fat" and "fatness" are also when summarizing the literature. Avoiding the words "obese" or "obesity" (where possible) to describe bodies that are fat supports rejection of the medicalizing of "non-conforming bodies." As mentioned, referring to body weight as simply BMI is more desirable to clients, whereas obesity and fat are less desirable (Volger et al., 2012). To find a middle ground, or a bridge between these tensions surrounding the language of body weight, the shorthand phrase "high BMI" is used throughout this thesis to speak about those who would be medically classified and labelled as having "obesity" or as being "obese" as defined by the Body Mass Index (≥30) and to describe those who identify as fat.

Introduction

Existing research has explored the experiences of weight discrimination among patients with high body mass index (BMI), and physician perceptions of these patients (Forhan et al., 2013; Murphree, 1994; Pausé, 2014; Puhl & Heuer, 2010; Puhl & Suh, 2015; Volger et al., 2012). Of those with high BMI, women with high BMI who seek reproductive are one sub-population that is garnering increasing academic and media attention (Abraham, 2011a, 2011b; McNaughton, 2011; McPhail et al., 2016). These women face discrimination and inequity within healthcare, ranging from mild weight stigma[iii] to the outright denial of care (Parker et al., 2019). Denial of care for women labelled with a high BMI is based on risk discourses, which are founded in inconclusive medical literature (Bombak et al., 2016). This denial of care is also based on judgements about what types of women make "fit mothers" – judgements based in old yet ongoing racist, classist, and misogynist ideas of which women are "fit" to reproduce and to parent (Eli & Lavis, 2016).

Although it is a growing area of scholarly interest, research exploring the intersections between weight discrimination and reproductive care is primarily focused on the doctor-patient interaction (Cook et al., 2019; McNaughton, 2011; Parker et al., 2019; Rice et al., 2020; Warin et al., 2012), while there is little research that examines the relationships women with high BMI have with other healthcare professionals working in reproductive care, such as dietitians. Physicians often refer clients to dietitians when a physician or client is concerned about high BMI, and dietitians are viewed as integral members of weight management teams (Campbell & Crawford, 2000; Macdonald-Wicks et al., 2015). Thus, dietitians and their clients' experiences are an important area of knowledge inquiry. Dietitians are also integral members of the health care team in supporting healthy pregnancies and are said to be a support for so-called "appropriate" gestational weight gain (Procter & Campbell, 2014). Yet, there is no research to date that has examined the experiences of weight discrimination among women who have received dietetic care in the perinatal period *and* the dietitians that provided that care. While work by Heslehurst et al. (2017) included women with high BMI in the perinatal period – which revealed that miscommunications were common in the perinatal client-dietitian relationship – their study did not include dietitians' voices. Further, virtually no research on weight

discrimination and reproductive care has occurred in Manitoba, except for that by McPhail et al., (2016).

Responding to these gaps in the research, this thesis explores the experiences of women with high BMI seeking perinatal care from dietitians, as well as the experiences of the dietitians providing that care. For this research, I interviewed 10 women with a high Body Mass Index (BMI) who had sought perinatal dietetic care. These interviews focused on the women's lived experience of this care, their underlying beliefs about themselves, their weight, and their experiences as women in a weight-focused society more broadly. Next, I interviewed 10[iv] dietitians who provide perinatal care to women with high BMI. The interviews with dietitians focused on their experiences of providing care, how they approach this work, and their perspectives on professional guidelines for care in the perinatal period. Having both the perspectives of clients and dietitians helps to lay a foundation to understand their interactions and what may improve the client-dietitian interaction.

The central research questions of this project are the following: 1) How do women with a high BMI in Manitoba experience their interactions with dietitians during the perinatal period, and what can we learn about healthcare delivery for people with a high BMI from these experiences? 2) How do dietitians in Manitoba approach discussions around body weight in the perinatal period with clients with a high BMI? and 3) Do client experiences with dietitians differ from those with other healthcare practitioners, such as doctors and nurses, as established in the literature, or are similar patterns of stigma evident? If so, how can fat women's experiences of reproductive care be improved to ensure socially just and sensitive healthcare delivery for women living in Manitoba?

All the women with high BMI in this current study had seen a dietitian in a healthcare setting during the perinatal period. The women with high BMI received perinatal dietetic care via individual nutrition consultations and in group education sessions. For individual nutrition consultations, the women with high BMI saw dietitians who worked in a variety of healthcare settings such as in primary care, as part of chronic disease management teams (i.e., diabetes care teams), and in practice private. For group education sessions, the women with high BMI described prenatal and postnatal group education sessions as the context in which they had received care from a dietitian. There was an exception to this; one woman attended group education sessions while she was pregnant, but pregnancy or the perinatal period in general was

not the focus of these sessions. The group education sessions she attended were dietitian-facilitated and were focused on developing a healthy relationship to food and body. In general, most of the women with high BMI in this current study share powerful and positive experiences and interactions with their dietetic care in the prenatal period in both individual and group sessions, but a minority of the women with high BMI did share experiences of weight stigma when receiving perinatal dietetic care.

The dietitians I interviewed for this study worked with clients in one-on-one nutrition consults, counselling, and education in private practice, primary care, inpatient and outpatient clinical and hospital settings, and facilitated group education sessions. Most dietitians in this study worked from a critical, weight-inclusive paradigm defined simply as focusing on health not weight, although a minority worked from a dominant, more traditional, weight-focused paradigm defined simply as a focus on weight loss for improved health. Some dietitians I interviewed held both critical and dominant perspectives, which has been described as "paradigm straddling" (Brady, 2021). Regardless of paradigm, one key commonality that all dietitians I interviewed shared was that they feel that the prenatal weight gain guidelines are unhelpful for practical use with the populations they work with, not only those with a high BMI.

Thesis Map

This thesis is separated into three chapters. In the first chapter, I discuss the methods and methodology used in this research and include a personal critical reflexive statement. Next is Chapter 2: Good, Vanilla, Bad: Women With High BMIs' Experiences of Perinatal Dietetic Care. In this chapter, I share good experiences that the women had with their perinatal dietetic care. For the women, this good care was empowering and client-centred, and they did not feel weight stigma in the interactions with their dietitian. The perinatal care provided by dietitians articulated as "vanilla" was care experienced by the women as an exchange of information which did not meet their unique needs. This vanilla health care could be considered neutral but was in fact harmful for some. Finally, in descriptions of the care labelled "bad," women felt they experienced weight stigma with their perinatal dietetic care that was harmful to their pregnancy care journeys and, in one case, impacted their decision to have future children.

Chapter 3 is titled, "What to do, What not to do: Recommendations for Change in Perinatal Dietetic Care." In this chapter, I summarize the advice that the women with high BMI

had for dietitians and other healthcare professionals that would improve the perinatal care experience. Novel to critical fat research, I summarize the dietitians' suggestions for improved care during the perinatal period. I report that both groups of participants overwhelmingly recommend a health not weight approach to reduce stigma and optimize health in reproductive dietetic care for fat women.

I close the thesis with a conclusion that weaves the data together, holding their collective significance, their strengths and weaknesses and suggest ways in which this imperfect "basket" of knowledge could be used to create change for women with high BMI seeking perinatal care from dietitians and other healthcare professionals with a focus on health not weight. The women with high BMI and the dietitians were overwhelmingly in favour of health not weight approaches. In the two instances in which my participants did not have a health not weight approach, they reported experiencing weight stigma. Had these participants experienced a health not weight approach that was client-centred, this stigma may have been prevented. Finally, I consider how this work could be used to improve healthcare in general to be more weight-inclusive, compassionate, and client-centred for people with a high BMI.

Literature Review

There are two main approaches to researching and understanding weight stigma: a dominant perspective and a critical perspective. In what follows, I begin with summarizing dominant research regarding high BMI surrounding weight discrimination in general. Then, I discuss dominant perspectives of BMI in the perinatal period specifically: the pre-conception period, pregnancy, and postpartum periods. Next, I discuss dominant perspectives regarding Indigenous people with high BMI in general and in the perinatal period. I also highlight a dominant perspective of prenatal weight gain guidelines.

Within the critical literature, I highlight critical dietetics, which is grounded in fat studies and critical weight studies. Critiques of dominant perspectives on BMI, body weight and pregnancy interrupt understandings of medical and reproductive science as a fixed, objective "truth" (Rice, 2014). I endeavour to provide these critiques, allowing for this "interruption" through this literature review.

Dominant Perspectives

Weight discrimination, a consequence of weight stigma, is a human rights concern (CBC, 2016; Change.org, 2019; Puhl et al., 2015) that affects health and quality of life (Puhl & Suh, 2015; Tomiyama et al., 2018), and disproportionally affects women (Duncan & Klos, 2014). Weight discrimination occurs in health care settings, where clients experience it at the hands of physicians, nurses, and dietitians (Puhl & Heuer, 2010; Tomiyama et al., 2018). Weight discrimination can have serious health implications, such as heart disease, depression, binge eating, avoidance of physical activity, and further weight gain (Bacon & Aphramor, 2011; Tomiyama, 2014; Tomiyama et al., 2018). There is public support to amend human rights law to include weight, height, and physical appearance as a protected category (Change.org, 2019; Pomeranz & Puhl, 2013; Puhl & Heuer, 2011; Puhl et al., 2015; Suh et al., 2014), with three provincial bills proposed for such laws between 2016 and 2018 in the Manitoba Legislature (Martin, 2016; MBGov, 2018; National Post, 2016). It is crucial that health care professionals and their regulatory bodies have the knowledge needed to provide weight-inclusive care.

The prevalence of weight discrimination has increased by 66% since 2000 (Puhl & Heuer, 2010). A review by Puhl & Heuer (2010) summarizes a plethora of quantitative data

about weight discrimination in health care settings and employment settings, but qualitative research is often limited to client experiences with physicians and nurses (Forhan et al., 2013; McPhail et al., 2016; Murphree, 1994). Dietitians are regarded as vital members of health care teams focusing on weight management (Campbell & Crawford, 2000; Macdonald-Wicks et al., 2015). When patients are identified as "overweight" or "obese" according to the BMI, a physician will often make a referral to a dietitian for weight loss or weight management (Campbell & Crawford, 2000; Macdonald-Wicks et al., 2015). In a review, dietitians were found to hold less weight stigmatizing views than other health professionals (Jung, Luck-Sikorski, Wiemers, & Riedel-Heller, 2015). At the same time, studies continue to find that weight stigma is prevalent among dietitians (Diversi et al., 2016) and that dietetic students with a high BMI are subject to weight stigma in dietetic education programs (Bessey et al., 2020).

All health care professionals, including dietitians, should not only be aware of their own weight stigmatizing views, but actively work to overcome these views to provide weight-inclusive care (Jung et al., 2015). Therefore, it is crucial to explore and understand the relationship between clients with high BMI and dietitians who provide care for these clients. Qualitative understandings of weight discrimination are lacking in general, and what is available does not typically concentrate on dietetic experiences (Forhan et al., 2013; McPhail et al., 2016; Murphree, 1994). An exception is a qualitative study that explored the relationship between clients and dietitians in general, i.e., not specific to body weight or weight stigma (Endevelt & Gesser-Edelsburg, 2014). This study found that clients wanted more tailored approaches instead of information-sharing approaches from their dietitians, while dietitians expressed difficulty adapting to more individualized, therapeutic approaches, after having been trained in more informational approaches (Endevelt & Gesser-Edelsburg, 2014). Researchers in another qualitative study interviewed women with high BMI about their experiences with dietitians in the perinatal period and found that, overall, these women had positive experiences (Heslehurst et al., 2017). However, there are no qualitative studies that explore the experiences of women with high BMI who sought perinatal dietetic care *and* those of dietitians who provide that care.

In summary, despite relative silence about weight discrimination with dietitians in relation to reproductive care, reports of high degrees of weight discrimination, among other health care provider-client encounters, are well established in the literature. Qualitative research shows that medical research, within the dominant paradigm, is one of the key underpinnings for

this form of discrimination – research which health care professionals often cite to patients – and leads to poorer quality care through an uncritical lens (McPhail & Mazur, in press; Parker et al., 2019). To better understand the dominant literature on obesity and reproductive care, I continue with a more detailed discussion of the literature specifically related to the pre-conception period, pregnancy, and the postpartum period. Next, I summarize research on Indigenous perspectives through the lens of the dominant literature. I also discuss "concerns" within the dominant literature about the prevalence of obesity among Indigenous populations in general, as well as concerns about Indigenous women and their body weight during the perinatal period. In the following section, I summarize critical perspectives about high BMI and Indigenous people, especially regarding Indigenous women, and I critique the "concerns" from the dominant perspectives. I discuss the rationale for including Indigenous perspectives in this literature review in my *Personal Critical Reflexive Statement* in Chapter 1: Methods, Methodology, and Ethics.

Dominant Perspectives: Pre-Conception

Maternal obesity is said to be associated with increased infertility (Yogev & Catalano, 2009). In the dominant literature, there is a concern that with increasing rates of overweight and obesity among women of child-bearing age, there will be increasing rates of infertility (Yogev & Catalano, 2009). Indeed, it is said that having obesity increases both men's and women's risk of infertility (Panth et al., 2018). During treatment of infertility in a clinical setting, a "healthy" BMI and good nutritional intake are both said to increase fertility (Panth et al., 2018). In the US, infertility rates are significantly higher among marginalized groups such as those who are racialized and those who have lower income or lower education (Panth et al., 2018). Because of this, Panth et al. (2018) recommend that nutrition guidelines should be included in clinical guidelines for infertility, with tailored recommendations for the aforementioned groups. A review of non-surgical weight loss interventions to improve fertility, for those with overweight and obesity, found that interventions such as healthy eating and exercise improved fertility but did not improve rate of miscarriage compared to control groups (Best et al., 2017). Best et al. (2017) caution, "Overweight and obese persons seeking fertility should be educated on the detrimental effects of fatness and the benefits of weight reduction, including improvement in pregnancy rates" (p. 1).

A considerable portion of the dominant literature focuses on polycystic ovarian syndrome (PCOS), which is a condition that causes insulin resistance and is more prevalent in women with obesity (Cena et al., 2020). A review summarized that PCOS is associated with infertility, and weight loss is recommended for women with PCOS and obesity to improve fertility (Cena et al., 2020). However, another review regarding PCOS and a type of fertility treatment called *in vitro* fertilization determined that it is uncertain whether weight loss supports increased effectiveness of the treatment (Tziomalos & Dinas, 2018). Tziomalos and Dinas (2018) conclude, "Notably, recent guidelines state that the health benefits of postponing pregnancy to achieve weight loss must be balanced against the risk of declining fertility with advancing age.…If weight loss is not achieved within a reasonable time period, assisted reproduction therapy should be offered in adequately selected patients with PCOS, regardless of the presence of obesity," (p. 1). The recent guidelines Tziomalos and Dinas (2018) reference are from "Obesity and reproduction: A committee opinion," by the American Society for Reproductive Medicine and were published in 2015. Although, Gambineri et al., (2019) noted that weight loss (via diet and exercise interventions in addition to weight loss via bariatric surgery) shows improvements in fertility and is recommended for women with obesity and infertility, regardless of diagnosis of PCOS. In their review of the literature, Gambineri et al., (2019) conclude that weight loss via diet, exercise, and bariatric surgery can "restore fertility in most cases" (p. 69), but there is not enough evidence to state what is the best method. Giroux et al. (2009) surveyed 107 pregnant women who are overweight about their usual body weight and their weight history prior to their current pregnancy. More than two-thirds of the women reported instability in their usual body weight pre-pregnancy. Eighty-eight percent of participants had attempted weight loss in the past, while 47% had attempted weight loss in the year prior to their current pregnancy. Further, 88% of the participants had retained weight gained during a previous pregnancy (Giroux et al., 2009). The following section focuses on the dominant perspectives about high BMI in pregnancy.

Dominant Perspectives: Pregnancy

Obesity and weight gain in pregnancy, has been studied extensively as part of the dominant obesity paradigm, and weight gain deemed excessive is said to be correlated with numerous adverse health outcomes for both mother and fetus (Vanstone et al., 2017; Yeo et al., 2017). Women with high BMI entering pregnancy are more likely to exceed pregnancy weight

gain recommendations in pregnancy (Vanstone et al., 2017). A systematic review by Yeo et al (2017) concludes that "appropriate" weight gain should be achieved for normal weight, overweight, and obese pregnant women.

A systematic review and meta-synthesis summarized women's beliefs regarding pregnancy weight gain (Vanstone et al., 2017). In general, this review found that women's experiences of discussions about weight with health care professionals were negative. More specifically, the review found that women felt "blame, guilt, and humiliation" (p. 8) when body weight was discussed, and they attributed these feelings to past negative experiences with other health care professionals who were insensitive to body weight concerns (Vanstone et al., 2017). The review also concluded that women's primary motivator for eating well during pregnancy was fetal health (Vanstone et al., 2017). Yeo et al. (2017) echo this, indicating that during pregnancy, importance of fetal development is a highly effective motivator for health behaviour change. Vanstone et al.'s (2017) review further reveals that women want to avoid excess pregnancy weight gain due to aesthetics and, to a lesser degree, to prevent diabetes and other health complications. Health care professionals expressed that inconsistent pregnancy weight gain messages were said to be a barrier to "appropriate" pregnancy weight gain (Vanstone et al., 2017). A population study of health care professionals in Canada asked participants about their approach to providing prenatal counselling (Vinturache et al., 2017). This study found that the health care professionals provided the same prenatal counselling across weight groups and did not change their approach or advice based on pre-pregnancy BMI (i.e., they did not tailor their prenatal counselling to target women with obesity). The authors concluded that using the same approach for all clients means opportunities to discuss weight concerns are being missed.

One qualitative study explored views of women with obesity who saw a dietitian during pregnancy (Heslehurst et al., 2017). The study included 15 white women and reported that, in general, women with obesity's experiences with dietitians were positive. These participants stated that they trusted dietitians as the "best source" of nutritional information. Some participants, however, shared negative experiences, including one woman who experienced harassment regarding her weight and a participant who described receiving a "devastating" information sheet (without discussion of it) from her midwife about the "risks" of obesity in pregnancy (ibid.). Even though sessions with dietitians were positive overall, women reported wishing they had been asked what they wanted from the dietitian appointments, as opposed to

being told by the dietitian what they *should* get out of them. Additionally, without explanation for the dietitian referral, women felt nervous to see the dietitian and feared that they would be made to "feel bad" about their eating and that they would be encouraged to lose weight during pregnancy, even though this was not the approach they experienced. Participants also received food and nutrition messaging in contradicting ways. For example, dietitians challenged the common colloquialism for pregnancy of "eating for two" in favour of current public health messaging of "eating just a little more," which some women found helpful and others found "patronizing." The women in the study felt unsupported regarding physical activity in that they were told what to avoid, rather than what activities *could* be done; and participants struggled with behaviour change when dietitian advice was not personalized to their lives. Yet, when participants reported that their expectations of the dietitian sessions were not met, they blamed themselves "for 'being different', 'fussy eaters', that they probably did not ask for the right information or may have given the dietitian the wrong information to work with," (Heslehurst et al., 2017, p. 50).

Faria-Schützer et al. (2015) found that women across the weight spectrum who were able to keep within Institute of Medicine prenatal weight gain guidelines did so only due to the anxiety and fear they felt about the fetus. They also noted that they continuously had to fight an "addiction to food" (p. 9). This study further reported that the obese women who could meet the prenatal weight gain guidelines were only able to do so because of frequent contact with health care professionals, scolding if weight gain was going beyond target, feeling hungry at times, and fearing the death of their baby and themselves if too much weight was gained (Faria-Schützer et al., 2015).

Some qualitative studies have included both the voices of pregnant women with obesity and their care providers such as obstetrician-gynecologists (OBGYNs) and midwives (Duthie et al., 2013; Furness et al., 2011). For example, a qualitative study with clients and OBGYNs revealed incongruencies with the messages that OBGYNs relayed about weight and nutrition and how clients received these messages (Duthie et al., 2013). Clients reported that body weight was not emphasized and that they felt nutrition and activity were not discussed enough, while OBGYNs reported the opposite (Duthie et al., 2013). A qualitative study of pregnant women with obesity and their midwives revealed midwives have an understanding about obesity stigma and therefore find it "difficult" to talk to their clients about weight and health, yet they still felt

they provided plenty of information about eating, exercise, and weight (Furness et al., 2011). On the contrary, the women with obesity in this study reported feeling like they did not receive enough information on eating, exercise, and weight in pregnancy from their midwives. Some of the midwives remarked that they felt like they had given up on their pregnant clients who were obese and felt they would not listen to their advice regarding weight anyway (Furness et al., 2011). Women said they would like to make changes in eating, exercise, and weight, but the midwives felt differently, with one midwife stating, "I think sometimes it is a motivation issue. Although they would like to lose the weight, they don't want to put the work in to actually do that. They think it's something that's not achievable, or they are just not motivated for it", (Furness et al., 2011, p. 4).

Streuling, Beyerlein, and Von Kries (2010) found in their review that diet or physical activity interventions alone were said to not be helpful in reducing pregnancy weight gain, but interventions combining diet and physical activity may be helpful (Streuling et al., 2010). Yet, another systematic review of randomized control trials and quasi-randomized control trials of dietary interventions in pregnancy showed dietary interventions alone were significantly associated with decreased pregnancy weight gain, reduced incidence of C-section, and long-term (i.e., six months) postpartum weight loss (Tanentsapf et al., 2011); although they note that weight loss was not significant at six weeks postpartum. They also note that more intensive dietary interventions should be made for overweight and obese mothers because when normal-weight, overweight, and obese women were given the same dietary intervention, reduced pregnancy weight gain only occurred in the normal weight women. Therefore, authors suggest low-calorie dietary interventions, specifically for the "high-risk" overweight and obese women (Tanentsapf et al., 2011).

Dominant Perspectives: Postpartum Period

Much of the dominant perspective in the literature regarding the postpartum period is focused on postpartum weight loss (Butte et al., 2003; Carter-Edwards et al., 2010; Devine et al., 2000; Montgomery et al., 2013; Nascimento et al., 2014; Subhan et al., 2019). One study indicated that high BMI before pregnancy and gaining "too much" weight during pregnancy leads to a higher chance of weight retention in the postpartum period and therefore is said to lead to obesity (Butte et al., 2003). A systematic review and meta-analysis on the topic echoes these

concerns about obesity "risks" (Nascimento et al., 2014). Health behaviours prior to pregnancy, such as exercising, are said to be predictors of "successful" postpartum weight loss efforts (Devine et al., 2000). In a US study with white and African American women in the postpartum period, both groups of women wished they were a smaller size six months postpartum, but African American women were more accepting of larger body sizes than white women (Carter-Edwards et al., 2010). The authors of this study concluded that there is a need and an opportunity for more "targeted" obesity prevention and management strategies for African American women.

In a qualitative study of 24 women, Montgomery et al. (2013) explored postpartum weight loss experiences. Few women were able to lose weight "easily," and the majority found postpartum weight loss stressful and difficult (Montgomery et al., 2013). Negative experiences included difficulty getting enough exercise or doing enough walking, or when they were able to do some walking, they claimed "nothing happened," i.e., no weight was lost (p. 133). Other negative experiences included women still having food cravings from pregnancy, having trouble eating well, having issues with body image, receiving comments regarding their postpartum bodies from partners and others, and experiencing feelings of depression. Some women reported "positive" experiences such as motivation to eat healthy while breastfeeding for weight loss (Montgomery et al., 2013). Another study found that postpartum depression was significantly associated with difficulties in losing weight at one year postpartum (Herring et al., 2008).

Dominant perspectives have constructed connections between breastfeeding and postpartum body weight whereby breastfeeding has been purported to support postpartum weight loss "success." Some studies show more postpartum weight loss for women who breastfeed, yet others report no difference in weight loss for breastfeeding women compared to those who use infant formula (Montgomery et al., 2013; Mysko, 2009). Further, dominant perspectives have connected breastfeeding rates or lack of breastfeeding to pre-pregnancy obesity. A 2018 systematic review and meta-analysis by Flores et al. about women with high BMI pre-pregnancy concluded that high BMI is associated with less exclusive breastfeeding. This review also found that women with obesity are less likely to continue breastfeeding and are said to introduce solid food sooner than is recommended (Flores et al., 2018).

Dominant literature is also concerned with childhood obesity. Obesity prevention or treatment is targeted during pregnancy, during infancy, and throughout childhood (Redsell et al., 2016). Maternal obesity is said to create lifelong consequences for offspring including higher

risk of obesity and chronic disease in later life (Patel et al., 2015; Starling et al., 2015; Zambrano et al., 2016). Mothers with household food insecurity, especially single mothers, are said to be more overweight and obese than childfree men and women with food insecurity (Martin & Lippert, 2012). However, dominant obesity research reports that if mothers gain weight within prenatal weight gain guidelines and adopt health behaviour changes during pregnancy, this does not impact infant obesity (Gregory et al., 2016; Kong et al., 2014; Mustila et al., 2013; Tanvig et al., 2015).

Dominant Perspectives: Indigenous People With High BMI

As I discuss in my personal critical reflexive statement within Chapter 1, I am a researcher of Métis descent, and it is important to me to discuss Indigenous people within the context of fat theory. Fat Indigenous bodies are an important subsection of fat theory that is under-discussed (Robinson, 2019). Although my study was not about Indigenous health per se, two of my participants identified as Indigenous. The indigeneity of these two research participants and my own indigeneity led me to include literature about Indigenous people and their bodies. It is important and would be irresponsible to not include literature about Indigenous health considering the indigeneity of these participants, as well as the problematic ways in which fat Indigenous bodies are targeted as "at risk." I thus summarize dominant and critical approaches to fatness and to reproductive care for fat women in Indigenous communities and provide a critique to the dominant approaches. I begin this summary of the dominant approaches below.

Obesity is labelled as an epidemic in Canada by researchers (Katzmarzyk, 2002; Kolahdooz et al., 2017), and media (HuffPost Canada, 2018). The epidemic is of even more concern in Canada's Indigenous population because of the high levels of obesity among that population in comparison to non-Indigenous Canadians (Kolahdooz et al., 2017). To prevent obesity for mothers and their children, researchers studying obesity in Indigenous women recommend more culturally relevant interventions such as acknowledging different food ways and cooking methods (Vallianatos et al., 2006; Vanstone et al., 2017). Another qualitative study included trans-generational perspectives of Cree women in Canada and concluded that there is a need to honour cultural identity regarding food to support improved health for Indigenous women across the lifespan (Bruner & Chad, 2014). More specifically related to pregnancy, a

qualitative study of Cree women's views of pregnancy weight gain revealed that Indigenous women equated weight with fitness level and nutritional status, i.e., higher body weight meant lower fitness levels and poor eating habits, and researchers echoed this belief (Vallianatos et al., 2006). Therefore, weight was used as a proxy for health status by researchers of this study, which is common within the dominant literature (Ernsberger, 2012; Ingraham & Boero, 2020; O'Reilly & Sixsmith, 2012). The participants also shared their beliefs about higher body weight and its connection to poor health behaviours, which critical researchers would acknowledge as a form of internalized weight stigma[v] (Ingraham & Boero, 2020; O'Reilly & Sixsmith, 2012), but internalized weight stigma was not mentioned by Vallianatos et al. (2006). The Indigenous women in this study also expressed that they ate to cope with stresses of motherhood and that weight gain and body changes were normalized as part of being a mother. This normalization of increased weight as part of being a mother was of concern for the researchers due to risk of obesity and its related complications. Finally, the researchers reported that excess weight gain and retention between pregnancies was common among the participants, which also led the researchers to express concern about women's obesity risk (Vallianatos et al., 2006).

Critical Perspectives

Critical perspectives of body weight challenge the dominant paradigm of weight and health (Lupton, 2013). As described above, the dominant paradigm, often labelled the "obesity epidemic," frames higher weight bodies as "diseased," and the "cure" is weight loss through diet and exercise (Bacon & Aphramor, 2011; Tylka et al., 2014). In contrast, critical scholars assert that the alarm about "obesity" is less about any actual harm that may be caused by fatness and more about reasserting the dominant paradigm and societal status quo across marginalized identities (Ellison et al., 2016). This alarm in the dominant paradigm is evident in the literature about obesity and pregnancy I reviewed. In contrast, literature from the critical paradigm acknowledges the natural diversity of body shape and size and rejects the notion that a "normal" weight range (a BMI of 18.5–24.9) *can* and *should* be attained by all (Bacon & Aphramor, 2011; Tylka et al., 2014). Critical perspectives attribute the attitudes and efforts to end the "obesity epidemic" to fuelling another epidemic – that of weight discrimination (Gard, 2005; Lupton, 2013).

Critical perspectives regarding weight, such as those in fat studies and critical weight studies, recognize the social and political aspects of body weight including the billion-dollar weight loss dieting industry, which mainly targets women's bodies, and the ensuing weight cycling, disordered eating, eating disorders, and weight gain that result from the focus on weight (Bacon & Aphramor, 2011; Duncan & Klos, 2014). Weight-inclusive approaches as described by Tylka et al. (2014) put the "emphasis on viewing health and well-being as multifaceted while directing efforts toward improving health access and reducing weight stigma" (p. 1). For example, a popular approach within critical perspectives is Health at Every Size®[vi] (HAES), which is based on weight inclusivity. The Association for Size Diversity and Health, a professional organization for researchers, health care providers, and students, trademarked HAES to prevent co-opting of the HAES principles by the weight loss dieting industry (ASDAH, 2018). These principles as per the Association for Size Diversity and Health (2018) are:

> **Weight Inclusivity:** Accept and respect the inherent diversity of body shapes and sizes and reject the idealizing or pathologizing of specific weights.
> **Health Enhancement:** Support health policies that improve and equalize access to information and services, and personal practices that improve human well-being, including attention to individual physical, economic, social, spiritual, emotional, and other needs.
> **Respectful Care**: Acknowledge our biases, and work to end weight discrimination, weight stigma, and weight bias. Provide information and services from an understanding that socio-economic status, race, gender, sexual orientation, age, and other identities impact weight stigma, and support environments that address these inequities.
> **Eating for Well-being:** Promote flexible, individualized eating based on hunger, satiety, nutritional needs, and pleasure, rather than any externally regulated eating plan focused on weight control.
> **Life-Enhancing Movement:** Support physical activities that allow people of all sizes, abilities, and interests to engage in enjoyable movement, to the degree that they choose.

Weight-inclusive approaches such as HAES were developed to challenge the dominant, weight-centred paradigm as described above and offer individuals of all shapes and sizes the opportunity to pursue health, if they choose, with a focus on health gain rather than weight loss (Bombak, 2014). These approaches have shown long-term benefits such as sustained health behaviour changes, sustained physical and mental health measures, and body weight stabilization (Clifford et al., 2015). Weight-centred approaches show weight loss, improved health behaviours, and improved health measures in the short term (e.g., six months or less) but show

weight regain and poorer measures of physical and mental health in the long term (Mann et al., 2007; Tomiyama, 2014). Individuals that maintain a higher, yet stable BMI show better health outcomes than those who have lost and gained weight multiple times (Brown & Kuk, 2015). Those in the overweight range live longer than those in the "normal" weight range, and those who are fit and fat show better health outcomes than those who are unfit and thin (Bacon & Aphramor, 2011; Tylka et al., 2014). Further, the validity of studies using BMI has been questioned since BMI is most often used out of convenience, as a proxy for nutritional status, fitness, and overall health (Chrisler & Barney, 2017; Ernsberger, 2012; Flores et al., 2018; Guthman, 2013; Ingraham & Boero, 2020; O'Reilly & Sixsmith, 2012; Vallianatos et al., 2006).

Critical weight science and weight-inclusive approaches such as HAES have been heavily debated (Penney & Kirk, 2015). Numerous health care professionals, such as physicians, nurses, and dietitians, consider these approaches controversial (Penney & Kirk, 2015). The controversy stems from misinterpretations of the principles of HAES as well as weight stigma of those who oppose such approaches (some dietitians in my study misinterpreted the HAES approach, to be sure). Common misinterpretations include the assumption that the phrase "Health at Every Size" means that every person in a large body size is metabolically healthy, and the assumption that the focus on enjoying food means that people end up eating "unhealthier" (ASDAH, 2018). Not everyone with a high BMI is healthy, just as not everyone with a "normal" BMI or thinner body is healthy (Clifford et al, 2005). Further, research has indicated that weight-inclusive approaches like HAES, which focus in part on enjoying food, improve eating habits rather than worsening them (ibid.).

In addition to critical approaches such as HAES, the dominant "obesity as a disease" approach is also gaining popularity. This perspective, as Obesity Canada (2021) (formerly Canadian Obesity Network) explains, understands obesity to be a metabolic disease of fat, in which fat is understood as an organ akin to skin or the heart. This perspective has shifted from the traditional, more simplified weight loss approaches to what Obesity Canada labels a more "health-centric" perspective of obesity, recognizing the disease of obesity as caused by a complex map of genetics, environment, and lifestyle (Obesity Canada, 2021). Proponents of this approach report that labelling obesity as a disease decreases weight stigma because it removes the belief that a person "caused" their obesity through eating unhealthily and not exercising and therefore is said to challenge the assumption that fat people are lazy and do not care for their own

health (Bombak et al., 2016). Within this approach, someone with a BMI in the so-called "normal" range could technically be diagnosed with obesity as it is about the dysfunctional organ of fat, not the body weight or number on the scale. This approach also acknowledges how BMI does not measure the type, location, or amount of body fat (Obesity Canada, 2021). In 2020, Obesity Canada, along with the Canadian Association of Bariatric Physicians and Surgeons, published the updated Canadian Adult Obesity Clinical Practice Guidelines (CPGs), in which they continue purporting an 'obesity as a disease' framework (Wharton et al., 2020). Weight-inclusive researchers, however, see the 'obesity as a disease' model as contributing to weight stigma because of the continued medicalization of fat bodies within the model (Bombak et al., 2016). An op-ed in the *Globe and Mail* by Orsini and McPhail (2020) echoes this, and the authors specifically critique the new CPGs, noting that while the CPGs do acknowledge weight stigma, the guidelines continue to pathologize obesity by conflating fatness with a "disease." Researchers within the dominant paradigm also critique the obesity as a disease approach, indicating there are not clear criteria for "diagnosis" (Brown & Mazur, 2019).

Quantitative and qualitative research among dietitians has indicated support for critical approaches that challenge the dominant paradigm (Barr et al., 2004; Chapman et al., 2005; Marchessault et al., 2007). For example, 514 Canadian dietitians were surveyed about beliefs regarding weight management, and dietitians said interventions should focus on lifestyle changes rather than body weight (Barr et al., 2004). These results were echoed in a qualitative study of Canadian dietitians in which focus groups revealed understanding the need to focus on health not weight loss and the importance of paying attention to psychological well-being in terms of body image (Chapman et al., 2005). Another qualitative study with Canadian dietitians found support for non-diet (i.e., weight-inclusive) approaches, but some dietitians said they lack the knowledge to implement these approaches (Marchessault et al., 2007). Conversely, quantitative and qualitative research from across the globe shows that dietitians hold stigmatizing views about clients with high BMI (Jung et al., 2015; Stone & Werner, 2012).

A hallmark of critical literature is taking an intersectional approach. This is why it is important for me to, in part, to talk about how fat studies and other work such as anti-racist and anti-homophobia work intersect. Described by Bowleg (2012), intersectionality is, "a theoretical framework that posits that multiple social categories (e.g., race, ethnicity, gender, sexual orientation, socioeconomic status) intersect at the micro level of individual experience to reflect

multiple interlocking systems of privilege and oppression at the macro, social-structural level (e.g., racism, sexism, heterosexism)" (p. 1267). Above, I discussed research within the dominant paradigm in which it was shown that African American women are generally more accepting of their bodies at higher body weights than white women (Carter-Edwards et al., 2010; Carla Rice, 2014). Lesbian women are also found to have higher body acceptance than non-lesbian women (McPhail & Bombak, 2014). While critical scholars support body acceptance as a positive, health-promoting trait, some dominant obesity researchers, like Carter-Edwards et al., (2010), use it as ammunition to target (or further marginalize) African American and lesbian women as "high-risk" groups for developing obesity and in need of more "urgent" interventions (McPhail & Bombak, 2014; Strings, 2015). Further, emerging evidence suggests that both African American and queer women's communities are increasingly influenced by fatphobic and anti-obesity messaging (McPhail & Bombak, 2014; Ristovski-Slijepcevic et al., 2008). At the same time, critical scholars also demonstrate the ways in which marginalized communities such as People of Colour, queer communities, Indigenous communities, and women generally are over-associated with fatness and obesity (Ellison et al., 2016; Strings, 2019). Critical scholars argue that this over-association creates fatphobia, which then attaches to and helps further other types of oppression such as racism, sexism, and homophobia (ibid., see also Rice et al., 2020).

In summary, critical approaches have established the ways in which dominant paradigms about fatness create and perpetuate weight stigma and aid in the perpetuation other types of social oppression. Critical approaches are also beginning to focus specifically on fatness in relation to infertility, pregnancy, and reproductive care in general (McPhail et al., 2017; Parker, 2020). For many researchers in this area, this research flows out of their own experiences of fatphobia in reproductive care (McPhail et al., 2017; Parker, 2020). Research in this area, as with fat studies generally, aims to interrupt the medicalization of fatness, specifically related to human reproduction (McPhail & Mazur, 2019; Parker, 2020). Here, I explore this critical literature further, and I begin with sharing critical perspectives in relation to the pre-conception period, followed by pregnancy and the postpartum period. I end with a discussion of the critical literature regarding the body weight of Indigenous people, specifically Indigenous women, in the perinatal period.

Critical Perspectives: Pre-Conception

In contrast to the assumption from the dominant paradigm, that fat women need to or should lose weight prior to pregnancy, critical researchers highlight the importance of focusing on health not weight at all life stages (Bombak, 2014). Health care professionals working from a critical approach do not avoid the topic of body weight altogether since weight cycling that occurs due to weight loss diet attempts contributes to ill health (Brown & Mazur, 2019; Tomiyama et al., 2018). Therefore, understanding a client's history of weight cycling and its contribution to ill health is an important part of the clinical assessment tools for a health care professional working from a critical perspective (Brown & Mazur, 2019). Weight cycling is associated with worsened metabolic outcomes such as high blood sugar, high blood cholesterol, and high blood pressure and other health measures such as lowered bone density and lowered immune function (Bacon & Aphramor, 2011). Health care professionals working from a dominant perspective often do not inquire about a client's history of weight loss dieting, and eating disorders are not discussed (O'Reilly & Sixsmith, 2012). With the significant health impacts of chronic dieting, weight cycling, and eating disorders (Bacon & Aphramor, 2011), the lack of attention to weight history and eating disorder history (Giroux et al., 2009; O'Reilly & Sixsmith, 2012) highlights a significant omission in the understanding of women's health, an overlooked consequence of the dominant obesity paradigm. This is an important yet underexplored consequence of a focus on weight over health that seeks to further marginalize women's health issues. Further, Health Canada's recommendations to advise patients who are overweight and obese to achieve a normal weight prior to conceiving and advising them the risk of high BMI in pregnancy (Health Canada, 2011) may be setting clients up for unhealthy dieting behaviours and weight cycling prior to conceiving and therefore potentially more weight gain in pregnancy. In addition to pre-pregnancy BMI, critical scholars also point to the research on PCOS and conception for fat women that is conflicting and contentious (Bombak et al., 2016; Ward & McPhail, 2019) and assert that no direct conflation can be made among fatness, PCOS, and infertility per se. Instead, these scholars note that PCOS has been shown to *cause* weight gain and query, then, whether it is the fatness or the PCOS that is causing a lack of conception (ibid.).

Critical Perspectives: Pregnancy

Critical literature on high BMI in pregnancy represents a smaller but emerging body of critical weight studies literature. Women with high BMI in pregnancy report weight stigma and poorer care experiences in comparison to "normal" weight women (Mulherin et al., 2013). Women discuss how "risk language" regarding excess weight in pregnancy and for some, a refusal of care, led to feelings of weight stigma (Bombak et al., 2016). The "high-risk" label in pregnancy led to health care provider actions that felt "punitive" and "traumatizing" (McPhail et al., 2016). Research thus suggests the ways in which ideologies of "mother-blame" inform medical understandings of "maternal obesity" (McPhail et al., 2016). Other critical researchers echo that the focus on the mother's weight and habits in pregnancy as responsible for her child's weight adds to the discourse of mother-blame (Lupton, 2013). Further, a recent qualitative study by Parker et al. (2019) examining the experiences of 11 Maori and Pasifika cisgender fat women found that such clinical encounters, which emphasized risk and mother-blame, were specifically racist for Indigenous women. Here, Parker et al. (2019) describe how the ways healthcare professionals discussed pregnancy risk with fat women "led participants to question the extent to which the problematizing of their fatness actually masked a racist…motivated interest in discouraging them from having babies" (p. 101). The authors conclude that "contemporary discourses of pregnancy and fatness work to perpetuate the harmful relations of colonization and reproductive legacies of reproductive injustice" (p. 98).

Dietitians are trained to educate clients about healthy weight gain during pregnancy, yet the pregnancy weight gain guidelines are controversial (Abrams et al., 2000). The history of the guidelines includes multiple changes, and they have been published through the Institute of Medicine and Society of Obstetricians and Gynecology (Davies et al., 2010). Health Canada (2011) guidelines regarding prenatal weight gain are based on Institute of Medicine recommendations, and these are the guidelines that dietitians in Canada use or are meant to use. One review draws attention to the pregnancy weight gain guidelines, in which weight gain recommendations are different based on pre-pregnancy BMI yet offers no guidance on how to achieve pregnancy weight gain within these ranges (Poston & Patel, 2014). These authors further report that there is no evidenced-based dietary regime or way to deliver it for pregnant women with obesity (Poston & Patel, 2014). A qualitative study with health care professionals working with women with high BMI during pregnancy indicated that weight gain guidelines are unclear

and lack consistency, making it difficult for healthcare professionals to know how to communicate about pregnancy weight gain with clients (Knight-Agarwal et al., 2014). Additionally, a qualitative study regarding low-income women with high BMI in the perinatal period revealed the need for consistent messages between nutrition professionals and physicians regarding nutrition and weight gain in pregnancy (Anderson et al., 2015). Health care professionals such as midwives and OBGYNs stress the need for classes led by dietitians for women with BMI > 30 in the perinatal period (Knight-Agarwal et al., 2014). However, regardless of BMI, optimizing nutrition status during the perinatal period can improve health and outcomes (Procter & Campbell, 2014). Overall, this research shows that the pregnancy weight gain guidelines lack information about *how* to discuss (or not discuss) body weight to ensure dietetic encounters and other health care encounters that are helpful, not harmful.

In their study, Faria-Schützer et al. (2017) found that participants with obesity experienced feelings of "addiction to food" while trying to keep within the pregnancy weight gain guidelines. Critical researchers acknowledge feelings of "addiction to food" as a defining part of or contributing factor to the development of an eating disorder (Brown-Bowers et al., 2016). Critical researchers have pointed out that recommendations given to fat people would be considered eating disordered behaviours in those who are thin (Lupton, 2014). It is well established among dietitians that improvements to nutrition status in pregnancy regardless of body weight of the mother benefit the health of the mother and fetus (ADA, 2008; Aphramor & Gingras, 2011; Procter & Campbell, 2014). Yet, for women with high BMI, restrictive diets are recommended by some researchers because of concern for "excess" pregnancy weight gain (Tanentsapf et al., 2011). It is important to consider the ethics in recommending restrictive eating patterns for women with high BMI and the potential negative impacts, short- and long-term, for mothers and infants. Of particular concern is that some health care providers recommend no weight gain in pregnancy or even support weight loss in pregnancy (Faria-Schützer et al., 2015). These recommendations are not in line with current prenatal weight gain guidelines in place to guide the work of health care providers, including dietitians (Health Canada, 2011).

In addition to the fact that dominant approaches and guidelines related to pregnancy and fatness are unclear and create mother-blame, critical scholars note that the literature from the dominant paradigm itself is contradictory and inconclusive (Bombak et al., 2016). For example, a review by Vanstone et al. (2017) reveals that fear-based messages about weight are less likely

to support health and more likely to contribute to concern about body image. This study also concluded that "obesity" occurs in a social context, and therefore, pregnancy weight gain should not target individual choice alone and should instead focus on environment, including supporting healthy food choices. In contrast, Yeo et al.'s (2017) review recommends that individualized interventions by prenatal care providers *should* target all pregnant women, with particular emphasis on mothers with obesity to ensure "appropriate" pregnancy weight gain. These review studies by Vanstone et al. (2017) and Yeo et al. (2017), as part of the dominant obesity literature, demonstrate these inconsistencies. These two review studies – published in the same year and focusing on dominant approaches to maternal obesity – make opposing recommendations: one encourages a focus on individual health choices, and one de-emphasizes individual choices in favour of improvements to the environment to support healthy choices. Critical weight scholars argue that both the individualized and environmental approaches to weight within the dominant paradigm are problematic (Lupton, 2014). While changes to the environment could support population health (Guthman, 2013), framing these interventions with a focus on obesity prevention or reduction, as opposed to a focus on health, rarely "works" (Bacon & Aphramor, 2011; Lupton, 2014), especially in pregnancy (Friedman et al., 2020). In fact, whether the focus is on the individual or the environment, dominant approaches to obesity prevention or reduction, and the focus on weight, have led to weight shaming and stigma (Bacon & Aphramor, 2011).

Critical Perspectives: Postpartum Period

While Montgomery et al. (2013) and Herring et al. (2008) view postpartum weight loss as positive, critical scholars acknowledge the ineffectiveness and dangers of weight loss attempts at any life stage (Bacon & Aphramor, 2011; Tylka et al., 2014). However, dominant obesity researchers, such as Montgomery et al. (2013) and Herring et al. (2008), have failed to address these dangers and instead see a postpartum focus on weight loss as a long-term health benefit, whereas critical researchers acknowledge its contribution to poor body image, disordered eating, and depression (Bacon & Aphramor, 2011).

Dominant obesity literature has also constructed connections between obesity and breastfeeding, conflating a lack of breastfeeding with fatness (Hashemi-Nazari et al., 2020; Krause et al., 2011); however, there are some issues with this literature. For example, in their study about obesity and breastfeeding, Flores et al. (2018) admitted that they used BMI as a

proxy for nutritional status of mothers, arguing that it is a good substitute (Flores et al., 2018), despite BMI not being a suitable indicator of nutritional status (Bacon & Aphramor, 2011; Guthman, 2013; Lupton, 2013). It is well established that breastfeeding has many known health and social benefits for the mother and infant, regardless of BMI (Binns et al., 2016; Clark & Bungum, 2003; Dieterich et al., 2013).

Critical Perspectives: Indigenous People With High BMI

While dominant approaches position fatness and obesity as a major concern in Indigenous communities, critical scholars are careful to re-think and scrutinize the conflation between fatness and indigeneity, given that fatness is a stigmatized embodiment (McPhail, 2016). For example, a qualitative study of obese Maori Indigenous people of New Zealand, revealed that the current medical model for obesity (i.e., the focus on calories, diet, and exercise) was not relatable, nor was it culturally appropriate (Bell et al., 2017). Further, dominant approaches that emphasize individual responsibility can be linked to colonial legacies and serve to further marginalize Indigenous people, who often emphasize relationality and connection as opposed to individual autonomy (Bell et al., 2017). Such studies demonstrate how dominant literature that privileges weight as a marker of overall health status does not acknowledge colonization and trauma experienced by Indigenous peoples, which has negatively impacted health and traditional foodways (McPhail, 2016; Robinson, 2019).

Demonstrating intersections between gender and indigeneity, Marchessault (2004) argued that Indigenous women's concern about body shape should be considered when planning interventions related to body weight. Studies about Indigenous women that I reviewed for this current study (Bruner & Chad, 2014; Vallianatos et al., 2006; Vanstone et al., 2017) did not include any consideration of body image concerns and associated problems, which is troubling considering body image concerns are often a precursor to eating disorders (O'Reilly & Sixsmith, 2012). While there is a dearth of research regarding the relationship between anti-obesity messaging and Indigenous women specifically, there is also a growing literature base demonstrating that anti-fat discourse is increasingly negatively impacting women in marginalized communities (McPhail & Bombak, 2014; Ristovski-Slijepcevic et al., 2008).

Critical Perspectives: Critical Dietetics

In this thesis, I use a critical dietetics perspective in addition to a critical weight perspective. Rooted in critical social theory, critical dietetics is a body of knowledge and inquiry focused on challenging the status quo and recognizing intersectionality throughout dietetic education, practice, and research (Gingras et al., 2014). Officially born in 2009, critical dietetics seeks to embrace critical scholarship across disciplines and support reflexivity ("Beyond Nutritionism," 2009). Critical dietitians question the past and present dominant dietetic practice of "helping" patients to achieve "normal" body weights and employ reflexivity to examine the ways in which they themselves have contributed and may continue to contribute to the dominant obesity paradigm, and how they can continue to work to reject it in favour of weight-inclusive approaches (Rochefort et al., 2016). Dietetics was developed using positivist science (Gingras et al., 2017). In contrast, critical dietetics recognizes the need for positivist approaches while also recognizing other forms of gathering and obtaining knowledge, and other ways of knowing. For example, "lived experience" is an important form of knowledge supported by critical dietetics (Gingras et al., 2017), and with this current study, one of my goals was to understand the lived experiences fat women and their dietitians.

Critical dietitians also acknowledge that the dominant view of obesity that dietetics has adopted actually creates health inequities instead of lessening them (Aphramor & Gingras, 2011). Despite increased awareness regarding the medicalization of obesity (Brown & Mazur, 2019), the dietetic profession has not substantially challenged the weight-centric approach to health (Aphramor & Gingras, 2011). Critical dietetic scholars, Aphramor & Gingras (2011), share this analogy: "Explaining any weight-linked differences in health status simply by fatness and then by a fat person's failure to lose weight, would be like suggesting that the failure of poor people to join gyms explains social-class differences in morbidity and mortality" (p. 213).

Regarding pregnancy and weight specifically, critical dietitians question the usefulness and ethics of recommendations about prenatal weight gain and caloric intake in pregnancy. For example, Brady et al. (2014) highlight inconsistencies in international guidelines for prenatal weight gain, in particular from Health Canada and the UK. Health Canada recommends no increases in caloric intake until the second trimester for pregnant women, whereas the UK guidelines say that no additional calories are needed until the third trimester. They also state that Health Canada's guidelines do not take systemic issues such as poverty into account. Further,

they assert that the discourse of "control" in regard to weight damages the client-provider interaction. For these reasons, they recommend the HAES approach to pregnancy be used by providers (Brady et al., 2013).

To conclude, this review of the critical fat literature revealed the inconsistencies, contradictions, and harms associated with dominant perspectives on obesity in general and in regard to pregnancy. This literature review also highlighted opportunities based in so-called "alternative" approaches, grounded in critical literature regarding body size. My research, as it takes up a critical perspective, adds to the critical literature and aims to support weight-inclusive practices in dietetics. As I consider stories of fat women and dietitians within the dietetic encounter, my research fills an important gap in the qualitative literature that has yet to address this topic from a critical perspective.

Chapter 1: Methods, Methodology and Ethics

Research Design and Procedure

For the current research, I employed a qualitative design with a critical social theory and social justice framework (Hesse-Biber, 2017) and a specific focus on critical approaches to fatness and embodiment that understand bodies as infused with or produced by inequitable social power dynamics (McPhail & Mazur, 2019). Saguy (2013) has articulated a fat studies methodology, which she describes as a "mixing and matching" approach, whereby scholars draw on the various "frames" in which "obesity" is viewed critically, such as critical biomedical perspectives, Health at Every Size, fat rights and fat activism, and critical dietetics – which I drew upon in this current research. The approaches of critical fat scholars are wide and varied, and thus, their research is grounded in a variety of disciplines with numerous methodological perspectives (Ellison et al., 2016). A fat studies methodology can be viewed as a type of research that is, at its heart, a social justice approach, in which dominant understandings of "obesity" that pathologize and medicalize fat bodies are challenged in the tradition of fat activists and activism (Cooper, 2016). In qualitative research, this is accomplished through exploring the experiences and identities of fat people (Bombak & Monaghan, 2017; Monahan et al., 2014), which often interrupt dominant imaginings of fat people as unhealthy and "abnormal."

Methodologically, the fat studies approach to research includes some other key elements. First, as mentioned, research within this approach focuses on de-medicalizing fatness by focusing on fat people's experiences and interpretations of their bodies, which challenge common notions of fatness as unhealthy and ugly (Bombak et al., 2019). Second, fat studies research is undertaken with the explicit intention of challenging "fat oppression" in the tradition of fat activists (Cooper, 2016; Schoenfielder & Wieser, 1995) and relies on critical social justice theories, such as feminist and anti-racist theories, to do so. For example, fat studies research that draws on feminist theories of the body and embodiment (Butler, 1993; Grosz, 1994) explore how fatness is attached to feminine bodies and therefore is demeaned in patriarchy (McPhail, 2017). Researchers using anti-racist theory suggest that fatness is degraded because of the ways in which "excess" body fat has become racialized and collapsed with Indigenous bodies and bodies of People of Colour (McPhail, 2016; Strings, 2019). Within empirical research, these

perspectives are influenced by intersectionality, and looking closely, through qualitative analysis, at the intersecting ways in which participants experience and "live" their fatness in relation to racism, sexism, and other social oppressions (Rice et al., 2020; Rinaldi et al., 2016).

Last, participants in fat studies research are typically encouraged in the sampling stage to define their own body types for themselves; that is, participants self-select as fat based on their own understandings of their bodies (Bombak et al., 2016). This is important in that it helps to question how we as researchers define "fatness," taking it out of the hands of scientists and medical professionals who use numerical and biomedical scales (Hopkins, 2012; McPhail et al., 2016; Rice, 2007). Being weighed or being asked for such measurements in the health care setting has led to clients feeling shame and stigma (Tylka et al., 2014). Self-identification can prevent these feelings of shame and stigma and therefore help foster trust between the researcher and the potential participant. I stayed true to this in the current research, and all participants who responded to the recruitment material were allowed to self-select and define their own bodies as fat or not. Selection criteria for the women included whether they self-identify as fat or as having a high BMI, or if they were labelled "obese" during their experiences of reproductive care.

During the ethics approval, I was encouraged to weigh and measure the participants to ensure they fit the criteria of what constitutes a high BMI. However, I wrote back to the ethics board and provided the rationale for self-identifying as I have already discussed, here. Thankfully, the ethics protocol was approved. Still, despite my best efforts to ensure a fat studies approach and non-stigmatizing language, one person from the public who had seen my advertisement called me to let me know that they would not be participating in my study because I need to stop using words like "obesity" and stop medicalizing body weight. I apologized for the harm caused by the advertisement, thanked the woman for her feedback, and told her I would discuss what she had said with my supervisor.

Research Questions

The central research questions of this project were, 1) How do women with a high BMI in Manitoba experience their interactions with dietitians during the perinatal period, and what can we learn about healthcare delivery for people with a high BMI from these experiences? 2) How do dietitians in Manitoba approach discussions around body weight in the perinatal period with clients with a high BMI? and 3) Do client experiences with dietitians differ from those with

other healthcare practitioners such as doctors and nurses as established in the literature, or are similar patterns of stigma evident? If so, how can fat women's experiences of reproductive care be improved to ensure socially just and sensitive healthcare delivery for women living in Manitoba?

Study Sample

There were 20 participants for this study. I recruited two types of participants. The first group of participants included women in Manitoba who self-identify as having a high BMI or as "fat," who are currently or who have been pregnant, and who have received pre-conception/fertility, prenatal, and/or postnatal dietetic care. The second group of participants included 10 dietitians in Manitoba who provide pre-conception/fertility, prenatal, and/or postnatal dietetic care to women with high BMI.

The first group of participants, women with high BMI, was recruited through a combination of methods, including notices in community newspapers, posters at key venues such as women's hospitals, notices sent to dietitians working in prenatal and postnatal groups, online via social media, word of mouth, and snowball sampling. As an incentive for participation, the 10 women with high BMI were give $20.00 in cash and two adult bus tickets from Winnipeg Transit. Dietitians were recruited primarily through professional email listservs that I have access to as a dietitian (e.g., Dietitians of Canada Member Communication Database). Dietitians were not offered incentives. For the women with high BMI, at the time of initial contact, I asked screening questions to facilitate purposive sampling with the women with high BMI to obtain a diverse sample, including variations in social class, education, income, sexual identity, and race. Given the over-representation of white, middle-class women in this topic area generally (Lind, 2019), it was my goal to have half or more of the women with high BMI identify as part of a marginalized group. I succeeded in this aim as half of the women with high BMI (n = 5) reported at least one or more marginalized identity, such as identifying as racialized, as part of a marginalized sexual identity, as a person with a disability, and as low income (please see Table 1 for the demographic information for the women with high BMI).

Recruitment was a challenge and occurred in waves. There were times when I was contacted directly following advertising, and other times when no one contacted me. In part, I wondered if this had to do with the recruitment posters. I employed a fat studies methodological

approach on the posters and did not want to use language that could be perceived as weight stigmatizing. Something that warrants further investigation is how to recruit using non-stigmatizing language but, at the same time, how to not offend people who feel traumatized by the word “fat.” There was also an issue in which some of the people who were interested in participating were not sure if they had seen a Registered Dietitian or not. Regarding the women with high BMI group, some potential participants who contacted me fit the selection criteria but had not seen a dietitian. Some expressed that they had seen a nutritionist or a naturopath from whom they received nutrition support.

When recruiting the dietitians, I encountered unique opportunities and challenges. At first, I received no response from dietitians. Then, I spoke with a dietitian about my study, and she offered to send the recruitment poster via email to a list of public health dietitians from across Manitoba, who worked primarily with prenatal and postnatal group education. From this, I received an overwhelmingly positive response. It is possible that dietitians who had heard of my critical approach to body weight and had a similar approach to mine were more likely to participate in this study.

I interviewed the women with high BMI first. Since the women with high BMI saw dietitians from a variety of work settings beyond group education, I wanted to ensure the sample of dietitians reflected that. In addition, I hoped the dietitian sample would reflect the different settings that dietitians provide perinatal care. When interviewing the first few dietitians, I asked for their advice on who I should contact, who works in perinatal care in Manitoba. I was then able to connect with dietitians who worked in clinical settings, primary care, diabetes care, and private practice. As I discuss in Chapter 1: Methods, Methodology, and Ethics, based on the advice of some of the dietitians I interviewed, I contacted some clinical dietitians. Some did not return my calls and emails. I was able to speak with one dietitian in diabetes care who, despite meeting the inclusion criteria to participate in my study, said that she was not a fit for the study because she focuses on blood sugar control, not weight. I explained that because of the dietetic profession’s historical focus on weight in diabetes and the fact that she focuses on blood sugar not weight, she would be an important voice to include in this study, but she declined. I was able to recruit some dietitians with experience in diabetes care in the perinatal period, and in the end, I felt I recruited a well-rounded sample of dietitians from a mix of clinical and community settings including public health, primary care, diabetes care, and private practice.

Table 1. Participant Information – Women with High BMI	
Age range	27–46
Highest level of education	High school education (1) Diploma or certificate program (3) Undergraduate degree (3) Graduate degree (3)
Highest level of education of participant's parent-1	Less than high school (1) High school completion (1) Diploma or certificate program (4) University degree (3) Graduate degree (1)
Highest level of education of participant's parent-2	Less than high school (1) High school completion (1) Diploma or certificate program (4) University degree (3) Graduate degree (1)
Self-identified race or ethnicity	White (8) Indigenous (2)
Sexual identity	Heterosexual (7) LGBT (3)
Identifies as a person living with a disability	Yes (2) No (8)
Estimated annual household income	Low income (2) Middle income (3) High income (5)
Current employment or engagement in schooling	Employed (6) On assistance (2) On maternity leave from job (2)
Marital status	Partnered (9) Single (1)

Table 2. Participant Information – Dietitians	
Age range	29–59
Highest level of education	Undergraduate degree (7) Graduate degree (3)
Highest level of education of participant's parent-1	Less than high school (1) High school completion (1) Diploma or certificate program (4) University degree (3) Graduate degree (1)
Highest level of education of participant's parent-2	Less than high school (4) High school completion (1) Diploma or certificate program (3) University degree (2) Graduate degree (0)
Self-identified race or ethnicity	White (9) Indigenous (1)
Sexual identity	Heterosexual (10) LGBT (0)
Identifies as a person living with a disability	Yes (0) No (10)
Estimated annual household income	Low income (0) Middle income (2) High income (6) Prefer not to answer (2)
Current employment or engagement in schooling	Part time (4) Full time (6)
Marital status	Partnered (10) Single (0)

Data Collection

Semi-structured interviews were completed for both the women with high BMIs and dietitians. These types of interviews are loosely but not totally guided by the interviewer. This allows the flexibility for participants to share their experiences and identify areas that are important to them (Britten, 1995). Semi-structured interviews are common when the researcher is familiar with the subject matter at hand as researchers are better able to engage in a natural flow during the interview and ask appropriate follow-up questions based on the direction of the conversation (Hesse-Biber, 2017). There was natural flow of conversation in the interviews as a result; and through reflective listening and follow-up and clarifying questions, participants naturally answered many of the questions without me having to pose them. As a result, one of the dietitian participants remarked, "Thank you for just letting me talk."

As a dietitian with experience working with women with high BMI, I was able to be sensitive to participants' stories and was able to follow up with appropriate questions to ensure research questions were addressed, while maintaining a compassionate and relaxed interview environment. Prior to starting, I asked whether participants needed anything (such as a beverage) and if not, to let me know at any point during the interview if that changed. To begin the interview, I asked participants to share a little about themselves, their work, their partners, their children, etc. which aided rapport but also led into some of the questions regarding their experiences that related to the interview questions.

Interviews were based on two separate interview guides, one for the women with high BMI (Appendix A) and one for the dietitians (Appendix B). The women's interviews focused on experiences with dietitians relating specifically to weight and "obesity," while dietitian interviews centred on their views on weight, "obesity" and the pregnancy weight gain guidelines, and the translation of those views into everyday practice with patients with high BMI.

Interviews were digitally recorded and lasted approximately 60–90 minutes. Data from the interviews were collected at a location of choice by the participants. I employed fat activist principles throughout every step of this research project, including when considering the location of the interviews. This is important as being fat in public comes with risks, such as weight-based teasing and bullying and weight discrimination. Further, as a graduate student researcher in the College of Medicine, and on a campus connected directly to a hospital, I did not want my participants to feel obligated to meet me at my place of study, where they may be subject to the

medical gaze and subsequent judgement. I wanted to ensure the interview environment was comfortable and accessible to them in all ways. My aim was also to prevent any potential limitations or barriers to participation based on meeting location. For example, the chairs available in some spaces are not large enough for fat people. Because I asked participants to select the interview place, they were able to select places that were appropriate and inclusive, and as such, interviews took place in the homes and workplaces of the participants, as well as in local coffee shops and restaurants. Once we arrived at the meeting location, I asked participants where they preferred to sit to ensure they chose a location within the space and a chair size most suitable for them. At the request of the participant, or if they lived outside of Winnipeg, some interviews were completed over online video chat. I was concerned about video chat interviews perhaps influencing the quality of the interviews, but I gathered rich data from both in-person and video chat interviews.

I recorded field notes on the audio recording device as well, immediately following or as soon as possible after the interview to capture my initial insights and things that would not be captured on an audio recording, such as if the "interviewee had tears in her eyes." I downloaded data from the recording device to an encrypted and password protected computer. The audio files were professionally transcribed by Transcript Heroes. The use of the professional transcription service by Transcript Heroes was approved by the University of Manitoba Health Research Ethics Board, and data was shared securely. Once the interviews and field notes had been transcribed, I uploaded them into the NVivo software program.

There were some practical challenges at the interviews such as background noise and soft tone of voice of participants. I was concerned about the recorder not picking up the sound. I troubleshooted this by suggesting we move to sit at a different place in the restaurant and in one case, by asking my participant if she would be comfortable holding the recorder close to her face instead of on the table in between us. Luckily, recordings were clear enough for transcription.

One location a participant chose had quite small chairs. I arrived before the interviewee to sit down and discovered that the chairs were uncomfortable for me, as a self-identified fat person. Once the participant arrived, I was quick to get up and greet her. I waited in line with her to get a beverage and casually mentioned that the seating was kind of uncomfortable and how that was unfortunate. She said that she usually chose the bench seating but that table was in use, so she suggested an alternative table. Upon reflection, I wish I had asked her if she felt

comfortable with me asking the folks at the bench seating, who happened to be in thinner bodies, if they would consider swapping seats with us. However, the participant seemed fine with the table she chose, and we continued with the interview. I was relieved that she appeared comfortable, and her interview ended up being rich.

For another interview, the participant chose a table away from the other patrons, although mid-interview people sat at the table right next to us during an emotional story. She looked at the people and at me, and I sensed her discomfort. So, I apologized for interrupting her, acknowledged that the folks were quite close, and asked if she wanted to change spots. We looked around, but there were no other tables, so we both agreed to speak in softer voices and leaned closer to the recorder. Again, I was surprised and happy that despite this, the interview yielded such rich data.

I conducted three interviews at the homes of the participants. I knew two of these participants as former classmates, so I felt safe and comfortable to go to their homes by myself as a researcher. I recruited the remaining interviewee during a visit to a prenatal group, so I was able to ask the screening questions right then in person and schedule the interview time and date. As a result of meeting her then, I felt comfortable offering to meet in her home if that worked better for her. There was slight discomfort on my part to be in someone's personal space, although, again, all three of these interviews at participants' homes ended up being quite rich.

Out of the 20 people I interviewed, I had a prior knowledge of, or some form of personal or professional connection with 11 of them. Regarding the women with high BMI, I knew five out of the 10, three as former classmates and two as former dietetic clients of mine. In the group of dietitians, six were former arms-length co-workers (as in, we only had professional contact a few times per year), one was a former classmate, and three I did not know prior to meeting. There was one dietetic intern who participated in the study with her preceptor; I had met this dietetic intern previously while speaking to her undergraduate nutrition class.

Although the efficacy and rigour of knowing participants in advance is debated (Taylor, 2011), having prior relationships of various types with some of the participants was beneficial to quickly establishing rapport, which allowed for a deeper dive, more quickly, into vulnerable topics because participants felt safer and more comfortable with me than they may have felt with a stranger. This is confirmed by Holder (2015) and their research on co-workers. In fact, a couple of the participants with prior knowledge of me said that, in part, they reached out to do to the

interview because they knew me and the work I do and wanted to share their story explicitly with me as a result; they knew their story would be safe with me. One woman with high BMI remarked that she follows my professional social media accounts because she appreciates my weight-inclusive approach. She saw me share the recruitment poster on my professional Instagram account and said that she wanted to be involved since she had seen a dietitian during her pregnancy. One dietitian remarked that they were glad that I, as a dietitian, was leading this research, and they really hoped, because I am a dietitian, changes would be made in this area of dietetics because of this research. Lastly, knowing participants prior is viewed as a part of critical, Indigenous, and anti-oppressive approaches to research, and can be considered an act of resistance to dominant forms of research in which researchers remove themselves to reduce "bias" in their studies (Brown & Strega, 2015).

Data Analysis

I used NVivo software for qualitative data management to perform the analysis of the data. This software facilitates creating codes and categories and their systematic application to data. I then conducted thematic analysis of the data on two levels. First, I reviewed the transcripts several times and completed "open coding" to determine emerging themes (Hesse-Biber, 2017). Second, I completed "axial coding," where the emerging themes or "open codes" were grouped into categories based on the relationship between the codes (Hesse-Biber, 2017). I then inputted the code list into NVivo and coded the data. Lastly, I analyzed the data was through a critical social theory lens, specifically using a fat studies methodology (Lupton, 2013; McPhail & Mazur, in press; Saguy, 2013), which in part challenges binary thinking (Hesse-Biber, 2017) or "dualism" (Bartky, 1988) around weight and health, recognizing power dynamics between provider and client. For the first group of participants, the women with high BMI, I considered how interactions with dietitians shaped self-perception of bodies and reproductive health. For the second group of participants, the dietitians, I paid particular attention to how views about body weight shape professionals' views of health, the body, and their clients' reproductive health, and how this translates into practice.

Devault (2004) has argued that words may not fully capture lived experiences and that sometimes a researcher needs to find ways to listen that involve more than the exact words that are expressed. I took this into account throughout the interview process and used "check-ins"

with participants during the interviews to see if I had captured the feelings beyond their words (Britten, 1995). For example, I would reflect back to the interviewee what they said and ask if I was understanding them correctly. If they validated that, yes, I had understood them, I might also ask a follow-up question to clarify their words more deeply. I may reflect back to the participant the words they said but also ask gently about the tone they used or the facial expression they made to ensure that I had correctly interpreted both the verbal and non-verbal communication.

Rigorous qualitative research and trustworthiness of the data were established through four criteria: credibility, transferability, dependability, and confirmability as described by Lincoln and Guba (1985). Credibility, or confidence or truth in the data gathered can be ensured by the strategy of *member checking* (Lincoln & Guba, 1985). While I initially wanted to member check through providing lay summaries to participants, I have yet to accomplish this but plan to do so in the near future. I did perform a process of integrated member checking, as described above, wherein I made sure I understood what participants were saying during interviews through check-ins and "reflecting back."

Transferability, or the ability of the data to be applied to other contexts (Ravitch & Carl, 2016) was supported by providing a "thick description" of the data in Chapters 2 and 3 in order to allow others to judge the data's usefulness in other contexts. Dependability, or how a researcher accounts for and recognizes how their own biases may impact the study (Willig, 2001), is supported through the process of critical reflexivity, which I include below. I ensured my positionality was considered throughout the study by reflecting on this while recording fieldnotes after each interview and also reflecting on my own relationship to participants throughout my analysis in this thesis. Finally, confirmability, or ensuring the data are accurately reported as true to the participants and not from biases or alternative motivations (Ravitch & Carl, 2016), was ensured through regular communication with my supervisor and MSc thesis committee to discuss such issues.

Ethical Considerations

This study was approved University of Manitoba Health Research Ethics Board. Informed consent (See consent forms in Appendix C and D) was obtained from participants prior to me undertaking each interview. The participants were screened by phone to ensure they were over 18 and fit other participant criteria as described. Once eligibility was confirmed, I

determined with the participant whether the interview would be in person or over video chat. Then, I verbally explained the study, the risks and benefits, privacy, and confidentiality, and asked if the participant had any questions. I let them know that they could withdraw from the study at any time. I then emailed participants the study information and consent form to review. For interviews over video chat, participants signed and emailed back the consent form. For in-person interviews, I brought the consent form for the participant to sign and gave them a paper copy of the completed form.

As mentioned, I knew some participants prior to this study, and I must acknowledge the ethical issues this raised. In qualitative research, when research participants are known to the researcher, it may raise concerns of the trustworthiness of the data (Taylor, 2011); however, this can also be an asset and support study rigour. I argued above that it was because these women knew me and had a level of trust in me that the interviews generated extraordinarily rich data, thus demonstrating that, in qualitative research, prior relationships with participants can often lend themselves to greater rigour in a study.

I was thoughtful, nonetheless, about the potential risks of having prior knowledge of some of the participants, and I did attempt to mitigate these risks. For example, I was concerned that the two participants who were my former clients may not feel comfortable being 100% honest with me about their experiences with me, their former dietitian. To try to account for this, I was upfront with these participants about this concern and told them that if they had something negative to share about their experience with me as their dietitian, I would welcome that. Both participants said that they had no concerns about that whatsoever. In the end, the data from these two participants were so rich that I no longer have concerns about the truthfulness of their responses.

Other potential risks of the research included potential emotional disturbance from discussing the sensitive topic of weight stigma. Some participants asked for professional resources for follow-up in this regard. Due to my experience as a dietitian in Manitoba, I was able to easily provide them with the resources requested. In other instances, I offered potential resources for the participants when it appeared they did not have professional supports.

Privacy and confidentiality were assured by keeping the digital and paper documents related to the study stored in secure locations, protected by encrypted passwords and physical locks. Participants were given a numerical identifier and eventually a pseudonym for

confidentiality purposes. Participants were also informed that their names and other identifying information, such as clinic or health care provider names, will be kept anonymous. One participant did decide to use her real first name, and this consent was provided in the consent form on file.

From these ethical considerations, I move on to my personal reflexive statement. As I explained, critical reflexivity is key to ethical research practice. It would be unethical for me to not locate myself, or not position myself within this research. While Saguy (2013) explains that mainstream obesity researchers not only distance themselves from their research because of the tradition of "objectivity" from scientific research, some of these researchers also remove their bodies from the research because they are, in fact, fat. As such, they do not want to be seen as unduly "biased." As a self-identified fat woman, I openly acknowledge my position in this regard. I share more about my own positionality below in order to interrupt typical obesity science scholarship, and to write as an embodied fat studies scholar who locates her body history within the study.

Personal Critical Reflexive Statement

Critical reflexivity is a strategy to recognize the researcher's own social location within the research in order to analyze themselves and the research critically (Hesse-Biber, 2017). This is important in qualitative research because the researcher is an "instrument" in the data-gathering process. It is therefore integral to think thoroughly about how the researcher influences all aspects of the research study. As Bunch, cited in Gard and Wright (2005), notes, "There is no private domain of a person's life that is not political and there is no political issue that is not ultimately personal," (p. 154). Therefore, my interest in this research comes from experiences in my professional and personal life, which I share below.

I completed my dietetic training in Manitoba, Canada in 2007–2008. At the time, the program was called the Manitoba Partnership Dietetic Education Program. The program consisted of 11 three-week placements in different work settings and locations across the province of Manitoba. The placements included training alongside a dietitian preceptor (i.e., mentor). The placements included clinical experiences in hospitals, long-term care facilities, and chronic disease management teams; community experiences in prenatal and postnatal groups such as Healthy Baby; food service management; and project management. Early into my

dietetic internship training, after four years of my undergraduate nutritional sciences degree, I saw the harm that I could have caused due to the weight-focused curriculum. One of my mentors worked for a women's clinic with feminist, women-centred, and HAES-focused care approaches. During my short time there, only five days to be exact, in my second month of a 10-month internship program, I observed my mentor's work with clients of all shapes and sizes who had developed disordered eating behaviours, in part because of a focus on weight. For me, after having grown up with a thin body type, in a family who supported a healthy relationship with food and body, observing the weight bias (internal and external) and disordered eating practices that these women experienced was a shock. I was angry that I had completed four years of an undergraduate degree without receiving weight-inclusive training. I felt that my eyes had been opened to the harms of a weight-centric approach to health in a fatphobic society, and my eyes could not be closed. Those five days changed the entire course of my career and life and started my journey as an advocate to end fatphobia and promote a weight-inclusive approach to health. The rest of my internship beyond those five days was difficult as I struggled with the power dynamics with my mentors who I was to learn from and emulate, but I now opposed their way of practicing. I feared being unable to pass my internship if I spoke out too much. Despite much emotional turmoil, I passed my internship and was able to practice as I chose, working in three rural communities in Manitoba as my first jobs post-internship. I brought the weight-inclusive message with me to these work settings. Later, a job posting came up at the Women's Clinic, where I learned about weight-inclusive approaches. I applied and got the job. I was finally able to work at a place that supported my values and weight-inclusive practices.

Throughout my time practicing in clinical and community dietetics, I witnessed the pain and shame of my clients at the hands of health care professionals (including other dietitians), who are meant to help, not harm. Clients have told me that they felt I was the first health care provider to respect them. I heard stories about weight loss dieting that, in part, led to devasting eating disorders, experienced by women across the weight spectrum. I counselled women of all shapes and sizes, ages, races, and economic statuses. Despite working with a supportive interdisciplinary health team at the Women's Clinic for seven years, which included clinical supervision to discuss the difficulties of the work, I at times felt powerless to help these women, which led to burnout. My experiences and feelings were in line with research regarding dietitians

and burnout (Gingras et al., 2010). I chose to leave that job for graduate studies, and I am now in the final stages of my master's degree as I write this thesis and prepare to defend.

While I now identify as fat, in the past, I benefited from thin privilege. While seeking pre-conception care, my so-called "normal" weight body likely offered me better treatment. I was offered testing and referrals to specialists without pressure to lose weight. Fast-forward several years, and because of chronic health issues, I find myself in a new body, one that would be labelled "obese." If I resume pre-conception care, will I be met with the same struggles of my participants? Do I even want attempt to conceive any longer? What impact, if any, has the negative experience of my participants impacted my interest in conceiving?

It is my hope that this research improves care for all women, including, potentially, myself. I wonder, though, whether my research will be received differently because of my new, fat body. Research indicates that my "body credibility" as a thin dietitian served to legitimize my knowledge as is the case with thin vs. fat researchers (McPhail et al. 2017). Since bodies are symbols that are read by others but also the inhabitants (Lupton, 2013), my thin body was considered a symbol of willpower and health, and clients told me so. My formerly thin body was more likely the product of a combination of my genetics, my age, having "so-called" normal eating and activity patterns, and being raised in a non-diet and body positive household. Further, as a fat rights advocate and founder of the grassroots awareness campaign, *Manitobans Against Weight Stigma* (CBC, 2016), which supports recognition of weight discrimination as an important human rights issue, I have been told that it was likely because of my formerly thin frame that the messages I was promoting would be taken more seriously. In this new fat body that I have now, though, clients, activists, and society have and will view me and the messages I advocate differently. In a world where women are encouraged to take up as little space as possible (Lupton, 2013), I am taking up more space, literally and politically, by promoting fat rights. With the fluid (not fixed) nature of bodies and fatness (Lupton, 2013), I cannot predict with certainty the future of my fat body (which is on the skinnier side of fatness spectrum) and its public perceptions.

I am within, outside, both, and neither. As a "radical" critical dietitian, I have always felt like an outsider within the profession (Gingras, 2009). As a novice researcher attempting to understand the experience of a pregnant person while having never been pregnant, I am a true outsider in this regard. My bodily experiences have ranged from thin to "obese." My skin, white

in appearance, does not reveal my Métis roots. My current professional position does not reveal my lower-class upbringing or my current low-income status as single graduate student who lives alone.

Because it considers these junctures of the personal, the political, intersecting identities, privilege, and oppression, this research project is an important addition to the literature – to highlight the voices of women with high BMI, to improve care for those with high BMI in perinatal period with dietitians and with other health professionals more broadly. It was my honour and privilege listen to and learn from the wisdom of my research participants, and I hope to use my power as a researcher, health care professional, and activist to elevate these voices for social good.

Chapter 2: Good, Vanilla, Bad: Fat Women's Experiences of Perinatal Dietetic Care

This chapter summarizes the experiences of 10 women who self-identified as fat, high BMI, or "overweight" or "obese" in perinatal dietetic care. Women with high BMI saw dietitians in individual settings, including primary care, private practice, as part of a diabetes care team, and in group settings such as "Healthy Baby.[vii]" Some women saw more than one dietitian individually or as part of multiple group sessions. In their interviews, women also shared their experiences with doctors, midwives, and other health care providers during their fertility, pregnancy, and postpartum care journeys. This chapter focuses on the experiences with dietitians. Weight stigma has many negative impacts for clients in health care (Tomiyama et al., 2018) and greater impact for those seeking fertility and pregnancy care (Incollingo et al., 2019). Experiences of weight stigma are understudied in the dietetic setting (Bessey et al., 2020), so this chapter focuses exclusively on the qualitative interviews about the experiences of 10 women with high BMI who received dietetic care for infertility concerns during the pre-conception period, during pregnancy, and in the postpartum period. These experiences are categorized as "good," "vanilla," and "bad."

Participants who described "good experiences" were Monica, Erin, and Nicole. They discussed relationships with health care professionals – and dietitians, specifically – as empowering, life affirming, non-judgemental, compassionate, and supportive. The dietitians had asked these participants what their goals were, which gave the participants a sense of agency. In comparison, Mandy's, Jessica's, and Rachel's and stories were of "vanilla experiences." These experiences were categorized based on participants' ambivalence about their health care experiences – what one participant described as "meh." Lastly, Phoebe and Susie outlined "bad experiences" and described weight stigma they experienced in health care settings. These participants felt traumatized, dehumanized, and powerless. Participants who had "bad" interactions with health providers were told what they should do with their health and did not feel a sense of agency in their own health care.

This chapter provides in-depth analysis of interviews with participants who shared stories of their lived experiences. I deploy the case study technique to provide a "deep dive" into the participants' lives and stories that exemplify good, vanilla, and bad experiences. According to Biba Starman (2013), a case study in qualitative research is "a comprehensive description of an

individual case and its analysis, i.e., the characterization of the case and the events, as well as a description of the discovery process of these features that is the process of the research itself" (p. 31; see also Ravitch & Carl, 2020). In each case study I outline participants' stories of reproductive healthcare and detail my interactions with them in the interview exchange and, in situations in which I knew the interviewee prior to this research, also beyond the interview.[viii]

Good Experiences

The participants had a range of positive experiences from a one-time, one-on-one dietitian consultation that proved to provide a source of strength that would last many years, to a long-term, one-on-one dietitian-client relationship that was very supportive and nurturing. In addition, some participants related nourishing group experiences.

Case Study 1: Monica

Monica is a married nursing instructor with three children. She is 38 years old, white, heterosexual, and higher income. She has a long history of weight loss dieting and has seen multiple dietitians. In the past, Monica hated her body and struggled with anxiety about weight gain in her first two pregnancies. The postpartum period was difficult for Monica as she wrestled with her own expectations and societal expectations to get her "pre-baby body" back. During her third pregnancy, Monica shared some of her weight gain concerns with her midwife and, as a result, was referred to a dietitian for an individual session and to group sessions facilitated by a dietitian. In both cases, Monica encountered me as I was the individual dietitian to whom she was referred, and I also led the group she attended. These group sessions were not specifically for pregnancy but were for women who had difficult relationships to food and body. Monica described the group sessions in her own words:

> It was about once a week, or it was once a week and it was probably over six to eight weeks, I think. So, in the evening for a couple of hours once a week a group of women, so probably about 10 regular participants, we saw each other regularly and went through a lot of information about…kind of challenging some of the beliefs that we maybe held from diet culture. So, from the way that the larger bodies are perceived or smaller bodies or whatever sized body that you have, how that plays into how you feel about it. Then food choices. …I remember…just what kind of information do we consider when we're making food choices sometimes. There was an example about an apple that I still think

about pretty often.

Monica's long history of weight loss dieting, also known as chronic dieting, largely shaped her ideas about food, food choices, and her body. I asked Monica to describe the apple example and how it changed her beliefs or, rather, expanded her thinking about how people can make food choices:

> So, if you were going to the store for a snack and you were going to choose an apple, would you choose it because it was low in fat and high in fibre, would you choose it because it was seasonal, or would you choose it because you just really love eating apples? And just kind of highlighting that there can be different reasons that you would choose to eat different foods. That hadn't ever really dawned on me.

The idea of selecting a food based on taste, as opposed to how healthy it was, seemed like quite the revelation for Monica, so I was curious about why it was so meaningful. I asked, "What was it like to hear that different sort of approach to choosing food for you? Like what was that impact, like emotionally or otherwise?" Monica answered,

> It really highlighted that I had categorized many foods into being…good and bad according to external rules.…I would choose the apple, because it fit in with maybe being in low in fat and high in fibre, because those were the rules that I was just supposed to follow. And, that if I did eat a food because it tasted good or because I enjoyed eating it, that it would always be a food that I would always only consider that piece when it was a "bad food," in quotation marks there. So, it was so new to me to think that you can choose foods that have a higher nutrient content and because you enjoy those food also, that it wouldn't just be…because you should. Yeah, so I'd say that was one of the biggest takeaways for me.

The group Monica describes here and above is called "Well Now," developed by UK Dietitian and scholar Dr. Lucy Aphramor, Well Now was originally based on the principles of HAES and social justice approaches to food, the body, and health (Aphramor, 2018). Research has shown that participants in this group improve their relationship to food and their bodies; see improvements to their food and exercise behaviours; and transform negative thoughts about food, body size, health, and weight (ibid.). In 2012, I received training to be a Well Now facilitator. Since I received this training, Well Now has shifted away from HAES to focus on "connected eating," defined by Aphramor (2018) as:

> A [philosophy] concerned with challenging oppression and repairing harm done and being done. …It seeks to re-orient food narratives, so they centre on respect i.e., dignity and justice. …This means it integrates body cues, values, our experiences (including trauma), and the context of our lives; it teaches that food and eating serve a range of roles and meet a range of needs concerning health, pleasure, values, relationship, self-care, emotions, identity etc. It is thus body aware, relational and intentionally political.

I asked Monica how she felt to be in her Well Now group, which I found significant given my own personal relationship to the Well Now philosophy. Monica's answer demonstrates the effectiveness of Aphramor's approach to group education:

> I loved it. I'm a nursing instructor by trade, and birth is my background, so I feel like I'm very situated in women populations, so it felt very comfortable for me to share my experiences and to hear other people's experiences kind of navigating the messages that they've received about their bodies and how those impact the choices that they make.

Monica had multiple experiences with dietitians prior to her individual dietitian consultations with me and joining the Well Now group:

> I had seen dietitians before that and historically it had been like "Bring your food journal, and we'll see what it says, and then we'll go through it and see where you can make some changes." So even though it was a group [led by a dietitian], I think I was kind of surprised that it wasn't like that: like "Let's all compare what we're eating and see what we should be doing." So, I was surprised that it wasn't filled with "should."…Yes, so I loved the experience. I thought it was really eye-opening to see because there was so much diversity in the group also – so women of different ages, women who have different experiences – because we're all different. So, hearing about some of the similarities and some of the different ways that we interpret the world.

Monica appreciated the ways in which Well Now did not focus on the "shoulds," as she describes them, but rather centred on manageable steps for clients that would be experienced as empowering, positive, and achievable dietary changes. Monica tearfully recalled a moment of clarity, a culmination of her journey to make peace with food and her body and how the experience of the group and individual dietitian sessions changed her perspective and supported that journey:

> One of my friends dropped a huge bag of monster cookies that were super delicious and a really quick and easy snack. They were so delicious that I remember them like five years

> later. So, in my third postpartum period I was like, "Yeah, I'm breastfeeding a baby, I'm caring for two other kids, I'm recovering from a C-section, these cookies are delicious and amazing. Somebody who cares for me made them." And I just ate some of them, and I loved them. I shared them with my kids. And they did what they needed to do. …They filled my body when it needed to be fed. [Tears.] I'm sorry. Surprise. Yeah. So, I never felt as though I needed to eat all of the cookies at one time. Like they lasted for a reasonable amount of time, but I also know that if those same cookies would've shown up at my second birth, that it probably would've been – there would've been much more energy spent deciding how many cookies can I eat, when can I eat these cookies, who else can have these cookies. And all of that energy that used to go into making food decisions. I don't spend that much time in my life now thinking about how…I used to feel, but when you do it's amazing.

In the above quotation, Monica articulates that when clients are supported to have permission to eat, they end up eating the amount that is right for them because, since less stress is associated with the choice of eating, the likelihood of overeating or binge eating is lessened (Schaefer & Magnuson, 2014). Unconditional permission to eat is defined as giving oneself permission to eat any type of food in any amount (Humphrey et al., 2015) and is counterintuitive to what most dietitians and other health care professionals believe is necessary for weight loss – which is restrictive dieting (Schaefer & Magnuson, 2014). Monica's story is demonstrative of this fact: that given permission to eat to taste and desire, people naturally maintain weight (ibid.).

Monica did not only receive positive messages about eating for satiation, taste, and satisfaction from her group experience with Well Now. Monica also said that she found the messaging around food and weight from the Well Now group, the individual dietitian sessions, and her midwife during her third pregnancy were consistent and provided reassurance. This was quite different than during her first two pregnancies, however, when Monica was more entrenched in diet culture, the idea that her body was "wrong," and the idea that her pregnancy weight gain was to be feared and monitored closely. Monica explained how her contact with her midwife during her third pregnancy helped to normalize her pregnancy weight gain, instead of making her feel ashamed:

> It was helpful, so I appreciated the reassurance [from the midwife]. I appreciated that it felt like the message was [your body weight is] just one part of you. So, yes, that is true, your BMI is increased [in pregnancy]. But that that focus wasn't on "Let's try and make your pregnant body smaller so that your risk is less. Let's focus instead on what you can do to help yourself have a healthy pregnancy, regardless of what shape or size your body is." So, it was super new; it felt new. But there was comfort in it.

Overall, Monica was extremely fortunate in that she was able to access affirming care throughout her third pregnancy from the Well Now group, the dietitian, and the midwife. Her story exemplifies the ways in which dietetic counselling with a "connected eating" and a fat-affirming approach can not only have positive impacts on pregnancy but can also have lasting effects on self-esteem and embodiment postnatally. Like Monic, Erin also had an affirming and positive approach.

Case Study 2: Erin

Erin is a 33-year-old schoolteacher who was on maternity leave with her first child at the time of our interview. She is married, heterosexual, white, and earns a higher income. Erin had struggled with an eating disorder since her teen years and received outpatient group treatment in her early 20s. At the same time Erin was actively struggling with an eating disorder, Erin and I were classmates during our undergraduate degree in Human Ecology and Nutrition. I was unaware that Erin was struggling with an eating disorder during those years. However, I later learned that Erin's story is not uncommon. Compared to the general university population, in which the prevalence of eating disorders of 14%, the prevalence of eating disorders in nutrition programs is 25% (Drummond & Hare, 2012). At the same time, research about dietitians' weight stigma is complicated. On the one hand, dietitians and dietitian students have been found to have less weight stigma than their health professional peers (Jung et al., 2015). At the same time, other research has shown that weight stigma is prominent in the dietetic profession (Stone & Werner, 2012). Nutrition educators have also been shown to have weight stigma (Nutter et al., 2019).

Erin, a nutrition teacher at the high school level, is aware of weight stigma and how to prevent it. Such knowledge proved important during pregnancy, as Erin conducted careful research to find a doctor with compassion regarding weight and eating disorders. Erin's high level of awareness allowed her to read and use pregnancy books and phone apps, while identifying and filtering out problematic ideas about her pregnancy weight gain.

Erin had a positive experience with a private practice dietitian during the preconception period and during pregnancy. When Erin wanted to get pregnant, she was on medication for a skin condition. Because this medication was contraindicated in pregnancy, Erin was referred to a dietitian to rule out a food allergy or intolerance that could have been causing or exacerbating the skin issue. Despite accessing eating disorder treatment, Erin still struggled with negative

thoughts and behaviours. While Erin's purging behaviours had resolved, Erin still experienced binge eating. Bulimia as defined by the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM–5; American Psychiatric Association, 2013) as characterized by cycles of binge eating and purging behaviours. Binge eating is defined in the DSM-5 as eating an amount of food that would be considered larger than what most people eat in a short timeframe (e.g., two hours) paired with a feeling of being out of control with their eating during this time. Purging behaviours are defined in the DSM-5 as "compensatory behaviors to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise" (p. 52). In a previous study conducted by McPhail and Mazur (2021, forthcoming), participants recounted a re-triggering of disordered eating after encountering fatphobic reproductive care. It was thus important to Erin to find a dietitian who would be able to compassionately address her health issue while at the same time not re-triggering disordered eating behaviours and thoughts. I now shift to exploring more of Erin's story with her specific descriptions of the experiences she had with the health care professionals in the preconception period and during pregnancy.

In Erin's preconception period, a doctor said her skin issue was shown to be improved with weight loss, as she recounted:

> I remember this specific doctor saying it has been found that weight loss will help with this skin condition. And part of it I understood, and she was really nice about it, I remember her saying…because it's the rubbing of – I would get them in my armpits, I'd get them in my groin; it was like rubbing. And she had said the research says if you lose weight, it can help, but she said you would literally have to lose so much weight that you wouldn't rub. And she said nobody has…space between their legs that doesn't rub. So, she said, that's just what it says, but I'd like you to go more to eliminate allergens or other things that could be triggering this because they just couldn't figure out why I was getting [the skin issue]. But she wasn't – it wasn't like, "You're fat; you need to lose weight to do this." She literally didn't know that much about the skin condition and printed out something and said, it says here weight loss can help.

People labelled as obese report going to health care providers for issues that are not associated with weight, such as strep throat or a sprained wrist, but weight loss is recommended; and this is an experience that patients perceive as weight stigmatizing (Bombak et al., 2016). However, for Erin, as the quote illustrates above, this was not the case. Erin mentioned that this doctor was not very knowledgeable about Erin's particular skin condition, so she looked up a

fact sheet to print off for her. On the fact sheet, it stated that weight loss could help with the condition, but the doctor then seemed to debunk the recommendation, likely preventing Erin from feeling weight discrimination. Because of this, Erin did not feel the encounter with the doctor was negative because the doctor did not recommend weight loss and did not focus on fat as a "catch all" for her health concerns, which is often the case for fat people in their healthcare encounters (Paine, 2021).

Erin's experience with the dietitian started during her preconception period and continued during her pregnancy. Erin noted that her experience with this dietitian, like with the doctor, was positive and expressed that it felt akin to therapist-client relationship. Erin saw the dietitian about once a month for about two years. She explained that at the beginning of her relationship with the dietitian the focus was on determining whether her skin condition was being caused or exacerbated by a food allergy or intolerance. While Erin did not name the specific skin condition, I know from my experience as a dietitian that it is a common evidenced-based practice in dietetics to support clients to rule out a food allergy or intolerance with the elimination diet, in which the goal is to eliminate foods one by one to determine whether this improves or triggers the symptoms of concern. Erin shared that she did not find any trigger foods because she got pregnant, and the skin condition resolved. So, Erin described how their focus shifted:

> We couldn't find [a food allergy/intolerance], but we did work on the binge eating and again…the whole idea of…food not being…good or bad. It's like, as much as I tried in my mind to…get away from that, I think now I do have a much better wrap on that kind of thing. But…for years and years, it was very much like, "This is good for you, this is bad for you." And it was weird because as a nutrition teacher, …I wouldn't teach that, you know. …I know what to preach, but it was…my own… mindset I needed to just get over the idea of good and bad. And…she really helped me focus on "food is fuel" and "eat what makes you feel good," and sometimes feeling good means…you're eating lots of like leafy greens and carrots, and you're feeling energized, and all the vitamins and whatever that you need, but sometimes feeling good means…mentally good and enjoying all the appetizers at a get together with friends or whatever.

Because of the long-term nature of their client-provider relationship, Erin was able to explore many of her deeply rooted feelings and beliefs about her body, food, and weight with her dietitian. Erin recounted that her one of her initial goals in seeing the dietitian in the preconception period was also to lose weight. She shared her goal of weight loss with the dietitian, and Erin recounted how the dietitian responded to that:

> I think that she thought I shouldn't be thinking about weight loss. Because she kind of – the first few times I saw her, a lot of it was back story, and I think that she thought because of my history with eating disorders that that weight loss shouldn't be on the table…If I wanted to focus on if it was doing things for the skin condition or if it was focusing on the binge eating or working on our relationship with food. I think I brought up weight loss. I don't think she ever brought up weight loss.

Despite the focus of their work not being on weight loss, Erin did still have a desire for her dietitian to weigh her. She expands on this desire to be weighed and her conflicted feelings about it considering her history of having an eating disorder. Erin expanded on this and described how her feelings changed during her time working with the dietitian:

> I do remember asking her if she could weigh me because I was curious if changes I was making were having an impact on my weight. But I was too scared to – I just have this really bad phobia of the number, and I think it was because I was so obsessive for so long that I eventually just – as I started gaining weight after that [eating disorder] program, it was getting really hard for me to constantly see that number go up for so long. And so, I think once I hit [xxx] pounds, I was like, "I never want to know again; I don't want to know what it is." And with her I felt like I was finding balance finally, and so I was curious what would happen to my weight now that I didn't feel that I was bingeing. And I did – I lost like 15 pounds over like the year and a half I was with her; it wasn't like a really – like it was definitely…maybe a pound difference each time I went kind of thing – like, once a month.

I asked Erin how her dietitian responded to her weight loss. She stated,

> She [the dietitian] wouldn't even talk about it. She just kind of said that she didn't want to focus on that. And I remember there was one time that I lost…a few pounds, and there was – she definitely just didn't want me to focus on the loss. She said, instead of being happy that you lost three pounds, how about be happy that you're developing a healthier relationship with food, and not – I don't know. She was really, really good. But she would only ever [weigh me] if I brought it up. …If I forgot and left, she would never be like, "It's time for your weigh in." It was only when I would ask, out of curiosity, "Can you weigh me and then tell me if I've changed at all?"

Erin then shared that her dietitian did not provide any commentary about her weight even when Erin explicitly asked for it. Overall, Erin described a positive experience with this dietitian for pre-conception support. This continued during her pregnancy, as she described:

> She was really excited for me because she knew that it was something that I had wanted for a long time. w…She as the one who said, "I don't think that you need to continue with me unless you feel like you really want to." She thought I had improved a lot in terms of my relationship with food, and I definitely did. I remember her saying, "I know you're always curious if you're losing weight or whatever else, and now that's done, don't let that be in your mind. Just focus on taking your prenatal vitamin, making sure you're getting the nutrients you need for the baby, and that's all you can really do at this point." It was good, too, for me because I wasn't feeding myself necessarily. I needed to make sure I had a well-rounded diet to make sure that my baby was getting what I needed too…and maybe I wasn't giving myself or overdoing it in some aspects, under doing it in others, and so on. It really helped because I am happy to take care of someone else in ways that maybe I wouldn't take care of myself. I always joke that [my child] healed so many things for me: my back pain went away, my skin thing went away, and I definitely felt I had a better relationship with food. And I definitely ate like one million peanut butter cups, but I didn't feel bad about it. And that was big for me to be able to eat sugar and not feel guilty about it.

Sugar is vilified in the media and in anti-obesity campaigns (Catling & Malson, 2012). Larger-bodied people are stereotyped by health care professionals and the general public as unhealthy eaters with poor, sugar-rich eating habits (Puhl & Heuer, 2010). Additionally, fat mothers are often blamed for their child's weight and in part blamed for what they ate or how much weight they gained during pregnancy, in addition to being treated as though not only their weight but their baby's weight was within their control (Herndon, 2014). I was curious about how Erin's dietitian responded to her eating peanut butter cups, as she described in the previous quotation:

> She was good, like she would definitely…wasn't a sugar pusher or anything like that, but she wasn't judgemental about…if I would say the things that I was eating, she would give me ideas for…alternative things that maybe I was missing. The one thing that is always missing from my diet is protein…I definitely don't get enough protein. And she's like, "Okay, well, you ate this here, so maybe next time try doing this or…whatever," and it was more like suggestions – always upping protein.

Thus, Erin described the ways in which her dietitian helped her form a self-affirming relationship with food and nourishment in relation to her growing pregnant body and supporting a healthy pregnancy.

As noted earlier, Erin's positive experiences with health professionals were not exclusive to the dietitian as she was also able to find, with research, affirming medical care from an obstetrician-gynecologist (OGBYN). She described her encounter with the OGBYN:

> [My OBGYN] was an angel; he was so good. I actually got a little nervous because I had looked up a whole bunch of obstetricians [on rate my MD]. I had a list of my top three. Then I got a phone call from the clinic saying that all three of them were full and that I could go see this other woman. I was reading [reviews] and thought, "I can't go to this woman; these are my worst fears of being shamed for [my weight]." So, I called them back and said, "I'm really sorry, I had my heart set on this specific doctor. He delivered babies for a couple of my friends and he is known for being very compassionate, sensitive; and I have a lot of anxieties." I just knew I would need someone who was good with that kind of stuff. From reviews and other people I talked to, she didn't sound like that type of doctor. But they ended up saying, "We'll talk to him and let him know your concerns and see if he'll take you." …Then he ended up taking me, and he was everything I dreamed of and more.

I asked Erin to expand on details of why her experience with this doctor was so positive.

> He was just so funny – like would make really light-hearted jokes about things – and just really compassionate. And honestly, one of the things I was concerned about was my weight … because I had heard doctors sometimes were like, if you're overweight [they would] tell you, you shouldn't gain any weight during the pregnancy and so – and he wasn't like that at all. … He never like told me how much I gained. … I knew that I hadn't gained … an unhealthy amount for the pregnancy to the point that … I know that it is possible to gain enough that … you can have certain risks with … conditions in your pregnancy. And I knew that I wasn't at risk for any of those things, so my weight didn't matter to me, so I was happy that it didn't matter to him either.

Erin, then, had positive experiences with professionals during conception and pregnancy because of her ability to research and her access to positive health care professionals who did not promote messages about fatness and pregnancy. As a result, Erin was less worried about her pregnancy weight gain than other participants I interviewed. Erin's story demonstrates "protective factors" against weight stigma. Erin had family support in her life to help her seek eating disorder treatment, and she was also university educated and able to critically review information that she read about weight and health. She was also articulate and able to advocate for herself to receive compassionate care. This was decidedly unlike other participants like Rachel and Crystal, who did not have the same familial support or income, and who were

Indigenous, therefore demonstrating yet another example of how fat oppression and weight discrimination are mitigated by white privilege, and social privileges generally (Lind, 2019; Rice et al, 2020). Erin reported that experiences with her dietitian and other health care professionals such as her OBGYN were positive. She noted that she did not gain much weight in her pregnancy. I noticed that when some participants reported "positive" experiences with healthcare professionals pertaining to body weight in pregnancy, they reported low pregnancy weight gain. Erin reflected on this toward the end of our interview and queried whether she would have been treated differently had she gained more weight in the pregnancy. We cannot know whether Erin would have been treated differently if she had gained more than the so-called "normal" weight. We do know from the literature that women who do gain "excess" amounts of weight in pregnancy are not treated the same as women who gain the "appropriate" amount (LaMarre et al., 2020). This raises concerns about equitable treatment and highlights the need for compassionate care, regardless of pre-pregnancy BMI, pregnancy weight gain, and ability to self-advocate.

Case Study 3: Nicole

Nicole is a 37-year-old woman who works full time in the childcare field. She is heterosexual, partnered, middle income, and identifies as French-Canadian. She has a son and was pregnant with her second child at the time of our interview. Nicole had a positive experience in a Healthy Baby group setting for postpartum mothers, where she felt supported and appreciated the more "hands-on" approach. As noted in the Introduction, Healthy Baby is funded by the Government of Manitoba. These groups are staffed by a dietitian, public health nurse, and outreach worker. The dietitian's role during the groups is to present on prenatal nutrition and health topics and to answer any questions the participants may have.

In our interview, Nicole recalled one dietitian in particular who stood out to her as "inviting" and described the characteristics of this dietitian. While Nicole went to other mom and baby groups, she did not remember the other dietitians, which speaks to the impact this dietitian had on Nicole:

> There's one dietitian that comes to mind. I don't really remember the … what the other ones even looked like, to be honest. But she was just so nice and helpful and just wanted … she'd be willing to answer anything and friendly, bubbly… just…inviting…

> Like I said, she's the only one I remember. That's five years later.

Nicole recounted more about this dietitian and why she made a memorable impression. This dietitian seemed to go above and beyond and took interest in the thoughts and opinions of the participants:

> Like I said, … she was willing: … "Oh, do you want me to hold the baby? … I know there was one gentleman, at this group – gentleman, first of all – with twin boys that was alone. … He was a single dad with twins. So, she was always like, "Here, let me take one." … She was there. She was present. She was involved. And you know, when you walked in, "oh hi," and you know, [she would] say hi to the babies, and they just made you feel welcome. And when she would present, … she would ask us questions or, you know, say, "That's a good question" or … support what your thoughts were or clarify.

Nicole stated that even years later, the approach of this dietitian, made a long-lasting impression, and now that she is pregnant again, she feels comfortable and excited to return to the groups.

Monica, Erin, and Nicole show that the health care journeys of fat women during vulnerable periods – such as during the pre-conception period, while pregnant, and in the postpartum period – can be positive and affirming. The findings described in these case studies can serve as important examples of "what to do" with clients to prevent weight stigma within health care and to ensure a compassionate health care environment that supports long-term behaviour change. Nevertheless, not all participants had positive experiences. One group of participants had what Mandy labelled "vanilla" experiences. I describe these experience in the next section.

Vanilla Experiences

In describing her experience of seeing a dietitian for one-on-one sessions during her pregnancy, Mandy called her dietetic care "vanilla." Mandy was using vanilla to describe care that was neither good nor bad or, as she described it, "meh." In this section, I share Mandy's, Jessica's, and Rachel's experiences with dietitians. These stories all have a core feature in common – the women described health care that lacked a certain "human touch," relational element, engagement, or connection.

The idea of vanilla experiences is not new in health care literature (Baker & Beagan, 2015), although Mandy's use of the term "vanilla" is, as far as I know, a novel expression to

describe health care. While one might think that vanilla health care is better than nothing, the cost is far greater than how it may appear on the surface, which I illustrate by sharing Mandy's, Jessica's, and Rachel's narratives.

Case Study 4: Mandy

Mandy is a 34-year-old professional researcher who works full time. Mandy is white, bisexual, and middle income. She has a partner who she shares a daughter with. I knew Mandy prior to our interview because we went to the same middle school. Mandy shared that, at the time she and I attended school together, she started weight loss dieting because of how horribly she felt about her body. At the time I knew Mandy, I had no idea that she struggled with her relationship to food and her body. During our interview, it was encouraging to hear how far Mandy had come on her journey to self-acceptance and how confident she had become in her body. She shared that she took hypnobirthing classes while pregnant. She explained that hypnobirthing incorporates mindfulness and bodily awareness into the pregnancy and birth experience. Mandy was a client of midwifery care during her pregnancy and wanted a Birth Centre birth, but Mandy was three weeks past her due date when she started having irregular contractions. At this point she went to see her midwife and then went to the hospital, where the OBGYN on call pushed for induction, but she did not want that. So, Mandy went home and tried walking around until her water broke. Her midwife came to her home, and because Mandy was not dilated, the midwife recommended that she go back to the hospital where she was induced. Mandy thought that being induced might have meant that that things would happen quickly, but this was not the case. Later, there was concern about her baby's heartrate, so the doctors performed a C-section. Luckily, her baby was fine and healthy. Mandy's midwife was able to attend the birth at the hospital, but an on-call OBGYN led the birth.

Mandy described the experience with her midwife and with the hospital with opposite and opposing language. For example, she equated physician care with "telling you what to do," powerlessness, feeling out of control in her body, and feeling "corralled." With midwives, however, she felt like she was asked questions, was empowered, was given choices that placed her in control of her body and like she had "free rein" with her birth experience. In general, Mandy felt that with midwifery care, midwives were "happy to let [her] lead the experience," which gave Mandy a sense of autonomy and that her birth, her body, and her general pregnancy

experience were her own. Specifically, regarding pregnancy weight gain, Mandy felt that the midwives "handed [her the] power" of removing the emphasis on weight, which resulted in Mandy not worrying about it as much. Mandy recounted to me why she wanted to see a dietitian during her pregnancy:

> I had never been pregnant before, and … right away I knew I wanted to do whatever I could to make my baby and myself the healthiest that we possibly could be throughout the pregnancy. And I just wanted information and really affirmation that – I mean, I know that you can be a healthy vegetarian and carry a baby. And you can be a healthy vegan and carry a baby and nurse and do all those things, but I wanted all of the information that I could possibly have. I just wanted to arm myself with as much information and prepare myself as much as I could be. Now, the dietitian I saw wasn't particularly helpful, but she did confirm that I was good to go.

People with a high BMI are assumed to not care about or take responsibility for their health (Ellison et al. 2013), but Mandy was not only concerned about her health and that of her fetus during pregnancy but wanted to be as "healthy as possible." She had hoped to achieve this in part through accessing good dietetic care, but unfortunately her goals and needs were not met overall, even though the dietitian was supportive and affirmed she was "good to go." Mandy also discussed how the dietitian responded to her pregnancy weight gain:

> She was maybe less organic in response. I don't know how to put it. The midwives, they didn't care; I shouldn't say they didn't care. They were never concerned. She did note it but made a comment, not a rude one per se – I suppose some people might have thought so – but that I was big, I was carrying large … Not in those words, but she just – I may have said it first, and she confirmed it. I can't remember the exact exchange, but something along the lines of like, I was – but I really was big…She wasn't rude about it at all. She may have just – and in fact, I vaguely remember her just sort of acknowledging my feelings about it, being like, "Oh yeah," or whatever it was, but not piping in with her own opinion. I was more just – because I mean, it's not even about weight gain, it's just about circumference.

Mandy expanded on the experience with the dietitian, noting that while she did not provide comments about her weight, nothing "in [her] pregnancy would have changed if [she] didn't see her." Mandy revealed more about the disconnect between who she is and how the dietitian approached the sessions:

> She was really nice, and she had folders of information for me, but also who I am as a person, … I'm a professional researcher. So, all the information she gave me, I was like,

> great, I totally could have found all of his on my own, but … I'm sure someone else might have found that super helpful. … If I had been having … some dietary issues, that would have probably been more helpful.

After Mandy expressed that her experience with the dietitian could have been more helpful, I asked what motivated Mandy to return to see this dietitian since she saw her three times during her pregnancy:

> You know what? Just to double check, make sure, how's it going, check in. I am also the type of person who, when the city, province, country provides you with a resource, I make use of it.

Mandy, therefore, returned for dietetic care not necessarily because it was useful, but because she wanted to make use of all resources available. As the interviewer, I wanted to further understand Mandy's experience because, while several other participants in my study related similar stories of health care, none of the other participants specifically articulated such experiences using the word "vanilla." I pressed her further and asked about the information that the dietitian shared:

> There was some information about protein sources and things like that, but it's all…old hat for me. [As for] any discussion of exercise, I'm a walker, I walk a lot unless it's -35˚. And I just wanted to keep that up. At the time, I was walking in the gym occasionally, and I was told that was fine but just not to take up anything strenuous and new. … Everything [the dietitian shared with me] felt really standard. I tried to stay as active, and I did. I did walk up until I started having some nerve pains in my pregnancy that made walking a little bit more difficult. But I continued to try, right.

I followed up to ask Mandy about the essence of her experience with the dietitian. She responded by saying the experience was:

> Cursory and uninvolved …very "meh," like the person was doing their job, but I don't know how to explain it. I was expecting more, but I was expecting more having not had any experience with the dietitian prior to that, and not knowing. But I will say it made me – I didn't worry about it as much. I thought I was going to be getting this big like, "Okay you need to be eating this, this, and this. You need to be doing this, this, and that." And that wasn't the experience. It was more like, "You're doing great, you're a fairly healthy person." I asked about caffeine intake, I asked about the standard questions that a woman

> would typically have when she's pregnant – about that sort of thing. And I got the answers that pretty much meshed with the general consensus. And if anything, [they] probably were a little bit like, "You don't have to worry about that as much as you're worrying about it." No, she was good.

Mandy's preconceived notions of what she to expect from her dietitian sessions are in line with research documenting clients' experiences with dietitians in general (Endevelt & Gesser-Edelsburg, 2014). One qualitative study, for example, revealed that clients felt their dietitian lacked care and was just there to pass on information and recommendations, which they would then be tested on (Endevelt & Gesser-Edelsburg, 2014). Such research also demonstrates that people are often nervous or even afraid to see a dietitian because they perceive dietitians as judgemental. In some cases, people avoid dietitians all together (Endevelt & Gesser-Edelsburg, 2014; Heslehurst et al., 2017). However, while Mandy's experience did not lead to her avoiding dietetic care, she felt her needs were unmet. I asked Mandy what would have made the dietitian better for her, and in her response, she compared her experience with the dietitian to her experience with the hypnobirthing classes she attended with her partner:

> I think the experience of pregnancy is so individual. But for me, maybe – I don't know. If anything, maybe just a little bit more of an acknowledgement of the concerns that I had. Does that make sense? And even then, this is not a complaint because I came away from it fine. But like I said, I do my own research, and I dig deep on my own. Maybe just a little bit more. The thing I took away from hypnobirthing that was so valuable to me was understanding everything. So, maybe just a little bit more like when you're pregnant or even when you're not, "This is why you need this, this is why you need that." That might have stuck with me personally, just how my brain works. A little bit better. Does that make sense? I think that my ideas surrounding food for pregnancy and otherwise come from my own education. I didn't really take much away from. … It was a very vanilla experience. Oh, no food pun intended.

Mandy's experience seeing a dietitian during her pregnancy was neither good nor bad, but simply fine. Similarly, while Jessica did not label her experience with dietitians as vanilla, through her story, it is clear why I have labelled it as such.

Case Study 5: Jessica

Jessica is a 34-year-old woman who works in a predominantly male workforce as a heavy equipment operator. We met near where she lived, a predominantly working class and

historically politically conservative neighbourhood. She attended the interview with her newborn son. As I got to know Jessica throughout the interview, I was deeply moved by her story, the losses she had experienced, and her strength and resiliency. She has had five pregnancies, two of which resulted in her daughter and newborn son; but with the others, she experienced a miscarriage, a stillbirth, and an ectopic pregnancy.

My interview with Jessica can best be described using an analogy of an onion – slowly peeling away the layers as Jessica was able to open up more and more about her experiences and her feelings surrounding then. To extend this metaphor, as we peeled the layers back from the core of her experience, as when one peels away the layers of the onion, there were tears as Jessica recounted some painful lived realities. I must admit, I had to hold my tears back as well at times. I recounted my own raw feelings I was left with after the interview in my field notes:

> I was struck by her story of an eating disorder history and that she has never had a referral to a dietitian before, that people never tuned in to the eating disorder. To some, that sounds like, you know, fatphobia assuming … "oh she's healthy." You know. And then, when she was gaining weight, assuming that she was not eating healthy. So, that's really sad and unfortunate – very sad but also difficult because it was sort of hard to get info from her. But I was impressed that as we went along she opened up even more, and she was quite tearful … several times throughout the interview when speaking about her body and how she felt about her body as a young person, and it seems like her body hatred is very strong, and that was kind of heartbreaking.

Jessica had struggled with an eating disorder since her teens but did not seek treatment, nor did she see a dietitian for a one-on-one consult. Instead, like many fat women with eating disorders, she was praised for weight loss, which in essence encourages an eating disorder (O'Reilly & Sixsmith, 2012). When weight is regained, there is no more praise, but rather fat shame (Tylka et al., 2014). Jessica told me that when she lost weight in her past, she would restrict her food intake and over-exercise. She shared her past motivations and how these have shifted over time:

> Before [having kids, losing weight was where] all my motivation was, too, right? And now, I'm tired [laughs]. … [Now] yeah, so … my thoughts daily are that I need to lose weight, like I really need to lose weight; but my motivation isn't like, "I need to lose weight." I've got so many other things to work on that I'm like … where am I going to find time to shower never mind anything else? [laughs]... Yeah, I've got a house that's a mess and two kids.

I was struck by how strong Jessica's negative thoughts about her body still are, as well as her drive for thinness. Indeed, toward the end of the interview, in response to my question about whether being pregnant had changed her perception of her body, Jessica shared,

> Absolutely. I think when you have failed pregnancies, you're... I don't know, you feel like your body failed you. I think that's what it is. There's no direct cause of [the failed pregnancies], so you feel like "Well, this is my doing; my body failed me."… I don't drink, and I don't do drugs. I don't even do anything crazy like that, so I don't feel that it was... I don't feel that that was – I don't know. … I think that when [a failed pregnancy] happens, your head just tells you, "You need to be healthy." And for me…being healthy manifested into eating, right? And I think it was because I spent so many years not eating that, well, obviously eating too much and putting so much weight on made my pregnancies a lot harder.

Jessica appeared somewhat conflicted. On the one hand, she had the goal and desire to eat healthy during her pregnancy. On the other, with her history of restrictive eating, she felt that she overate and gained too much weight during pregnancy, which she felt caused "harder" pregnancies. Seemingly, then, Jessica made a connection between fatness and her miscarriage experience.

Jessica's relationship with a dietitian was in the context of a group setting, specifically a postpartum group. At first, I had categorized Jessica's story as a positive experience, but as I dug deeper into her narrative, I began understanding it as vanilla. Overall, Jessica, felt positive about the group setting and appreciated sharing with women with similar journeys. She stated, "Yeah, it was nice to get out and see other moms; and there's other people struggling in the same way as I am." Similarly, when I asked specifically about Jessica's experience with the dietitian in the group setting, she described the dietitian as "nice" and said that her experience of the dietitian was "really good." I asked if the dietitian ever approached Jessica one-on-one, and Jessica said the dietitian did not. This surprised me as in my experience interning with Healthy Baby, it is common for the dietitian, nurse, and outreach worker to check in with group participants one-on-one in a casual way. I asked for more details about the dietitian, and Jessica said:

> She sat in the corner of the group. Yeah, she was really nice. She went through the recipe book and was going through the healthy recipes, and I remember her mentioning … "Lentils are really healthy to eat." She gave a lot of information…Yeah…I followed the recipes for quite a few months. [The dietitian talked about] dietary needs of baby and

> what and, you know, what age appropriate [food] we should be feeding baby, healthy eating habits for children.

With Jessica's further thoughts on her experience with the dietitian in the group setting, I began to see similarities with Mandy's story. Like Mandy, Jessica felt like she received a lot of information from the dietitian but did not gain a great deal from the experience on a personal level. While education in prenatal and postpartum nutrition is valuable (PHAC, 2013), how do we, as health care professionals, know whether what we are providing is meeting the needs of everyone in the group? It seems to be a delicate dance, particularly in a group setting, to assess whether we are serving every group member. It is key to take the necessary steps in this delicate dance to ensure we, as health care professionals, are not "stepping on toes" and that we are being helpful, not simply neutral.

To conclude Jessica's story, and as I transition in the chapter from discussing vanilla experiences to describing the bad, I highlight how a vanilla experience can actually lead to a bad experience – to weight discrimination. Jessica described how at one point her vanilla experience started to become more shaming:

> I just remember [the dietitian] saying… "Well, a breastfed baby is easier; you know, breast milk is easier digested," and what's going to happen – "blah-blah-blah" – versus formula feeding and stuff like that. … I remember [the dietitian] saying, "If you're breastfeeding, you lose weight more quickly," and I was like, "Yeah, that's bullshit [laughs], no you don't" [laughs]. No, no, weight just doesn't fall off [laughs]. That's what everybody says, and I'm like, "Where's this weight falling off? I'm not experiencing it" [laughs]. … I walk every day, and I was. I was literally walking every day, every day. I had [my daughter] in the spring, so I was walking every day. I even walked to Healthy Baby group. And then I had her in swimming lessons, and I'm going swimming with her, and man, I'm like, "Ah man, I'm just trying so hard."

Jessica was frustrated while recounting her experience. Not only did she feel shame and confusion about how her body was not meeting the standard of the group, but she also felt that the health care professional – who was meant to help and guide through providing information – led to Jessica feeling awful about her body. At this juncture of the interview, I found it important to summarize some information for her. I felt obligated in a way to make up for the harm caused in this group at the hands of the "nice dietitian" who gave out "lots of information." So, I explained the research highlighting how breastfeeding does not necessarily precipitate weight

loss (Montgomery et al., 2013; Mysko, 2009). Jessica seemed heartened by this information. It is likely that women like Jessica, who feel badly about their bodies and their weight and who attribute their "excess" weight to failed pregnancies, may have a difficult time speaking up within a group setting, especially when other group members celebrate their own weight loss, as Jessica described above.

When discussing her vanilla experience with the dietitian, Mandy noted, "I came away from it fine" but this was not the case for Jessica. While the other mothers in the group were validated by the dietitian's assertion that breastfeeding supports postpartum weight loss, Jessica was invalidated by this because she did not experience weight loss while breastfeeding. Because of this, Jessica felt like a failure. Thus, the cost of this experience for Jessica was not neutral, it was not harmless. It was harm*ful*. I now move on to Rachel's story to conclude the "vanilla" experiences section. At the same time, Rachel's story serves as a transition to summarizing the "bad" experiences because her story had some "ok" and some injurious components. Like Jessica, Rachel described some of her health care professionals with positive descriptors initially, but then it becomes clearer that these experiences were not positive, and not even neutral.

Case Study 6: Rachel

Rachel is 34-year-old, single, heterosexual, mother of two. She has a diploma and an undergraduate degree. She originally worked in a male-dominated STEM field but then moved into the criminal justice field. Her mother is a nurse, and her father an electrician. Her parents separated when Rachel was a child. Rachel identifies as First Nations/mixed background. She lives north of Winnipeg, Manitoba. Rachel is a person with a disability, and at the time of the interview she was on medical leave related to mental health issues, specifically postpartum depression. Prior to medical leave, Rachel was working in the justice system.

Rachel had pre-existing depression since childhood and experienced a major depressive episode in her 20s after a close family member died of a drug overdose. Pre-existing depression increases risk for postpartum depression (Ghaedrahmati et al., 2017). Rachel noted that her postpartum depression was exacerbated by an abusive intimate partner relationship that ended abruptly. She described it as being "abandoned." Rachel's story not only illustrates vanilla care, but also the importance of understanding the ways in which social identities intersect to create fat women's experiences of reproductive dietetic care. While I highlight Rachel here with a specific

case study, Crystal's story shared many similarities. While Crystal did not have the same opportunities regarding education and employment, Rachel and Crystal share a past history of trauma and health challenges related to the intersections of anti-Indigenous racism and fatphobia.

Rachel and I began talking about her care with her first child. She saw an OBGYN, and I asked how he approached her body weight. She responded:

> No, I never felt like he looked at my weight. He would just – kind of like how much weight I was gaining for the baby because my baby grew fast; he was big, right? Well, he thought that my baby was getting too big, too fast. And then he asked me if I took that sugar test, and I did, but it didn't – Yeah. I probably should've ate that day, right? I think at six months, six or seven months, my baby was 6 or 7 lbs.

I asked Rachel if her OBGYN did anything or asked her to do anything differently because her baby was measuring larger for gestational age. Rachel said, "No, he just said that my baby was big and that I might have to be induced early depending on how big he got." I then asked if she was labelled high risk at that time or referred to a dietitian during that pregnancy, and she said, "No" to both. When I asked about her birth experience and how the health professionals treated her, she said:

> Awful. There was so much fluid. It's like you piss the bed lots…It was all day from start to finish. From when my water broke to the time they induced me, it was 50 hours. I had a really bitchy nurse; I didn't like her. She was kind of an arsehole…I had an epidural headache, and she discharged me after three days, and then I remember, because I was crying because my head was hurting so bad. Then she thought she made a mistake discharging me, but I was already discharged, so it didn't matter. She was just very short and curt with me when she was talking to me…They're supposed to show you how to bath your baby and stuff like that – things that I'm sure my mom could've shown me, but that's their job. She was kind of bossy and seemed like she didn't want to be at work. At the time I took it personal. If I go back on it now, I don't know…Maybe she was just the way she was, but I took it personally when I was there. I remember the one lady that I got when I had my baby, she was cunty, and then the nurse that I got after to take care of me, she was a cunt to…My doctor wasn't there yet, and the way she talked to me, it was not nice.

When I followed up, asking why the nurse was difficult, Rachel noted that she "just … she couldn't be bothered." Rachel attempted to advocate for a new nurse:

> I tried to get her off when the other nurse was on; she was super nice…It was like, "Can

> you come on? You're going to get this baby before I leave my shift." And then I couldn't get him out before she left, and then I had to be with the other lady.

I asked about some of the other health care professionals. Rachel responded:

> My doctor, he is a snake. He was a really good doctor, he just had poor bedside manners. Like it was like – because he's old, really old; but apparently, he was the best baby doctor in Winnipeg. Just kind of…gets what he gots to do then rushes you out for the next person, kind of thing…Not like he has anything personal towards you, it's just…Yeah. No, but he was a good doctor though…It's like a business transaction, right?

Between having her first and second child, Rachel developed type 2 diabetes. During our interview, she described how her doctor approached her diagnosis of type 2 diabetes:

> Well, before I had my daughter, she told me to walk and try keeping my sugars down, but she put me on Metformin. And then eventually, because I didn't listen, I also got Jardiance and Januvia – so those three. My doctor just basically said if I could walk and keep my sugars down and get some of [the weight] off, I wouldn't be on so much medication, right? Easier said than done, especially when you have kids. And … not trying to make excuses because there are people that do put their health first and can do it, but I think just because … I suffer with mental health issues, that's more work than I'm willing to put in.

Reflecting on the experiences of all the women, Rachel did not seem to receive the same follow-up, care, and concern as the other women. For example, Rachel did not receive any specific dietary advice regarding her diabetes other than to "get her sugars down." In her words, "easier said than done." Additionally, Rachel described being discharged after giving birth with little instruction or care from a brusque nurse regarding postnatal care or follow-up. Interestingly, Rachel identified her health care experiences during pregnancy as not so bad. The other participants in this study spoke of a variety of general nutrition recommendations from their physicians and dietitians. My assessment of Rachel's experiences is that her health care providers did not seem to provide as many nutrition or postnatal recommendations as the other participants in the study had received. Like Jessica, Rachel initially described some of her health care professionals as "great" but then, for example, shared that her doctor had "poor bedside manners" and that the experience was more like a "business transaction." Rachel seemed to almost concede to the poor treatment of being rushed out by stating that it was "not like he has

anything personal towards you" and that he had a reputation as one of the "best baby doctors." While Rachel did not talk about racism explicitly, research clearly demonstrates that Indigenous people experience high levels of racism in health care (Anderson, 2018), which can take the form of ignoring patients or quickly shuffling out the door (ibid.), and Rachel experienced this, both in the hospital and in the lack of detailed dietetic advice. Rachel's story, which concludes the "vanilla" section, overlaps with theme of the next and final section of Chapter 2, "bad" experiences.

While vanilla experiences of health care were not great, participants felt that they were not outrightly or immediately traumatic. On the other hand, some participants did describe health care encounters that were obviously traumatic. I turn now to bad experiences, the harmful experiences that some of my participants had while seeking reproductive care. I begin with Phoebe's story.

Bad Experiences

Some participants had negative experiences in the health care settings with doctors, midwives, and dietitians. Phoebe's and Susie's stories best illustrate these negative experiences. Phoebe saw a dietitian during her pregnancy, and Susie saw multiple dietitians while trying to lose weight to support conception.

Case Study 7: Phoebe

Phoebe is a 31-year-old, white, bisexual woman who is partnered and has a baby. She is middle income, has a graduate degree, and has a strong awareness and analysis of fat positivity. Phoebe considers herself a body positivity activist. Phoebe was very aware of her white, middle-class privilege and named this during our interview. She was knowledgeable about weight-inclusive approaches such as HAES. Phoebe sees health as diverse and unique to the individual, but also challenges the HAES philosophy, critiquing its healthism. Healthism is the idea that we morally judge individuals based on their health status or health behaviours, such as those typically espoused by public health messaging (Crawford, 1980). For those reasons, Phoebe's perspective is that HAES can be limiting. Critical weight scholars have echoed Phoebe's thoughts (Brady et al., 2013). As a dietitian who has worked from a HAES paradigm, I was

grateful to hear Phoebe's knowledge and analysis of this topic, and also to hear about her lived experience as a self-identified fat woman.

Phoebe described herself as a fat kid who was teased in grade school and was told by another child that she could not do sports because she was fat. In puberty her body changed to a taller and thinner frame. She remembers noticing how she was perceived differently in the world in her new, thin body. I asked what she noticed, and she described the following:

> … boys being nice to you and … feeling good going clothing shopping or – yes. And then … late teens, I started to become fat again and noticed extra how that impacted my experience of the world and relationships and dateability.

Phoebe explained that after gaining weight, in her late teens and early 20s, she would undertake periods of restriction dieting and did what she described as "extremely restrictive" cleanses. She noted that back then she would not have labelled her behaviours as restrictive or as dieting, but with her current knowledge and awareness, she would characterize them as such. Phoebe related one experience from her early 20s when she did a cleanse, during which she did not eat "any bread products, any dairy, and of … several vegetable groups" and she took "herbal supplements":

> I had … a low blood sugar thing and broke my boyfriend's windshield. … I was having a panic attack; I was having a low blood sugar panic attack. It was so clearly that. [My partner] was like, "Just please eat a banana. Please eat a banana." And I was … shaking and panicking, and my feet were up on the dashboard, and they pressed against the windshield, and the whole thing … shattered. … Anyways, at that point I agreed to eat the banana. I haven't done [a cleanse] … since that experience.

Despite giving up dieting herself, Phoebe described herself as living in an area that is "hip with restriction" and expanded to say:

> … crunchy granola community. You know, "Dairy is bad, wheat products are bad, sugar is bad," so trying to … navigate what I know, which is that … everything is good; food is good for your body, and also – I don't know – still internalizing lots of that stuff.

In the above, one can hear the incongruence between Phoebe's politics and personal beliefs and the community around her, as well as her struggles against internalizing messages

about food restriction. Phoebe is no doubt influenced by the community around her, and the community around her is influenced by a culture in which extreme health messages run rampant in the media. These messages are often touted by celebrities yet lack scientific backing (Caulfield, 2016). Such messages were also evident during a family holiday dinner, which Phoebe narrated to me in detail:

> I now have a daughter, and we were just at my in-laws for the weekend, and my in-laws are also crunchy hippies. And you know, my partner's mom [was] eating sugar because it's Easter, and she had a treat, which is reasonable and fine, and then talking for the next three hours about how sugar is the devil … and … not wanting my kid to be exposed to such negative messages about reasonable food, which having treats is a reasonable, good thing. And that's the message I want her to get, not that any of those things are bad.

At this point, after hearing about Phoebe's strong history of dieting, her report of what sounded like a severe low blood sugar episode due to dieting, her familial dieting influences and the influence of the community around her, I was curious about how she came to be so rooted in in her current position on dieting and body positivity. I reflected to Phoebe that it sounded like she grew up with negative messages around food and body but that at some point she got a different message:

> Oh, yes, 100% volunteering when I was 15. I did the training in sexual health and body image. There were great fat role models and really positive messaging. I'm still friends with lots of people and still have a connection with that community, where there's a lot more positive talk about food, even from fat people, which is where I need to hear it from especially, you know? Even at the time, I wasn't fat, but I had the idea that I probably would be again, and I remember thinking about my own body and fatness: "Oh, being fat is okay for other people, but I don't want to be fat," which obviously had to change because I was going to be fat. But it gave me kind of a question about what thin people actually internalize when they're engaged in body positivity and fat positivity politics … because I have friends who are hip with body positivity but are thin and also still heavily engaged in diet culture themselves, through cleanses and popular culture restriction and over-exercise and yoga world … or westernized yoga world, more accurately. I wonder what they actually think of my body, even though they're theoretically hip with body positivity. "Are you really that hip with body positivity? You're also restricting so hard," I don't know.

Although Phoebe explained that she had a positive in experience in her youth through volunteering, she also shared with me that, while she was growing up, her mom was a "heavy

restrictor." she described her perception of her mom's body size today and recounted a recent argument with her:

> She's … I don't think she's a fat person. She's definitely a little bit bigger than she was when I was little, because now she's in her 50s. … She still restricts. We actually had a fight after I had my daughter. We went out for breakfast, which is a common activity for us, and she started saying like, "Oh, I just need to figure out what's the lowest fat on the menu to get." And I was like, "Mom, I don't want to talk like that in front of [daughter]," and she was furious. My mom has a temper to begin with – dominant personality – and she was like, "Well, why don't you just make me a list of what I'm allowed to talk about in front of [daughter] and what I can't." She ended up storming out of the restaurant. … I don't know how to navigate that. I'm scared to try to navigate that again with her or with … my in-laws, who are also big on restriction.

Phoebe's desire to have her daughter grow up in a food and body positive environment, however, is complicated by the fact her daughter has life-threatening allergies:

> My child has … life-threatening allergies, so navigating … we don't want to talk smack about food, but also you need to kind of talk smack about food and figure out what's in this food and if it will kill you. And if something makes you not feel good, you actually need to talk about that because … it could be an allergy, right? So, … while I don't want my mother-in-law talking for three hours about how the sugar made her feel crappy, if my daughter eats something that makes her feel crappy, I need her to talk about it in case it's an allergic reaction.

Regardless of Phoebe's knowledge and feelings around food and body positivity, the environment in which she lives and is raising her daughter is thus challenging to navigate. Phoebe's persistence and passion for supporting her daughter and herself with food and body positivity was admirable to me. She was determined, and she hoped for a better world for her daughter than the one in which she grew up. Despite her positive outlook, Phoebe outlined difficult experiences of her health care during her pregnancy.

During pregnancy, Phoebe was diagnosed with gestational diabetes mellitus (GDM). She was referred to a diabetes team for care, and she saw an endocrinologist, a nurse, and a dietitian, although she spent most of the time with the dietitian. Phoebe related her experience with diabetes health care team: "I also had gestational diabetes, which was very stressful and panic-inducing, and my intersections of the medical system around my gestational diabetes were my least favourite parts of pregnancy and would actually prevent me from getting pregnant again."

Phoebe's statement – that her difficult healthcare experiences during pregnancy would prevent her from becoming pregnant again – is stunning, yet sadly not unrepresented in the literature (McPhail et al., 2016).

As mentioned, Phoebe saw the dietitian the most frequently for brief appointments, in which she was to bring her daily food logs and blood sugar monitoring numbers, and the dietitian would review them. Phoebe felt like she constantly had to justify herself with the dietitian. She stated, "It just felt like reporting to … the worst boss you ever had or something." Phoebe expressed that the whole diabetes team engaged in fear mongering, including the dietitian. This echoes a qualitative study of prenatal women (Heslehurst, 2017) in which participants also experienced fear mongering during pregnancy due to the pressure to keep within prenatal weight gain guidelines. With Phoebe, it was the "threat" of having to go on insulin that produced the greatest pressure. She felt the diabetes team did not believe her about her food choices, even though she felt she had a lot of food knowledge and was making healthy choices. Phoebe actually noticed that when she attempted to eat the amount of carbohydrates at meals that the dietitian recommended, her blood sugar would be too high; thus, Phoebe made adjustments on her own and at the advice of her sister. I was curious as to why nutrition advice was better received by Phoebe from her sister and discovered that Phoebe's sister had a professional background in nutrition. I reflected on this in my field notes:

> Some other things that struck me were … her trust of her sister who had a nutrition degree more than the dietitian. And then, when that came out … it was sort of the same things I've been hearing around … because dietitians don't seem to be meeting people where the client is at, and the sister listened to her and, you know, … took into account her unique life and help her make practical solutions that fit for her.

While I was happy that Phoebe had supports in the form of her sister, and I admired her resilience and creativity in receiving what she required from the resources available to her, I was also disappointed and disturbed that she could not find similar support through dietetic care.

Case Study 8: Susie

Susie is a 40-year-old white woman who identifies as a person with a disability. She works full time in a government job and lives with her partner. She always wanted to have a child, but she experienced infertility and eventually made the decision to no longer try for

biological children. It was a long journey for Susie, but during our interview I felt as though she had reached a sense of acceptance about this. As her former dietitian, it was thrilling to hear her describe how far she has come in her journey to make peace with food and her body.

During her weight loss journey, Susie saw three different dietitians whom her doctors recommended to help her lose weight to increase her chances of conceiving a child. The recommendation of weight loss to improve fertility is heavily debated. Thin and fat women alike have healthy pregnancies and babies every day (Ward & McPhail, 2018). Susie has polycystic ovary syndrome (PCOS), and many people with PCOS live in larger bodies (Sam, 2007). It is argued that decreasing insulin resistance could improve fertility, and weight loss is often considered the solution, but there are evidence-based strategies to support a dietary pattern that decrease insulin resistance, regardless of weight loss (Bacon et al., 2005). Despite this, Susie's second dietitian asked her to complete food logs and weight logs:

> It was like the harsh sports coach: "You got to do this." …. "You got to put in the work in order to get results" – that sort of thing…I was a wreck during that time.
> And it was not an easy process and…probably didn't – it contributed to me not following through with her very long.

Susie's story echoes Phoebe's in that she refused to see the dietitian after a negative experience. Like Phoebe, Susie's experience as a whole dealing with the medical system around her fertility was difficult and impacted her greatly:

> And I just read an article recently about that through…the [local clinic] about "You may or may not have a binge eating disorder, here's some reason or ways to tell how." I didn't have an eating disorder at all. It was really just people hammering at me…I wanted the results of having a baby and losing the weight in order to have the baby and that sort of thing.

Susie's feelings around infertility were like Jessica's, in that she attributed her inability to conceive as a failure of her body. She stated, "It felt like [my body] was faulty." These feelings are reflected in literature that describes the ways in which discourses of "mother-blame" negatively impact fat women's health care (Bombak et al., 2016; McPhail et al., 2016; McPhail & Huynh, 2015). In this literature, health care professionals continuously communicate the risk that fat mothers pose to their (potential) fetus, causing high levels of stress and perceived weight

stigma for fat women (ibid.). When discussing the whole process, Susie said, "You know Sisyphus up the hill, pushing the rock? That's what it felt like. Oh, it was frustrating, upsetting, stressful. … It was honestly the pits."

To summarize, bad experiences were common for all participants with a variety of health care professionals, but only two participants, Susie and Phoebe, explicitly labelled their experience with a dietitian as weight stigmatizing. While the other participants described bad experiences without labelling them as weight stigmatizing, much of their narratives about the experiences is consistent with other studies' definitions of weight stigma. For example, Jessica's narrative about her body, health, and embodiment is consistent with the definition of internalized stigma whereby people blame themselves for their weight and often believe they are a failure for not achieving a so-called normal body weight (Tomiyama et al., 2018).

Chapter 2 Conclusion

In this chapter, I deployed a case studies approach to describe the ways in which participants experienced of reproductive dietetic care that can be classified as "good," "vanilla," and "bad." Many of the above experiences are in line with previous fat studies literature, which has demonstrated that fat women experience both good and bad/stigmatizing care (Bombak et al., 2016). This chapter contributes the idea that women can also report care that is vanilla – neither good nor bad but simply "meh." While vanilla care may seem innocuous, it can in fact lead to harmful and stigmatizing dietetic care. In a qualitative study assessing clients' experiences with dietitians, clients said their experiences were simply more informational and less personal (Endevelt & Gesser-Edelsburg, 2014), which was similar to the "vanilla" care participants in my study experienced. Heslehurst et al. (2017) specifically explored experiences of women with high BMI in the perinatal period and their experiences of dietetic care. Like in my study, the women in Heslehurst et al.'s (2017) qualitative study stated that dietitians did not tailor health advice to their lives. My study and Heslehurst et al.'s (2017) study both report, however, that the perinatal dietetic care experiences were positive overall. More research is necessary to explore whether perinatal dietetic care experiences for women with high BMI are truly positive overall and whether that provides confirmation that the dietetic care environment is

less weight stigmatizing than other health care environments, as Jung et al. (2015) have suggested.

As a health care provider, myself, it is discouraging to learn from my participants that we continue to pathologize one of the most natural and human lived experiences, and this, ironically, leads to clients feeling less than human. Upon reflection on the medicalization of pregnancy, the following thought came to my mind: It is a womb, not a wound! Wounds need emergency treatment. Wombs need nurturing, nourishing, caring, and compassionate support. As health care professionals, it would serve us well to step back and reflect on our approaches, asking where we have forgotten the human in caring for humans. Where have we lost the client in client-centred care? In the following chapter, I explain what we might do as dietitians to move toward better care for fat women. I explore some recommendations participants have for reproductive health care professionals because, at the end of the day, it is the opinions of our clients that truly matter the most. These women and their voices should be involved in the guidelines created for pregnancy weight gain.

Chapter 3: What to do, What not to do – Recommendations for Improved Perinatal Care for Women with a High BMI

Introduction

In Chapter 2, I highlighted the experiences of the women I interviewed who had received dietetic care while experiencing infertility, during the pre-conception period, during pregnancy, and in the postpartum period. In Chapter 3, I expand on the stories of these women to focus on advice for health care providers. In addition to outlining advice from clients, I summarize the suggestions of 10 dietitians who participated in my study and who currently work or have worked in perinatal care with women with high BMI. The intention of these suggestions is not only to improve health care for clients, but also to inform education and policy in dietetics. These dietitians worked in public health, facilitating Healthy Baby and Healthy Start for Mom and Me groups, serving prenatal and postnatal clients; in primary care; in outpatient hospital settings; and in chronic disease management teams, seeing clients who had GDM or pre-existing type 2 diabetes and then became pregnant.

I categorize the advice from the women with high BMI and the dietitians I interviewed into four main themes: (1) Health not weight; (2) Client-centred approaches; (3) Group education approaches; and (4) What not to do. "Health not weight" identifies a primary theme that all participants identified that, in essence, lays the groundwork for all other pieces of advice they wished to impart. The second theme, "client-centred approaches," focuses on individual approaches to care that support the client's unique needs within a "health not weight" focus. The third theme, "group education approaches," focuses on providing quality health care to groups of individuals that suits the needs of each individual group member as well as the group as a whole. Lastly, the fourth theme, "what not to do," provides health care professionals with sobering reminders of how health care, which is meant to help, can actually harm. The intention of this chapter is to improve the health care experience for people with high BMI who struggle with infertility, pregnant people, and people in the postpartum period.

Summary of Findings

Through analysis of the data, "health not weight" emerged as a foundational recommendation that encapsulated the suggestions for change that the women to see in dietitians

and other health care professionals. All the women with high BMI expressed that they wanted to see a shift from a weight-centred focus to "health not weight" to ensure their care emphasized overall health rather than the number on the scale. As a researcher situated in a critical approach, as described in Chapter 1, I view the spectrum of body weight as a normal variant of human body diversity, and my work is rooted in a social justice and equity framework. The theme "health not weight" is an illustration of how health care can be reconceived to incorporate and reflect body diversity. Building upon health not weight, the second theme, "client-centred approaches," emerged as a major theme since all the women with high BMI viewed it as necessary. Not all the women with high BMI explicitly used the words "client-centred," but each of them shared recommendations to improve their care in ways that focussed on the client, listened to her needs, and involved care providers putting themselves in the shoes (and bodies) of their clients. Another facet of perinatal care that was integral to the women's experiences was seeing a dietitian in the context of group education, and thus, the women made recommendations for the third theme of the chapter, "group education approaches." Some of the women had contact with dietitian facilitators in provincially or federally funded programs such as Healthy Baby and Healthy Start for Mom and Me, and one participant saw a dietitian in a psychoeducational group setting pertaining to food and eating while she was pregnant, but the group was not pregnancy focused per se. Finally, I end Chapter 3 with the theme "what not to do," which self-evidently reveals how the women with high BMI do *not* want to be treated.

Health *N*ot *W*eight

Since, within a critical framework, higher weight is understood as a normal variant of body diversity in humans (Bell, 2016), and since research suggests that food and activity changes can result in improved health measures in the absence of weight loss (Clifford et al., 2015; Roberts & Barnard, 2005; Tylka et al., 2014), this framework recommends shifting the focus from weight to health. Critical weight scholars focus on "health not weight" and reject the reification of weight loss (Bacon & Aphramor, 2011; Brady et al., 2013; Lupton, 2013). Indeed, research has demonstrated that weight loss can occur for a variety of different reasons, both intentional and unintentional.

Many clients and health care providers in this study agreed that a weight-centred care is ineffective, particularly in pregnancy. Research has previously demonstrated that pregnancy care

for women generally (Jette & Rail, 2013) and for fat women in particular (Bombak et al., 2016) focuses intently on weight, and practitioners often weigh patients consistently. This same research has demonstrated that such an approach creates undue worry and stress for women, even if their pregnancies are perfectly healthy (McPhail et al., 2016; Parker et al, 2019). To decrease this stress and worry, participants in my study suggested addressing biased first impressions about a client's health based on body size and focusing instead on actual health markers pertaining to pregnancy.

In particular, participants wondered why health care professionals must label their body as overweight and why health care professionals need to mention their body weight at all. Here, participants echoed previous research demonstrating that a focus on health not weight can serve to decrease weight stigma in the health care setting (Tylka et al., 2014). Research encourages health care providers to emphasize health behaviour changes like eating and activity – behaviours we can control – and stresses that weight loss (or gain) is not a behaviour, it is a symptom or outcome and therefore not appropriate for intervention (Daghofer, 2013; Monaghan et al., 2011). On this note, Jessica reflected on the advice she would want her health care providers to know:

> [Laughs] I know I am overweight; you don't have to tell me that…I know; I'm not blind here. So, I don't think they need to mention [my weight] all the time, you know. Maybe ask – maybe not beat around the bush but ask questions around healthy eating options; and then you don't need to come out front and be like, "You need to lose weight; you're overweight."

There have been shifts in the dominant paradigm to de-emphasize weight in favour of other, more accurate health measures, such as blood pressure and blood sugar levels (Nutter et al., 2018). Despite this, weight is often still measured in the clinic, and weight loss is often still considered a success (Pausé, 2014). In the dietetic profession, there is a division between a more traditional weight-focused approach and weight-inclusive approaches (Penney & Kirk, 2015). Few studies, however, have highlighted dietitians' own thoughts on these debates, although some studies have revealed support for weight-inclusive approaches (Chapman et al., 2005; Marchessault et al., 2007). Dietitians in my study were overwhelmingly, with a few exceptions, in favour of a focus on health not weight, instead of a traditional weight loss focus. Among the dietitians in this study, those who disagreed most with a health not weight approach seemed to

work in more clinical roles, such as in diabetes care. This, however, may have been due to a limitation in my sample that made it so dietitians who were more knowledgeable about and who agreed more with health not weight approaches were more likely to participate because of my positionality as a dietitian who works from a critical lens. In other words, it is possible that dietitians who had heard of my approach, and who had a similar approach, were more likely to participate in this study. During recruitment I contacted some offices where clinical dietitians work and, when speaking to a dietitian, was told that they were not interested in participating. They did not give reasons except to say they did not feel they "fit the study criteria," even though I had explained I was looking for a variety of perspectives on weight, pregnancy, and BMI. My interaction with this dietitian may suggest that my reputation had preceded me, and some potential participants felt their perspectives may be unwelcome. Having said this, one dietitian I interviewed, Cassandra (Age 39, white, straight, higher income, has a graduate degree), was vehemently against health not weight approaches – specifically naming HAES. Cassandra worked full time in diabetes care in a rural area. She said:

> I think that there's a time and place for weight loss, and if I have a client who's coming in and feels strongly that that weight is something that they want to address, I'm going to talk about it with them; I'm not going to shy away from it. But I feel like Health at Every Size is really the sort of almost refusal to talk about weight. And how HAES people can be very dismissive of weight having any role in health or health outcomes. It's probably been about eight or nine years that I've been hearing about HAES…I first saw a presentation about it, and it was this new exciting thing. And I'm open to hearing about it, but I've never been convinced. Considering I don't necessarily love – it's not that I'm anti; I won't label myself HAES, right. I don't think I would also take that into a pregnancy approach or pre-natal approach…I don't think we need to be telling pregnant woman, like all pregnant woman with a high BMI to lose weight, but acknowledge it as a risk factor…Part of why I can't embrace the HAES movement is because I see my sister, and she's very large in size, and she's not healthy, and I don't know that she could ever be healthy at her size.

However, most of the dietitian participants agreed with "health not weight" approaches. April (Age 35, works full time, has a graduate degree, Indigenous, straight, higher income) is a primary care dietitian in an urban area. She sees only a few prenatal patients per year, most of whom have higher body weights. These clients are typically referred to her through midwifery care. April told me that when working with clients in general, regardless of BMI, she makes it a priority to ask her clients what they would like to focus on. She shared that she tries to get to

know her clients in order to understand their unique needs so that she can support them in the best way possible. April also noted that when she is working with pregnant people, she makes an extra effort to understand their current life situation. As a mother herself, April understands, from her own experience in addition to her training, about the multitude of challenges mothers may be facing and realizes that stress may be higher during the prenatal period.

If weight is brought up by any client, regardless of weight or pregnancy status, April is proactive and states to them that body weight is not 100% within our control. When pregnant people ask her about prenatal weight gain and have concerns, April's first step is to explore why they asked about that and what their specific concerns are. She stated:

> I try to get out there right off the bat – that what we'll be talking about is healthy behaviours, not weight. And people will bring it back to their weight, and so there's often a lot of redirection that needs to go on in a conversation that's…at the end of the day, that's not something you can completely control. Your body is going to do what it's going to do. You can eat well, you can try to be active, but…sometimes your weight goes up, it goes down, or it stays the same, and we don't have control over that. … I try to be proactive about saying that, so that people kind of know that it's okay to talk from that perspective. … I think it's important to realize that women, when they're pregnant or trying to become pregnant or have just had a baby, they become so focused on their bodies, and criticisms of that can just really make them feel like they're doing it wrong, especially if they've got issues with fertility and stuff like that…It's really personal. So, I just feel for somebody who's told that the reason why they can't get pregnant is because they're overweight. That's heartbreaking, you know.

As April noted, women generally become "so focused on their bodies" during pregnancy. It is therefore important for dietitians, regardless of whether their clients are fat or thin, to encourage women to accept the agency of their bodies – to embrace their bodies for what they are and will become.

Shelley (age 52, works full time, white, straight, higher income) is a dietitian working in a chronic disease management team with a focus on diabetes. Shelley shared similar sentiments to April. She argued:

> … just helping other healthcare providers to get away from using any type of weight language around people, and really focus on what's important in that person's life, right. It's helping them to deal with whatever chronic health condition they're living with. And to be honest, maybe in some situations they need to lose weight in order to see improvements in their health condition. But that doesn't need to be the focus; that doesn't

> need to be what we talk about. We might be talking about "What are some healthier food choices you could be choosing? How can we look at ways of becoming more active? What are some things you'd like to try?" And when we focus on positive lifestyle changes, the other often comes along, too, or it doesn't because sometimes it just doesn't happen, and … sometimes you just have to be okay with that.

Like April, Shelley emphasized both the agency of the body and the fact that oftentimes, what a person may need for optimum health may or may not be weight loss. Here, Shelley stressed that a dietitian's advice should be led by health and not weight and that dietetic care should not be centred around whether a person looks or seems "overweight," but rather should be based on other health markers related, in her example, to chronic disease management. When I asked Shelley how she developed her perspective, she told me about how her career has developed over time and has matured along with her age:

> Well, as you can see, there is some age here, and I think I have a little bit more freedom in my practice than I did earlier in my career. So, yeah, now I feel like we don't need to weigh; I don't think that's really helpful. Or I have some clients that come and say, "You know what? I'm here to lose weight. Can you weigh me?" I'll say, "I don't have a scale in my office. Why do you feel you need to be weighed in my office?" And so, then that spurs on a discussion around that. And then they might tell me they weigh themselves every day at home, and then we talk about that: "What does that tell you when you weigh yourself every day at home? How does that make you feel?" Yeah, so it spurs on more discussion.

Instead of visually assessing or using the BMI to label a person's weight, a health care professional can ask their client what they want to talk about and what their concerns are, and ask about health behaviours related to their concerns. Previously, Jessica noted that she would rather be asked about her eating behaviours than simply be told to lose weight. April, who is an early career dietitian, provides a framework for how to de-emphasize weight and shift the focus to healthy behaviours instead. Should clients specifically ask about weight concerns, as April said, a dietitian can find out a client's specific concerns about their weight or about prenatal weight gain and start working from there. Getting to know clients' concerns also facilitates supporting people where they are at. Shelley, a dietitian who is later in her career, described how she shifts the focus from size to health and how she addresses weight when her clients bring it up, encouraging them to de-emphasize their weight, embrace the agency of their bodies, and attempt to discern if weight loss would in fact make them feel more (or less) healthy. Both April's and Shelley's perspectives

are examples of how dietitians can approach weight in such a way that aligns with participants' advice regarding their pregnancy journeys.

I am More Than a Number. This subtheme of "health not weight" is based specifically on participants' feelings about the focus on the number on the scale. In this section, I describe how participants felt about the number on the scale historically and how they felt about it during pregnancy.

Much research about pounds indicates that a focus on weight can be harmful (Tylka et al., 2014), and many participants in my study echoed this thought. Erin (age 33, white, straight, higher income, undergraduate degree) shared that after she got up to a certain weight, she found it difficult to know the number and did not wish to know it anymore. She also had a history of an eating disorder and had received group treatment for this in the past. For Erin, having a dietitian who did not focus on weight was helpful to her:

> To have a dietitian that doesn't focus on loss or gain when trying to improve your health, I guess that was really appreciated for me…To find a person that didn't ever focus on the number was helpful to me. And in the beginning, when I felt like I still wanted to be weighed all the time and stuff, she would still do that for me [i.e., weigh me], but definitely that wasn't her priority in our appointments, and it was very much appreciated.

Mandy (age 34, white, bisexual, middle income) also expressed that not focusing on the number on the scale was important to her in the context of her relationship with her midwife. Like Erin, Mandy also had a history of an eating disorder, but Mandy had not received eating-disorder-specific treatment. Mandy shared how she continues to untangle the number on the scale from her health and self-worth. She also expressed hope that she can support her daughter to have positive body image and not focus on weight:

> I think the midwives not placing an emphasis on my weight was a turning point for me. I have the education and the know how to know that when we talk about dietitians, we're not talking about being on a diet; talking to a dietitian is not necessarily about your weight, it's about your health. But I think that there is a connection there that needs to be broken; and I think that not having the emphasis placed on weight unless it has to be. Just like my birth wasn't a medical event until they made it one, weight doesn't have to be a medical event.

While Mandy did not use the word "medicalization," what she described here was medicalization of body weight, which I discussed in the Introduction to this thesis. Erin expanded on this as well, in the context of her relationship with her OBGYN. Erin had an eating disorder in her past and has been sensitive about the number on the scale in general. Erin did not want to be treated differently during her pregnancy due to her weight status. In her own words, Erin described wanting to "protect herself" from "weight stigma" in pregnancy. As described in Chapter 2, Erin researched online and read reviews of local OBGYNs. She saw many reviews where women discussed having negative experiences in regard to their body weight. Erin shared specifically how much it meant for her OBGYN to not focus on the number on the scale during her pregnancy:

> I think that I had a fear because of…reviews and things like that that I had read about other people – that there was a possibility that when I saw an obstetrician, that my weight was going to be a focus in it with my pregnancy. And so with him never bringing [my weight] up, it just made me feel like I was just any other person. You know, it's not because I'm overweight that I needed to be treated differently in the pregnancy.

My interpretation of Erin's experiences with her OBGYN is that she seemed to describe as sense of acceptance and feeling like she is "normal," regardless of her weight, even though Western culture problematizes higher BMI as "abnormal." Although critical scholars reject the medicalization of body weight and problematizing larger bodies as diseased (Cooper, 2016 McPhail & Mazur, 2019), they have noted how larger bodies in pregnancy are problematized and often labelled "at risk" (Cook et al., 2019). Thus, it was not a surprise to me that Erin wondered whether she would have been treated negatively by her OBGYN had she gained more weight than is "normal" in her pregnancy, as noted in Chapter 1. Erin also wondered whether her OBGYN treated her well, regarding her weight, because she shared her past history of an eating disorder:

> I had told him when I first saw him about my history of eating disorders, and so I don't know if when you share things to people, if maybe they are more sensitive to you about that — like if he just knew not to, you know. You never know, if one doctor's like that with you, if they are with everyone who's overweight or whoever else, you know? But definitely just not focusing on [the number on the scale] because it wasn't an important part of my pregnancy. There were so many other things going on that were focused on that were much more important, and I was glad that that wasn't an extra thing added to my plate. You know, I was glad that I was never made to slow my weight gain.

Research has demonstrated that some health care professionals do not bring up weight at all for fear of being weight stigmatizing (Puhl & Heuer, 2010), whereas some pregnant women are told to lose weight, maintain weight, or to keep within the prenatal weight guidelines (PWGs) during pregnancy (McPhail et al., 2016; Parker et al., 2019). Erin's and Mandy's OBGYN and midwife, respectively, de-emphasized weight in their pregnancies, which was important for them to feel that they were more than a number on the scale, to not worry about their weight as much, and to focus on health instead of weight.

Participants who had health care providers that de-emphasized the number on the scale during their pregnancy experienced a decrease in stress as it was helpful to not have to worry about the shame of "the number." One limitation to this study, however, was that most participants did not report gaining weight beyond the PWGs. Participants in this study reported losing weight during the first trimester of pregnancy due to nausea and vomiting, others were told to either not worry about their weight gain during pregnancy, or they reported gaining a normal amount of weight during their pregnancies. It is unclear, then, whether participants would have experienced stigma had they gained a greater amount of weight throughout their pregnancies and had the number on the scale increased more dramatically. Despite this limitation, participants in this study expressed wanting their "number" to be de-emphasized.

How to (Not) Weigh Me. As Shelley's advice relates above, there are moments in dietetic practice when clients do need or want to be weighed. Clients and practitioners who participated in this study provided important advice about how to weigh clients in the safest way possible. As such, a subtheme that emerged within "health not weight" was how to weigh clients to accommodate body size and, related, how to ensure there is properly sized medical equipment to assess health markers and/or create comfortability.

One of my client participants, Lydia, spoke about being weighed in a hospital prior to her birth without explanation as to why. She expressed to me how this felt:

> Standing on a scale, full-stop, can be very anxiety-provoking for larger-bodied people, even if the intention is, "We want to ensure that our medications are at the correct dosages, our bed is as comfortable as possible for you,"…whatever the case may be. I think that there is something to be said for, you know, the standing on a scale and someone looking at it and judging.

Here, Lydia is aware that a health care professional may need to know someone's weight to administer medication or ensure properly sized equipment. Her statements are supported by literature that demonstrates that weight is important to know in such instances (Pan et al., 2016). Additionally, a person may need other types of larger equipment such as higher-weight-capacity hospital beds, and thus it may be necessary to know a person's weight in these instances (Wiggermann et al., 2017).

On the surface, these examples may seem like neutral reasons for weighing a patient, but for fat women, standing on a scale is often not a neutral experience and can provide significant anxiety because the number on the scale has precipitated past experiences of stigma in health care settings (Paine, 2020). It is important to recognize that even seemingly neutral reasons for knowing body weight can be interpreted as a negative judgement about a person's body, as Lydia described. When we as health care professionals weigh clients, they do not know if we are only discerning whether they need a certain bed size, or if we are judging them based on stereotypical views of their body size. Based on this, in addition to my findings, I therefore recommend that health care professionals provide the explicit reasons for weighing clients before doing so and emphasizing that we not want to stigmatize or judge their bodies. Health care professionals may even consider going further than this and state that they recognize that stepping on a scale can be an anxiety-provoking act for some. Research shows that asking a client to be weighed is less stigmatizing than telling them to do so (Fruh et al., 2016). Further, health care professionals explaining why they are asking to weigh clients would allow clients to make an informed decision on whether they want to be weighed.

Most dietitians in my study stated that they do not weigh their clients, and many do not have scales in their offices. Dietitians who worked in prenatal and postnatal groups explained that they used to have scales in the groups but had decided to remove them. Eleanor (age 59, works part time, white, straight, higher income, had immigrant parents), a dietitian who worked in prenatal and postnatal group settings recalled how staff noticed that having the scales seemed to make the women feel badly or become overly focused with the number on the scale, as opposed to considering the health of themselves and their fetus. Eleanor noted that in a community or public health nutrition setting, dietitians should not be monitoring weight like they might in a clinical setting:

> A long time ago the scales were probably out [in the groups], but then they definitely stopped using them. I haven't seen a scale in a long time, unless it was accidentally taken out by somebody else, and then [I would say], "No, you have to put that back" and "Why are we having it here? Yeah, put it back; put it away." [I thought,] "Why are we doing this?" And it's just going to lead to questions that I'm not in a capacity to answer… "Look how fat I am" or make people feel bad. If you're fat, you know it; you don't need a scale to tell you that.

Eleanor reflected on her own experience as a woman and a patient in health care and how this informs her work:

> You know, when I was a student, and I remember in my internship I had to go to the [hospital], and for some reason, this doctor weighed me. And he said, "You're overweight" and all this and, you know, "You need to be careful young lady." Like, "Fuck you," right. And it just – you know, obviously it just makes you feel bad, right? And …what do I have to be careful of, you know what I mean?

As demonstrated in Eleanor's personal account of how she felt about being weighed and the doctor's commentary about her weight, dietitians are not immune to being made to feel badly about their weight. Dietitians, many of whom are women, are also impacted by the social norms that determine what women can eat, what they can look like, and how much they should weigh (Bessey et al., 2020). These experiences, however, can also positively inform dietitians' interactions with fat pregnant women, in that dietitians can, as Eleanor did, channel negative experiences to express sensitivity with clients.

Like Eleanor, Shelley, a dietitian specializing in diabetes, recounted how her practice changed from weighing clients to not weighing clients and stated that she had removed the scales from her office:

> Earlier on, we were weighing clients, assessing peoples BMIs…There was a lot of weight talk earlier in my profession, which I was never – I can be completely honest with you – I was never comfortable with. I try very hard to be aware of how my language can impact another person and how shaming and harmful weight talk can be. So, now 20-plus years later, I don't have scale in my office. [When I used to weigh people,] I would always ask permission, but I always felt a little awkward … so I slowly got away from it. I was able to get rid of the scale in my office – I think it was 10 years ago – because I just didn't want to even look at it. I didn't want people to even look at it because that just brought up weight talk when the scale was sitting there. So, it's a gradual thing that [the health care providers I work closely with] just got away from doing.

Dietitians in my study shared how, over the course of their careers, scales were removed from their groups and offices. Eleanor suggested that monitoring the weight of participants in group education for prenatal and postnatal populations is not appropriate. While on the other hand, Eleanor stated that weighing may be appropriate in a more clinical setting. Shelley, however, who works in a clinical outpatient setting, does not weigh her clients and does not recommend doing so. Finally, Lydia, one of the 10 participants I interviewed who has a high BMI, articulated the anxiety around being weighed for any reason, seemingly neutral or not. If health care providers do need to weigh a client (e.g., to determine correct medication dose), how this is explained or not explained to a client warrants further investigation. Most of the dietitians interviewed actually said that they do not use the pregnancy weight gain guidelines because their focus in on health, optimizing nutrition status. They also stated that in diabetes care, the focus in on blood sugar control. Some dietitians labelled the prenatal weight gain guidelines as unrealistic and impractical. Some dietitians also noted that they often advocate for physicians to encourage de-emphasizing weight – in pregnancy and in general – for their clients. When, however, a client's weight is measured, it is crucial to not focus on that specific number.

Send a Letter to My Doctor or Specialist to Advocate for a Focus on Health Not Weight. In addition to not weighing and/or de-emphasizing the number on a scale, another suggestion that participants had to help health care professionals focus on "health not weight" was to advocate for clients by writing letters to allied health care providers. This subtheme is based on advice from both clients and practitioners. As Susie noted, "When [the dietitian] sent a letter to my doctor, that was a game changer."

Susie had visited many different types of health care professionals related to infertility, and she had a specialist related to her diagnosis of PCOS. After seeing two more conventional dietitians, she then saw a dietitian who focused on health not weight; this dietitian was me. Susie recounted that I wrote a referral letter back to her family doctor and specialists. This letter included information from her nutrition assessment, indicated the positive health behaviours that Susie had implemented into her life and the new health goals she was working on. Susie stated that this letter also included information about a focus on health not weight and how and why that would be beneficial for Susie.

When a doctor refers a patient to a dietitian, it is common for the dietitian to write a follow-up letter to the doctor. A standard dietitian follow-up letter includes things such as a client's presenting concern(s), some background of the client's health history, the client's current health status, a summary of the nutrition assessment, and a summary of the nutrition diagnosis. It is also common to end with recommendations and plans for follow up. The intention of such follow-up letters is to ensure continuity of care and facilitate a team approach to the client's care. I am not aware of research that indicates the use of referral letters/follow-up letters as a tool for education and advocacy, nor of the efficacy of such a practice. I am also not aware of such a practice to specifically advocate for a health not weight approach or to combat weight stigma in health care.

However, Susie shared the impact that this letter had for her. Susie said, "[The letter] really was helpful because they completely backed off." By "backed off," Susie meant that her health care team, which included the specialist treating her PCOS and infertility, no longer talked about her weight or pressured her to lose weight. Susie expressed that historically she had felt badly about her weight after seeing members of that health care team, but the letter created a situation in which Susie felt more comfortable returning to that health care team for her future appointments. Dietitians I interviewed for this study shared their experience with referral and follow-up letters. Shelley and Renee (Age 41, works part time, white, straight, income not disclosed), stated that they often send referral letters back to physicians, and they do not mention weight. Renee's letters include information about health not weight and the rationale for this approach for each client.

In summary, while it is common practice for health care professionals to write letters back to the referring doctor or other referring health care professional, a focus on health not weight in these types of letters may be a tool for advocacy. It would be beneficial to further study this strategy and assess the impact of this practice from the client perspective as well as the health care provider perspective, as this practice could be a potential tool to combat weight stigma particularly – like in Susie's case – when encountering fertility specialists.

With Infertility, Don't Just Tell me to "Lose Weight." Within the overarching "health not weight" theme, one subtheme emerged that focussed specifically on fertility care. As I mentioned above, one participant, Susie, had experiences that are particularly illustrative of the ways in which fertility specialists have emphasized unhealthy weight loss, which has also been

explored in previous literature (c.f. McPhail & Mazur, 2021, forthcoming). Susie experienced a lot of frustration within the medical system regarding infertility and brought to light how many doctors often recommended weight loss for improving fertility and increasing chances of getting pregnant. In addition to the focus on her weight making her feel badly about herself and her body, Susie found it frustrating that doctors did not adequately explain why they recommended weight loss. She described being told simply to lose weight to improve her chances of conceiving, rather than being given a more comprehensive explanation that so little is known about fertility, health, and body weight. She stated, "I feel like they just say, 'You need to lose weight [to improve fertility],' without explaining why they are making that recommendation."

The assertion that weight loss is needed to improve chances of conceiving is not accurate because women with high BMI conceive all the time, whether they experienced pre-conception weight loss or not (Lang et al., 2019). When health care professionals recommend weight loss in general, this recommendation is not typically accompanied by information about the side effects of weight loss dieting (Tylka et al., 2014). Crash diets, fasts, low-calorie diets, cleanses, detoxes, supplements, etc. have many short- and long-term side effects, some that are detrimental to overall health (Bacon & Aphramor, 2011). In addition, most weight lost on weight loss diets is regained (Tylka et al., 2014). Regarding fertility specifically, a client may lose weight and still not get pregnant (Best et al., 2017). Weight is not a behaviour. Focusing on health behaviour changes instead of focusing on weight loss my lead to health improvements, regardless of weight (Bacon et al., 2005; Clifford et al., 2015). Improving overall health through health behaviour changes may therefore improve fertility, regardless of weight changes (Panth et al., 2018). With much of the research on weight being centred around the flawed BMI and its correlation with certain health conditions (Ernsberger, 2012; Flegal et al., 2019; Nuttall, 2015; Puhl & Heuer, 2009), it is important for clients to fully understand health recommendations coming from their health care professionals. The days of blindly following the recommendations from our health care providers seem to be over, especially with easy access to "Dr. Google" as Phoebe, one of my participants, called the ability to use the internet to learn more about her health issues. Participants in this study wanted to feel agency over their bodies and their health care – to be a partner in their care and not simply be told what to do. When talking about the recommendation of weight loss to improve infertility, Susie shared the following:

> From the second obstetrician/gynecologist I went to see, I think you have to look at the other side. A lot is unknown about exactly how the conception happens. So, you know, a lot of the care [for infertility] is actually shots in the dark and seeing what actually sticks and works.

It is worth further study to determine whether people who struggle with infertility improve their chances of conceiving with a health not weight approach, in comparison to a traditional weight loss approach. A health not weight approach would contribute to informed consent that is more comprehensive than the current common practice of suggesting weight loss for those with high BMI to improve infertility without explaining the detrimental impacts. Focusing on health and explaining any suggestions for weight loss would respond to client needs; in other words, this would be a client-centred approach.

Client-*C*entred *A*pproaches

The second major overarching theme discussed by my participants was the need for practitioners to develop client-centred approaches. This approach includes the idea of meeting people "where they are at," getting to know clients well and forming partnerships with them, focusing on small goals and not rapid change, and recognizing that clients are experts in their own bodies.

Meet People Where They Are at, i.e., Motivational Interviewing. This subtheme is based on the participants who wanted their health care providers to meet them where they are at, with Susie and Lydia specifically naming Motivational Interviewing as an approach they would like to see their health care providers utilize as it was something they had learned about in their professional work. Susie articulated it well when she described her professional experience learning about Motivational Interviewing and wished her dietitians had been able to meet her where she was at: "People work very hard to find a dietitian that works for them with schedules, price, etc., etc. So, it's important to know about your client and be prepared to meet them where they're at." Susie also described specifically what this could look like: "So, [health care professionals] find out places where [your clients] are willing to change, explore that with them, and you know, just work with them where they're at and to change the habits that they want to change."

Phoebe and Crystal (age 27, Indigenous, low income, on social assistance) described the importance of client-centred care. Phoebe found that the dietitian she saw did not meet her where

she was at and did not provide the information she needed and wanted, whereas Crystal felt she received the specific information she needed and wanted. Phoebe suggested that dietitians should provide more information for people that want it and said her dietitian did not provide evidence for the recommendations they made. As mentioned previously, Phoebe saw a dietitian in a diabetes team during her pregnancy. She considered herself to have slightly more than basic nutrition knowledge and wanted to manage her gestational diabetes with healthy habits and not insulin. She had questions about nutrition but felt her questions were dismissed or not taken seriously by her dietitian:

> … like having more information available for clients that want it. I get that not everyone would want the amount of information that I might have wanted, but I think it's important to have it available. … It's either you're giving it to them, or they're getting it from Dr. Google, so you might as well have stuff that you [as the health care professional] vetted.

Crystal saw dietitians in the context of a prenatal nutrition group. Because Crystal ate fish as part of her typical eating pattern, she found it helpful to learn about the mercury content in fish and whether she needed to do anything differently during pregnancy regarding her dietary intake of fish:

> Because I love my fish, so I would question with the dietitian "am I allowed to have – what kind of fish is allowed and how much?" Because I knew about the mercury content – you don't want anything with too high mercury and … yeah, that [the dietitians] were helpful with.

While Phoebe did not receive the information she wanted from a dietitian because the dietitian was focused on weight, Crystal's dietitian was able to "meet her where she was at" and provide the information she actually needed and desired beyond that regarding weight and weight loss.

Get to Know Your Client, Partner With Your Client, Find out Their Goals. Participants in my study wanted their health care providers to know them better and to find out what their goals were for health behaviour change regardless of body type. Monica, for example, wished that one of her dietitians and her doctor would have "checked in" about what her specific goals were with her health. Monica wanted to be a partner in her own health care and stated that

she wished she had been treated by her OBGYN:

> I think the other thing would be to check in and see what my goal or priority is. So, maybe don't assume because my body is fat that I do want to lose weight. Maybe it's something else, so that we can kind of line up and set the goals together. So, according to the research, these are the best things that we could recommend: … "Does that work for you? Is that kind of where you're headed and what you're thinking also?" and then giving the opportunity for me to express … "yeah," or "no, thanks," and to still feel supported through that decision. So, yeah, an instrumental vaginal birth often has less kind of potential consequences than a C-section, but it wasn't for me. So, I did feel supported in my decision to take the other option.

Monica described how a health care provider who does not get to know their client, may make recommendations that are unhelpful or may be based on assumptions about body size and health:

> Reserve judgments about what you think you know about myself and my health, like based just on what you see, what size my body is. So that, yes, I have a fat body, and I love vegetables, and I eat from a variety of food groups, and I'm fairly active and, I mean, I have lots of fairly healthy behaviours even though I'm in a big body. So … give me the opportunity to share some of those things about myself before kind of making up your mind about what recommendations would be the best fit for me. And that might extend [to] … dietitians, but also drawing on some of my experiences with other healthcare providers.

When clients are subjected to unfair assumptions about their fat bodies being unhealthy, they feel stigmatized by their health care providers (Puhl & Heuer, 2010). Thus, removing the focus from weight and getting to know clients' goals apart from weight loss is important to good care and crucial in avoiding stigma.

Focus on Small Goals Over a Longer Period of Time. One way in which participants suggested practitioners may achieve partnering with clients is by focusing on small, achievable goals. There is ample evidence suggesting clients make changes more easily when they do this in small increments and slowly over time rather than attempting to make rapid changes (Clifford et al., 2015). Rachel's story provides an example of this.

Rachel had pre-existing diabetes before she became pregnant with her second child and was therefore being monitored by her health care team. She related that when her health care providers focused on a small-step approach, this was helpful in her pregnancy journey. Rachel shared that, in general, her health care team focused on blood sugar control and not body weight

during her pregnancy. She also related a specific example about how her dietitian helped her decrease her pop intake during pregnancy. Rachel expressed that she really enjoyed pop, and if someone had recommended cutting it out altogether, that she would reject that recommendation:

> They didn't focus on weight, it more about maintaining sugar levels or how to eat better … like small goals. Not…rapid change. I think one of the things was – I can't remember if it was the first dietitian or the second dietitian when we were talking about pop drinking. I remember that was – they were just like, "Count how many you drink a day, and then maybe just drop one, and then in a week or two take away another one." Say, you had seven, then go down to six and then to five. Slowly cut it out.
> It was better [for the dietitian to make the recommendation in this way] because if you do, do it slow, you're more likely to make a long-term change. I think I've been told just to … stop drinking pop, and I just – that's funny.

The evidence base echoes what Rachel said in that when a client makes small, manageable goals, they are able to succeed and are more likely to sustain the changes in the long term (Clifford et al., 2015). We see this with the SMART goals approach, which is framework that supports setting goals that are sustainable, measurable, attainable, realistic, and time-lined (Bovend'Eerdt et al., 2009). Part of helping clients make the best goals for themselves is reminding them that they are experts of their experience and of their own bodies. Helping clients make goals that suit their own lives and bodies is key to client-centred approaches, and clients want health care providers to remember this, which is highlighted in the next subtheme.

Clients Want Health Care Providers to Remember, "WE are the experts of our own bodies." Participants expressed how good it felt when their health care providers had honoured their knowledge and experiences; this centres the client in their own care. Lydia provided an example. Lydia has experience working in the health care field, and when she was pregnant with her first child, she sought out a private practice dietitian. Despite having much knowledge in nutrition, body positivity, and fat rights, when Lydia became pregnant for the first time, she wanted to ensure she was doing the "right" things. While new mothers face many challenges, Lydia shared that because of her fat body, she wanted to ensure she was eating well and was not going to gain too much weight or put her child at risk. She described a positive experience with her dietitian for which, years later, Lydia is grateful. She remembers the experience well, but she knows not every fat woman has these sorts of life-affirming experiences with dietitians or in health care in general:

> And so, I would just say, … so, I was lucky, is what I'm trying to get at. But ultimately, advice around pregnancy, discourse around risk, I think is so shaming and blaming and so unhelpful for someone. You can look at the determinants of health: what does it mean to have nutrition – like access to nutrition, access to dietitians, and different things. And so, I think sometimes we really look to dietitians or other healthcare professionals as experts in our bodies, and the truth is that we're the experts of our bodies…just looking at the whole person and validating that, you know, there's so many different body types that can be perfectly healthy, whatever that means for them, and they get to decide.

Unlike Lydia, many clients were not asked to share their own knowledge of nutrition and their lived experiences. Lydia felt very affirmed by her experience with the private practice dietitian whom she only saw once during her first pregnancy, and she remembered the experience years after and identified it as an important part of her journey and her reason for wanting to participate in this study. This may speak to the power of validating a client's experiences. When we affirm clients as they are, clients are empowered to continue to enjoy health-supporting behaviours that are right for them, or they may feel empowered to ask for help if they need it in the future. Lydia's experiences were unusual in my study, however, as few dietitians, as described by client participants, affirmed and recognized the expertise and agency of clients during their pregnancy journeys.

Group *E*ducation *A*pproaches

Many client participants encountered group dietetic care, so much so that "group education approaches" emerged as a major theme pertaining to recommendations for health care providers. The theme "Group education approaches" builds upon the foundational themes of "health not weight" and "client-centred approaches" but relates specifically to group sessions, not individual sessions. The women with high BMI I interviewed, who had been involved in prenatal or postnatal groups, generally describe those experiences as positive. The overarching advice provided here was for group leaders to allow participants to "hold space" – to allow time and space for sharing, while providing emotional safety and allowing clients to feel comfortable and supported.

Regarding feel comfortable, seen, and heard within group settings, participants emphasized the importance having the space to discuss what was important for them. While this does not relate specifically to preventing weight stigma, this does set the stage for group participants to feel comfortable being themselves and getting their needs met in a group setting.

The women in this study described experiences in group settings that would be labelled as client-centred, thus indicating that group members' individual needs can be met even in group education settings.

Participants in this study said it was important to them to have their experiences acknowledged in the group, even if their experiences were different than those of other group members. For example, recall that Jessica noted, in Chapter 2, how frustrating it was for her to feel like her experience of her postpartum body was not acknowledged in the group because she did not lose weight while breastfeeding. She also noted that the thinner group members were celebrating their postpartum weight loss after the dietitian described weight loss as a benefit of breastfeeding. Monica also shared her experience of prenatal and postpartum groups, as well as group education in general, and how important it has been for her. Her experience was more positive than Jessica's:

> In the groups that I was a part of, I really appreciated the time and space that was given to each participant to be able to share things that were important and relevant to them and their perspectives. So, I would say [to health care professionals who facilitate groups] continue to hold space for each of those members. It was such a powerful experience to be able to connect with, prenatally, other women in the group, and then even in the mom and baby group that I went to, to hear other peoples' experiences and how they were making their way through those transitions and finding some camaraderie. I think that there is value in having and offering group experiences that are facilitated by professionals.

Regarding her health history, Erin had participated in various types of group education and therapy. She shared how difficult it was to hear about the traumatic experiences of others in a group setting while she was in eating disorder treatment. Research has indeed demonstrated that others disclosing trauma can create vicarious trauma for the listener (Baird & Alaggia, 2019). Safety, which includes emotional safety, is of utmost importance in the group setting when working with clients of different backgrounds, experiences, and health statuses (Baird & Alaggia, 2019).

Oliva (age 48, works full time, straight, middle income, immigrant parents), a dietitian who has worked with prenatal and postnatal groups for many years, has noticed group facilitators "hold space" in positive ways but has also observed the opposite. During our interview, Olivia

beautifully set a stage for how a group environment should be, what it should include, and how she wants her participants to feel when they come to the groups:

> I think it's lovely when [the group participants] come and they trust, regardless of who it is; they just know that we'll take care of them. It's that number one thing. You walk in that door; someone makes you feel welcome. I'll give you an analogy. You go to a house party, you know the house parties are going to be crap, the ones you go to where you walk in, they barely acknowledge you … or the ones we walk in, everybody's around the table, and they're laughing, "Oh my god, I'm so glad you're here." Number one, you set it up right there, people have got their guard down. That's huge. And then the next is how you present information. Is it very casual, is it practical, is it going to meet your need? And then, when someone asks you questions, are you listening to what they're saying, or what you want? … We all have ideas of how we want people to – because "I can solve that issue for you right now. Okay, all you have to do is go to Housing, take care of this, get rid of that man because he's an asshole. If you just do that, I swear to god, life will be so much easier, and you'll have a great life." But damn, I can't do that. … You can't do that. And they'll come back to you again if you just listen to what they're asking for at that moment. But it's zipping your mouth and listening – that's the hard part for all of us, be it our family, be it our friends, and be it people who we serve. It's critical because all of us just want to just be heard. And when people talk about being non-judgemental … you can't just say the words – who cares? It's just words. What are you actually doing to create that environment?

Nicole's experience seems to embody the essence of the group environment that Olivia, in her role as a dietitian, strives to create for prenatal and postnatal groups. Nicole had an experience with a dietitian in a prenatal and postnatal group setting in which she felt supported. She described the dietitian in the group as "bubbly," and as someone who would offer to hold Nicole's baby if needed, which was helpful for Nicole. This denotes how a supportive group nutrition education environment is about more than nutrition facts and having a snack prepared. Other supports, such as offering to hold a person's baby, help to build stronger connections.

In addition to being generally open and supportive, as Nicole described, participants want dietitians in group settings to acknowledge that every body is different. Participants also stated that, when sharing information on guidelines for healthy eating, dietitians should acknowledge these differences. Crystal, for example, demonstrated how dietitians in group settings should tailor their food advice according to the bodies and tastes of those in the room:

> Well, the way they do it at this one, I feel is the best way to do it – where they make it fun, and you get your snacks. This way you can try it because when they do just the

> demos, or … just the talking about it, it's like, "Ew, gross. I don't want to eat that stuff." But having the opportunity to actually try the stuff and seeing how they make it, you get to taste it … and it's up to you to taste it if you want to. I always do it, and it's like, "Okay, that didn't taste too bad. I'll eat it, and I'll try and make it myself." But other stuff is like, "Nah, whatever" in other groups – in one ear and out the other because I don't want to hear about it. It's like, "No, I'm going to eat the way I want."

Crystal also rejected specific food recommendations and wanted a more tailored, client-centred type of approach, even in a group setting. She wished her dietitians had said the following:

> No two people are the same. That the recommended amount is this, but listen to your body because your body knows better what's good for you. Be in tune with your body. If you're craving a frigging chocolate bar, it's your body telling you, you need sugar. Because I'll crave the weirdest — like I'll crave vegetables one day — like okay, then I need vegetables. And some cravings are weird, but it's your body telling you what you need.

I asked Crystal whether the dietitians talked about food cravings during pregnancy and how they approach this topic, and Crystal said:

> Sometimes, but a lot of the times it's "try and ignore it" because it's all sweets. Well, no, if you're craving sweet, eat your sweets because it's probably telling you your blood sugar's down. … I was like, "Oh, I need chocolate, I need chocolate, I need chocolate," and I was so tired. I had the chocolate, and I was fine. And so, it was like, "Okay, my blood sugar must have been down." It's why I was feeling tired, because when your blood sugars are low, you're tired. Had the chocolate bar, I was fine.

Thus, Crystal expressed that she is fine with hearing guidelines for nutrition during pregnancy, but ultimately, she will do what she wants. It seems it would be helpful in a group setting for dietitians to express, "Yes, this is a guideline, but everyone is different, and you need to do what's best for your body."

What *"N*ot to *D*o*"*

While it is helpful to focus on what *to* do in regard to fatness and reproductive care, it is also important to know the harm that can be caused by health care providers. In this final section, I discuss what participants suggested dietitians *do not do* in relationship with fat and pregnant

clients, and I focus specifically on not making blanket recommendations, not being alarmist, and not engaging in their own biases about weight when encountering clients.

Do Not Make Blanket Recommendations. Participants stated that recommendations from dietitians in both individual and group settings were not always tailored to their specific needs. Some felt that they did not get anything out of their interactions with dietitians, or worse, that their experiences with dietitians had been negative.

Susie, for example, experienced infertility and saw multiple dietitians. She desperately wanted to have a baby, and Susie's doctors told her that to conceive, she would need to lose a significant amount of weight. However, this "blanket recommendation" was not helpful for Susie, especially given her history with an eating disorder. Susie required the opposite; she required a tailored health not weight approach. Eventually, as I mentioned in the previous chapter, she received this tailored approach from me because she was referred to me as her dietitian. I asked Susie what it was like for me, as her dietitian, to not show concern about her weight, and she said:

> It was empowering, to realize that I'm good just as I am, and whether or not it was going to lead to a baby anyways. And also, [it] made me realize that I probably didn't have disordered eating. So, I was okay … being okay as a human. I think that's a specific trend because as women our identity gets so bound up with the idea of being a mother. So, I think it started me on the path of, "I'm okay. Whatever happens, I'm okay."

People want to feel empowered in a health care setting, not disempowered and afraid. Susie shared that she felt empowered not only in regard to her body, but also in her humanity, in that she's okay, no matter her body size or whether or not she is a mother.

Do Not be Alarmist. Be Empowering. As noted in Chapter 2, Phoebe had an extremely negative and weight stigmatizing experience with her diabetes team, including the diabetes dietitian, during her pregnancy. Phoebe shared what she would like to see changed, and her advice is for health providers to de-emphasize risk to avoid being alarmist:

> … yes, having more information available for the people that want it. Being empowering and not alarmist. There's a lot to be said for being calm. I have a friend that works with women who use drugs, which is obviously not the same thing, but the alarm is the same, in that the service provider is concerned that the choices you're making are bad for your fetus. And that woman that works with people with addictions said, "The number one

> thing service providers can do is take a chill pill and just talk to people in a more reasonable way." And I think my advice for dietitians working with people with gestational diabetes would be the same thing: the best thing you can do is relax a little bit and save your alarm. Like, there might be a time for alarm. But figure out where that actually is because it's not – it's not there. It's not alarming if you can have the same alarming conversation every week, three times a week for 10 weeks; it's not actually that alarming. Like, if it's not alarming enough to take steps, it's not alarming for us. So, that would be my number one thing.

Several of the other participants expressed a similar sentiment, which is also supported by the literature (McPhail et al. 2016). Although it may be important for health care providers to communicate some risk, such as in the case of gestational diabetes, it is not fruitful nor helpful for such communication to consistently place clients in states of high stress. Future research may wish to focus on this further and to develop guidelines for outlining pre- and postnatal risks to clients with *all* BMIs (i.e., not just fat women), while at the same time deflating the stress of such information as much as possible.

Do Not Put Biases on Clients: Engage in Critical Reflexivity and Anti-Oppressive Training that Includes Body Positivity and Food Positivity. Since health care provider biases can harm their clients, it is vital for health care professionals to build awareness of their own biases. Through the process of critical reflexivity (as defined in Chapter 1: Methods, Methodology, and Ethics), health care professionals can learn to be aware of these biases. The awareness piece is a critical first step because once the health care provider is aware, then they can change any behaviour that could have (un)intentionally harmed their clients. Further, the process of critical reflexivity can reveal biases about dietetic client's race, sex, gender, sexuality, culture, language, religion, and income level. This was highlighted by Lydia, who shared her experience with a midwife, which she found to be weight stigmatizing, and shared her advice and recommendations for change:

> I think it's really important for people who are in those positions of authority or power, and you know, to be able to look at their own stuff and, you know, what is leaking out here? Like, what is my value and how helpful is it?

Lydia also reflected on her work in health care and her experience as a client:

> … doing our own work, because you know, "What's coming up in my body or my

> thoughts or my feelings that are getting in the way of care?" And although I think I was someone who was very accommodating or could be respectful around those kinds of exchanges, I think it does shut people down. It does make people feel like they can't – they don't feel like they can trust their healthcare provider, and that's really, ultimately, the issue. I guess the truth is that being able to examine what's our own stuff, what are our own values, and to what extent is that coming out in the work that we do, I think for all of us – whether you're a midwife or a dietitian quite frankly – …I think that's the hope: that each person is looked at as a unique person with unique set of needs. And for one person, a measure of success might be something that is no-brainer for someone else – so, even looking at, where are people in terms of their level of readiness and their agency, their ability to make healthy choices and whatever that looks like for them? And so, for one person, it could simply be cutting back cigarettes, you know?

Thus, the participants and I recommend that training for health care professionals include anti-oppressive work. This work should also include anti-weight discrimination training. Specific topics to addressed could include body positivity, body neutrality, fat positivity, and fat rights. Further, food positivity should be specifically addressed and should focus on understanding psychological, emotional, and cultural connections to food, rather than binary views of food as good or bad, healthy or unhealthy.

Chapter 3 Conclusion

Chapter 3 summarized changes my research participants, women with high BMI and dietitians, recommended to improve care for fat women in the perinatal period and in health care more broadly. The advice and experiences of the women with high BMI and the dietitians as outlined in Chapter 3 can serve as a framework to begin to build improved, more compassionate, weight-inclusive, and anti-oppressive guidelines for fat women in the perinatal period and in health care in general. These recommendations can inform guidelines tailored specifically for use in dietetic research, education, and training, but may also be used for guidelines for health care professionals more broadly. Since policies are best informed by the end users of the policies (Straus et al., 2009), including both women with high BMI and dietitians was a strength of the current study, as both perspectives can more comprehensively inform guidelines for fat women seeking conception, pregnancy, and postnatal care.

Thesis Conclusion

In this master's thesis, I summarized the data from 20 qualitative interviews that included the thoughts, feelings, experiences, and knowledge of 10 women with high BMI who have received perinatal care from dietitians, as well as 10 dietitians who work in perinatal care. In Chapter 2, I shared the experiences of the women with high BMI that were good, bad, and vanilla. I argued that vanilla health is not just neutral and harmless, but that it can in fact be harmful. In Chapter 3, I shared the advice that the participants wanted dietitians and other health care professionals to know in order to improve the experiences of fat people in reproductive care. In Chapter 3, I also explored the experiences and advice of dietitians, and put words into action in the form of specific actionable steps that health care providers can put into practice – additional tools for the dietetic toolbox.

Contributions to Knowledge

With this current research, I contribute to the knowledge base for critical fat studies in a variety of ways. To my knowledge, this is the only study to date that has included interviews with both women with high BMI *and* dietitians. I chose to interview both women with high BMI and dietitians to support optimal knowledge translation from research to practice, whereby the voices of the end users of the data are at the forefront of the knowledge inquiry needed to create changes to practice (Straus et al., 2009). As end users of perinatal health policies, women with high BMI *in addition* to those providing care are best suited to provide insight into policies that will ultimately impact health care and their work, respectively. I hope this thesis is successful in these aims.

While research on dietitian experiences in general is lacking, and virtually non-existent in relation to weight stigma and the perinatal period, some research suggests that dietitians exhibit less weight stigma than other healthcare practitioners (Jung et al., 2015). Yet, other research indicates weight stigma is still present in dietetics (Bessey et al., 2020; Diversi et al., 2016; Puhl, Wharton, & Heuer, 2009; Stone & Werner, 2012). In my research, only two out of 10 women in my study expressed explicitly that they felt they had experienced weight stigma with a dietitian, while most of the women with high BMI had good or "vanilla" experiences. The experiences described as "vanilla" in this current study are a novel contribution to knowledge inquiry

concerning the relationship between client and health care provider, and specifically the relationship between client and dietitian. While vanilla health care may be interpreted as neutral or satisfactory, as I noted in Chapter 2, this is a harmful assumption. While the women with high BMI described their experiences as "not so bad," ultimately their vanilla health care was not client centred. In other words, vanilla health care experiences with the dietitians did not provide the client with care that was uniquely tailored to the clients' needs. For example, as highlighted in Chapter 2, while one participant initially described her dietitian as "good," as she revealed more about the experience with the dietitian, her experience turned out to have been negative and profoundly invalidating. This participant left her experience with her dietitian feeling worse than when she came, and this is unacceptable health care.

In Chapter 3, I explored the basic adage, inspired by Chapter 2, that we must "put the care back in health care." As mentioned, the women with high BMI and the dietitians made specific recommendations about how to do this. Overall, participants strongly recommended a focus on health not weight for health care provision for women with high BMI in the perinatal period. All 10 women with high BMI in this study made this recommendation. From this foundation of health not weight, the participants also recommended a client-centred approach.

Within Chapter 3, one key theme that emerged concerned how (not) to weigh people from a health not weight perspective. I highlight this here because, to my knowledge, this is a novel recommendation and contribution to knowledge. Within the dominant paradigm, weighing to calculate BMI has been a common, convenient, and unquestioned practice to determine health (Hodges, 2015). Some have even pushed to have BMI be recognized as a vital sign (Kirk et al., 2009). Yet, the original intent of the BMI was not to be used to assess individual health status, but rather to assess populations' health status (Ernsberger, 2012). However, there has been a shift within the dominant paradigm whereby scholars, health care professionals, and clients have taken part in developing sensitive weighing procedures (Rudd Center, 2018; Fruh et al., 2016; Puhl & Heuer, 2010). Within the critical paradigm, scholars, health care professionals, clients, and activists have long advocated for *not* weighing clients, and the clients themselves have advocated to not be weighed (Paine, 2021; Tylka et al., 2014). However, as I noted in Chapter 3, there are times when weight does need to be known for health and safety reasons and to administer thorough and client-centred health care. Thus, the recommendations I suggested in Chapter 3 regarding weighing clients from a health not weight perspective contribute to the

critical fat studies literature and to weight stigma literature as a whole. This also serves as an important teaching to scholars in both the dominant and critical paradigms: to notice our own binary thinking around health care education, research, and practice in relation to weighing clients. The question should not be simply whether to weigh or not to weigh. Beyond the binary, my research suggests that sometimes we need to weigh people and sometimes we do not – but how do we do that in a compassionate, health-not-weight-centred way? One of the participant's stories struck me in this regard. This participant, who had a history of an eating disorder, wanted to find a dietitian to focus on improving her health in the pre-conception period. She did not want a focus on weight or be weighed. The dietitian used a health not weight approach, and eventually, this client asked to be weighed because she felt this was important information in her pregnancy journey. She wanted to know her weight on her own terms, not as part of the agenda of the health care provider. To me, this story displays a powerful message about building a foundation of trust between provider and client: when weight is de-emphasized and health is prioritized, a client may eventually feel safe and comfortable enough to be weighed.

Strengths and Limitations of the Study

The strengths of this current study include the innovative exploration of *both* the experiences of women with high BMI who have sought perinatal dietetic care and the dietitians who provide perinatal care, for which no known research has been completed to date. Further, the study included a Manitoba-only sample, which will hopefully uniquely serve to benefit women's health care in Manitoba in particular, while also providing research contributions and recommendations that are transferrable to Canada more broadly. Furthermore, half (n = 5) of the sample of the women with high BMI belonged to one or more historically oppressed group, which supports transferability of data by elevating voices that are often marginalized in healthcare research (Browne et al., 2016; Dodgson & Struthers, 2005; Kurtz et al., 2013; Williams & Cooper, 2019). Finally, the study generated a rich qualitative data set from both the women and dietitians, which arguably supports the trustworthiness of the data (Ravitch & Carl, 2016).

The limitations of this current study include that data are not generalizable due to the small sample size (n = 20). While the data are not statistically generalizable, the study may be analytically generalizable (Hesse-Biber, 2017) to other studies of this nature, meaning that the

analytical methods used in the study may be generalizable to other studies. While in the Introduction, I discussed some of the benefits of knowing some of the research participants prior to their interviews, this could also be considered a limitation in that it may have created a situation in which the participants may not have felt comfortable to be completely honest with me about their experiences. Further, my positionality as a fat rights activist and a weight-inclusive and HAES registered dietitian may have potentially influenced those who "opted in" to my study. For example, people with similar critical perspectives may have agreed to participate in this current study because of shared views, thereby biasing the data to be more supportive of health not weight approaches. Those with opposite or more neutral views – those operating within the dominant paradigm or with more traditional weight-loss perspectives – may have chosen to not participate because they may not have felt welcomed or validated by recruitment materials and/or my established reputation. As I explained in Chapter 3, one dietitian verbally declined participating in this current study for these reasons. While there have been shifts within the dominant paradigm to more health not weight and weight-inclusive approaches, the dominant paradigms continue to frame research within an understanding of obesity as a disease (Bombak et al., 2016). In contrast, a critical paradigm rejects the use of the word "obesity" and the definition of obesity as a disease, and instead favours reclaiming "fat" as a neutral description of a body size and focuses on treating health issues regardless of BMI with a foundation rooted in social justice.

Study Significance and Impacts

Despite the thesis' limitations, this research is well-situated to support dietetic policy in Manitoba for women with high BMI in the perinatal period. This research provides rich insight into the lived experiences of women with high BMI in the perinatal period, which are essentially absent in dietetic policy. The experiences and advice of these women and dietitians may be used to frame weight-inclusive guidelines for dietitians in the perinatal period and could contribute to weight-inclusive guidelines for dietitians in general. With this knowledge, dietitians and other health care professionals may be able to gain more insight into how to provide more tailored health care or client-centred care for their clients and therefore contribute to a more beneficial and supportive health care encounter overall. Because it included dietitian voices, this research may support more understanding and buy-in of dietitians for health not weight approaches in the

perinatal period and in dietetics more broadly. As a researcher, and also a dietitian, this research is well-positioned to have true impact in these aims. Further, as the voices of those with high BMI are limited in the literature, this research may support transferability to inform best practice guidelines for weight-inclusive care more broadly.

Seeking the voices of those with high BMI, in particular women who are disproportionately impacted by weight stigma (Duncan & Klos, 2014) and who have sought dietetic care in the perinatal period, allows these voices to help shape the future of dietetic care. Dietitians may be well-suited for piloting interventions to decrease weight stigma. As an occupational group, dietitians are a smaller and arguably more manageable target group for intervention. With some research reporting that dietitians' views are less weight stigmatizing (Jung et al., 2015), the culture of dietetics may be more easily shifted toward supporting more weight-inclusive health care guidelines and strategies.

I plan to share this knowledge in a variety of ways. I have begun sharing via academic presentations, and I plan future publication. In addition to the typical academic outlets, I also intend to work with local leaders in Manitoba to present this research at professional development days for those who work with the perinatal population, such as public health teams across the province who facilitate prenatal and postnatal groups, as well as primary care providers and chronic disease management teams who work with women experiencing infertility, who are pregnant, and/or who have gestational diabetes or pre-existing type 2 diabetes prior to becoming pregnant. As I noted in the Introduction, I also intend to prepare lay summaries of the data for all participants, and I look forward to hearing their feedback in this regard to support future research I may conduct in this area.

Areas of Future Research

Health care professionals state that the lack of guidance regarding the prenatal weight gain guidelines make these guidelines difficult to communicate to patients (Grohmann et al., 2012; Knight-Agarwal et al., 2014; Whitaker et al., 2016). This current research echoes this. Dietitians in my study felt the guidelines were "useless" because, as dietitians, their focus is on supporting optimal nutrition status rather than optimal weight gain, and the two are often not synonymous. The women with high BMI felt the guidelines were unrealistic, and, important when considering the relationship of prenatal appointments to maternal and child health

outcomes (Kuhnt & Vollmer, 2017), some clients avoided appointments with health care professionals due to fear about being pressured to keep within weight expectations. My MSc research thus revealed significant health equity gaps with regard to the PWGs and clients with high BMI and indicates a need for future research exploring the origins and effects of the guidelines.

The PWGs have been deemed controversial and internationally inconsistent (Abrams et al., 2000; Brady et al., 2013; Hamad et al., 2016; Kapadia et al., 2015; Mufiza Zia Kapadia et al., 2015; Poston & Patel, 2014). Particularly contentious, the PWGs differ for patients labelled "obese" but lack guidance on the means to implement the guidelines specific to higher weight individuals (Poston & Patel, 2014; Swift et al., 2016). The intent of the PWGs was to support health care providers in advising pregnant people to prevent weight gain deemed excessive and achieve optimal health status during pregnancy (Health Canada, 2011). While this MSc thesis laid the groundwork for demonstrating the ways in which the PWGs do not work for women or practitioners, performing this research left me with a question: where did these guidelines come from? How did the PWGs become so integral in reproductive care? I would like to therefore launch from the research I did for this thesis to a project exploring the history of the PWGs in Canada and interview key policy actors about these guidelines. By exploring the past, with such research, I hope to map out a way forward for the prenatal weight and health guidelines that is more compassionate, inclusive, and free of discrimination.

In addition to a history of the PWGs, my MSc research highlighted other areas that warrant future research. One of the women with high BMI reported explicitly that she had experienced weight discrimination during her care for gestational diabetes, which may signify a need to explore this population's experiences specifically. This woman's experience was so poor that she is not sure if she wants to have another child. Further exploration about fat women with gestational diabetes and their health care experiences may thus be necessary to understand whether this is a rare occurrence or common in diabetes care. It may also be interesting to explore whether fat women with gestational diabetes have different health care experiences than thin women with gestational diabetes. Finally, future research projects might ask, "What is it about the diabetes care environment that may lead to differing experiences for thin women and to more explicit experiences of weight discrimination for fat women?"

Concluding Thoughts

When embarking on this thesis, I did not know how much I would grow as a researcher, or as a person. As I write this conclusion, I reflect on the fragility of this process. I recall the fragility of the interview process – of bearing witness to the struggles, pain, and tears that women experienced as the hands of health care professionals who are meant to help not harm. Yet, I also reflect on the strength and resiliency within this process – the power of these women's words. I reflect on fragility and strength, on fragility *as* strength, and on how my participants embodied this as they shared their stories –t he strength within this process, held within a fragile *womb*, with the words of these women as sustenance, as substance. While I am not a mother, the analogy of a womb feels fitting: a womb, a surrogate. As a researcher, this project, these words, are not *mine*. However, what I must own, what we must all own, is our collective responsibility to *raise* or elevate these words to create change. The common colloquialism "It takes a village to raise a child" is fitting here, as well, in that it takes leaders in education, health, research, and policy to grow and create change. Whatever your place or role is within the *village*, as my participants' words enter your hands, hold them with care. While I cannot truly predict the future implications of this project (despite my attempts to do so, as mentioned above), I know that in the hands of the right people this small project could make a large contribution to creating positive change in health care education, policy, and practice. Hopefully, to extend the metaphor of reproductive care, this thesis will help to foster health care *delivery* that is more compassionate, nurturing, and nourishing.

Appendix A

Sample Interview Guide: Women with High BMI

1. Tell me a little bit about yourself – what is your occupation? Do you have a partner? Do you have children? What drew you to participate in this study?

2. Have you been pregnant in the past? How many times? If yes: What sort of experiences did you have with these pregnancies? Were they "difficult," "easy"? What kind of health professionals did you see during these pregnancies in addition to dietitians (e.g., midwife, doctor, nurse practitioners)? What was the birth experience like?

3. Can you tell me a little about your weight gain or loss during these pregnancies?

4. How did your healthcare provider respond to this weight gain or loss? What were their main concerns (if any)? How did they communicate their concerns? OR Why do you think they weren't concerned about your weight? How did they communicate this lack of concern? Do you wish they had been more or less concerned? PROBE: doctors, nurses, midwives.

5. Specifically, in relation to dietitians: How did your dietitian(s) respond to this weight gain or loss? What were their main concerns (if any)? How did they communicate their concerns? OR Why do you think they weren't concerned about your weight? How did they communicate this lack of concern? Do you wish they had been more or less concerned? Did the health care providers' concerns (if any) translate into changes in how you felt about your body or how you ate?

6. If you were to use one word or short phrase to describe your relationship with your dietitian, what would it be? Why did you choose this? What impact do you think this relationship had on your experience of your pregnancy, birth, or directly after birth?

7. Can you describe how you felt about your weight and body prior to attempting to become pregnant? PROBE: Were you satisfied with your body weight? Have you ever been on diets? Have you always been the same size? What caused you to gain or lose weight? What factors do you think led you to develop these feelings about your weight/body? Have you always felt this way about your body?

8. Do you think that your experiences of being pregnant have changed your perceptions of your body? How? Do you think that your experiences with/interactions with dietitians influenced this change of perception [or lack thereof]? Did any comments from family members affect the way you felt about your body?

9. [If weight bias experienced]: You have described some negative experiences regarding your weight. What changes would you like to see so that dietitians and other health care providers can provide better treatment? (Use as a probe: If you could make any recommendations to dietitians based on these experiences, what would you advise?)

10. Those are all of my questions. Would you like to add anything else?

11. Thank you for participating. How are you feeling? It can sometimes be a little unsettling to remember and talk about these experiences. [Note: if participant is feeling upset by this discussion, remind her of the resources we list in the consent form for counseling and encourage her to be gentle with herself as she goes back in to her routine.]

Appendix B

Sample Interview Guide: Dietitians

Preamble: I am coming to this conversation as genuinely interested in your story. We each have our own story of becoming a dietitian and different approaches to practice and I am looking forward to hearing yours today.

Introduction/Background

1. How long have you been a dietitian? Where did you do your training? What is your experience in providing fertility, pre-pregnancy, prenatal and postnatal advice? What drew you to work in this area of practice? Have you had your own personal experience being pregnant and working with a dietitian?
2. How often would you say you encounter clients you would call obese? How do you determine this obesity? PROBE: How do clients come to you? Do you receive referrals from doctors? What do the referrals say? Do you work with marginalized women at your clinic/worksite/private practice? Do you work through a specific program such as Healthy Baby or Healthy Start for Mom and Me?

II. General views on maternal obesity

3. a) In your view, what are the central issues that dietitians need to consider when dealing with maternal obesity? Probes: Before woman is pregnant? While pregnant? During childbirth? Post-pregnancy?

b) Can you describe how you know about these issues? Did you learn them in school, via medical journals, conversations with colleagues, conferences?

c) You may know there is some debate about obesity generally in dietetics, with some dietitians taking a "Healthy at Every Size Approach." What have you heard about this debate, if anything? Do you think it is useful or workable? Could you say a little bit more about that? And, in particular, do you think it is useful during pregnancy? Could you say a little bit more about that?

III. Views on provision of services

4. What guidelines do you follow pertaining to dietetic counselling during maternal obesity? Or do you have any personal guidelines that you follow when caring for obese women pre- and postnatally? PROBE: Do you make any special provisions? Do you do anything different with them than with other women? Have you ever advocated to have the guidelines changed to fit the way that you practice? Do you belong to a DC network that engages in these types of conversations? Who do you look up to as a mentor in this area of practice?

5. There has been some debate in Canada about pregnancy and weight, and also about weight LOSS or weight gain during pregnancy. Some bodies advise no weight gain for pregnant women, some advise weight loss. Some advise no weight control whatsoever. Where do you fall within this debate? How did you come to these conclusions?

6. Are these conclusions more based upon your own research and reading, guidelines, or from your actual work with clients? If you could, how would you change the guidelines for future dietitians working in this area? What would you tell a novice dietitian starting in this area about what to expect and what support is needed?

7. How do you encourage or enact weight guidelines in the clinical encounter. PROBE: what do you do with someone who is “non-compliant.”? What is the hardest part of your work? Do you see yourself working in this area for a long time? If not, what area of dietetic practice are you drawn to?

8. Thanks very much, those are all of my questions. Do you have anything you’d like to add?

Appendix C

Consent Form: Women with High BMI

UNIVERSITY OF MANITOBA | Rady Faculty of Health Sciences

Department of Community Health Sciences
Max Rady College of Medicine
Rady Faculty of Health Sciences
S113 - 750 Bannatyne Avenue
University of Manitoba
Winnipeg, MB R3E 0W3
Phone: (204) 789-3473
Fax: (204) 789-3905

RESEARCH PARTICIPANT INFORMATION AND CONSENT FORM
Individual Interview for Women with High BMI

Title of Study: "Weight Stigma in Perinatal Dietetic Care: Perspectives of Women with High Body Mass Index (BMI) and Dietitians".

Principal Investigator: Lindsey Mazur, University of Manitoba, Department of Community Health Sciences, 750 Bannatyne Avenue, Winnipeg MB, R3E 0W3, Phone: 204-480-1352
Co-Investigator: Dr. Deborah McPhail
Sponsor: Not applicable
Funder: Research Manitoba Studentship Award

You are being asked to participate in a research study involving a one-on-one interview. Please take your time to review this consent form and discuss any questions you may have with the study staff, your friends, or family before you make your decision. This consent form may contain words that you do not understand. Please ask the study staff to explain any words or information that you do not clearly understand.

Purpose of this Study
This research study will look at the experiences of women with high BMI who have seen dietitians regarding body weight concerns while trying to get pregnant, while pregnant and after pregnancy. We also want to understand the experiences of the dietitians who provide care for women with high BMI during these time periods. If we understand the experiences of dietitians and their clients, we can create a better health care experience for clients in the future. This research will be focused on women with high BMI and dietitians in Manitoba, so we hope this research will help women in Manitoba but also across Canada.

Participants Selection
You are being asked to participate in this study because little is known about the experiences of women with a high BMI who have seen dietitians, while trying to get pregnant, while pregnant and after pregnancy.

A total of 20 women with a high BMI will be asked to participate.

Study procedure
- The method of data collection for this study will be individual interviews.
- The Principal Investigator (Lindsey Mazur), will be conducting the interviews.
- You will be asked some questions relating to your experience with seeing a dietitian while you were trying to get pregnant, while pregnant and/or after pregnancy. These questions will help us to better understand how you felt about meeting with a dietitian, whether it was helpful or not, and whether or not you experienced positive/negative feelings about your body/weight.
- The individual interviews will be audio-taped and the audio-tapes will be transcribed by a

professional transcriptionist who will be required to sign confidentiality agreement to ensure your information is stored safely and the transcripts will be reviewed by the Principal Investigator to ensure accurate reporting of the information that you provide.
- The audio-tapes will be stored in locked files before being transcribed. Tapes will be destroyed immediately after transcription.
- The study will involve follow-up at a later date when you will be asked by email to review some of the initial findings from the interviews and provide feedback to ensure your interviews were well interpreted. This feedback will be incorporated into the final research report.
- Once the study is complete, results will be provided to you, at your request.

Time Required for Participation
The interview will take 60-90 minutes. At a later date you will be asked to review the initial findings and provide feedback which will take 60 minutes. The total time required for participation is therefore, 120-150 minutes.

Risks and Discomforts
There are no anticipated physical risks to participants.

There are very few risks. However, you may find talking about your weight or weight stigma to be upsetting or emotional. You do not have to answer any question that makes you feel uncomfortable or that you find too upsetting.

Should you need any additional help or support after the interview, you can call the toll-free Klinic Community Health Centre, 24/7 Crisis Line at 1-888-322-3019.

If, during the interview, you share any intent to harm yourself or others, this will need to be reported to the appropriate support systems.

Benefits
People who participate in research interviews have described feeling empowered to share their stories through the interview process. You may personally experience feelings of relief or empowerment to participate in this research interview. Your participation will also benefit future development of health care guidelines for women with high BMI in the perinatal period as well as future training and support for dietitians and other health care professionals.

Costs
There is no cost to you to attend the individual interview.

Payment for participation
You will receive $20 at the end of the interview for your participation. If you travelled to the interview by city bus, you will be given 2 bus tickets, if needed, once the interview is complete.

Confidentiality
We will do everything possible to keep your personal information confidential. Your name will not be used at all in the study records. A list of names and email addresses of participants will be kept in a secure file so we can send you a summary of the results of the study. If the results of this study are presented in a meeting, or published, nobody will be able to tell that you were in the study. Please note that although you will not be identified as the speaker, your words may be used to highlight a specific point. The collection and access to personal information or health related information will be in compliance with provincial and federal privacy legislations.

Some people or groups may need to check the study records to make sure all the information is correct. All of these people have a professional responsibility to protect your privacy.

These people or groups are:

- The Health Research Ethics Board of the University of Manitoba which is responsible for the protection of people in research and has reviewed this study for ethical acceptability.

All records will be kept in a locked secure area and only those persons identified will have access to these records. If any of your research records need to be copied to the Health Research Ethics Board of the University of Manitoba, your name and all identifying information will be removed. No information revealing any personal information such as your name, address or telephone number will leave the University of Manitoba.

Permission to Quote:
We may wish to quote your words directly in reports and publications resulting from this. With regards to being quoted, please check yes or no for each of the following statements:

Researchers may publish documents that contain quotations by me under the following conditions:		
☐ Yes	☐ No	I agree to be quoted directly (my name is used).
☐ Yes	☐ No	I agree to be quoted directly if my name is not published (I remain anonymous).
☐ Yes	☐ No	I agree to be quoted directly if a made-up name (pseudonym) is used.
☐ Yes	☐ No	I do not want to be quoted at all.

Voluntary Participation/Withdrawal from the Study
Your decision to take part in this study is voluntary. You may refuse to participate or you may withdraw from the study at any time.

Questions
If any questions come up during or after the study contact the principal investigator and the study staff: Lindsey Mazur or Dr. Deborah McPhail at (204) 480-1352.

For questions about your rights as a research participant, you may contact The University of Manitoba, Bannatyne Campus Research Ethics Board Office at (204) 789-3389.

Consent Signatures:

1. I have read all 4 pages of the consent form.
2. I have had a chance to ask questions and have received satisfactory answers to all of my questions.
3. I understand that by signing this consent form I have not waived any of my legal rights as a participant in this study.
4. I understand that my records, which may include identifying information, may be reviewed by the research staff working with the Principal Investigator and the agencies and organizations listed in the Confidentiality section of this document.
5. I understand that I may withdraw from the study at any time and my data may be withdrawn prior to publication.
6. I understand I will be provided with a copy of the consent form for my records.
7. I agree to participate in the study.

Participant signature_____ **Date** _____
(day/month/year)

Participant printed name: _____

Person obtaining consent: Lindsey Mazur, Principal Investigator **Date** _____
(day/month/year)

Person obtaining consent signature: _____

Appendix D

Consent Form: Dietitians

UNIVERSITY OF MANITOBA | Rady Faculty of Health Sciences

Department of Community Health Sciences
Max Rady College of Medicine
Rady Faculty of Health Sciences
S113 - 750 Bannatyne Avenue
University of Manitoba
Winnipeg, MB R3E 0W3
Phone: (204) 789-3473
Fax: (204) 789-3905

RESEARCH PARTICIPANT INFORMATION AND CONSENT FORM
Individual Interview for Dietitians

Title of Study: "Weight Stigma in Perinatal Dietetic Care: Perspectives of Women with High Body Mass Index (BMI) and Dietitians".

Principal Investigator: Lindsey Mazur, University of Manitoba, Department of Community Health Sciences, 750 Bannatyne Avenue, Winnipeg MB, R3E 0W3, Phone: 204-480-1352
Co-Investigator: Dr. Deborah McPhail
Sponsor: Not applicable
Funder: Research Manitoba Studentship Award

You are being asked to participate in a research study involving an individual interview. Please take your time to review this consent form and discuss any questions you may have with the study staff, your friends, or family before you make your decision. This consent form may contain words that you do not understand. Please ask the study staff to explain any words or information that you do not clearly understand.

Purpose of this Study
This research study will look at the experiences of weight stigma for women with high BMI who have seen dietitians regarding body weight concerns while trying to get pregnant, while pregnant and after pregnancy. We also want to understand the experiences of the dietitians who provide care for women with high BMI during these time periods. If we understand the experiences of dietitians and their clients, we can create a better health care experience for clients in the future. This research will be focused on women with high BMI and dietitians in Manitoba so we hope this research will help women in Manitoba but also across Canada.

Participants Selection
You are being asked to participate in this study as little is known about dietitian perspectives and their experiences of working with women with high BMI in the perinatal period.

A total of 10 dietitians will be asked to participate.

Study procedure
- The method of data collection for this study will be one-on-one interviews.
- The Principal Investigator (Lindsey Mazur), will be conducting the interviews.
- You will be asked some questions relating to your experience of providing care for women with high BMI in the perinatal period and using the nutrition/weight guidelines for this period. These questions will help us understand your successes/challenges with working with these women and with the practice guidelines.
- The individual interviews will be audio-taped and the audio-tapes will be transcribed by a professional transcriptionist who will be required to sign confidentiality agreement to ensure your information is stored safely and the transcripts will be reviewed by the

Principal Investigator to ensure accurate reporting of the information that you provide.
- The audio-tapes will be stored in locked files before being transcribed. Tapes will be destroyed immediately after transcription.
- The study will involve follow-up at a later date when you will be asked by email to review some of the initial findings from the interviews and provide feedback to ensure the interviews were well interpreted. This feedback will be incorporated into the final research report.
- Once the study is complete, results will be provided to you, at your request.

Time Required for Participation
The interview will take 60-90 minutes. At a later date you will be asked to review the initial findings and provide feedback which will take 60 minutes. The total time required for participation is therefore, 120-150 minutes.

Risks and Discomforts
There are no anticipated physical risks to participants.

There are very few risks. However, you may find talking about the difficulties of your work to be upsetting or emotional. You do not have to answer any question that makes you feel uncomfortable or that you find too upsetting.

Should you need any additional help or support after the interview, you can call the toll-free Klinic Community Health Centre, 24/7 Crisis Line at 1-888-322-3019.

If, during the interview, you share any intent to harm yourself or others, this will need to be reported to the appropriate support systems.

Benefits
People who participate in research interviews have described feeling empowered to share their stories through the interview process. You may personally experience feelings of relief or empowerment to participate in this research interview. Your participation will also benefit future development of health care guidelines for women with high BMI in the perinatal period as well as future training and support for dietitians and other health care professionals.

Costs
There is no cost to you to attend the individual interview.

Payment for participation
No payment will be given for your participation.

Confidentiality
We will do everything possible to keep your personal information confidential. Your name will not be used at all in the study records. A list of names and email addresses of participants will be kept in a secure file so we can send you a summary of the results of the study. If the results of this study are presented in a meeting, or published, nobody will be able to tell that you were in the study. Please note that although you will not be identified as the speaker, your words may be used to highlight a specific point. The collection and access to personal information or health related information will be in compliance with provincial and federal privacy legislations.

Some people or groups may need to check the study records to make sure all the information is correct. All of these people have a professional responsibility to protect your privacy.

These people or groups are:

- The Health Research Ethics Board of the University of Manitoba which is responsible for the protection of people in research and has reviewed this study for ethical acceptability.

All records will be kept in a locked secure area and only those persons identified will have access to these records. If any of your research records need to be copied to the Health Research Ethics Board of the University of Manitoba, your name and all identifying information will be removed. No information revealing any personal information such as your name, address or telephone number will leave the University of Manitoba.

Permission to Quote:
We may wish to quote your words directly in reports and publications resulting from this. With regards to being quoted, please check yes or no for each of the following statements:

Researchers may publish documents that contain quotations by me under the following conditions:	
☐ Yes ☐ No	I agree to be quoted directly (my name is used).
☐ Yes ☐ No	I agree to be quoted directly if my name is not published (I remain anonymous).
☐ Yes ☐ No	I agree to be quoted directly if a made-up name (pseudonym) is used.
☐ Yes ☐ No	I do not want to be quoted at all.

Voluntary Participation/Withdrawal from the Study
Your decision to take part in this study is voluntary. You may refuse to participate or you may withdraw from the study at any time.

Questions
If any questions come up during or after the study contact the principal investigator and the study staff: Lindsey Mazur or Dr. Deborah McPhail at (204) 480-1352.

For questions about your rights as a research participant, you may contact The University of Manitoba, Bannatyne Campus Research Ethics Board Office at (204) 789-3389.

Consent Signatures:

1. I have read all 4 pages of the consent form.
2. I have had a chance to ask questions and have received satisfactory answers to all of my questions.
3. I understand that by signing this consent form I have not waived any of my legal rights as a participant in this study.
4. I understand that my records, which may include identifying information, may be reviewed by the research staff working with the Principal Investigator and the agencies and organizations listed in the Confidentiality section of this document.
5. I understand that I may withdraw from the study at any time and my data may be withdrawn prior to publication.
6. I understand I will be provided with a copy of the consent form for my records.
7. I agree to participate in the study.

Participant signature_____ **Date** _____
(day/month/year)

Participant printed name: _____

Person obtaining consent: Lindsey Mazur, Principal Investigator **Date** _____
(day/month/year)

Person obtaining consent signature: _____

References

Abraham, C. (2011a). Canadian MDs consider denying fertility treatments to obese women. Retrieved from https://beta.theglobeandmail.com/life/health-and-fitness/canadian-mds-consider-denying-fertility-treatments-to-obese-women/article595016/?ref=http://www.theglobeandmail.com&

Abraham, C. (2011b). A new prime suspect behind the global upsurge in obesity and diabetes: The womb. Retrieved from https://beta.theglobeandmail.com/life/health-and-fitness/health/conditions/a-new-prime-suspect-behind-the-global-upsurge-in-obesity-and-diabetes-the-womb/article597022/?ref=http://www.theglobeandmail.com&page=all

Abrams, B., Altman, S., & Pickett, K. (2000). Pregnancy weight gain: Still controversial. *The American Journal of Clinical Nutrition, 71*(5S), 1233S-1241S.

ADA. (2008). Position of the American Dietetic Association: Nutrition and Lifestyle for a Healthy Pregnancy Outcome. *Journal of the American Dietetic Association, 108*(3), 553-561. doi:https://doi.org/10.1016/j.jada.2008.01.030

Anderson, C. K., Walch, T. J., Lindberg, S. M., Smith, A. M., Lindheim, S. R., & Whigham, L. D. (2015). Excess gestational weight gain in low-income overweight and obese women: A qualitative study. *Journal of Nutrition Education and Behavior, 47*(5), 404-411.e401. doi:10.1016/j.jneb.2015.05.011

Aphramor, L. (2018). Well Now: Radical Dietitian. Retrieved from https://lucyaphramor.com/

Aphramor, L., & Gingras, J. (2011). Reproducing inequalities: Theories and ethics in dietetics. In M. Unnithan-Kumar & S. Tremayne (Eds.), *Fatness and the maternal body: Women's experiences of corporeality and the shaping of social policy* (pp. 205-223). Oxford: Berghahn Books.

ASDAH. (2018). Association for Size Diversity and Health: Health at Every Size® Principles. Retrieved from https://www.sizediversityandhealth.org/content.asp?id=152

Bacon, L., & Aphramor, L. (2011). Weight science: Evaluating the evidence for a paradigm shift (Vol. 10, pp. 69-69).

Bacon, L., Stern, J. S., Van Loan, M. D., & Keim, N. L. (2005). Size acceptance and intuitive eating improve health for obese, female chronic dieters. *Journal of the American Dietetic Association, 105*(6), 929-936. doi:10.1016/j.jada.2005.03.011

Baird, S. L., & Alaggia, R. (2019). Trauma-Informed Groups: Recommendations for Group Work Practice. *Clinical Social Work Journal*. doi:10.1007/s10615-019-00739-7

Barr, S., Yarker, K., Levy-Milne, R., & Chapman, G. (2004). Canadian dietitians views and practices regarding obesity and weight management. *Journal of Human Nutrition and Dietetics, 17*(6), 503-512. doi:10.1111/j.1365-277X.2004.00562.x

Bartky, S. L. (1988). *Foucault, Femininity, and the Modernization of Patriarchal Power*. Boston: Boston: Northeastern UP.

Bell, A. V. (2016). The margins of medicalization: Diversity and context through the case of infertility. *Social Science & Medicine, 156*, 39-46. doi:https://doi.org/10.1016/j.socscimed.2016.03.005

Bell, R., Smith, C., Hale, L., Kira, G., & Tumilty, S. (2017). Understanding obesity in the context of an Indigenous population—A qualitative study. *Obesity Research and Clinical Practice, 11*(5), 558-566. doi:10.1016/j.orcp.2017.04.006

Bessey, M., Brady, J., Lordly, D., & Leighteizer, V. (2020). "This is what you're supposed to do": Weight stigma in dietetics education. *Fat Studies*, 1-13. doi:10.1080/21604851.2020.1859078

Best, D., Avenell, A., & Bhattacharya, S. (2017). How effective are weight-loss interventions for improving fertility in women and men who are overweight or obese? A systematic review and meta-analysis of the evidence. *Human Reproduction Update, 23*(6), 681-705. doi:10.1093/humupd/dmx027

Beyond Nutritionism. (2009). *Dietitians of Canada: Practice*(48), 1-2.

Binns, C., Lee, M., & Low, W. Y. (2016). The long-term public health benefits of breastfeeding. *Asia Pacific Journal of Public Health, 28*(1), 7-14. doi:10.1177/1010539515624964

Bombak, A. (2014). Obesity, health at every size, and public health policy. *American Journal of Public Health, 104*(2), e60. doi:10.2105/AJPH.2013.301486

Bombak, A. E., McPhail, D., & Ward, P. (2016). Reproducing stigma: Interpreting "overweight" and "obese" women's experiences of weight-based discrimination in reproductive healthcare. *Social science & medicine., 166*, 94-101. doi:10.1016/j.socscimed.2016.08.015

Bombak, A. E., Meadows, A., & Billette, J. (2019). Fat acceptance 101: Midwestern American women's perspective on cultural body acceptance. *Health Sociology Review, 28*(2), 194-208. doi:10.1080/14461242.2019.1604150

Bombak, A. E., & Monaghan, L. F. (2017). Obesity, bodily change and health identities: A qualitative study of Canadian women. *Sociology of Health & Illness, 39*(6), 923-940. doi:https://doi.org/10.1111/1467-9566.12537

Bovend'Eerdt, T. J. H., Botell, R. E., & Wade, D. T. (2009). Writing SMART rehabilitation goals and achieving goal attainment scaling: a practical guide. *Clinical Rehabilitation, 23*(4), 352-361. doi:10.1177/0269215508101741

Brady, J. (January 10, 2021). Jennifer Brady and Lindsey Mazur. [Personal communication].

Brady, J., Aphramor, L., & Gingras, J. (2013). Relating food and bodies to health at every size (HAES) in midwifery *Nutrition in Pregnancy and Child Birth* (pp. 169-182).

Brady, J., Gingras, J., & Aphramor, L. (2013). Theorizing health at every size as a relational–cultural endeavour. *Critical Public Health, 23*(3), 345-355. doi:10.1080/09581596.2013.797565

Britten, N. (1995). Qualitative interviews in medical research. *BMJ (Clinical research ed.), 311*(6999), 251.

Brown, J., & Mazur, L. (2019). Weight/obesity: Weight stigma background. Practice-based Evidence in Nutrition: The global resource for nutrition practice from Dietitians of Canada https://www.pennutrition.com/KnowledgePathway.aspx?kpid=803&trcatid=38&trid=28010

Brown, L., & Strega, S. (2015). *Research As Resistance, Second Edition: Revisiting Critical, Indigenous, and Anti-Oppressive Approaches*. Toronto, CANADA: Canadian Scholars.

Brown, R. E., & Kuk, J. L. (2015). Consequences of obesity and weight loss: A devil's advocate position (Vol. 16, pp. 77-87).

Brown-Bowers, A., Ward, A., & Cormier, N. (2016). Treating the binge or the (fat) body? Representations of fatness in a gold standard psychological treatment manual for binge eating disorder. *Health, 21*(1), 21-37. doi:10.1177/1363459316674788

Browne, A. J., Varcoe, C., Lavoie, J., Smye, V., Wong, S. T., Krause, M., & Fridkin, A. (2016). Enhancing health care equity with Indigenous populations: Evidence-based strategies

from an ethnographic study. *BMC Health Services Research, 16*(1), 544. doi:10.1186/s12913-016-1707-9

Bruner, B. G., & Chad, K. E. (2014). Dietary practices and influences on diet intake among women in a Woodland Cree community. *Journal of Human Nutrition and Dietetics, 27*(SUPPL2), 220-229. doi:10.1111/jhn.12121

Butler, J. (1993). *Bodies that matter: On the discursive limits of "sex."* New York: Routledge

Butte, N. F., Ellis, K. J., Wong, W. W., Hopkinson, J. M., & O'Brian Smith, E. (2003). Composition of gestational weight gain impacts maternal fat retention and infant birth weight. *American Journal of Obstetrics and Gynecology, 189*(5), 1423-1432. doi:10.1067/S0002-9378(03)00596-9

Campbell, K., & Crawford, D. (2000). Management of obesity: Attitudes and practices of Australian dietitians. *International Journal of Obesity, 24*(6), 701. doi:10.1038/sj.ijo.0801226

Carter-Edwards, L., Bastian, L. A., Revels, J., Durham, H., Lokhnygina, Y., Amamoo, M. A., & Ostbye, T. (2010). Body image and body satisfaction differ by race in overweight postpartum mothers. *Journal of women's health (2002), 19*(2), 305-311. doi:10.1089/jwh.2008.1238

Caulfield, T. (2016). *Is Gwyneth Paltrow Wrong about Everything?: When Celebrity Culture and Science Clash*: Penguin Canada Books Incorporated.

CBC. (2016). 'This is a human rights issue': Local dietitian creates campaign against weight stigma. Retrieved from http://www.cbc.ca/news/canada/manitoba/manitoba-weight-discrimination-1.3855774

Cena, H., Chiovato, L., & Nappi, R. E. (2020). Obesity, Polycystic Ovary Syndrome, and Infertility: A New Avenue for GLP-1 Receptor Agonists. *The Journal of clinical endocrinology and metabolism, 105*(8), e2695-e2709. doi:10.1210/clinem/dgaa285

Change.org. (2019). Make Size, Appearance and Weight Discrimination Illegal in Canada. Retrieved from https://www.change.org/m/make-size-appearance-based-discrimination-illegal

Chapman, G. E., Sellaeg, K., Levy-Milne, R., Ottem, A., Barr, S. I., Fierini, D., & Thiele, K. (2005). Canadian dietitians' approaches to counseling adult clients seeking weight-

management advice. *Journal of the American Dietetic Association, 105*(8), 1275-1279. doi:10.1016/j.jada.2005.05.004

Chrisler, J. C., & Barney, A. (2017). Sizeism is a health hazard. *Fat Studies, 6*(1), 38-53. doi:10.1080/21604851.2016.1213066

Clark, S., & Bungum, T. (2003). The benefits of breastfeeding: An introduction for health educators. *Californian Journal of Health Promotion, 1*, 158-163. doi:10.32398/cjhp.v1i3.527

Clifford, D., Ozier, A., Bundros, J., Moore, J., Kreiser, A., & Morris, M. N. (2015). Impact of non-diet approaches on attitudes, behaviors, and health outcomes: A systematic review. *Journal of Nutrition Education and Behavior, 47*(2), 143-155.e141. doi:10.1016/j.jneb.2014.12.002

Cook, K., LaMarre, A., Rice, C., & Friedman, M. (2019). "This isn't a high-risk body": Reframing risk and reducing weight wtigma in midwifery practice. *Canadian Journal of Midwifery Research and Practice, 18*(1).

Cooper, C. (2016). *Fat activism: A radical social movement.* HammerOn Press.

Crawford, R. (1980). Healthism and the medicalization of everyday life. *International Journal of Health Services., 10*(3), 365-388.

Davies, G. A. L., Maxwell, C., McLeod, L., Gagnon, R., Basso, M., Bos, H., & Wilson, K. (2010). SOGC Clinical Practice Guidelines: Obesity in pregnancy. No. 239, February 2010. *International journal of gynaecology and obstetrics: The official organizatoin of the International Federation of Gynaecology and Obstetrics, 110*(2), 167.

Devault, M. (2004). Talking and listening from women's standpoint: Feminist strategies for interviewing and analysis. In B. SharleneNagyHesse & M. L. Yaiser (Eds.), *Feminist perspectives on social research* (pp. pp. 227-250). New York: Oxford University Press.

Devine, C. M., Bove, C. F., & Olson, C. M. (2000). Continuity and change in women's weight orientations and lifestyle practices through pregnancy and the postpartum period: The influence of life course trajectories and transitional events. *Social Science and Medicine, 50*(4), 567-582. doi:10.1016/S0277-9536(99)00314-7

Dieterich, C. M., Felice, J. P., O'Sullivan, E., & Rasmussen, K. M. (2013). Breastfeeding and health outcomes for the mother-infant dyad. *Pediatric clinics of North America, 60*(1), 31-48. doi:10.1016/j.pcl.2012.09.010

Diversi, T. M., Hughes, R., & Burke, K. J. (2016). The prevalence and practice impact of weight bias amongst Australian dietitians. *Obesity Science & Practice, 2*(4), 456-465. doi:10.1002/osp4.83

Dodgson, J. E., & Struthers, R. (2005). Indigenous women's voices: Marginalization and health. *Journal Transcultural Nursing, 16*(4), 339-346. doi:10.1177/1043659605278942

Drummond, D., & Hare, M. (2012). Dietitians and eating eisorders: An international issue. *Canadian Journal of Dietetic Practice and Research, 73*(2), 86-90. doi:10.3148/73.2.2012.86

Duncan, M. C., & Klos, L. A. (2014). Paradoxes of the Flesh. *Journal of Sport & Social Issues, 38*(3), 245-262. doi:10.1177/0193723512467190

Duthie, E. A., Drew, E. M., & Flynn, K. E. (2013). Patient-provider communication about gestational weight gain among nulliparous women: A qualitative study of the views of obstetricians and first-time pregnant women. *BMC Pregnancy and Childbirth, 13*. doi:10.1186/1471-2393-13-231

Eli, K., & Lavis, A. (2016). Becoming fit to be a mother: Class, learning, and redemption in Supersize vs. Superskinny. *Journal of Gender Studies*, 1-12. doi:10.1080/09589236.2016.1178630

Ellison, J., McPhail, D., & Mitchinson, W. (2016). *Obesity in Canada: Critical perspectives/ edited by Jenny Ellison, Deborah McPhail, and Wendy Mitchinson*: Toronto, Ontario; Buffalo, New York; London, Engalnd: University of Toronto Press.

Endevelt, R., & Gesser-Edelsburg, A. (2014). A qualitative study of adherence to nutritional treatment: Perspectives of patients and dietitians. *Patient preference and adherence, 8*, 147-154. doi:10.2147/PPA.S54799

Ernsberger, P. (2012). BMI, body build, body fatness, and health risks. *Fat Studies, 1*(1), 6-12. doi:10.1080/21604851.2012.627788

Faria-Schützer, D. B., Surita, F. G. D. C., Alves, V. L. P., Vieira, C. M., & Turato, E. R. (2015). Emotional experiences of obese women with adequate gestational weight variation: A qualitative study. *PLOS ONE, 10*(11). doi:10.1371/journal.pone.0141879

Flegal, K. M., Ioannidis, J. P. A., & Doehner, W. (2019). Flawed methods and inappropriate conclusions for health policy on overweight and obesity: The Global BMI Mortality

Collaboration meta-analysis. *Journal of cachexia, sarcopenia and muscle, 10*(1), 9-13. doi:10.1002/jcsm.12378

Flores, T. R., Mielke, G. I., Wendt, A., Nunes, B. P., & Bertoldi, A. D. (2018). Prepregnancy weight excess and cessation of exclusive breastfeeding: A systematic review and meta-analysis. *European Journal of Clinical Nutrition, 72*(4), 480-488. doi:10.1038/s41430-017-0073-y

Forhan, M., Risdon, C., & Solomon, P. (2013). Contributors to patient engagement in primary health care: Perceptions of patients with obesity. *Primary Health Care Research & Development, 14*(4), 367-372. doi:10.1017/S1463423612000643

Friedman, M., Rice, C., & Lind, E. (2020). A high-risk body for whom? On fat, risk, recognition and reclamation in restorying reproductive care through digital storytelling. *Feminist Encounters: A Journal of Critical Studies in Culture and Politics, 4*(2), 12.

Fruh, S. M., Nadglowski, J., Hall, H. R., Davis, S. L., Crook, E. D., & Zlomke, K. (2016). Obesity stigma and bias. *The journal for nurse practitioners: JNP, 12*(7), 425-432. doi:10.1016/j.nurpra.2016.05.013

Furness, P. J., McSeveny, K., Arden, M. A., Garland, C., Dearden, A. M., & Soltani, H. (2011). Maternal obesity support services: A qualitative study of the perspectives of women and midwives. *BMC Pregnancy and Childbirth, 11*, 69-69. doi:10.1186/1471-2393-11-69

Gambineri, A., Laudisio, D., Marocco, C., Radellini, S., Colao, A., & Savastano, S. (2019). Female infertility: Which role for obesity? *International journal of obesity supplements, 9*(1), 65-72. doi:10.1038/s41367-019-0009-1

Gard, M. (2005). *The obesity epidemic science, morality, and ideology*. London.

Ghaedrahmati, M., Kazemi, A., Kheirabadi, G., Ebrahimi, A., & Bahrami, M. (2017). Postpartum depression risk factors: A narrative review. *Journal of education and health promotion, 6*, 60-60. doi:10.4103/jehp.jehp_9_16

Gingras, J. (2009). *Longing for Recognition: The Joys, Complexities, and Contradictions of Practicing Dietetics*. York: Raw Nerve Books.

Gingras, J., Asada, Y., Brady, J., & Aphramor, L. (2017). Critical Dietetics: Challenging the profession from within. In M. Koc, J. Sumner, & A. Winson (Eds.), *Critical Perspectives in Food Studies* (Second ed., pp. 95-107): Oxford University Press.

Gingras, J., De Jonge, L. A., & Purdy, N. (2010). Prevalence of dietitian burnout. *Journal of Human Nutrition and Dietetics, 23*(3), 238-243. doi:10.1111/j.1365-277X.2010.01062.x

Giroux, I., Lander, S., Charlesworth, S., & Mottola, M. F. (2009). Weight history of overweight pregnant women. *Canadian Journal of Dietetic Practice and Research, 70*(3), 127-134. doi:10.3148/70.3.2009.127

Gregory, E. F., Goldshore, M. A., Henderson, J. L., Weatherford, R. D., & Showell, N. N. (2016). Infant growth following maternal participation in a gestational weight management intervention. *Childhood Obesity, 12*(3), 219-225. doi:10.1089/chi.2015.0238

Grohmann, B., Brazeau-Gravelle, P., Momoli, F., Moreau, K., Zhang, T., & J Keely, E. (2012). Obstetric healthcare providers' perceptions of communicating gestational weight gain recommendations to overweight/obese pregnant women. *Obstetric Medicine, 5*(4), 161-165. doi:10.1258/om.2012.120003

Grosz, E. A. (1994). *Volatile bodies: Toward a corporeal feminism*. Bloomington: Indiana University Press.

Guthman, J. (2013). Fatuous measures: The artifactual construction of the obesity epidemic. *Critical Public Health*, 1-11. doi:10.1080/09581596.2013.766670

Hamad, R., Cohen, A. K., & Rehkopf, D. H. (2016). Changing national guidelines is not enough: The impact of 1990 IOM recommendations on gestational weight gain among US women. *International Journal of Obesity, 40*(10), 1529-1534. doi:10.1038/ijo.2016.97

Hashemi-Nazari, S.-S., Hasani, J., Izadi, N., Najafi, F., Rahmani, J., Naseri, P., & Clark, C. (2020). The effect of pre-pregnancy body mass index on breastfeeding initiation, intention and duration: A systematic review and dose-response meta-analysis. *Heliyon, 6*(12), e05622-e05622. doi:10.1016/j.heliyon.2020.e05622

Health Canada. (2011). *Prenatal nutrition guidelines for health professionals gestational weight gain*. Ottawa: Health Canada.

Herndon, A. M. (2014). *Fat blame: How the war on obesity victimizes women and children*. University Press of Kansas.

Herring, S. J., Rich-Edwards, J. W., Oken, E., Rifas-Shiman, S. L., Kleinman, K. P., & Gillman, M. W. (2008). Association of postpartum depression with weight retention 1 year after childbirth. *Obesity, 16*(6), 1296-1301. doi:10.1038/oby.2008.71

Heslehurst, N., Dinsdale, S., Brandon, H., Johnston, C., Summerbell, C., & Rankin, J. (2017). Lived experiences of routine antenatal dietetic services among women with obesity: A qualitative phenomenological study. *Midwifery, 49*, 47-53. doi:10.1016/j.midw.2016.11.001

Hesse-Biber, S. N. (2017). *The practice of qualitative research*. Thousand Oaks: SAGE Publications.

Hodges, N. (2015). Weighing Ourselves Down: Scale Stories. *Departures in Critical Qualitative Research, 4*(3), 51-69. doi:10.1525/dcqr.2015.4.3.51

Holder, J. (2015). Our Community Action Research Project: A Blueprint for Resistance. In L. Brown & S. Strega (Eds.), *Research As Resistance, Second Edition: Revisiting Critical, Indigenous, and Anti-Oppressive Approaches*. Toronto: Canadian Scholars' Press.

Hopkins, P. (2012). Everyday politics of fat. *Antipode, 44*(4), 1227-1246. doi:10.1111/j.1467-8330.2011.00962.x

Humphrey, L., Clifford, D., & Neyman Morris, M. (2015). Health at every size college course reduces dieting behaviors and improves intuitive eating, body esteem, and anti-fat attitudes. *Journal of Nutrition Education Behaviour, 47*(4), 354-360.e351. doi:10.1016/j.jneb.2015.01.008

Incollingo Rodriguez, A. C., Dunkel Schetter, C., Brewis, A., & Tomiyama, A. J. (2019). The psychological burden of baby weight: Pregnancy, weight stigma, and maternal health. *Social Science & Medicine, 235*, 112401. doi:https://doi.org/10.1016/j.socscimed.2019.112401

Ingraham, N., & Boero, N. (2020). Thick Bodies, Thick Skins: Reflections on Two Decades of Sociology in Fat Studies. *Fat Studies, 9*(2), 114-125. doi:10.1080/21604851.2019.1629262

Jette, S., & Rail, G. (2013). Ills from the womb? A critical examination of clinical guidelines for obesity in pregnancy. *Health, 17*(4), 407-421. doi:10.1177/1363459312460702

Jung, F. U. C. E., Luck-Sikorski, C., Wiemers, N., & Riedel-Heller, S. G. (2015). Dietitians and nutritionists: Stigma in the context of obesity. A systematic review. *PLOS ONE, 10*(10), e0140276. doi:10.1371/journal.pone.0140276

Kapadia, M. Z., Park, C. K., Beyene, J., Giglia, L., Maxwell, C., & McDonald, S. D. (2015). Can we safely recommend gestational weight gain below the 2009 guidelines in obese

women? A systematic review and meta-analysis. *Obesity Review, 16*(3), 189-206. doi:10.1111/obr.12238

Kapadia, M. Z., Park, C. K., Beyene, J., Giglia, L., Maxwell, C., & McDonald, S. D. (2015). Weight loss instead of weight gain within the guidelines in obese women during pregnancy: A systematic review and meta-analyses of maternal and infant outcomes. *PLOS ONE, 10*(7), e0132650-e0132650. doi:10.1371/journal.pone.0132650

Katzmarzyk, P. (2002). The Canadian obesity epidemic, 1985-1998. *Canadian Medical Association. Journal, 166*(8), 1039-1040.

Kirk, S. F., Cramm, C. L., Price, S. L., Penney, T. L., Jarvie, L., & Power, H. (2009). BMI: a vital sign for patients and health professionals. *Canadian Nurse, 105*(1), 25-28.

Knight-Agarwal, C. R., Kaur, M., Williams, L. T., Davey, R., & Davis, D. (2014). The views and attitudes of health professionals providing antenatal care to women with a high BMI: A qualitative research study. *Women and Birth, 27*(2), 138-144. doi:10.1016/j.wombi.2013.11.002

Kolahdooz, F., Sadeghirad, B., Corriveau, A., & Sharma, S. (2017). Prevalence of overweight and obesity among indigenous populations in Canada: A systematic review and meta-analysis. *Critical Reviews in Food Science and Nutrition, 57*(7), 1316-1327. doi:10.1080/10408398.2014.913003

Kong, K. L., Campbell, C., Wagner, K., Peterson, A., & Lanningham-Foster, L. (2014). Impact of a walking intervention during pregnancy on post-partum weight retention and infant anthropometric outcomes. *Journal of Developmental Origins of Health and Disease, 5*(3), 259-267. doi:10.1017/S2040174414000117

Krause, K. M., Lovelady, C. A., & Østbye, T. (2011). Predictors of breastfeeding in overweight and obese women: Data from Active Mothers Postpartum (AMP). *Maternal and Child Health Journal, 15*(3), 367-375. doi:10.1007/s10995-010-0667-7

Kuhnt, J., & Vollmer, S. (2017). Antenatal care services and its implications for vital and health outcomes of children: Evidence from 193 surveys in 69 low-income and middle-income countries. *BMJ Open, 7*(11), e017122. doi:10.1136/bmjopen-2017-017122

Kurtz, D. L. M., Nyberg, J. C., Van Den Tillaart, S., Mills, B., & Res, T. O. U. A. H. (2013). Silencing of Voice: An Act of Structural Violence - Urban Aboriginal Women Speak Out

About Their Experiences with Health Care. *International Journal of Indigenous Health, 4*(1). doi:10.18357/ijih41200812315

LaMarre, A., Rice, C., Cook, K., & Friedman, M. (2020). Fat reproductive justice: Navigating the boundaries of reproductive health care. *Journal of Social Issues, 76*(2), 338-362. doi:https://doi.org/10.1111/josi.12371

Lang, A. Y., Harrison, C. L., & Boyle, J. A. (2019). Preconception lifestyle and weight-related behaviors by maternal Body Mass Index: A cross-sectional study of pregnant women. *Nutrients, 11*(4), 759. doi:10.3390/nu11040759

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry / Yvonna S. Lincoln, Egon G. Guba*. Beverly Hills, Calif.

Lupton, D. (2013). *Fat*. Abingdon, Oxon

Lydecker, J. A., Galbraith, K., Ivezaj, V., White, M. A., Barnes, R. D., Roberto, C. A., & Grilo, C. M. (2016). Words will never hurt me? Preferred terms for describing obesity and binge eating. *International Journal of Clinical Practice, 70*(8), 682-690. doi:10.1111/ijcp.12835

Macdonald-Wicks, L. K., Gallagher, L. M., Snodgrass, S. J., Guest, M., Kable, A., James, C., & Collins, C. E. (2015). Difference in perceived knowledge, confidence and attitudes between dietitians and other health professionals in the provision of weight management advice. *Nutrition and Dietetics, 72*(2), 114-121. doi:10.1111/1747-0080.12115

Mann, T., Tomiyama, A., Westling, E., Lew, A.-M., Samuels, B., & Chatman, J. (2007). Medicare's search for effective obesity treatments: Diets are not the answer. *American psychologist, 62*(3), 220-233. doi:10.1037/0003-066X.62.3.220

Marchessault, G., Thiele, K., Armit, E., & Chapman, G. (2007). Canadian Dietitians' Understanding of Non-Dieting Approaches in Weight Management. *Canadian Journal of Dietetic Practice and Research, 68*(2), 67-72.

Martin, M. A., & Lippert, A. M. (2012). Feeding her children, but risking her health: The intersection of gender, household food insecurity and obesity. *Social Science and Medicine, 74*(11), 1754-1764. doi:10.1016/j.socscimed.2011.11.013

Martin, N. (November 23, 2016). Rally calls for end to 'shaming and blaming' people for weight. *Winnipeg Free Press*. Retrieved from

http://www.winnipegfreepress.com/local/rally-calls-for-end-to-shaming-and-blaming-people-for-weight-402736406.html

MBGov. (2018). Legistlative Assembly of Manitoba: Hansard. Retrieved from https://www.gov.mb.ca/legislature/hansard/hansard.html

McNaughton, D. (2011). From the womb to the tomb: Obesity and maternal responsibility. *Critical Public Health, 21*(2), 179-190. doi:10.1080/09581596.2010.523680

McPhail, D. (2016). Indigenous people's clinical encounters with obesity: A conversation with Barry Lavallee. In J. Ellison, D. McPhail, & W. Mitchinson (Eds.), *Obesity in Canada: Critical perspectives* (pp. 175-186). Toronto: University of Toronto Press..

McPhail, D., & Bombak, A. (2014). Fat, queer and sick? A critical analysis of 'lesbian obesity' in public health discourse. *Critical Public Health*, 1-15. doi:10.1080/09581596.2014.992391

McPhail, D., Bombak, A., Ward, P., & Allison, J. (2016). Wombs at risk, wombs as risk: Fat women's experiences of reproductive care. *Fat Studies, 5*(2), 98-115. doi:10.1080/21604851.2016.1143754

McPhail, D., Brady, J., & Gingras, J. (2017). Exposed social flesh: Toward an embodied fat pedagogy. *Fat Studies, 6*(1), 17-37. doi:10.1080/21604851.2016.1142813

McPhail, D., & Huynh, A. (2015). Geographies of maternal obesity, eugenics, and the clinical space. In B. Evans, J. Horton, & T. Skelton (Eds.), *Geographies of children and affect* (pp. 1-23.). London: Springer.

McPhail, D., & Mazur, L. (2019). Medicalization, maternity, and the materiality of resistance: "Maternal obesity" and experiences of reproductive care. In M. Friedman, C. Rice, & J. Rinaldi (Eds.), *Thickening fat: Fat bodies, intersectionality, and social justice* (pp. 122-136). New York, NY: Routledge.

McPhail, D., & Mazur, L. (in press). Discouraging fatness: Exploring eugenics in maternal obesity.

Monahan, C., Goldman, T., & Oswald, D. (2014). Establishing a physical impairment of weight under the ADA/ADAAA: Problems of bias in the Legal System*. *ABA Journal of Labor & Employment Law, 29*(3), 537-562.

Montgomery, K. S., Best, M., Aniello, T. B., Phillips, J. D., & Hatmaker-Flanigan, E. (2013). Postpartum weight loss: Weight struggles, eating, exercise, and breast-feeding. *Journal of Holistic Nursing, 31*(2), 129-138. doi:10.1177/0898010112464120

Mulherin, K., Miller, Y. D., Barlow, F. K., Diedrichs, P. C., & Thompson, R. (2013). Weight stigma in maternity care: Women's experiences and care providers' attitudes. *BMC Pregnancy and Childbirth, 13*. doi:10.1186/1471-2393-13-19

Murphree, D. (1994). Patient attitudes toward physician treatment of obesity. *Journal of Family Practice, 38*(1), 45.

Mustila, T., Raitanen, J., Keskinen, P., Saari, A., & Luoto, R. (2013). Pragmatic controlled trial to prevent childhood obesity in maternity and child health care clinics: Pregnancy and infant weight outcomes (The VACOPP Study). *BMC Pediatrics, 13*(1). doi:10.1186/1471-2431-13-80

Mysko, C. A., Magali. (2009). *Does this pregnancy make me look fat? The essential guide to loving your body before and after baby*. Florida: Health Communications, Inc.

Nascimento, S. L., Pudwell, J., Surita, F. G., Adamo, K. B., & Smith, G. N. (2014). The effect of physical exercise strategies on weight loss in postpartum women: A systematic review and meta-analysis. *International Journal of Obesity, 38*(5), 626-635. doi:10.1038/ijo.2013.183

National Post, The. (October 7, 2016). Manitoba Liberal wants human rights code to forbid discriminating against obese people. Retrieved from https://nationalpost.com/news/politics/manitoba-liberal-wants-the-provinces-human-rights-code-to-forbid-discriminating-obese-people

Nuttall, F. Q. (2015). Body Mass Index: Obesity, BMI, and Health - A Critical Review. *Nutrition today, 50*(3), 117-128. doi:10.1097/NT.0000000000000092

Nutter, S., Alberga, A. S., MacInnis, C., Ellard, J. H., & Russell-Mayhew, S. (2018). Framing obesity a disease: Indirect effects of affect and controllability beliefs on weight bias. *International Journal of Obesity , 42*(10), 1804-1811. doi:10.1038/s41366-018-0110-5

Nutter, S., Ireland, A., Alberga, A. S., Brun, I., Lefebvre, D., Hayden, K. A., & Russell-Mayhew, S. (2019). Weight bias in educational eettings: A systematic review. *Current Obesity Reports, 8*(2), 185-200. doi:10.1007/s13679-019-00330-8

O'Reilly, C., & Sixsmith, J. (2012). From theory to policy: Reducing harms associated with the weight-centered health paradigm. *Fat Studies, 1*(1), 97-113. doi:10.1080/21604851.2012.627792

Obesity and reproduction: A committee opinion. (2015). *Fertility and Sterility, 104*(5), 1116-1126. doi:https://doi.org/10.1016/j.fertnstert.2015.08.018

Obesity Canada. (2021). Retrieved from https://obesitycanada.ca/.

Orsini, M., & McPhail, D. (2020). Ending fatphobia isn't enough - we need to stop pathologizing obesity. Retrieved from https://www.theglobeandmail.com/opinion/article-ending-fatphobia-isnt-enough-we-need-to-stop-pathologizing-obesity/

Paine, E. A. (2021). "Fat broken arm syndrome": Negotiating risk, stigma, and weight bias in LGBTQ healthcare. *Social Science & Medicine, 270*, 113609. doi:https://doi.org/10.1016/j.socscimed.2020.113609

Pan, S.-D., Zhu, L.-L., Chen, M., Xia, P., & Zhou, Q. (2016). Weight-based dosing in medication use: what should we know? *Patient preference and adherence, 10*, 549-560. doi:10.2147/PPA.S103156

Panth, N., Gavarkovs, A., Tamez, M., & Mattei, J. (2018). The influence of diet on fertility and the implications for public health nutrition in the United States. *Frontiers in public health, 6*, 211-211. doi:10.3389/fpubh.2018.00211

Parker, G. (2020). *Doctoral thesis reflection: On the complexities of doctoral research and having babies.* (Doctoral), Univerity of Auckland, Auckland, New Zealand. Retrieved from https://www.amat.org.nz/Doctoral%20thesis%20reflection%20G%20Parker.pdf

Parker, G., Pausé, C., & Le Grice, J. (2019). "You're just another friggin' number to add to the problem": Constructing the Racialized (m)other in contemporary discourses of pregnancy fatness. In M. Friedman, C. Rice, & J. Rinaldi (Eds.), *Thickening fat: Fat bodies, intersectionality and social justice* (pp. 97-109). New York, NY: Routledge

Parker, H. W., Tovar, A., McCurdy, K., & Vadiveloo, M. (2019). Associations between pre-pregnancy BMI, gestational weight gain, and prenatal diet quality in a national sample. *PLOS ONE, 14*(10), e0224034. doi:10.1371/journal.pone.0224034

Patel, N., Pasupathy, D., & Poston, L. (2015). Determining the consequences of maternal obesity for offspring health. *Experimental Physiology, 100*(12), 1421-1428. doi:10.1113/EP085132

Pausé, C. (2014). Die another day: The obstacles facing fat people in accessing quality healthcare. *Narrative Inquiry in Bioethics, 4*(2), 135-141. doi:10.1353/nib.2014.0039

Penney, T. L., & Kirk, S. F. L. (2015). The health at every size paradigm and obesity: Missing empirical evidence may help push the reframing obesity debate forward. (Report). *105*(5), e38. doi:10.2105/AJPH.2015.302552

Pomeranz, J., & Puhl, R. (2013). New developments in the law for obesity discrimination Protection. *Obesity, 21*(3), 469-471. doi:10.1002/oby.20094

Poston, L., & Patel, N. (2014). Dietary recommendations for obese pregnant women: Current questions and controversies. *Acta Obstetricia et Gynecologica Scandinavica, 93*(11), 1081-1084. doi:10.1111/aogs.12507

Procter, S. B., & Campbell, C. G. (2014). Position of the Academy of Nutrition and Dietetics: Nutrition and Lifestyle for a Healthy Pregnancy Outcome. *Journal of the Academy of Nutrition and Dietetics, 114*(7). doi:10.1016/j.jand.2014.05.005

Public Health Agency of Canada - PHAC (2013). Canadian Prenatal Nutrition Program. Retrieved from https://www.canada.ca/en/public-health/services/health-promotion/childhood-adolescence/programs-initiatives/canada-prenatal-nutrition-program-cpnp.html.

Puhl, R., & Heuer, C. (2010). Obesity stigma: Important considerations for public health. *American Journal of Public Health, 100*(6), 1019-1028.

Puhl, R., & Heuer, C. (2011). Public opinion about laws to prohibit weight discrimination in the United States. *Obesity, 19*(1), 74-82. doi:10.1038/oby.2010.126

Puhl, R., & Suh, Y. (2015). Health consequences of weight stigma: Implications for obesity prevention and treatment. *Curr Obes Rep, 4*(2), 182-190. doi:10.1007/s13679-015-0153-z

Puhl, R., Wharton, C., & Heuer, C. (2009). Weight bias among dietetics students: Implications for treatment practices. *Journal of the American Dietetic Association, 109*(3), 438-444. doi:10.1016/j.jada.2008.11.034

Puhl, R. M., & Heuer, C. A. (2009). The stigma of obesity: A review and update (Vol. 17, pp. 941-964). Oxford, UK.

Puhl, R. M., Latner, J. D., Brien, K. S., Luedicke, J., Danielsdottir, S., & Salas, X. R. (2015). Potential policies and laws to prohibit weight discrimination: Public views from 4 countries. *Milbank Quarterly, 93*(4), 691-731. doi:10.1111/1468-0009.12162

Ravitch, S. M., & Carl, N. M. (2016). *Qualitative research: Bridging the conceptual, theoretical, and methodological / Sharon M. Ravitch, Nicole Mittenfelner Carl*. Thousand Oaks, California: SAGE Publications.

Rebolj, A. B. (2013). The case study as a type of qualitative research. *Journal of Contemporary Educational Studies*, 28–43.

Redsell, S. A., Edmonds, B., Swift, J. A., Siriwardena, A. N., Weng, S., Nathan, D., & Glazebrook, C. (2016). Systematic review of randomised controlled trials of interventions that aim to reduce the risk, either directly or indirectly, of overweight and obesity in infancy and early childhood. *Maternal and Child Nutrition, 12*(1), 24-38. doi:10.1111/mcn.12184

Rice, C. (2007). Becoming "the fat girl": Acquisition of an unfit identity. *Women's Studies International Forum, 30*(2), 158-174. doi:10.1016/j.wsif.2007.01.001

Rice, C. (2014). *Becoming Women - The Embodied Self in Image Culture*: Toronto; Buffalo; London: University of Toronto Press.

Rice, C., Jiménez, K. P., Harrison, E., Robinson, M., Rinaldi, J., LaMarre, A., & Andrew, J. (2020). Bodies at the Intersections: Refiguring Intersectionality through Queer Women's Complex Embodiments. *Signs: Journal of Women in Culture and Society, 46*(1), 177-200. doi:10.1086/709219

Rinaldi, J., Rice, C., Lamarre, A., Pendleton Jiménez, K., Harrison, E., Friedman, M., & Tidgwell, T. (2016). Through Thick and Thin: Storying queer women's experiences of idealized body images and expected body management practices. *Psychology of Sexualities Review, 7*, 63-77.

Ristovski-Slijepcevic, S., Chapman, G. E., & Beagan, B. L. (2008). Engaging with healthy eating discourse(s): Ways of knowing about food and health in three ethnocultural groups in Canada. *Appetite, 50*(1), 167-178. doi:https://doi.org/10.1016/j.appet.2007.07.001

Roberts, C., & Barnard, R. (2005). Effects of exercise and diet on chronic disease. *Joural of Applied Physiology* (Vol. 98, pp. 3-30).

Robinson, M. (2019). The Big Colonial Bones of Indigenous North America's "Obesity Epidemic". In M. Friedman, C. Rice, & J. Rinaldi (Eds.), *Thickening Fat: Fat Bodies, Intersectionality, and Social Justice*. New York, NY: Routledge.

Rudd Center. (2018). *Preventing weight bias: Helping without harming in clinical practice*. Retrieved from Hartford, CT: http://biastoolkit.uconnruddcenter.org/

Saguy, A. C. (2013). *Problem Frames*: Oxford University Press.

Sam, S. (2007). Obesity and polycystic ovary syndrome. *Obesity management, 3*(2), 69-73. doi:10.1089/obe.2007.0019

Schaefer, J. T., & Magnuson, A. B. (2014). A review of interventions that promote eating by internal cues. *Journal of the Academy of Nutrition and Dietetics, 114*(5), 734-760. doi:10.1016/j.jand.2013.12.024

Schoenfielder, L., & Wieser, B. (1995). *Shadow on a Tightrope: Writings by Women on Fat Oppression*. Iowa City, Iowa: Aunt Lute Books.

Starling, A. P., Brinton, J. T., Glueck, D. H., Shapiro, A. L., Harrod, C. S., Lynch, A. M.,... Dabelea, D. (2015). Associations of maternal BMI and gestational weight gain with neonatal adiposity in the Healthy Start study. *American Journal of Clinical Nutrition, 101*(2), 302-309. doi:10.3945/ajcn.114.094946

Stone, O., & Werner, P. (2012). Israeli dietitians' professional stigma attached to obese patients. *Qualitative Health Research, 22*(6), 768-776. doi:10.1177/1049732311431942

Straus, S., Tetroe, J., & Graham, I. (2009). Defining knowledge translation. *Canadian Medical Association. Journal, 181*(3/4), 165-168.

Streuling, I., Beyerlein, A., & Von Kries, R. (2010). Can gestational weight gain be modified by increasing physical activity and diet counseling? A meta-analysis of interventional trials. *American Journal of Clinical Nutrition, 92*(4), 678-687. doi:10.3945/ajcn.2010.29363

Strings, S. (2015). Obese Black Women as 'Social Dead Weight': Reinventing the 'Diseased Black Woman'. *Signs, 41*(1), 107-130.

Strings, S. (2019). *Fearing the Black Body: The Racial Origins of Fat Phobia*. New York: NYU Press.

Subhan, F. B., Shulman, L., Yuan, Y., McCargar, L. J., Kong, L., Bell, R. C., & Enrich. (2019). Association of pre-pregnancy BMI and gestational weight gain with fat mass distribution and accretion during pregnancy and early postpartum: A prospective study of Albertan women. *BMJ Open, 9*(7). doi:10.1136/bmjopen-2018-026908

Suh, Y., Puhl, R., Liu, S., & Milici, F. (2014). Support for laws to prohibit weight discrimination in the United States: Public attitudes from 2011 to 2013. *Obesity, 22*(8), 1872-1879. doi:10.1002/oby.20750

Swift, J. A., Choi, E., Puhl, R. M., & Glazebrook, C. (2013). Talking about obesity with clients: Preferred terms and communication styles of UK pre-registration dieticians, doctors, and nurses. *Patient Education and Counseling, 91*(2), 186-191. doi:10.1016/j.pec.2012.12.008

Swift, J. A., Pearce, J., Jethwa, P. H., Taylor, M. A., Avery, A., Ellis, S., & McMullen, S. (2016). Antenatal weight management: Women's experiences, behaviours, and expectations of weighing in early pregnancy. *Journal of pregnancy, 2016*, 8454759-8454759. doi:10.1155/2016/8454759

Tanentsapf, I., Heitmann, B. L., & Adegboye, A. R. A. (2011). Systematic review of clinical trials on dietary interventions to prevent excessive weight gain during pregnancy among normal weight, overweight and obese women. *BMC Pregnancy and Childbirth, 11*. doi:10.1186/1471-2393-11-81

Tanvig, M., Vinter, C. A., Jørgensen, J. S., Wehberg, S., Ovesen, P. G., Beck-Nielsen, H., & Jensen, D. M. (2015). Effects of lifestyle intervention in pregnancy and anthropometrics at birth on offspring metabolic profile at 2.8 years: Results from the lifestyle in pregnancy and offspring (LiPO) study. *Journal of Clinical Endocrinology and Metabolism, 100*(1), 175-183. doi:10.1210/jc.20142675

Taylor, J. (2011). The intimate insider: Negotiating the ethics of friendship when doing insider research. *Qualitative Research, 11*(1), 3-22. doi:10.1177/1468794110384447

Tomiyama, A. J. (2014). Weight stigma is stressful. A review of evidence for the Cyclic Obesity/ Weight- Based Stigma model. *Appetite, 82*, 8-15. doi:10.1016/j.appet.2014.06.108

Tomiyama, A. J., Carr, D., Granberg, E. M., Major, B., Robinson, E., Sutin, A. R., & Brewis, A. (2018). How and why weight stigma drives the obesity 'epidemic' and harms health. *BMC Medicine, 16*(1), 123. doi:10.1186/s12916-018-1116-5

Tylka, T. L., Annunziato, R. A., Burgard, D., Danielsdottir, S., Shuman, E., Davis, C., & Calogero, R. M. (2014). The weight-inclusive versus weight-normative approach to health: Evaluating the evidence for prioritizing well-being over weight loss. *Journal of Obesity*.

Tziomalos, K., & Dinas, K. (2018). Obesity and outcome of assisted reproduction in patients with polycystic ovary syndrome. *Frontiers in endocrinology, 9*, 149-149. doi:10.3389/fendo.2018.00149

Vallianatos, H., Brennand, E. A., Raine, K., Stephen, Q., Petawabano, B., Dannenbaum, D., & Willows, N. D. (2006). Beliefs and practices of first nation women about weight gain during pregnancy and lactation: Implications for women's health. *Canadian Journal of Nursing Research, 38*(1), 102-119.

Vanstone, M., Kandasamy, S., Giacomini, M., DeJean, D., & McDonald, S. D. (2017). Pregnant women's perceptions of gestational weight gain: A systematic review and meta-synthesis of qualitative research. *Maternal and Child Nutrition, 13*(4). doi:10.1111/mcn.12374

Vinturache, A. E., Winn, A., & Tough, S. C. (2017). Recall of prenatal counselling among obese and overweight women from a Canadian population: A population based study. *Maternal and Child Health Journal, 21*(11), 2092-2101. doi:10.1007/s10995-017-2324-x

Volger, S., Vetter, M. L., Dougherty, M., Panigrahi, E., Egner, R., Webb, V., & Wadden, T. A. (2012). Patients preferred terms for describing their excess weight: Discussing obesity in clinical practice. *Obesity (Silver Spring, Md.), 20*(1), 147. doi:10.1038/oby.2011.217

Wadden, T., & Didie, E. (2003). What's in a name? Patients preferred terms for describing obesity. *Obesity Research, 11*(9), 1140-1146. doi:10.1038/oby.2003.155

Ward, P., & McPhail, D. (2019). Fat shame and blame in reproductive care: Implications for ethical health care interactions. *Women's Reproductive Health, 6*(4), 225-241. doi:10.1080/23293691.2019.1653581

Warin, M., Zivkovic, T., Moore, V., & Davies, M. (2012). Mothers as smoking guns: Fetal overnutrition and the reproduction of obesity. *Feminism & Psychology, 22*(3), 360-375. doi:10.1177/0959353512445359

Wharton, S., Lau, D. C. W., Vallis, M., Sharma, A. M., Biertho, L., Campbell-Scherer, D., & Wicklum, S. (2020). Obesity in adults: A clinical practice guideline. *Canadian Medical Association Journal, 192*(31), E875. doi:10.1503/cmaj.191707

Whitaker, K. M., Wilcox, S., Liu, J., Blair, S. N., & Pate, R. R. (2016). Patient and provider perceptions of weight gain, physical activity, and nutrition counseling during pregnancy: A qualitative study. *Women's health issues: Official publication of the Jacobs Institute of Women's Health, 26*(1), 116-122. doi:10.1016/j.whi.2015.10.007

Wiggermann, N., Smith, K., & Kumpar, D. (2017). What bed size does a patient need? The relationship between body mass index and space required to turn in Bed. *Nursing research, 66*(6), 483-489. doi:10.1097/NNR.0000000000000242

Williams, D. R., & Cooper, L. A. (2019). Reducing racial inequities in health: Using what we already know to take action. *International journal of environmental research and public health, 16*(4), 606. doi:10.3390/ijerph16040606

Willig, C. (2001). *Introducing qualitative research in psychology adventures in theory and method*. Buckingham [England] Philadelphia: Open University Press.

Yeo, S., Walker, J. S., Caughey, M. C., Ferraro, A. M., & Asafu-Adjei, J. K. (2017). What characteristics of nutrition and physical activity interventions are key to effectively reducing weight gain in obese or overweight pregnant women? A systematic review and meta-analysis. *Obesity Reviews, 18*(4), 385-399. doi:10.1111/obr.12511

Yogev, Y., & Catalano, P. M. (2009). Pregnancy and Obesity. *Obstetrics and Gynecology Clinics of North America, 36*(2), 285-300. doi:10.1016/j.ogc.2009.03.003

Zambrano, E., Ibáñez, C., Martínez-Samayoa, P. M., Lomas-Soria, C., Durand-Carbajal, M., & Rodríguez-González, G. L. (2016). Maternal obesity: Lifelong metabolic outcomes for offspring from poor developmental trajectories during the perinatal period. *Archives of Medical Research, 47*(1), 1-12. doi:10.1016/j.arcmed.2016.01.004

[i] BMI is calculated by dividing weight in kilograms by the square of height in meters (Brown & Mazur, 2019).
[ii] Indeed, one cannot publish in the journal *Fat Studies* without placing quotation marks around the word "obesity."
[iii] Weight stigma is defined as negative social attitudes that may lead to prejudice, stereotyping and unfair treatment of individuals based on their body weight, shape or size (Tomiyama, 2014).
[iv] Ten dietitians were interviewed, and one interview was with both a dietitian and a dietetic intern but their participation was minimal and, therefore, I did not include the data in the analysis. For this reason, I refer to the 10 dietitians throughout this thesis, instead of 10 dietitians and one dietetic intern.
[v] Internalized weight stigma is believing the negative assumptions and stereotypes about fatness about oneself (R. Puhl & Suh, 2015).
[vi] Critical scholars Gingras & Cooper (2012) critique the use of the "Registered Trademark" or "®" for Health at Every Size approach as further feeding into the concept of dualism, something this study aims to break down. Reference: Gingras, J. & Cooper, C. (2012). Down the rabbit hole: A critique of the ® in HAES®. *Journal of Critical Dietetics*, *1*(3), 2-5.)
[vii] Healthy Baby is a program funded by the Province of Manitoba that includes facilitating educational groups that include both prenatal and postnatal mothers (Healthy Baby, 2021).
[viii] Please see the Chapter One: Methods, methodology and ethics, for an in-depth conversation about and rationale for interviewing participants I had known in advance.